SECOND REGULAR SESSION

HOUSE COMMITTEE SUBSTITUTE FOR

SENATE SUBSTITUTE FOR

SENATE BILL NO. 498

97TH GENERAL ASSEMBLY

4428H.06C D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 43.530, 208.631, 208.636, 208.640, 208.643, 208.646, and 376.2004, RSMo, and to enact in lieu thereof ten new sections relating to health insurance, with penalty provisions.

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

Section A. Sections 43.530, 208.631, 208.636, 208.640, 208.643, 208.646, and 376.2004, RSMo, are repealed and ten new sections enacted in lieu thereof, to be known as sections 43.530, 208.631, 208.636, 208.640, 208.643, 208.646, 208.662, 376.685, 376.998, and 376.2004, to read as follows:

43.530. 1. For each request requiring the payment of a fee received by the central repository, the requesting entity shall pay a fee of not more than nine dollars per request for criminal history record information not based on a fingerprint search. In each year beginning on or after January 1, 2010, the superintendent may increase the fee paid by requesting entities by an amount not to exceed one dollar per year, however, under no circumstance shall the fee paid by requesting entities exceed fifteen dollars per request.

2. For each request requiring the payment of a fee received by the central repository, the requesting entity shall pay a fee of not more than twenty dollars per request for criminal history record information based on a fingerprint search, unless the request is required under the provisions of subdivision (6) of section 210.481, section 210.487, **subsection 6 of section 376.2004,** or section 571.101, in which case the fee shall be fourteen dollars.

3. A request made under subsections 1 and 2 of this section shall be limited to check and search on one individual. Each request shall be accompanied by a check, warrant, voucher, money order, or electronic payment payable to the state of Missouri-criminal record system or

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.

payment shall be made in a manner approved by the highway patrol. The highway patrol may establish procedures for receiving requests for criminal history record information for classification and search for fingerprints, from courts and other entities, and for the payment of such requests. There is hereby established by the treasurer of the state of Missouri a fund to be entitled as the "Criminal Record System Fund". Notwithstanding the provisions of section 33.080 to the contrary, if the moneys collected and deposited into this fund are not totally expended annually for the purposes set forth in sections 43.500 to 43.543, the unexpended moneys in such fund shall remain in the fund and the balance shall be kept in the fund to accumulate from year to year.

208.631. 1. Notwithstanding any other provision of law to the contrary, the MO HealthNet division shall establish a program to pay for health care for uninsured children. Coverage pursuant to sections 208.631 to **[**208.659**]** **208.658** is subject to appropriation. The provisions of sections 208.631 to **[**208.569**]** **208.658**, health care for uninsured children, shall be void and of no effect if there are no funds of the United States appropriated by Congress to be provided to the state on the basis of a state plan approved by the federal government under the federal Social Security Act. If funds are appropriated by the United States Congress, the department of social services is authorized to manage the state children's health insurance program (SCHIP) allotment in order to ensure that the state receives maximum federal financial participation. Children in households with incomes up to one hundred fifty percent of the federal poverty level may meet all Title XIX program guidelines as required by the Centers for Medicare and Medicaid Services. Children in households with incomes of one hundred fifty percent to three hundred percent of the federal poverty level shall continue to be eligible as they were and receive services as they did on June 30, 2007, unless changed by the Missouri general assembly.

2. For the purposes of sections 208.631 to **[**208.659**]** **208.658**, "children" are persons up to nineteen years of age. "Uninsured children" are persons up to nineteen years of age who are emancipated and do not have access to affordable employer-subsidized health care insurance or other health care coverage or persons whose parent or guardian have not had access to affordable employer-subsidized health care insurance or other health care coverage for their children **[**for six months**]** prior to application, are residents of the state of Missouri, and have parents or guardians who meet the requirements in section 208.636. A child who is eligible for MO HealthNet benefits as authorized in section 208.151 is not uninsured for the purposes of sections 208.631 to **[**208.659**]** **208.658**.

208.636. Parents and guardians of uninsured children eligible for the program established in sections 208.631 to **[**208.657**]** **208.658** shall:

(1) Furnish to the department of social services the uninsured child's Social Security number or numbers, if the uninsured child has more than one such number;

(2) Cooperate with the department of social services in identifying and providing information to assist the state in pursuing any third-party insurance carrier who may be liable to pay for health care;

(3) Cooperate with the department of social services, division of child support enforcement in establishing paternity and in obtaining support payments, including medical support; **and**

(4) Demonstrate upon request their child's participation in wellness programs including immunizations and a periodic physical examination. This subdivision shall not apply to any child whose parent or legal guardian objects in writing to such wellness programs including immunizations and an annual physical examination because of religious beliefs or medical contraindications**[**; and

(5) Demonstrate annually that their total net worth does not exceed two hundred fifty thousand dollars in total value**]**.

208.640. 1. Parents and guardians of uninsured children with incomes of more than one hundred fifty but less than three hundred percent of the federal poverty level who do not have access to affordable employer-sponsored health care insurance or other affordable health care coverage may obtain coverage for their children under this section. Health insurance plans that do not cover an eligible child's preexisting condition shall not be considered affordable employer-sponsored health care insurance or other affordable health care coverage. For the purposes of sections 208.631 to **[**208.659**]** **208.658**, "affordable employer-sponsored health care insurance or other affordable health care coverage" refers to health insurance requiring a monthly premium of:

(1) Three percent of one hundred fifty percent of the federal poverty level for a family of three for families with a gross income of more than one hundred fifty and up to one hundred eighty-five percent of the federal poverty level for a family of three;

(2) Four percent of one hundred eighty-five percent of the federal poverty level for a family of three for a family with a gross income of more than one hundred eighty-five and up to two hundred twenty-five percent of the federal poverty level;

(3) Five percent of two hundred twenty-five percent of the federal poverty level for a family of three for a family with a gross income of more than two hundred twenty-five but less than three hundred percent of the federal poverty level.

The parents and guardians of eligible uninsured children pursuant to this section are responsible for a monthly premium as required by annual state appropriation; provided that the total aggregate cost sharing for a family covered by these sections shall not exceed five percent of such family's income for the years involved. No co-payments or other cost sharing is permitted

with respect to benefits for well-baby and well-child care including age-appropriate immunizations. Cost-sharing provisions for their children under sections 208.631 to **[**208.659**]** **208.658** shall not exceed the limits established by 42 U.S.C. Section 1397cc(e). If a child has exceeded the annual coverage limits for all health care services, the child is not considered insured and does not have access to affordable health insurance within the meaning of this section.

2. The department of social services shall study the expansion of a presumptive eligibility process for children for medical assistance benefits.

208.643. 1. The department of social services shall implement policies establishing a program to pay for health care for uninsured children by rules promulgated pursuant to chapter 536, either statewide or in certain geographic areas, subject to obtaining necessary federal approval and appropriation authority. The rules may provide for a health care services package that includes all medical services covered by section 208.152, except nonemergency transportation.

2. Available income shall be determined by the department of social services by rule, which shall comply with federal laws and regulations relating to the state's eligibility to receive federal funds to implement the insurance program established in sections 208.631 to **[**208.657**]** **208.658**.

208.646. There shall be a thirty-day waiting period after enrollment for uninsured children in families with an income of more than two hundred twenty-five percent of the federal poverty level before the child becomes eligible for insurance under the provisions of sections 208.631 to **[**208.660**]** **208.658**. If the parent or guardian with an income of more than two hundred twenty-five percent of the federal poverty level fails to meet the co-payment or premium requirements, the child shall not be eligible for coverage under sections 208.631 to **[**208.660**]** **208.658** for **[**six months**]** **ninety days** after the department provides notice of such failure to the parent or guardian.

208.662. 1. There is hereby established within the department of social services the "Show-Me Healthy Babies Program" as a separate children's health insurance program (CHIP) for any low-income unborn child. The program shall 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.

2. For an unborn child to be enrolled in the show-me healthy babies program, his or her mother shall not be eligible for coverage under Title XIX of the federal Social Security Act, the Medicaid program, as it is administered by the state, and shall not have access to affordable employer-subsidized health care insurance or other affordable health care coverage that includes coverage for the unborn child. In addition, the unborn child

shall be in a family with income eligibility of no more than three hundred percent of the federal poverty level, or the equivalent modified adjusted gross income, unless the income eligibility is set lower by the general assembly through appropriations. In calculating family size as it relates to income eligibility, the family shall include, in addition to other family members, the unborn child, or in the case of a mother with a multiple pregnancy, all unborn children.

3. Coverage for an unborn child enrolled in the show-me healthy babies program shall include all prenatal care and pregnancy-related services that benefit the health of the unborn child and that promote healthy labor, delivery, and birth. Coverage need not include services that are solely for the benefit of the pregnant mother, that are unrelated to maintaining or promoting a healthy pregnancy, and that provide no benefit to the unborn child. However, the department may include pregnancy-related assistance as defined in 42 U.S.C. 1397ll.

4. There shall be no waiting period before an unborn child may be enrolled in the show-me healthy babies program. In accordance with the definition of child in 42 CFR 457.10, coverage shall include the period from conception to birth. The department shall develop a presumptive eligibility procedure for enrolling an unborn child. There shall be verification of the pregnancy.

5. Coverage for the child shall continue for up to one year after birth, unless otherwise prohibited by law or unless otherwise limited by the general assembly through appropriations.

6. Pregnancy-related and postpartum coverage for the mother shall 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 unless otherwise limited by the general assembly through appropriations. The department may include pregnancy-related assistance as defined in 42 U.S.C. 1397ll.

7. The department may provide coverage for an unborn child enrolled in the show-me healthy babies program through:

(1) Direct coverage whereby the state pays health care providers directly or by contracting with a managed care organization or with a group or individual health insurance provider;

(2) A premium assistance program whereby the state assists in payment of the premiums, co-payments, coinsurance, or deductibles for a person who is eligible for health coverage through an employer, former employer, labor union, credit union, church, spouse, other organizations, other individuals, or through an individual health insurance

policy that includes coverage for the unborn child, when such person needs assistance in paying such premiums, co-payments, coinsurance, or deductibles;

(3) A combination of direct coverage, such as when the unborn child is first enrolled, and premium assistance, such as after the child is born; or

(4) Any other similar arrangement whereby there:

(a) Are lower program costs without sacrificing health care coverage for the unborn child or the child up to one year after birth;

(b) Are greater covered services for the unborn child or the child up to one year after birth;

(c) Is also coverage for siblings or other family members, including the unborn child's mother, such as by providing pregnancy-related assistance under 42 U.S.C. 1397ll, relating to coverage of targeted low-income pregnant women through the children's health insurance program (CHIP); or

(d) Will be an ability for the child to transition more easily to non-government or less government-subsidized group or individual health insurance coverage after the child is no longer enrolled in the show-me healthy babies program.

8. The department shall provide information about the show-me healthy babies program to maternity homes as defined in section 135.600, pregnancy resource centers as defined in section 135.630, and other similar agencies and programs in the state that assist unborn children and their mothers. The department shall consider allowing such agencies and programs to assist in the enrollment of unborn children in the program, and in making determinations about presumptive eligibility and verification of the pregnancy.

9. Within sixty days after the effective date of this section, the department shall submit a state plan amendment or seek any necessary waivers from the federal Department of Health and Human Services requesting approval for the show-me healthy babies program.

10. At least annually, the department shall prepare and submit a report to the governor, the speaker of the house of representatives, and the president pro tempore of the senate analyzing and projecting the cost savings and benefits, if any, to the state, counties, local communities, school districts, law enforcement agencies, correctional centers, health care providers, employers, other public and private entities, and persons by enrolling unborn children in the show-me healthy babies program. The analysis and projection of cost savings and benefits, if any, may include but need not be limited to:

(1) The higher federal matching rate for having an unborn child enrolled in the show-me healthy babies program versus the lower federal matching rate for a pregnant woman being enrolled in MO HealthNet or other federal programs;

(2) The efficacy in providing services to unborn children through managed care organizations, group or individual health insurance providers or premium assistance, or through other nontraditional arrangements of providing health care;

(3) The change in the proportion of unborn children who receive care in the first trimester of pregnancy due to a lack of waiting periods, by allowing presumptive eligibility, or by removal of other barriers, and any resulting or projected decrease in health problems and other problems for unborn children and women throughout pregnancy; at labor, delivery, and birth; and during infancy and childhood;

(4) The change in healthy behaviors by pregnant women, such as the cessation of the use of tobacco, alcohol, illicit drugs, or other harmful practices, and any resulting or projected short-term and long-term decrease in birth defects; poor motor skills; vision, speech, and hearing problems; breathing and respiratory problems; feeding and digestive problems; and other physical, mental, educational, and behavioral problems; and

(5) The change in infant and maternal mortality, pre-term births and low birth weight babies and any resulting or projected decrease in short-term and long-term medical and other interventions.

11. The show-me healthy babies program shall not be deemed an entitlement program, but instead shall be subject to a federal allotment or other federal appropriations and matching state appropriations.

12. Nothing in this section shall be construed as obligating the state to continue the show-me healthy babies 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.

13. Nothing in this section shall be construed as expanding MO HealthNet or fulfilling a mandate imposed by the federal government on the state.

376.685. 1. No agreement between a health carrier or other insurer that writes vision insurance and an optometrist for the provision of vision services on a preferred or in-network basis to plan members or insurance subscribers in connection with coverage under a stand-alone vision plan, medical plan, health benefit plan, or health insurance policy shall require that an optometrist provide optometric or ophthalmic services or materials at a fee limited or set by the plan or health carrier unless the services or materials are reimbursed as covered services under the contract.

2. No provider shall charge more for services or materials that are not covered under a health benefit or vision plan than his or her usual and customary rate for those services or materials.

3. No amount of a contractual discount shall result in a fee less than the health benefit or vision plan would pay for covered services or materials but for the application of an enrollee's contractual limitations of deductibles, co-payments, coinsurance, waiting periods, annual or lifetime maximums, alternative benefit payments, or frequency limitations.

4. Reimbursement paid by the health benefit or vision plan for covered services or materials shall be reasonable and shall not provide nominal reimbursement in order to claim that services or materials are covered services. No health carrier shall provide de minimis reimbursement or coverage in an effort to avoid the requirements of this section.

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

(1) "Covered services", optometric or ophthalmic services or materials for which reimbursement from the health benefit or vision plan is provided for by an enrollee's plan contract, or for which a reimbursement would be available but for the application of the enrollee's contractual limitations of deductibles, co-payments, coinsurance, waiting periods, annual or lifetime maximums, alternative benefit payments, 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) "Materials", includes, but is not limited to, lenses, frames, devices containing lenses, prisms, lens treatment and coatings, contact lenses, orthoptics, vision training devices, and prosthetic devices to correct, relieve, or treat defects or abnormal conditions of the human eye or its adnexa;

(5) "Optometric services", any services within the scope of optometric practice under chapter 336;

(6) "Vision plan", any policy, contract of insurance, or discount plan issued by a health carrier, health benefit plan, or company which provides coverage or a discount for optometric or ophthalmic services or materials.

376.998. 1. Any health insurance mandate that is applicable to health benefit plans written by a health carrier, as both terms are defined in section 376.1350, shall not apply to excepted benefit plans, as defined in section 376.450. For purposes of the exemption under this section, a "health insurance mandate" means a state requirement for a health carrier to offer or provide coverage for:

(1) A treatment by a particular type of health care provider;

(2) A certain treatment or service, including procedures, medical equipment, or drugs that are used in connection with a treatment or service; and

(3) Screening, diagnosis, or treatment of a particular disease or condition.

2. All excepted benefit plans issued on or after January 1, 2015, shall include a disclaimer printed in no less than twelve-point font on the front of the policy, certificate, application and enrollment form, and all advertising materials which states: "NOTICE TO CONSUMER: THIS PLAN IS NOT CONSIDERED "MINIMUM ESSENTIAL COVERAGE" AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE. THIS PLAN HAS LIMITS AND EXCLUSIONS AND MAY NOT COVER ALL HEALTH BENEFITS OR SERVICES.".

3. If plan identification cards are issued to enrollees, as defined in section 376.1350, of excepted benefit plans, the cards shall clearly and conspicuously state on the front of the card: "THIS IS NOT MINIMUM ESSENTIAL COVERAGE.".

4. This section applies to all insurers that provide coverage to residents of this state which is issued or renewed on or after January 1, 2015.

376.2004. 1. An individual applying for a navigator license shall make application to the department on a form developed by the director and declare under penalty of refusal, suspension, or revocation of the license that the statements made in the application are true, correct, and complete to the best of the individual's knowledge and belief. Before approving the application, the director shall find that the individual:

(1) Is eighteen years of age or older;

(2) Resides in this state or maintains his or her principal place of business in the state;

(3) Is not disqualified for having committed any act that would be grounds for refusal to issue, renew, suspend, or revoke an insurance producer license under section 375.141;

(4) Has successfully passed the written examination **[**prescribed**]** **created and administered** by the director**. The department may contract with an independent testing service to administer the examination. An individual shall not satisfy the examination requirement by demonstrating achievement of a passing score on any approved certification examination that allows the individual to perform the duties identified in Title 42, U.S.C. Section 18031(i) or related duties, irrespective of whether the examination is for purposes of serving as a navigator, certified application counselor, in-person assister, or health center outreach and enrollment assistance worker in lieu of an examination administered by the department**;

(5) When applicable, has the written consent of the director under 18 U.S.C. 1033 or any successor statute regulating crimes by or affecting persons engaged in the business of insurance whose activities affect interstate commerce;

(6) Has identified the entity with which he or she is affiliated and supervised; and

(7) Has paid the fees prescribed by the director.

2. An entity that acts as a navigator, supervises the activities of individual navigators, or receives funding to perform such activities shall obtain a navigator entity license. An entity applying for an entity navigator license shall make application on a form containing the information prescribed by the director.

3. The director may require any documents deemed necessary to verify the information contained in an application submitted in accordance with subsections 1 and 2 of this section.

4. Entities licensed as navigators shall, in a manner prescribed by the director, provide a list of all individual navigators that are employed by or in any manner affiliated with the navigator entity and shall report any changes in employment or affiliation within twenty days of such change.

5. Prior to any exchange becoming operational in this state, the director shall prescribe initial training, continuing education, and written examination standards and requirements for navigators.

6. Each applicant for licensure as an individual navigator shall provide two sets of fingerprints to the department for the purpose of completing a criminal background check as a condition of being granted a license to act as a navigator. The department shall use the fingerprints to conduct a Missouri criminal record review of the applicant and a national criminal record review of the applicant with the Federal Bureau of Investigation as defined in section 43.540.

7. Any criminal history information received by the department pursuant to the provisions of this section shall be used solely for the internal purposes of the department in determining eligibility for the individual navigator license. The dissemination of criminal history information from the Federal Bureau of Investigation beyond the authorized or related governmental entity is prohibited. All criminal record check information shall be confidential and any person who discloses the information beyond the scope allowed is guilty of a class A misdemeanor.

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