FIRST REGULAR SESSION

HOUSE COMMITTEE SUBSTITUTE FOR

HOUSE BILL NO. 497

95TH GENERAL ASSEMBLY

1260L.08C D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 376.960, 376.966, and 376.986, RSMo, and to enact in lieu thereof twenty-one new sections relating to transparency of health care information, the Missouri health insurance pool, and patient privacy, with a penalty provision and an effective date for certain sections.

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

Section A. Sections 376.960, 376.966, and 376.986, RSMo, are repealed and twenty-one new sections enacted in lieu thereof, to be known as sections 191.015, 191.1005, 191.1008, 191.1010, 197.550, 197.553, 197.556, 197.559, 197.562, 197.565, 197.568, 197.571, 197.574, 197.577, 197.580, 197.586, 376.960, 376.966, 376.986, 376.988, and 376.1373, to read as follows:

191.015. 1. This section shall be known and may be cited as the "Missouri Patient Privacy Act".

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

(1) "Disease state management programs", delivery of services for patients with chronic illness, including education, health management support, and coordination of health care services;

(2) "Health care provider", any corporation organized for the primary purpose of maintaining medical information for treatment or diagnosis, or to allow an individual to manage his or her information, including but not limited to a physician, hospital, health maintenance organization, ambulatory surgical center, long-term care facility including facilities licensed under chapter 198, RSMo, dentist, registered or licensed practical nurse, optometrist, podiatrist, pharmacist, chiropractor, professional physical therapist,

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.

psychologist, physician in training, or any other person or entity that provides health care services under the authority of a license or certificate;

(3) "Personal health information", any identifiable information, in electronic or physical form, regarding an individual's health, medical history, medical treatment, or diagnosis by a health care provider that is:

(a) Created or stored by the health care provider or health carrier in the normal course of its business operations; and

(b) Not otherwise publicly available or in the public domain.

3. No personal health information of a patient which can be identified as specific to such patient shall be disclosed to any employer, public or private payor, or employee or agent of a state department or agency without the written consent of the patient and health care provider; except that, such information may be disclosed to a health insurer, employer, state employee or agent of the Missouri consolidated health care plan, the department of health and senior services, the department of insurance, financial institutions and professional registration, or the MO HealthNet division within the department of social services in connection with the performance of such employee's official duties. Such official duties shall be for purposes allowed under 45 CFR 164.512, as amended, including but not limited to:

(1) Oversight of state health programs, including disease state management programs;

(2) Tracking of infectious or communicable diseases throughout the state;

(3) State wellness initiatives and programs; and

(4) Research state medical trends.

4. Nothing in this section shall be construed as prohibiting disclosure of personal health information of a patient consistent with federal law, including the federal Health Insurance Portability and Accountability Act (HIPAA) and the privacy rules set forth in this section.

5. No health care provider shall be required to redact information when disclosing personal health information under this section.

191.1005. 1. For purposes of this section, the following terms shall mean:

(1) "Estimate of cost", an estimate given prior to the provision of medical services which is based on specific patient information or general assumptions about typical utilization and costs for medical services. Upon written request by a patient, a provider or insurer shall be required to provide the patient a timely estimate of cost for any elective or nonemergent health care service. Such requirement shall not apply to emergency health care services or any provider documenting to consumers the cost of the provider's twenty

most common charges electronically or in paper format, or to any referral services that the provider does not provide directly to a patient. Any estimate of cost may include a disclaimer noting the actual amount billed may be different from the estimate of cost. An estimate of cost shall not be deemed an authorization for the provision of services;

(2) "Insurer", the same meaning as the term "health carrier" is defined in section 376.1350, RSMo, and includes the state of Missouri for purposes of the rendering of health care services by providers under a medical assistance program of the state.

2. Programs of insurers that publicly assess and compare the quality and cost efficiency of health care providers shall conform to the following criteria:

(1) The insurers shall retain, at their own expense, the services of a nationally-recognized independent health care quality standard-setting organization to review the plan's programs for consumers that measure, report, and tier providers based on their performance. Such review shall include a comparison to national standards and a report detailing the measures and methodologies used by the health plan. The scope of the review shall encompass all elements described in this section and section 191.1008;

(2) The program measures shall provide performance information that reflects consumers' health needs. Programs shall clearly describe the extent to which they encompass particular areas of care, including primary care and other areas of specialty care;

(3) Performance reporting for consumers shall include both quality and cost efficiency information. While quality information may be reported in the absence of cost-efficiency, cost-efficiency information shall not be reported without accompanying quality information;

(4) When any individual measures or groups of measures are combined, the individual scores, proportionate weighting, and any other formula used to develop composite scores shall be disclosed. Such disclosure shall be done both when quality measures are combined and when quality and cost efficiency are combined;

(5) Consumers or consumer organizations shall be solicited to provide input on the program, including methods used to determine performance strata;

(6) A clearly defined process for receiving and resolving consumer complaints shall be a component of any program;

(7) Performance information presented to consumers shall include context, discussion of data limitations, and guidance on how to consider other factors in choosing a provider;

(8) Relevant providers and provider organizations shall be solicited to provide input on the program, including the methods used to determine performance strata;

(9) Providers shall be given reasonable prior notice before their individual performance information is publicly released;

(10) A clearly defined process for providers to request review of their own performance results and the opportunity to present information that supports what they believe to be inaccurate results, within a reasonable time frame, shall be a component of any program. Results determined to be inaccurate after the reconsideration process shall be corrected;

(11) Information about the comparative performance of providers shall be accessible and understandable to consumers and providers;

(12) Information about factors that might limit the usefulness of results shall be publicly disclosed;

(13) Measures used to assess provider performance and the methodology used to calculate scores or determine rankings shall be published and made readily available to the public. Elements shall be assessed against national standards as defined in subdivisions (17) and (18) of this subsection. Examples of measurement elements that shall be assessed against national standards include: risk and severity adjustment, minimum observations, and statistical standards utilized. Examples of other measurement elements that shall be fully disclosed include: data used, how providers' patients are identified, measure specifications and methodologies, known limitations of the data, and how episodes are defined;

(14) The rationale and methodologies supporting the unit of analysis reported shall be clearly articulated, including a group practice model versus the individual provider;

(15) Sponsors of provider measurement and reporting shall work collaboratively to aggregate data whenever feasible to enhance its consistency, accuracy, and use. Sponsors of provider measurement and reporting shall also work collaboratively to align and harmonize measures used to promote consistency and reduce the burden of collection. The nature and scope of such efforts shall be publicly reported;

(16) The program shall be regularly evaluated to assess its effectiveness, accuracy, reliability, validity, and any unintended consequences, including any effect on access to health care;

(17) Measures shall be based on national standards. The primary source shall be measures endorsed by the National Quality Forum (NQF). When nonNQF measures are used because NQF measures do not exist or are unduly burdensome, it shall be with the understanding that they will be replaced by comparable NQF-endorsed measures when available;

(18) Where NQF-endorsed measures do not exist, the next level of measures to be considered, to the extent practical, shall be those endorsed by the Ambulatory Care Quality Alliance, national accrediting organizations such as the National Committee for Quality Assurance, or the Joint Commission on the Accreditation of Healthcare Organizations, Healthcare Effectiveness and Data Information Set (HEDIS), other national provider specialty organizations, or federal agencies;

(19) The public, including consumers and employers, has a right to obtain reliable and valid information to assist them in comparing the cost and quality of health care services and health care providers. For such purpose, health carriers shall have the ability to use reliable data which is collected from medical claims, health care providers, medical records review or other sources, including the federal Centers for Medicare and Medicaid Services (CMS) and other entities for such purpose. Health carriers and health care providers are prohibited from entering into new contracts or amending existing contracts that limit the use of medical claims data to payment of claims or otherwise preclude health carriers from responding to the public's need for comparative cost, quality, and efficiency information, or other performance information, on health care services and health care providers. Health carriers may use claims and contracted rate data to report on cost, quality, and efficiency consistent with the patient charter or other nationally recognized standards, such as those issued by the National Committee for Quality Assurance. No health carrier or any other entity shall use such information in a manner that violates any state or federal law, including antitrust law; and

(20) A health plan shall be deemed compliant with this section if the health plan receives certification from the National Committee for Quality Assurance (NCQA) on programs that evaluate the quality of physicians and hospitals. The health plan is deemed to be in compliance for the length of time the NCQA certification has been granted or awarded.

191.1008. 1. Any person who sells or otherwise distributes to the public health care quality and cost efficiency data for disclosure in comparative format to the public shall identify the measure source or evidence-based science behind the measure and the national consensus, multi-stakeholder, or other peer review process, if any, used to confirm the validity of the data and its analysis as an objective indicator of health care quality.

2. Articles or research studies on the topic of health care quality or cost efficiency that are published in peer-reviewed academic journals that neither receive funding from nor are affiliated with a health care insurer or by state or local government shall be exempt from the requirements of subsection 1 of this section.

3. (1) Upon receipt of a complaint of an alleged violation of this section by a person or entity other than a health carrier, the department of health and senior services shall investigate the complaint and, upon finding that a violation has occurred, shall be authorized to impose a penalty in an amount not to exceed one thousand dollars. The department shall promulgate rules governing its processes for conducting such investigations and levying fines authorized by law.

(2) Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, 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, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, 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, 2009, shall be invalid and void.

191.1010. All alleged violations of sections 191.1005 to 191.1008 by a health insurer shall be investigated and enforced by the department of insurance, financial institutions and professional registration under the department's powers and responsibilities to enforce the insurance laws of this state in accordance with chapter 374, RSMo.

197.550. As used in sections 197.550 to 197.586, the following terms shall mean:

(1) "Identifiable information", information that is presented in a form or manner that allows the identification of any provider, patient, or reporter of patient safety work product. With respect to patients, such information includes any individually identifiable health information, as defined in federal regulations promulgated under Section 264(c) of the Health Insurance Portability and Accountability Act of 1996, as amended;

(2) "Nonidentifiable information", information that is presented in a form and manner that prevents the identification of any provider, patient, or reporter of patient safety work product. With respect to patients, such information shall be de-identified consistent with the federal regulations promulgated under Section 264(c) of the Health Insurance Portability and Accountability Act of 1996, as amended;

(3) "Patient safety organization", any entity which:

(a) Is organized as an independent nonprofit corporation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, and applicable state law governing nonprofit corporations;

(b) Meets the statutory and regulatory criteria for certification as a patient safety organization under the federal Patient Safety and Quality Improvement Act of 2005, 42 U.S.C. Section 299b-21, et seq., as amended, and regulations promulgated thereunder;

(c) Has a governing board or advisory committee that includes representatives of hospitals, physicians, an employer or group representing employers, an insurance company or group representing insurance companies, the long-term care industry, and a federally-recognized quality improvement organization that contracts with the federal government to review medical necessity and quality assurance in the Medicare program;

(d) Conducts, as the organization's primary activity, efforts to improve patient safety and the quality of health care delivery;

(e) Collects and analyzes patient safety work product that is submitted by providers;

(f) Develops and disseminates evidence-based information to providers with respect to improving patient safety, such as recommendations, protocols, or information regarding best practices;

(g) Utilizes patient safety work product to carry out activities limited to those described under this section and for the purposes of encouraging a culture of safety and of providing direct feedback and assistance to providers to effectively minimize patient risk;

(h) Maintains confidentiality with respect to identifiable information under federal and state law and regulations;

(i) Implements appropriate security measures with respect to patient safety work product;

(j) Submits, if authorized by its governing board and certified by federal law and regulation, nonidentifiable information to a national patient safety database;

(k) Provides technical support to health care providers in the collection, submission, and analysis of data and patient safety activities as described in sections 197.553 and 197.562;

(4) "Patient safety work product", the same meaning as such term is defined in federal regulations promulgated to implement the federal Patient Safety and Quality Improvement Act of 2005, 42 U.S.C. Section 299b-21, et seq., as amended;

(5) "Provider", the same meaning as such term is defined in federal regulations promulgated to implement the federal Patient Safety and Quality Improvement Act of 2005, 42 U.S.C. Section 299b-21, et seq., as amended;

(6) "Reportable incident", an occurrence of a serious reportable event in health care as such event is defined in this section;

(7) "Reportable incident prevention plan", a written plan that:

(a) Defines, based on a root cause analysis, specific changes in organizational policies and procedures designed to reduce the risk of similar incidents occurring in the future or that provides a rationale that no such changes are warranted;

(b) Sets deadlines for the implementation of such changes;

(c) Establishes who is responsible for making the changes; and

(d) Provides a mechanism for evaluating the effectiveness of such changes;

(8) "Root cause analysis", a structure process for identifying basic or causal factors that underlie variation in performance, including but not limited to the occurrence or possible occurrence of a reportable incident. A root cause analysis focuses primarily on systems and processes rather than individual performance and progresses from special causes in clinical processes to common causes in organization processes and identifies potential improvements in processes or systems that would tend to decrease the likelihood of such events in the future, or determines after analysis that no such improvement opportunities exists;

(9) "Serious reportable event in health care", an occurrence of one or more of the actions or outcomes included in the list of serious adverse events in health care as initially defined by the National Quality Forum in its March 2002 report and subsequently updated by the National Quality Forum, including all criteria established for identifying such events.

197.553. 1. Beginning January 1, 2010, a hospital shall report each reportable incident to a federally-designated patient safety organization, as defined by the federal Patient Safety and Quality Improvement Act of 2005, as amended. The hospital's initial report of the incident shall be submitted to the patient safety organization no later than the close of business on the next business day following discovery of the incident. The initial report shall include a description of immediate actions to be taken by the hospital to minimize the risk of harm to patients and prevent a reoccurrence and verification that the hospital's patient safety and performance improvement review processes are responding to the reportable incident. The hospital shall, within forty-five days after the incident is discovered, submit a completed root cause analysis and a reportable incident prevention plan to the patient safety organization.

2. Upon request of the hospital, a patient safety organization may provide technical assistance in the development of a root cause analysis or reportable incident prevention plan relating to a reportable incident. If the patient safety organization finds the initial report, root cause analysis, or reportable incident prevention plan to be insufficient, the hospital shall have two attempts to correct. If such attempts are unsuccessful, the hospital shall conduct the process with the department of health and senior services, as permitted

by the federal Patient Safety and Quality Improvement Act of 2005. If a hospital chooses not to provide an initial report, root cause analysis, or reportable incident prevention plan to a federally-designated patient safety organization within the specified time frames, the hospital shall submit all three elements to the department of health and senior services, as permitted by the federal Patient Safety and Quality Improvement Act of 2005.

3. All hospitals shall establish a policy whereby the patient or the patient's legally authorized representative is notified of the occurrence of a serious reportable event in health care. Such notification shall be provided not later than one business day after the hospital or its agent becomes aware of the occurrence. The time, date, participants, and content of the notification shall be documented in the patient's medical record. The provision of notice to a patient under this section shall not, in any action or proceeding, be considered an acknowledgment or admission of liability.

197.556. Under paragraphs (f) and (g) of subdivision (3) of section 197.550 and 42 U.S.C. Section 299b-21, et seq., the patient safety organization shall assess the information provided regarding the reportable incident and furnish the hospital with a report of its findings and recommendations as to how to prevent future incidents.

197.559. 1. The provisions of sections 197.550 to 197.586 shall not be construed to:

(1) Restrict the availability of information gleaned from original sources;

(2) Limit the disclosure or use of information from original sources regarding a reportable incident to:

(a) State or federal agencies or law enforcement under law or regulation; or

(b) Health care facility accreditation agencies.

2. Nothing in sections 197.550 to 197.586 shall modify the duty of a hospital to report disciplinary actions or medical malpractice actions against a health care professional under law.

197.562. As permitted by the Patient Safety and Quality Improvement Act of 2005, the department of health and senior services shall publish an annual report to the public on reportable incidents. The first report and each subsequent annual report shall include twelve months of reported data and shall be published not more than fifteen months after the date data collection begins. The first report and each subsequent annual report shall indicate the number of reportable events by the then current National Quality Forum category of reportable incident and rate per patient encounter by region and by category of reportable incident, and by facility as such categories are established by the National Quality Forum in defining reportable incidents, and may identify reportable incidents by type of facility. The report for the previous year shall be made public no later than April thirtieth. To provide the department with this data, hospitals shall report errors quarterly

to the department. Such reports shall include the type of error, rate of error, whether death or serious disability occurred, and whether a root cause analysis and a reportable incident prevention plan have been submitted to the patient safety organization. The department shall determine when a frequency or pattern of harm necessitates further action.

197.565. No person shall disclose the actions, decisions, proceedings, discussions, or deliberations occurring at a meeting of a patient safety organization except to the extent necessary to carry out one or more of the purposes of a patient safety organization. A meeting of the patient safety organization shall include:

(1) Any meetings of:

(a) The patient safety organization;

(b) The organization's staff;

(c) The organization's governing body;

(d) Any and all committees, work groups, and task forces of the organization, whether or not formally appointed by the governing body;

(e) The organization's president and chairperson; and

(2) Any meeting in any setting in which patient safety work product is discussed in the normal course of carrying out business of the patient organization.

The proceedings and records of a patient safety organization shall not be subject to discovery or introduction into evidence in any civil action against a provider arising out of the matter or matters that are the subject of consideration by a patient safety organization. Information, documents, or records otherwise available from original sources shall not be immune from discovery or use in any civil action merely because they were presented during proceedings of a patient safety organization. The provisions of this section shall not be construed to prevent a person from testifying to or reporting information obtained independently of the activities of a patient safety organization or which is public information.

197.568. Patient safety work product shall be privileged and confidential under the federal Patient Safety and Quality Improvement Act of 2005, 42 U.S.C. Section 299b-21, et seq., as amended, and regulations promulgated thereunder.

197.571. 1. Any reference to or offer into evidence in the presence of the jury or other fact finder or admission into evidence of patient safety work product during any proceeding that is contrary to sections 197.550 to 197.586 shall constitute grounds for a mistrial or a similar termination of the proceeding and reversible error on appeal from any

judgment or order entered in favor of any party who so discloses or offers into evidence patient safety work product.

2. The prohibition against discovery, disclosure, or admission into evidence of patient safety work product is in addition to any other protections provided by law.

197.574. A patient safety organization may disclose nonidentifiable information and nonidentifiable aggregate trend data identifying the number and types of patient safety events that occur. A patient safety organization shall publish educational and evidence-based information from the summary reports that can be used by all providers to improve the care provided.

197.577. 1. The confidentiality of patient safety work product shall in no way be impaired or otherwise adversely affected solely by reason of the submission of the same to a patient safety organization. The confidentiality of patient safety work product submitted in compliance with sections 197.550 to 197.586 to a patient safety organization shall not be adversely affected if the entity later ceases to meet the statutory definition of a patient safety organization.

2. The exchange or disclosure of patient safety work product by a patient safety organization shall not constitute a waiver of confidentiality or privilege by the health care provider who submitted the data.

197.580. Any provider furnishing services to a patient safety organization shall not be liable for civil damages as a result of such acts, omissions, decisions, or other such conduct in connection with the lawful duties on behalf of a patient safety organization, except for acts, omissions, decisions, or conduct done with actual malice, fraudulent intent, or bad faith.

197.586. 1. Beginning January 1, 2010, any hospital that reports a reportable incident shall not charge for or bill any entity, including third-party payors and patients, for all services related to the reportable incident. If a third-party payor denies a claim, in whole or in part, because there is no coverage for services that resulted in any of the reportable incidents described in sections 197.550 to 197.586, the health care professional or facility that provided such services is prohibited from billing the patient for such services.

2. For purposes of this section, "third-party payor" means a health carrier as defined in section 376.1350, RSMo, an organization entered into a preferred provider agreement, and a third-party administrator for a self-funded health benefit plan.

376.960. As used in sections 376.960 to 376.989, the following terms mean:

(1) "Benefit plan", the coverages to be offered by the pool to eligible persons pursuant to the provisions of section 376.986;

(2) "Board", the board of directors of the pool;

(3) "Church plan", a plan as defined in Section 3(33) of the Employee Retirement Income Security Act of 1974, as amended;

(4) "Creditable coverage", with respect to an individual:

(a) Coverage of the individual provided under any of the following:

a. A group health plan;

b. Health insurance coverage;

c. Part A or Part B of Title XVIII of the Social Security Act;

d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928;

e. Chapter 55 of Title 10, United States Code;

f. A medical care program of the Indian Health Service or of a tribal organization;

g. A state health benefits risk pool;

h. A health plan offered under Chapter 89 of Title 5, United States Code;

i. A public health plan as defined in federal regulations; or

j. A health benefit plan under Section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e);

(b) Creditable coverage does not include coverage consisting solely of excepted benefits;

(5) "Department", the Missouri department of insurance, financial institutions and professional registration;

(6) "Dependent", a resident spouse or resident unmarried child under the age of nineteen years, a child who is a student under the age of twenty-five years and who is financially dependent upon the parent, or a child of any age who is disabled and dependent upon the parent;

(7) "Director", the director of the Missouri department of insurance, financial institutions and professional registration;

(8) "Excepted benefits":

(a) Coverage only for accident, including accidental death and dismemberment, insurance;

(b) Coverage only for disability income insurance;

(c) Coverage issued as a supplement to liability insurance;

(d) Liability insurance, including general liability insurance and automobile liability insurance;

(e) Workers' compensation or similar insurance;

(f) Automobile medical payment insurance;

(g) Credit-only insurance;

(h) Coverage for on-site medical clinics;

(i) Other similar insurance coverage, as approved by the director, under which benefits for medical care are secondary or incidental to other insurance benefits;

(j) If provided under a separate policy, certificate or contract of insurance, any of the following:

a. Limited scope dental or vision benefits;

b. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;

c. Other similar, limited benefits as specified by the director;

(k) If provided under a separate policy, certificate or contract of insurance, any of the following:

a. Coverage only for a specified disease or illness;

b. Hospital indemnity or other fixed indemnity insurance;

(l) If offered as a separate policy, certificate or contract of insurance, any of the following:

a. Medicare supplemental coverage (as defined under Section 1882(g)(1) of the Social Security Act);

b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code;

c. Similar supplemental coverage provided to coverage under a group health plan;

(9) "Federally defined eligible individual", an individual:

(a) For whom, as of the date on which the individual seeks coverage through the pool, the aggregate of the periods of creditable coverage as defined in this section is eighteen or more months and whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with any such plan;

(b) Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act, or state plan under Title XIX of such act or any successor program, and who does not have other health insurance coverage;

(c) With respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated because of nonpayment of premiums or fraud;

(d) Who, if offered the option of continuation coverage under COBRA continuation provision or under a similar state program, both elected and exhausted the continuation coverage;

(10) "Governmental plan", a plan as defined in Section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan;

(11) "Group health plan", an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 and Public Law 104-191 to the extent

that the plan provides medical care and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement or otherwise, but not including excepted benefits;

(12) "Health insurance", any hospital and medical expense incurred policy, nonprofit health care service for benefits other than through an insurer, nonprofit health care service plan contract, health maintenance organization subscriber contract, preferred provider arrangement or contract, or any other similar contract or agreement for the provisions of health care benefits. The term "health insurance" does not include accident, fixed indemnity, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;

(13) "Health maintenance organization", any person which undertakes to provide or arrange for basic and supplemental health care services to enrollees on a prepaid basis, or which meets the requirements of section 1301 of the United States Public Health Service Act;

(14) "Hospital", a place devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment or care for not less than twenty-four hours in any week of three or more nonrelated individuals suffering from illness, disease, injury, deformity or other abnormal physical condition; or a place devoted primarily to provide medical or nursing care for three or more nonrelated individuals for not less than twenty-four hours in any week. The term "hospital" does not include convalescent, nursing, shelter or boarding homes, as defined in chapter 198, RSMo;

(15) "Insurance arrangement", any plan, program, contract or other arrangement under which one or more employers, unions or other organizations provide to their employees or members, either directly or indirectly through a trust or third party administration, health care services or benefits other than through an insurer;

(16) "Insured", any individual resident of this state who is eligible to receive benefits from any insurer or insurance arrangement, as defined in this section;

(17) "Insurer", any insurance company authorized to transact health insurance business in this state, any nonprofit health care service plan act, or any health maintenance organization;

(18) "Medical care", amounts paid for:

(a) The diagnosis, care, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(b) Transportation primarily for and essential to medical care referred to in paragraph (a) of this subdivision; and

(c) Insurance covering medical care referred to in paragraphs (a) and (b) of this subdivision;

(19) "Medicare", coverage under both part A and part B of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq., as amended;

(20) "Member", all insurers and insurance arrangements participating in the pool;

(21) "Physician", physicians and surgeons licensed under chapter 334, RSMo, or by state board of healing arts in the state of Missouri;

(22) "Plan of operation", the plan of operation of the pool, including articles, bylaws and operating rules, adopted by the board pursuant to the provisions of sections 376.961, 376.962 and 376.964;

(23) "Pool", the state health insurance pool created in sections 376.961, 376.962 and 376.964;

(24) "Resident", an individual who has been legally domiciled in this state for a period of at least thirty days, except that for a federally defined eligible individual, there shall not be a thirty-day requirement;

(25) "Significant break in coverage", a period of sixty-three consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage**. As used in this subdivision, "waiting period" and "affiliation period" shall have the same meaning as such terms are defined in section 376.450**;

(26) "Trade act eligible individual", an individual who is eligible for the federal health coverage tax credit under the Trade Act of 2002, Public Law 107-210.

376.966. 1. No employee shall involuntarily lose his or her group coverage by decision of his or her employer on the grounds that such employee may subsequently enroll in the pool. The department shall have authority to promulgate rules and regulations to enforce this subsection.

2. The following individual persons shall be eligible for coverage under the pool if they are and continue to be residents of this state:

(1) An individual person who provides evidence of the following:

(a) A notice of rejection or refusal to issue substantially similar health insurance for health reasons by at least two insurers; or

(b) A refusal by an insurer to issue health insurance except at a rate exceeding the plan rate for substantially similar health insurance;

(2) A federally defined eligible individual who has not experienced a significant break in coverage;

(3) A trade act eligible individual;

(4) Each resident dependent of a person who is eligible for plan coverage;

(5) Any person, regardless of age, that can be claimed as a dependent of a trade act eligible individual on such trade act eligible individual's tax filing;

(6) Any person whose health insurance coverage is involuntarily terminated for any reason other than nonpayment of premium or fraud, and who is not otherwise ineligible under subdivision (4) of subsection 3 of this section. If application for pool coverage is made not later than sixty-three days after the involuntary termination, the effective date of the coverage shall be the date of termination of the previous coverage;

(7) Any person whose premiums for health insurance coverage have increased above the rate established by the board under paragraph (a) of subdivision (1) of subsection 3 of this section;

(8) Any person currently insured who would have qualified as a federally defined eligible individual or a trade act eligible individual between the effective date of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the effective date of this act**;**

(9) Any person who has exhausted his or her maximum in benefits from a health insurer.

3. The following individual persons shall not be eligible for coverage under the pool:

(1) Persons who have, on the date of issue of coverage by the pool, or obtain coverage under health insurance or an insurance arrangement substantially similar to or more comprehensive than a plan policy, or would be eligible to have coverage if the person elected to obtain it, except that:

(a) This exclusion shall not apply to a person who has such coverage but whose premiums have increased to **[**one hundred fifty percent to**] beyond the eligibility limit set by the board. The board shall not set the eligibility limit in excess of** two hundred percent of rates established by the board as applicable for individual standard risks**[**. After December 31, 2009, this exclusion shall not apply to a person who has such coverage but whose premiums have increased to three hundred percent or more of rates established by the board as applicable for individual standard risks**]**;

(b) A person may maintain other coverage for the period of time the person is satisfying any preexisting condition waiting period under a pool policy; **[**and**]**

(c) A person may maintain plan coverage for the period of time the person is satisfying a preexisting condition waiting period under another health insurance policy intended to replace the pool policy; **and**

(d) Such exclusion shall not apply to a federally defined eligible individual;

(2) Any person who is at the time of pool application receiving health care benefits under section 208.151, RSMo;

(3) Any person having terminated coverage in the pool unless twelve months have elapsed since such termination, unless such person is a federally defined eligible individual;

(4) Any person on whose behalf the pool has paid out **[**one**]** **two** million dollars in benefits;

(5) Inmates or residents of public institutions, unless such person is a federally defined eligible individual, and persons eligible for public programs;

(6) Any person whose medical condition which precludes other insurance coverage is directly due to alcohol or drug abuse or self-inflicted injury, unless such person is a federally defined eligible individual or a trade act eligible individual;

(7) Any person who is eligible for Medicare coverage.

4. Any person who ceases to meet the eligibility requirements of this section may be terminated at the end of such person's policy period.

5. If an insurer issues one or more of the following or takes any other action based wholly or partially on medical underwriting considerations which is likely to render any person eligible for pool coverage, the insurer shall notify all persons affected of the existence of the pool, as well as the eligibility requirements and methods of applying for pool coverage:

(1) A notice of rejection or cancellation of coverage;

(2) A notice of reduction or limitation of coverage, including restrictive riders, if the effect of the reduction or limitation is to substantially reduce coverage compared to the coverage available to a person considered a standard risk for the type of coverage provided by the plan.

6. When an insurer determines an insured has exhausted eighty-five percent of his or her total lifetime benefits, the insurer shall notify any affected person of the existence of the pool, of the person's eligibility for the pool when all lifetime benefits have been exhausted, and of methods of applying for pool coverage. When any affected person has exhausted one hundred percent of his or her total lifetime benefits, the insurer shall notify the affected person of his or her eligibility for pool coverage and of the methods of applying for such coverage. The insurer shall provide a copy of such notice to the pool with the name and address of such affected person.

376.986. 1. The pool shall offer major medical expense coverage to every person eligible for coverage under section 376.966 **and shall offer other health plans that the board determines to be in the best interest of the individuals covered under the pool, including but not limited to dental and vision coverage, and limited mandate plans or other similar flexible benefit plans**. The coverage to be issued by the pool and its schedule of benefits, exclusions and other limitations, shall be established by the board with the advice and

recommendations of the pool members, and such plan of pool coverage shall be submitted to the director for approval. The pool shall also offer coverage for drugs and supplies requiring a medical prescription and coverage for patient education services, to be provided at the direction of a physician, encompassing the provision of information, therapy, programs, or other services on an inpatient or outpatient basis, designed to restrict, control, or otherwise cause remission of the covered condition, illness or defect.

2. In establishing the pool coverage the board shall take into consideration the levels of health insurance provided in this state and medical economic factors as may be deemed appropriate, and shall promulgate benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of and commensurate with health insurance provided through a representative number of insurers in this state.

3. The pool shall establish premium rates for pool coverage as provided in subsection 4 of this section. Separate schedules of premium rates based on age, sex**, family size,** and geographical location may apply for individual risks. Premium rates and schedules shall be submitted to the director for approval prior to use.

4. The pool, with the assistance of the director, shall determine the standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. **[**Initial rates for pool coverage shall not be less than one hundred twenty-five percent of rates established as applicable for individual standard risks.**]** Subject to the limits provided in this subsection, **[**subsequent**]** rates shall be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein. In no event shall pool rates exceed the following:

(1) For federally defined eligible individuals and trade act eligible individuals, rates shall be equal to the percent of rates applicable to individual standard risks actuarially determined to be sufficient to recover the sum of the cost of benefits paid under the pool for federally defined and trade act eligible individuals plus the proportion of the pool's administrative expense applicable to federally defined and trade act eligible individuals enrolled for pool coverage, provided that such rates shall not exceed one hundred **[**fifty**] twenty-five** percent of rates applicable to individual standard risks; and

(2) For all other individuals covered under the pool, one hundred **[**fifty**] twenty-five** percent of rates applicable to individual standard risks.

5. Pool coverage established pursuant to this section shall provide an appropriate high and low deductible to be selected by the pool applicant. The deductibles and coinsurance factors

may be adjusted annually in accordance with the medical component of the consumer price index.

6. Pool coverage shall exclude charges or expenses incurred during the first twelve months following the effective date of coverage as to any condition for which medical advice, care or treatment was recommended or received as to such condition during the six-month period immediately preceding the effective date of coverage. Such preexisting condition exclusions shall be waived to the extent to which similar exclusions, if any, have been satisfied under any prior health insurance coverage which was involuntarily terminated, if application for pool coverage is made not later than sixty-three days following such involuntary termination and, in such case, coverage in the pool shall be effective from the date on which such prior coverage was terminated. **The board may establish a premium rate load to allow enrollees to buy down creditable coverage.**

7. No preexisting condition exclusion shall be applied to the following:

(1) A federally defined eligible individual who has not experienced a significant gap in coverage; or

(2) A trade act eligible individual who maintained creditable health insurance coverage for an aggregate period of three months prior to loss of employment and who has not experienced a significant gap in coverage since that time.

8. Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other health insurance, or insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program except Medicaid. The insurer or the pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the pool may be reduced or refused as a setoff against any amount recoverable under this subsection.

9. Medical expenses shall include expenses for comparable benefits for those who rely solely on spiritual means through prayer for healing.

10. Subject to appropriations, the pool shall establish a premium assistance program for qualified individuals under section 376.966. Under the program:

(1) An individual shall be eligible for premium assistance if the individual qualifies for coverage under the pool and the individual's income does not exceed the income eligibility level established by the pool for the premium assistance program;

(2) Premium assistance shall be available for a qualified individual who is employed if such qualified individual's employer or the qualified individual, or both, contribute their

respective shares of the required premium. If the employer of a qualified individual does not participate, the qualified individual, or such employed qualified individual and such individual's qualified spouse, may directly enroll in the premium assistance program. Any moneys awarded to the pool through a grant or from a federal agency for the purpose of premium assistance shall be used through the pool's premium assistance program;

(3) Premium assistance shall be provided based on a sliding income scale to be established by the pool; except that, any person with an income exceeding three hundred percent of the federal poverty level shall be ineligible for the premium assistance program;

(4) Any cost-sharing requirements, such as deductibles, co-payments, or co-insurance, shall be established by the pool.

11. In providing coverage to enrollees under the health insurance pool and payments to providers for providing health care services to enrollees under the pool, the board shall take into consideration the special needs of Missouri's Tier I Safety Net providers so that they are not disproportionately impacted by rules promulgated by the board as it implements the provisions of sections 376.960 to 376.990.

376.988. All agents and brokers selling or renewing Missouri health insurance pool policies shall receive a seven and one-half percent commission from the pool upon approval of a new application or renewal of coverage under a health insurance pool policy. Such commissions shall not be paid by enrollees or included in the premium rates established for policies under the pool.

376.1373. 1. As used in this section, the following terms shall mean:

(1) "Change in participation status", a change of a provider from an in-network provider to an out-of-network provider;

(2) "In-network provider", a provider under contract with a health carrier to provide services to enrollees at the reimbursement rates and enrollee costs associated with covered network services;

(3) "Out-of-network", a provider not under contract with a health carrier and who provides services to enrollees at the reimbursement rate and enrollee costs associated with out-of-network services;

(4) "Participating provider", an in-network provider that provides services at in-network reimbursement rates and enrollee costs;

(5) "Participation status", the contracted or otherwise agreed upon level of reimbursement that a provider may expect from the health carrier and which affects the amount of payment owed to the provider by the enrollee.

2. All health carriers shall provide notification in writing or electronically, or telephonically with the permission of the enrollee, to all enrollees if the participation status

of any in-network provider changes from in-network to out-of-network. Such notice shall be delivered to enrollees at least thirty business days before the effective date of the change in the provider's participation status or as soon as reasonably possible. At the health carrier's option and in lieu of notifying all enrollees, the health carrier may notify only enrollees who have been seen by the in-network provider whose participation status is changing in the twelve-calendar-month period immediately preceding the date of the change of the provider's participation status.

3. (1) All health carriers shall have a written procedure for ensuring continuity of care when a change in the participation status of any in-network provider occurs. Such written procedure shall be applicable regardless of the reason for the change.

(2) The procedure shall include enrollee notification of the change in the in-network provider's participation status and, if necessary, transferred to other health care providers in the provider network in a timely manner.

(3) The health carrier shall provide a copy of the procedure to the enrollee, providers, or the director upon request.

(4) The procedure shall be subject to any requirements the director may deem necessary to ensure compliance with state law.

4. If the participation status of an in-network provider changes, regardless of the reason for the change, the provision of health care services by a health carrier shall be subject to the following:

(1) The health carrier shall assure continuation of care to enrollees affected by such change for a period of up to ninety days when the continuation of care is medically necessary and in accordance with the dictates of medical prudence, including but not limited to circumstances such as disability, pregnancy, or life-threatening illness;

(2) If continuation of care is necessary or if the health carrier failed to timely notify the enrollees as prescribed by subsection 2 of this section, an enrollee shall continue to receive services at the contracted rate and costs specified for in-network provider services, including all deductibles, coinsurance, and copayments, in the certificate of coverage or other contract between the enrollee and the health carrier. No such enrollee shall be responsible or otherwise liable for any costs incurred which exceed the in-network rates and costs associated with the provision of such services;

(3) If the in-network provider whose participation status changes to out-of-network is authorized to continue to provide services to an enrollee under this section, the health carrier shall reimburse such provider for services provided to the enrollee at the previously contracted rate for the provider when the provider was an in-network provider under the certificate of coverage or other contract between the provider and the health carrier. Such

provider shall not bill or otherwise charge the enrollee for any costs other than the authorized in-network costs, such as deductibles, coinsurance, or copayments, specified in the certificate of coverage or other contract between the enrollee and the health carrier;

(4) The health carrier shall include the continuation of care requirements described in this subsection in the evidence of coverage provided to enrollees and in all provider contracts entered into, including any subcontracts and affected subcontractors;

(5) Upon request of the director, the health carrier shall provide a copy of provider contracts or subcontracts. Such contracts and subcontracts shall be subject to any requirements the director deems necessary to ensure compliance with state law.

5. The director may promulgate rules to administer and implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, 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, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, 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, 2009, shall be invalid and void.

Section B. Sections 191.1005, 191.1008, and 191.1010 of section A of this act shall become effective January 1, 2010.

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