JOURNAL OF THE HOUSE

First Regular Session, 99th GENERAL ASSEMBLY

FIFTY-EIGHTH DAY, WEDNESDAY, APRIL 19, 2017

The House met pursuant to adjournment.

Speaker Richardson in the Chair.

Prayer by Representative Tommie Pierson, Jr.

Dear Heavenly Father,

We come to You this morning, thanking You for all of Your many blessings. For this morning's rise, we say thank You. For a reasonable portion of health and strength, we say thank You. For a sound mind, we say thank You. For sufficient resources to carry out Your will, we thank You, O God!

And in thanking You, Lord, help us to be ever mindful of the grace and mercy that You extend to us each day so that we as Legislators of the great state of Missouri may extend that same grace and mercy to others.

Lord, as we go about our business today, may the words of our mouths and the meditation of our hearts be pleasing in Your sight, Lord, our rock and our redeemer.

And the House says, "Amen!"

The Pledge of Allegiance to the flag was recited.

The Speaker appointed the following to act as an Honorary Page for the Day, to serve without compensation: Logan O'Hara.

The Journal of the fifty-seventh day was approved as printed by the following vote:

AYES: 136

Adams	Alferman	Anders	Anderson	Arthur
Austin	Bahr	Bangert	Baringer	Barnes 28
Basye	Beard	Beck	Bernskoetter	Black
Bondon	Brattin	Brown 27	Brown 94	Burnett
Burns	Butler	Chipman	Christofanelli	Cierpiot
Conway 10	Conway 104	Corlew	Crawford	Cross
Davis	DeGroot	Dogan	Dohrman	Dunn
Eggleston	Ellebracht	Engler	Evans	Fitzpatrick
Fitzwater 144	Fitzwater 49	Fraker	Francis	Franklin
Frederick	Gannon	Gray	Green	Haahr
Haefner	Hannegan	Hansen	Harris	Helms
Henderson	Higdon	Hill	Houghton	Houx
Hubrecht	Johnson	Justus	Kelley 127	Kelly 141
Kendrick	Kidd	Kolkmeyer	Lant	Lauer

Lavender	Lichtenegger	Lynch	Marshall	Mathews
Matthiesen	McCaherty	McCann Beatty	McCreery	McGaugh
McGee	Meredith 71	Merideth 80	Messenger	Miller
Mitten	Moon	Morgan	Morris	Mosley
Neely	Newman	Nichols	Peters	Pfautsch
Phillips	Pierson Jr	Pietzman	Pike	Quade
Razer	Redmon	Reiboldt	Reisch	Remole
Rhoads	Roberts	Roden	Roeber	Rone
Ross	Rowland 29	Runions	Ruth	Schroer
Shaul 113	Shull 16	Shumake	Smith 85	Smith 163
Sommer	Stacy	Stephens 128	Stevens 46	Swan
Tate	Taylor	Trent	Unsicker	Vescovo
Walker 3	Walker 74	Wessels	White	Wiemann
Mr. Speaker				

NOES: 002

Hurst Pogue

PRESENT: 000

ABSENT WITH LEAVE: 024

Andrews	Barnes 60	Berry	Brown 57	Carpenter
Cookson	Cornejo	Curtis	Curtman	Ellington
Franks Jr	Gregory	Grier	Korman	Love
May	McDaniel	Muntzel	Plocher	Rehder
Rowland 155	Spencer	Wilson	Wood	

VACANCIES: 001

SPECIAL RECOGNITION

The Honorable Roy Blunt, United States Senator, was introduced by Speaker Richardson.

Senator Blunt addressed the House.

SECOND READING OF SENATE BILLS

The following Senate Bills were read the second time:

SCS SB 88, relating to actions against veterinarians.

SB 99, relating to electronic monitoring of persons who have been charged with or found guilty of violating protection orders, with an expiration date.

SB 204, relating to the collection of biological samples from individuals arrested for felony offenses, with an existing penalty provision.

SB 373, relating to the Missouri senior farmers' market nutrition program.

SB 376, relating to the designation of state dogs.

PERFECTION OF HOUSE BILLS

HCS HB 194, relating to abortion, was taken up by Representative Franklin.

Speaker Pro Tem Haahr assumed the Chair.

Representative Franklin offered **House Amendment No. 1**.

House Amendment No. 1

AMEND House Committee Substitute for House Bill No. 194, Page 1, Section 188.027, Lines 6-8, by deleting all of said lines and inserting in lieu thereof the following:

"has informed the woman orally, reduced to writing, and in person, of the following:"; and

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

On motion of Representative Franklin, **House Amendment No. 1** was adopted.

Representative Miller offered **House Amendment No. 2**.

House Amendment No. 2

AMEND House Committee Substitute for House Bill No. 194, Page 7, Section 188.027, Line 211, by inserting after all of said section and line the following:

"188.028. 1. **Except in the case of a medical emergency,** no person shall knowingly perform **or induce** an abortion upon a pregnant woman under the age of eighteen years unless:

(1) The attending physician has secured the informed written consent of the minor and one parent or guardian**, and the consenting parent or guardian of the minor has notified any other custodial parent or guardian in writing prior to the securing of the informed written consent of the minor and one parent or guardian. For purposes of this subdivision, "custodial parent" means any parent of a minor in a family in which the parents have not separated or dissolved their marriage, or any parent of a minor who has been awarded joint legal custody or joint physical custody of such minor by a court of competent jurisdiction. Notice shall not be required for any parent or guardian:**

(a) Who has been found guilty of any offense in violation of chapter 565, relating to offenses against the person; chapter 566, relating to sexual offenses; chapter 567, relating to prostitution; chapter 568, relating to offenses against the family; or chapter 573, related to pornography and related offenses, if a child was a victim;

(b) Who has been found guilty of any offense in any other state or foreign country, or under federal, tribal, or military jurisdiction if a child was a victim, which would be a violation of chapter 565, 566, 567, 568, or 573 if committed in this state;

(c) Who is listed on the sexual offender registry under sections 589.400 to 589.425;

(d) Against whom an order of protection has been issued, including a foreign order of protection given full faith and credit in this state under section 455.067;

(e) Whose custodial, parental, or guardianship rights have been terminated by a court of competent jurisdiction; or

(f) Whose whereabouts are unknown after reasonable inquiry, who is a fugitive from justice, who is habitually in an intoxicated or drugged condition, or who has been declared mentally incompetent or incapacitated by a court of competent jurisdiction; or

(2) The minor is emancipated and the attending physician has received the informed written consent of the minor; or

(3) The minor has been granted the right to self-consent to the abortion by court order pursuant to subsection 2 of this section, and the attending physician has received the informed written consent of the minor; or

(4) The minor has been granted consent to the abortion by court order, and the court has given its informed written consent in accordance with subsection 2 of this section, and the minor is having the abortion willingly, in compliance with subsection 3 of this section.

2. The right of a minor to self-consent to an abortion under subdivision (3) of subsection 1 of this section or court consent under subdivision (4) of subsection 1 of this section may be granted by a court pursuant to the following procedures:

(1) The minor or next friend shall make an application to the juvenile court which shall assist the minor or next friend in preparing the petition and notices required pursuant to this section. The minor or the next friend of the minor shall thereafter file a petition setting forth the initials of the minor; the age of the minor; the names and addresses of each parent, guardian, or, if the minor's parents are deceased and no guardian has been appointed, any other person standing in loco parentis of the minor; that the minor has been fully informed of the risks and consequences of the abortion; that the minor is of sound mind and has sufficient intellectual capacity to consent to the abortion; that, if the court does not grant the minor majority rights for the purpose of consent to the abortion, the court should find that the abortion is in the best interest of the minor and give judicial consent to the abortion; that the court should appoint a guardian ad litem of the child; and if the minor does not have private counsel, that the court should appoint counsel. The petition shall be signed by the minor or the next friend;

(2) A hearing on the merits of the petition, to be held on the record, shall be held as soon as possible within five days of the filing of the petition. If any party is unable to afford counsel, the court shall appoint counsel at least twenty-four hours before the time of the hearing. At the hearing, the court shall hear evidence relating to the emotional development, maturity, intellect and understanding of the minor; the nature, possible consequences, and alternatives to the abortion; and any other evidence that the court may find useful in determining whether the minor should be granted majority rights for the purpose of consenting to the abortion or whether the abortion is in the best interests of the minor;

(3) In the decree, the court shall for good cause:

(a) Grant the petition for majority rights for the purpose of consenting to the abortion; or

(b) Find the abortion to be in the best interests of the minor and give judicial consent to the abortion, setting forth the grounds for so finding; or

(c) Deny the petition, setting forth the grounds on which the petition is denied;

(4) If the petition is allowed, the informed consent of the minor, pursuant to a court grant of majority rights, or the judicial consent, shall bar an action by the parents or guardian of the minor on the grounds of battery of the minor by those performing **or inducing** the abortion. The immunity granted shall only extend to the performance **or inducement** of the abortion in accordance herewith and any necessary accompanying services which are performed in a competent manner. The costs of the action shall be borne by the parties;

(5) An appeal from an order issued under the provisions of this section may be taken to the court of appeals of this state by the minor or by a parent or guardian of the minor. The notice of intent to appeal shall be given within twenty-four hours from the date of issuance of the order. The record on appeal shall be completed and the appeal shall be perfected within five days from the filing of notice to appeal. Because time may be of the essence regarding the performance **or inducement** of the abortion, the supreme court of this state shall, by court rule, provide for expedited appellate review of cases appealed under this section.

3. If a minor desires an abortion, then she shall be orally informed of and, if possible, sign the written consent required **[**~~by section 188.039~~**] under this chapter** in the same manner as an adult person. No abortion shall be performed **or induced** on any minor against her will, except that an abortion may be performed **or induced** against the will of a minor pursuant to a court order described in subdivision (4) of subsection 1 of this section that the abortion is necessary to preserve the life of the minor."; and

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

Speaker Richardson resumed the Chair.

Representative Cierpiot moved the previous question.

Which motion was adopted by the following vote:

AYES: 094

Alferman	Anderson	Austin	Bahr	Basye
Beard	Bernskoetter	Black	Bondon	Brattin
Brown 94	Chipman	Christofanelli	Cierpiot	Conway 104
Corlew	Cornejo	Crawford	Cross	Curtman
Davis	DeGroot	Dohrman	Eggleston	Engler
Evans	Fitzpatrick	Fitzwater 49	Francis	Franklin
Frederick	Gannon	Gregory	Grier	Haahr
Haefner	Hannegan	Hansen	Helms	Henderson
Hill	Houghton	Houx	Hubrecht	Hurst
Johnson	Justus	Kelley 127	Kelly 141	Korman
Lant	Lauer	Lichtenegger	Love	Lynch
Marshall	Mathews	McGaugh	Messenger	Miller
Moon	Morris	Muntzel	Neely	Pfautsch
Pietzman	Plocher	Pogue	Redmon	Reiboldt
Reisch	Remole	Roeber	Rone	Ross
Ruth	Shaul 113	Shull 16	Shumake	Smith 163
Sommer	Spencer	Stacy	Stephens 128	Swan
Tate	Taylor	Trent	Vescovo	Walker 3
White	Wiemann	Wood	Mr. Speaker	

NOES: 043

Adams	Anders	Arthur	Bangert	Baringer
Barnes 28	Beck	Brown 27	Burnett	Burns
Butler	Conway 10	Dunn	Ellebracht	Ellington
Franks Jr	Gray	Green	Harris	Kendrick
Lavender	McCann Beatty	McCreery	McGee	Meredith 71
Merideth 80	Mitten	Morgan	Mosley	Newman
Nichols	Peters	Pierson Jr	Quade	Razer
Roberts	Rowland 29	Runions	Smith 85	Stevens 46
Unsicker	Walker 74	Wessels		

PRESENT: 000

ABSENT WITH LEAVE: 025

Andrews	Barnes 60	Berry	Brown 57	Carpenter
Cookson	Curtis	Dogan	Fitzwater 144	Fraker
Higdon	Kidd	Kolkmeyer	Matthiesen	May
McCaherty	McDaniel	Phillips	Pike	Rehder
Rhoads	Roden	Rowland 155	Schroer	Wilson

VACANCIES: 001

On motion of Representative Miller, **House Amendment No. 2** was adopted.

Representative Swan offered **House Amendment No. 3**.

House Amendment No. 3

AMEND House Committee Substitute for House Bill No. 194, Page 13, Section 197.230, Lines 10-12, by deleting all of said lines and inserting in lieu thereof the following:

"**2. In the case of any ambulatory surgical center operated for the purpose of performing or inducing an abortion, the department shall make or cause to be made an unannounced on-site inspection and investigation at least annually. Such on-site inspection and investigation shall include, but not be limited to, the following areas:**

(1) Compliance with all statutory and regulatory requirements for an ambulatory surgical center, including requirements that the facility maintain adequate staffing and equipment to respond to medical emergencies;

(2) Compliance with the requirement in section 188.047 that all fetal organs or tissue removed at the time of abortion be submitted to a board certified or eligible pathologist and that the resultant tissue report be made a part of the patient's permanent record;

(3) Review of patient records to ensure that no consent forms or other documentation authorizes any utilization of fetal organs or tissue in violation of sections 188.036 and 194.275;

(4) Compliance with sections 188.205, 188.210, and 188.215 prohibiting the use of public funds, facilities, and employees to perform or to assist a prohibited abortion or to encourage or to counsel a woman to have a prohibited abortion; and

(5) Compliance with the requirement in section 197.215 that continuous physician services or registered professional nursing services be provided whenever a patient is in the facility.

3. Inspection, investigation, and quality assurance reports shall be made available to the public. Any portion of a report may be redacted when made publicly available if such portion would disclose information that is not subject to disclosure under the law."; and

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

On motion of Representative Swan, **House Amendment No. 3** was adopted.

Representative Marshall raised a point of order that a member was in violation of Rule 85.

The Chair took the point of order under advisement.

Representative McCreery raised a point of order that a member was in violation of Rule 85.

The Chair took the point of order under advisement.

Representative Lavender raised a point of order that a member remained in violation of Rule 85.

The Chair ruled the point of order not well taken.

Representative Cierpiot moved the previous question.

Which motion was adopted by the following vote:

AYES: 090

Alferman	Anderson	Austin	Bahr	Basye
Beard	Bernskoetter	Berry	Black	Brattin
Brown 94	Chipman	Christofanelli	Cierpiot	Corlew
Cornejo	Crawford	Cross	Curtman	Davis
Dohrman	Eggleston	Engler	Evans	Fitzpatrick
Fitzwater 49	Francis	Franklin	Frederick	Gannon
Gregory	Grier	Haahr	Haefner	Hannegan
Hansen	Helms	Hill	Houghton	Houx

Hubrecht	Hurst	Johnson	Justus	Kelley 127
Kelly 141	Korman	Lant	Lauer	Lichtenegger
Love	Lynch	Marshall	Mathews	Matthiesen
McGaugh	Messenger	Miller	Moon	Morris
Muntzel	Neely	Pfautsch	Pietzman	Pogue
Reisch	Remole	Rhoads	Roeber	Rone
Ross	Schroer	Shaul 113	Shull 16	Shumake
Smith 163	Sommer	Spencer	Stacy	Stephens 128
Swan	Tate	Taylor	Trent	Vescovo
Walker 3	White	Wiemann	Wood	Mr. Speaker

NOES: 042

Adams	Anders	Arthur	Bangert	Baringer
Barnes 28	Beck	Brown 27	Burnett	Burns
Carpenter	Conway 10	Curtis	Dunn	Ellebracht
Ellington	Gray	Green	Harris	Kendrick
Lavender	McCann Beatty	McCreery	McGee	Meredith 71
Merideth 80	Morgan	Mosley	Newman	Nichols
Peters	Pierson Jr	Quade	Razer	Roberts
Rowland 29	Runions	Smith 85	Stevens 46	Unsicker
Walker 74	Wessels			

PRESENT: 000

ABSENT WITH LEAVE: 030

Andrews	Barnes 60	Bondon	Brown 57	Butler
Conway 104	Cookson	DeGroot	Dogan	Fitzwater 144
Fraker	Franks Jr	Henderson	Higdon	Kidd
Kolkmeyer	May	McCaherty	McDaniel	Mitten
Phillips	Pike	Plocher	Redmon	Rehder
Reiboldt	Roden	Rowland 155	Ruth	Wilson

VACANCIES: 001

On motion of Representative Franklin, the title of **HCS HB 194, as amended**, was agreed to.

On motion of Representative Franklin, **HCS HB 194, as amended**, was adopted.

On motion of Representative Franklin, **HCS HB 194, as amended**, was ordered perfected and printed.

On motion of Representative Cierpiot, the House recessed until 3:00 p.m.

AFTERNOON SESSION

The hour of recess having expired, the House was called to order by Speaker Pro Tem Haahr.

Representative Cierpiot suggested the absence of a quorum.

The following roll call indicated a quorum present:

AYES: 043

Alferman	Basye	Bernskoetter	Berry	Black
Bondon	Brown 27	Burns	Butler	Christofanelli
Engler	Evans	Fitzwater 144	Fraker	Francis
Gannon	Grier	Hannegan	Harris	Houghton
Hubrecht	Hurst	Justus	Kelley 127	Kelly 141
Korman	Lant	Lauer	Lichtenegger	Matthiesen
McCaherty	McGaugh	Miller	Morris	Newman
Pogue	Reiboldt	Remole	Roeber	Smith 163
Taylor	White	Wiemann		

NOES: 003

Franks Jr	Merideth 80	Smith 85

PRESENT: 080

Adams	Anders	Anderson	Arthur	Austin
Bahr	Bangert	Baringer	Barnes 28	Beard
Beck	Burnett	Carpenter	Chipman	Cierpiot
Conway 104	Corlew	Cornejo	Crawford	Davis
DeGroot	Dogan	Dohrman	Dunn	Eggleston
Ellebracht	Fitzwater 49	Franklin	Frederick	Gray
Green	Haahr	Haefner	Helms	Henderson
Higdon	Hill	Houx	Johnson	Kendrick
Love	Lynch	Mathews	McCann Beatty	Meredith 71
Messenger	Moon	Morgan	Muntzel	Neely
Nichols	Pfautsch	Pierson Jr	Pike	Quade
Razer	Reisch	Rhoads	Roberts	Roden
Rone	Ross	Rowland 29	Runions	Ruth
Schroer	Shaul 113	Shull 16	Shumake	Sommer
Stacy	Swan	Tate	Trent	Unsicker
Vescovo	Walker 3	Walker 74	Wood	Mr. Speaker

ABSENT WITH LEAVE: 036

Andrews	Barnes 60	Brattin	Brown 57	Brown 94
Conway 10	Cookson	Cross	Curtis	Curtman
Ellington	Fitzpatrick	Gregory	Hansen	Kidd
Kolkmeyer	Lavender	Marshall	May	McCreery
McDaniel	McGee	Mitten	Mosley	Peters
Phillips	Pietzman	Plocher	Redmon	Rehder
Rowland 155	Spencer	Stephens 128	Stevens 46	Wessels
Wilson				

VACANCIES: 001

PERFECTION OF HOUSE COMMITTEE BILLS

HCB 10, relating to insurance proceedings, was taken up by Representative Wiemann.

Representative Engler offered **House Amendment No. 1**.

House Amendment No. 1

AMEND House Committee Bill No. 10, Page 6, Section 379.160, Line 37, by inserting after all of said line the following:

"379.321. 1. Every insurer shall file with the director, except as to commercial property or commercial casualty insurance as provided in subsection 6 of this section, every manual of classifications, rules, underwriting rules and rates, every rating plan and every modification of the foregoing which it uses and the policies and forms to which such rates are applied. Any insurer may satisfy its obligation to make any such filings by becoming a member of, or a subscriber to, a licensed rating organization which makes such filings and by authorizing the director to accept such filings on its behalf, provided that nothing contained in section 379.017 and sections 379.316 to 379.361 shall be construed as requiring any insurer to become a member of or a subscriber to any rating organization or as requiring any member or subscriber to authorize the director to accept such filings on its behalf. Filing with the director by such insurer or licensed rating organization within ten days after such manuals, rating plans or modifications thereof or policies or forms are effective shall be sufficient compliance with this section.

2. Except as to commercial property or commercial casualty insurance as provided in subsection 6 of this section, no insurer shall make or issue a policy or contract except pursuant to filings which are in effect for that insurer or pursuant to section 379.017 and sections 379.316 to 379.361. Any rates, rating plans, rules, classifications or systems, in effect on August 13, 1972, shall be continued in effect until withdrawn by the insurer or rating organization which filed them.

3. Upon the written application of the insured, stating his or her reasons therefor, filed with the insurer, a rate in excess of that provided by a filing otherwise applicable may be used on any specific risk.

4. Every insurer which is a member of or a subscriber to a rating organization shall be deemed to have authorized the director to accept on its behalf all filings made by the rating organization which are within the scope of its membership or subscribership, provided:

(1) That any subscriber may withdraw or terminate such authorization, either generally or for individual filings, by written notice to the director and to the rating organization and may then make its own independent filings for any kinds of insurance, or subdivisions, or classes of risks, or parts or combinations of any of the foregoing, with respect to which it has withdrawn or terminated such authorization, or may request the rating organization, within its discretion, to make any such filing on an agency basis solely on behalf of the requesting subscriber; and

(2) That any member may proceed in the same manner as a subscriber unless the rating organization shall have adopted a rule, with the approval of the director:

(a) Requiring a member, before making an independent filing, first to request the rating organization to make such filing on its behalf and requiring the rating organization, within thirty days after receipt of such request, either:

a. To make such filing as a rating organization filing;

b. To make such filing on an agency basis solely on behalf of the requesting member; or

c. To decline the request of such member; and

(b) Excluding from membership any insurer which elects to make any filing wholly independently of the rating organization.

5. Any change in a filing made pursuant to this section during the first six months of the date such filing becomes effective shall be approved or disapproved by the director within ten days following the director's receipt of notice of such proposed change.

6. Commercial property and commercial casualty requirements differ as follows:

(1) **[**~~All~~**]** commercial property and commercial casualty insurance rates, rate plans, modifications, and manuals of classifications, **[**~~where appropriate~~**] except as specified in subdivision (2) of this subsection**, shall be filed with the director for informational purposes only **within ten days of use**. Such rates are not to be reviewed or approved by the department of insurance, financial institutions and professional registration as a condition of their use. Nothing in this subsection shall require the filing of individual rates where the original manuals, rates and rules for the insurance plan or program to which such individual policies conform have already been filed with the director;

(2) **Subject to the provisions of subdivision (4) of this subsection, commercial property and casualty underwriting rules or guidelines, rates, rate plans, modifications, and manuals of classification are exempt from filing requirements otherwise applicable under this chapter, whether the insurance coverage is endorsed to or otherwise made part of another type of insurance or sold as a stand-alone policy;**

(3) Subject to the provisions of subdivision (4) of this subsection, commercial property and casualty insurance policy forms are exempt from filing requirements otherwise applicable under this chapter when the aggregate total annual commercial insurance premiums for all property and casualty insurance purchased by a commercial policyholder, excluding premiums for the types of insurance specified in subdivision (4) of this subsection, are equal to or exceed one hundred thousand dollars and the commercial policyholder employs a fulltime risk manager or has retained a licensed insurance producer to negotiate on its behalf;

(4) The filing exemptions in paragraphs (2) and (3) shall not apply to:

(a) Workers' compensation;

(b) Medical malpractice liability;

(c) Farm property and liability;

(d) Any coverage issued by an assigned risk or residual market plan pursuant to section 303.200; and

(e) Any specific policy or bond required by the Division of Workers' Compensation of a self-insured employer or group trust, their trustees, or entities providing services to self-insured employers or group trusts;

(5) All policies exempt from filing pursuant to subdivisions (2) or (3) of this subsection shall include, at the time of policy issuance, a notice advising the policy holder that the policy may include rates or forms exempt from filing with the department. Such notice shall state that this policy may include rates and forms which may not be filed with the Missouri department of insurance;

(6) If an insurer will only renew a commercial casualty or commercial property insurance policy with an increase in premium of twenty-five percent or more, a "premium alteration requiring notification" notice must be mailed or delivered by the insurer at least sixty days prior to the expiration date of the policy, except in the case of an umbrella or excess policy the coverage of which is contingent on the coverage of an underlying policy of commercial property or casualty insurance, in which case notice of an increase in premium of twenty-five percent or more shall be mailed or delivered at least thirty days prior to the expiration date of the policy. Such notice shall be mailed or delivered to the agent of record and to the named insured at the address shown in the policy. If the insurer fails to meet this notice requirement, the insured shall have the option of continuing the policy for the remainder of the notice period plus an additional thirty days at the premium rate of the existing policy or contract. This provision does not apply if the insurer has offered to renew a policy without such an increase in premium or if the insured fails to pay a premium due or any advance premium required by the insurer for renewal. For purposes of this section, "premium alteration requiring notification" means an annual increase in premium of twenty-five percent or more, exclusive of premium increases due to a change in the operations of the insured which increases either the hazard insured against or the individual loss characteristics, or due to a change in the magnitude of the exposure basis, including, without limitation, increases in payroll or sales. For commercial multiperil policies, no "premium alteration requiring notification" shall be required unless the increase in premium for all of a policyholder's policies taken together amounts to a twenty-five percent or more annual increase in premium;

[~~(3)~~**] (7)** Commercial property and commercial casualty policy forms **, except as specified in subdivision (3) of this subsection,** shall be filed with the director **within ten days of use** as provided pursuant to subsection 1 of this section. However, if after review, it is determined that corrective action must be taken to modify the filed forms, the director shall impose such corrective action on a prospective basis for new policies. All policies previously issued which are of a type that is subject to such corrective action shall be deemed to have been modified to conform to such corrective action retroactive to their inception date;

(8) An insurer renewing a policy issued with policy forms not filed with the director pursuant to subdivision (3) of this subsection shall provide written notice to the first named insured and producer of record, if any, at least ten days prior to the current policy's expiration date if, after renewal, there will be a material restriction or reduction in coverage not specifically requested by the insured, required by law or based on the altered nature or extent of the risk insured. The notice may be in a printed or electronic form and shall explain what coverage will be reduced or eliminated or what condition will be restricted. It shall be a rebuttable presumption that all insureds received the notice if it was sent by e-mail or first-class mail to the first named insured's last known e-mail address or mailing address contained in the policy. If the insurer has not so notified the policyholder, the policyholder may elect to cancel the renewal policy within 30 days of delivery of the renewal policy and the earned premium for the time the renewal policy was in force shall be calculated pro rata at the lower of the current or previous year's rate. If the insured accepts the renewal, any premium change or alteration of coverage, terms or conditions shall be effective immediately upon the expiration of the prior policy. Nothing in this subdivision shall restrict the right of the parties to an insurance contract to amend an insurance policy if requested by the insured without the requirement for any notice;

[~~(4)~~**] (9)** For purposes of this section, "commercial casualty" means "commercial casualty insurance" as defined in section 379.882. For purposes of this section, "commercial property" means property insurance, which is for business and professional interests, whether for profit, nonprofit or public in nature which is not for personal, family or household purposes, and shall include commercial inland marine insurance, but does not include title insurance;

[~~(5)~~**] (10)** Nothing in this subsection shall limit the director's authority over excessive, inadequate or unfairly discriminatory rates **or affect the application of any any laws governing unfair trade practices, unfair claims practices or the content of policy forms;**

(11) The commercial casualty and commercial property insurance filing requirement exemptions included in this section shall apply to all property and casualty insurance policies issued or renewed on or after January 1, 2018."; and

Further amend said bill, Pages 6-7, Section 379.386, Lines 1-60, by removing all of said section and lines from the bill; and

Further amend said bill, Page 7, Section 379.387, Lines 1-2, by removing all of said section and lines from the bill; and

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

On motion of Representative Engler, **House Amendment No. 1** was adopted.

Representative McGaugh offered **House Amendment No. 2**.

House Amendment No. 2

AMEND House Committee Bill No. 10, Page 2, Section 316.160, Lines 15 to 18, by deleting the words, "**any county of the third classification with a township form of government and with more than nine thousand but fewer than ten thousand inhabitants and with a special charter city with more than three thousand but fewer than four thousand inhabitants as the county seat,**"; and

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

On motion of Representative McGaugh, **House Amendment No. 2** was adopted.

Representative Hill offered **House Amendment No. 3**.

House Amendment No. 3

AMEND House Committee Bill No. 10, Page 3, Section 374.191, Line 9, by inserting after all of said line the following:

"**376.008. All short-term major medical policies sold in this state shall include on any application for coverage and on the fact page of all policies a conspicuous and clearly captioned paragraph stating that, "this policy does not satisfy the individual mandate of the Affordable Care Act and you may be subject to the individual shared responsibility payment fee**".

376.385. 1. Each entity offering individual and group health insurance policies providing coverage on an expense-incurred basis, individual and group service or indemnity type contracts issued by a health services corporation, individual and group service contracts issued by a health maintenance organization, all self-insured group arrangements, to the extent not preempted by federal law, and all managed health care delivery entities of any type or description, that are delivered, issued for delivery, continued or renewed in this state on or after January 1,

1998, shall offer coverage for all physician-prescribed medically appropriate and necessary equipment, supplies and self-management training used in the management and treatment of diabetes. Coverage shall include persons with gestational, type I or type II diabetes.

2. Health care services required by this section shall not be subject to any greater deductible or co-payment than any other health care service provided by the policy, contract or plan.

3. No entity enumerated in subsection 1 of this section may reduce or eliminate coverage due to the requirements of this section.

4. Nothing in this section shall apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, **short-term major medical policies having a duration of less than one year,** or other limited benefit health insurance policies.

376.429. 1. All health benefit plans, as defined in section 376.1350, that are delivered, issued for delivery, continued or renewed on or after August 28, 2006, and providing coverage to any resident of this state shall provide coverage for routine patient care costs as defined in subsection 7 of this section incurred as the result of phase II, III, or IV of a clinical trial that is approved by an entity listed in subsection 4 of this section and is undertaken for the purposes of the prevention, early detection, or treatment of cancer. Health benefit plans may limit coverage for the routine patient care costs of patients in phase II of a clinical trial to those treating facilities within the health benefit plans' provider network; except that, this provision shall not be construed as relieving a health benefit plan of the sufficiency of network requirements under state statute.

2. In the case of treatment under a clinical trial, the treating facility and personnel must have the expertise and training to provide the treatment and treat a sufficient volume of patients. There must be equal to or superior, noninvestigational treatment alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the noninvestigational alternatives.

3. Coverage required by this section shall include coverage for routine patient care costs incurred for drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, including coverage for reasonable and medically necessary services needed to administer the drug or use the device under evaluation in the clinical trial.

4. Subsections 1 and 2 of this section requiring coverage for routine patient care costs shall apply to phase III or IV of clinical trials that are approved or funded by one of the following entities:

(1) One of the National Institutes of Health (NIH);

(2) An NIH cooperative group or center as defined in subsection 7 of this section;

(3) The FDA in the form of an investigational new drug application;

(4) The federal Departments of Veterans' Affairs or Defense;

(5) An institutional review board in this state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects (45 CFR 46); or

(6) A qualified research entity that meets the criteria for NIH Center support grant eligibility.

5. Subsections 1 and 2 of this section requiring coverage for routine patient care costs shall apply to phase II of clinical trials if:

(1) Phase II of a clinical trial is sanctioned by the National Institutes of Health (NIH) or National Cancer Institute (NCI) and conducted at academic or National Cancer Institute Center; and

(2) The person covered under this section is enrolled in the clinical trial. This section shall not apply to persons who are only following the protocol of phase II of a clinical trial, but not actually enrolled.

6. An entity seeking coverage for treatment, prevention, or early detection in a clinical trial approved by an institutional review board under subdivision (5) of subsection 4 of this section shall maintain and post electronically a list of the clinical trials meeting the requirements of subsections 2 and 3 of this section. This list shall include: the phase for which the clinical trial is approved; the entity approving the trial; the particular disease; and the number of participants in the trial. If the electronic posting is not practical, the entity seeking coverage shall periodically provide payers and providers in the state with a written list of trials providing the information required in this section.

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

(1) "Cooperative group", a formal network of facilities that collaborate on research projects and have an established NIH-approved Peer Review Program operating within the group, including the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program;

(2) "Multiple project assurance contract", a contract between an institution and the federal Department of Health and Human Services (DHHS) that defines the relationship of the institution to the DHHS and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects;

(3) "Routine patient care costs" shall include coverage for reasonable and medically necessary services needed to administer the drug or device under evaluation in the clinical trial. Routine patient care costs include all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except:

(a) The investigational item or service itself;

(b) Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and

(c) Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

8. For the purpose of this section, providers participating in clinical trials shall obtain a patient's informed consent for participation on the clinical trial in a manner that is consistent with current legal and ethical standards. Such documents shall be made available to the health insurer upon request.

9. The provisions of this section shall not apply to a policy, plan or contract paid under Title XVIII or Title XIX of the Social Security Act.

10. Nothing in this section shall apply to any accident-only policy, specified disease policy, hospital indemnity policy, Medicare supplement policy, long-term care policy, short-term major medical policy **[**~~of six months or less duration~~**] having a duration of less than one year**, or other limited benefit health insurance policies.

11. The provisions of this section regarding phase II of a clinical trial shall not apply automatically to an individually underwritten health benefit plan, but shall be an option to any such plan.

376.446. 1. Health carriers shall permit individuals to learn the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's health benefit plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, such information shall be made available to such individual through an internet website and such other means for individuals without access to the internet. As used in this section, the terms "health carrier" and "health benefit plans" shall have the same meanings assigned to them in section 376.1350.

2. This section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, hospitalization-surgical care policy, short-term major medical policy **[**~~of six months or less duration~~**] having a duration of less than one year**, or any other supplemental policy.

3. The provisions of subsections 1 and 2 shall become effective on January 1, 2014."; and

Further amend said bill, Page 4, Section 376.625, Line 10, by inserting after all of said line the following:

"376.779. 1. All health plans or policies that are individually underwritten or provide for such coverage for specific individuals and the members of their families, which provide for hospital treatment, shall provide coverage, while confined in a hospital or in a residential or nonresidential facility certified by the department of mental health, for treatment of alcoholism on the same basis as coverage for any other illness, except that coverage may be limited to thirty days in any policy or contract benefit period. All Missouri individual contracts issued on or after January 1, 2005, shall be subject to this section. Coverage required by this section shall be included in the policy or contract and payment provided as for other coverage in the same policy or contract notwithstanding any construction or relationship of interdependent contracts or plans affecting coverage and payment of reimbursement prerequisites under the policy or contract.

2. Insurers, corporations or groups providing coverage may approve for payment or reimbursement vendors and programs providing services or treatment required by this section. Any vendor or person offering services or treatment subject to the provisions of this section and seeking approval for payment or reimbursement shall submit to the department of mental health a detailed description of the services or treatment program to be offered. The department of mental health shall make copies of such descriptions available to insurers, corporations or groups providing coverage under the provisions of this section. Each insurer, corporation or group providing coverage shall notify the vendor or person offering service or treatment as to its acceptance or rejection for payment or reimbursement; provided, however, payment or reimbursement shall be made for any service or treatment program certified by the department of mental health. Any notice of rejection shall contain a detailed statement of the reasons for rejection and the steps and procedures necessary for acceptance. Amended descriptions of services or treatment programs to be offered may be filed with the department of mental health. Any vendor or person

rejected for approval of payment or reimbursement may modify their description and treatment program and submit copies of the amended description to the department of mental health and to the insurer, corporation or group which rejected the original description.

3. The department of mental health may issue rules necessary to carry out the provisions of this section. No rule or portion of a rule promulgated under the authority of this section shall become effective unless it has been promulgated pursuant to the provisions of section 536.024.

4. All substance abuse treatment programs in Missouri receiving funding from the Missouri department of mental health must be certified by the department.

5. This section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, hospitalization-surgical care policy, short-term major medical policy **[**~~of six months or less duration~~**] having a duration of less than one year**, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

376.781. 1. All group health insurance policies providing coverage on an expense-incurred basis, all group service or indemnity contracts issued by a not-for-profit health service corporation, all self-insured group health benefit plans of any type or description, and all such health plans or policies that are individually underwritten or provide for such coverage for specific individuals and the members of their families as nongroup policies, which provide for hospital treatment, shall offer coverage for the necessary care and treatment of loss or impairment of speech or hearing subject to the same durational limits, dollar limits, deductibles and coinsurance factors as other covered services in such policies or contracts. All Missouri group contracts issued or renewed on or after December 31, 1984, shall be subject to this section. Notwithstanding any construction or relationship of interdependent contracts or plans affecting coverage and payment of reimbursement prerequisites under the policy or contract, coverage required by this section shall be included in the policy or contract and payment provided as for other coverage in the same policy or contract.

2. The offer of benefits under subsection 1 of this section shall be in writing and may be rejected by the individual or group policyholder.

3. Nothing in this section shall prohibit the insurance company or not-for-profit health service corporation from including any coverage for loss or impairment of speech, language or hearing as standard coverage in their policies or contracts, but same shall not contain terms contrary to this section.

4. The phrase "loss or impairment of speech or hearing" shall include those communicative disorders generally treated by a speech pathologist, audiologist or speech/language pathologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association (ASHA), or both, and which fall within the scope of his or her license or certification.

5. Any provision in a health insurance policy contrary to or in conflict with the provisions of this section shall, to the extent of the conflict, be void, but such invalidity shall not offset the validity of the other provisions of such policy.

6. The department of insurance, financial institutions and professional registration may issue rules necessary to carry out the provisions of this section. No rule or portion of a rule promulgated under the authority of this section shall become effective unless it has been promulgated pursuant to the provisions of section 536.024.

7. This section shall not apply to short-term major medical policies having a duration of less than one year.

376.811. 1. Every insurance company and health services corporation doing business in this state shall offer in all health insurance policies benefits or coverage for chemical dependency meeting the following minimum standards:

(1) Coverage for outpatient treatment through a nonresidential treatment program, or through partial- or full-day program services, of not less than twenty-six days per policy benefit period;

(2) Coverage for residential treatment program of not less than twenty-one days per policy benefit period;

(3) Coverage for medical or social setting detoxification of not less than six days per policy benefit period;

(4) The coverages set forth in this subsection may be subject to a separate lifetime frequency cap of not less than ten episodes of treatment, except that such separate lifetime frequency cap shall not apply to medical detoxification in a life-threatening situation as determined by the treating physician and subsequently documented within forty-eight hours of treatment to the reasonable satisfaction of the insurance company or health services corporation; and

(5) The coverages set forth in this subsection:

(a) Shall be subject to the same coinsurance, co-payment and deductible factors as apply to physical illness;

(b) May be administered pursuant to a managed care program established by the insurance company or health services corporation; and

(c) May deliver covered services through a system of contractual arrangements with one or more providers, hospitals, nonresidential or residential treatment programs, or other mental health service delivery entities certified by the department of mental health, or accredited by a nationally recognized organization, or licensed by the state of Missouri.

2. In addition to the coverages set forth in subsection 1 of this section, every insurance company, health services corporation and health maintenance organization doing business in this state shall offer in all health insurance policies, benefits or coverages for recognized mental illness, excluding chemical dependency, meeting the following minimum standards:

(1) Coverage for outpatient treatment, including treatment through partial- or full-day program services, for mental health services for a recognized mental illness rendered by a licensed professional to the same extent as any other illness;

(2) Coverage for residential treatment programs for the therapeutic care and treatment of a recognized mental illness when prescribed by a licensed professional and rendered in a psychiatric residential treatment center licensed by the department of mental health or accredited by the Joint Commission on Accreditation of Hospitals to the same extent as any other illness;

(3) Coverage for inpatient hospital treatment for a recognized mental illness to the same extent as for any other illness, not to exceed ninety days per year;

(4) The coverages set forth in this subsection shall be subject to the same coinsurance, co-payment, deductible, annual maximum and lifetime maximum factors as apply to physical illness; and

(5) The coverages set forth in this subsection may be administered pursuant to a managed care program established by the insurance company, health services corporation or health maintenance organization, and covered services may be delivered through a system of contractual arrangements with one or more providers, community mental health centers, hospitals, nonresidential or residential treatment programs, or other mental health service delivery entities certified by the department of mental health, or accredited by a nationally recognized organization, or licensed by the state of Missouri.

3. The offer required by sections 376.810 to 376.814 may be accepted or rejected by the group or individual policyholder or contract holder and, if accepted, shall fully and completely satisfy and substitute for the coverage under section 376.779. Nothing in sections 376.810 to 376.814 shall prohibit an insurance company, health services corporation or health maintenance organization from including all or part of the coverages set forth in sections 376.810 to 376.814 as standard coverage in their policies or contracts issued in this state.

4. Every insurance company, health services corporation and health maintenance organization doing business in this state shall offer in all health insurance policies mental health benefits or coverage as part of the policy or as a supplement to the policy. Such mental health benefits or coverage shall include at least two sessions per year to a licensed psychiatrist, licensed psychologist, licensed professional counselor, licensed clinical social worker, or, subject to contractual provisions, a licensed marital and family therapist, acting within the scope of such license and under the following minimum standards:

(1) Coverage and benefits in this subsection shall be for the purpose of diagnosis or assessment, but not dependent upon findings; and

(2) Coverage and benefits in this subsection shall not be subject to any conditions of preapproval, and shall be deemed reimbursable as long as the provisions of this subsection are satisfied; and

(3) Coverage and benefits in this subsection shall be subject to the same coinsurance, co-payment and deductible factors as apply to regular office visits under coverages and benefits for physical illness.

5. If the group or individual policyholder or contract holder rejects the offer required by this section, then the coverage shall be governed by the mental health and chemical dependency insurance act as provided in sections 376.825 to 376.836.

6. This section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, hospitalization-surgical care policy, short-term major medical policy **[**~~of six months or less duration~~**] having a duration of less than one year**, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

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

(1) "Eating disorder", pica, rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa, binge eating disorder, other specified feeding or eating disorder, and any other eating disorder contained in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association where diagnosed by a licensed physician, psychiatrist, psychologist, clinical social worker, licensed marital and family therapist, or professional counselor duly licensed in the state where he or she practices and acting within their applicable scope of practice in the state where he or she practices;

(2) "Health benefit plan", shall have the same meaning as such term is defined in section 376.1350; however, for purposes of this section "health benefit plan" does not include a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policy **[**~~of six months or less duration~~**] having a duration of less than one year**, or any other supplemental policy;

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

(4) "Medical care", health care services needed to diagnose, prevent, treat, cure, or relieve physical manifestations of an eating disorder, and shall include inpatient hospitalization, partial hospitalization, residential care, intensive outpatient treatment, follow-up outpatient care, and counseling;

(5) "Pharmacy care", medications prescribed by a licensed physician for an eating disorder and includes any health-related services deemed medically necessary to determine the need or effectiveness of the medications, but only to the extent that such medications are included in the insured's health benefit plan;

(6) "Psychiatric care" and "psychological care", direct or consultative services provided during inpatient hospitalization, partial hospitalization, residential care, intensive outpatient treatment, follow-up outpatient care, and counseling provided by a psychiatrist or psychologist licensed in the state of practice;

(7) "Therapy", medical care and behavioral interventions provided by a duly licensed physician, psychiatrist, psychologist, professional counselor, licensed clinical social worker, or family marriage therapist where said person is licensed or registered in the states where he or she practices;

(8) "Treatment of eating disorders", therapy provided by a licensed treating physician, psychiatrist, psychologist, professional counselor, clinical social worker, or licensed marital and family therapist pursuant to the powers granted under such licensed physician's, psychiatrist's, psychologist's, professional counselor's, clinical social worker's, or licensed marital and family therapist's license in the state where he or she practices for an individual diagnosed with an eating disorder.

2. In accordance with the provisions of section 376.1550, all health benefit plans that are delivered, issued for delivery, continued or renewed on or after January 1, 2017, if written inside the state of Missouri, or written outside the state of Missouri but covering Missouri residents, shall provide coverage for the diagnosis and treatment of eating disorders as required in section 376.1550.

3. Coverage provided under this section is limited to medically necessary treatment that is provided by a licensed treating physician, psychiatrist, psychologist, professional counselor, clinical social worker, or licensed marital and family therapist pursuant to the powers granted under such licensed physician's, psychiatrist's, psychologist's, professional counselor's, clinical social worker's, or licensed marital and family therapist's license and acting within their applicable scope of coverage, in accordance with a treatment plan.

4. The treatment plan, upon request by the health benefit plan or health carrier, shall include all elements necessary for the health benefit plan or health carrier to pay claims. Such elements include, but are not limited to, a diagnosis, proposed treatment by type, frequency and duration of treatment, and goals.

5. Coverage of the treatment of eating disorders may be subject to other general exclusions and limitations of the contract or benefit plan not in conflict with the provisions of this section, such as coordination of benefits, and utilization review of health care services, which includes reviews of medical necessity and care management. Medical necessity determinations and care management for the treatment of eating disorders shall consider the overall medical and mental health needs of the individual with an eating disorder, shall not be based solely on weight, and shall take into consideration the most recent Practice Guideline for the Treatment of Patients with Eating Disorders adopted by the American Psychiatric Association in addition to current standards based upon the medical literature generally recognized as authoritative in the medical community."; and

Further amend said bill, Page 4, Section 376.1110, Line 19, by inserting after all of said line the following:

"376.1192. 1. As used in this section, "health benefit plan" and "health carrier" shall have the same meaning as such terms are defined in section 376.1350.

2. Beginning September 1, 2013, the oversight division of the joint committee on legislative research shall perform an actuarial analysis of the cost impact to health carriers, insureds with a health benefit plan, and other private and public payers if state mandates were enacted to provide health benefit plan coverage for the following:

(1) Orally administered anticancer medication that is used to kill or slow the growth of cancerous cells charged at the same co-payment, deductible, or coinsurance amount as intravenously administered or injected cancer medication that is provided, regardless of formulation or benefit category determination by the health carrier administering the health benefit plan;

(2) Diagnosis and treatment of eating disorders that include anorexia nervosa, bulimia, binge eating, eating disorders nonspecified, and any other severe eating disorders contained in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. The actuarial analysis shall assume the following are included in health benefit plan coverage:

(a) Residential treatment for eating disorders, if such treatment is medically necessary in accordance with the Practice Guidelines for the Treatment of Patients with Eating Disorders, as most recently published by the American Psychiatric Association; and

(b) Access to medical treatment that provides coverage for integrated care and treatment as recommended by medical and mental health care professionals, including but not limited to psychological services, nutrition counseling, physical therapy, dietician services, medical monitoring, and psychiatric monitoring.

3. By December 31, 2013, the director of the oversight division of the joint committee on legislative research shall submit a report of the actuarial findings prescribed by this section to the speaker of the house of representatives, the president pro tempore of the senate, and the chairpersons of the house of representatives committee on health insurance and the senate small business, insurance and industry committee, or the committees having jurisdiction over health insurance issues if the preceding committees no longer exist.

4. For the purposes of this section, the actuarial analysis of health benefit plan coverage shall assume that such coverage:

(1) Shall not be subject to any greater deductible or co-payment than other health care services provided by the health benefit plan; and

(2) Shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policies **[**~~of six months' or less duration~~**] having a duration of less than one year**, or any other supplemental policy.

5. The cost for each actuarial analysis shall not exceed thirty thousand dollars and the oversight division of the joint committee on legislative research may utilize any actuary contracted to perform services for the Missouri consolidated health care plan to perform the analysis required under this section.

6. The provisions of this section shall expire on December 31, 2013.

376.1199. 1. Each health carrier or health benefit plan that offers or issues health benefit plans providing obstetrical/gynecological benefits and pharmaceutical coverage, which are delivered, issued for delivery, continued or renewed in this state on or after January 1, 2002, shall:

(1) Notwithstanding the provisions of subsection 4 of section 354.618, provide enrollees with direct access to the services of a participating obstetrician, participating gynecologist or participating obstetrician/gynecologist of her choice within the provider network for covered services. The services covered by this subdivision shall be limited to those services defined by the published recommendations of the accreditation council for graduate medical education for training an obstetrician, gynecologist or obstetrician/gynecologist, including but not limited to diagnosis, treatment and referral for such services. A health carrier shall not impose additional co-payments, coinsurance or deductibles upon any enrollee who seeks or receives health care services pursuant to this subdivision, unless similar additional co-payments, coinsurance or deductibles are imposed for other types of health care services received within the provider network. Nothing in this subsection shall be construed to require a health carrier to perform, induce, pay for, reimburse, guarantee, arrange, provide any resources for or refer a patient for an abortion, as defined in section 188.015, other than a spontaneous abortion or to prevent the death of the female upon whom the abortion is performed, or to supersede or conflict with section 376.805; and

(2) Notify enrollees annually of cancer screenings covered by the enrollees' health benefit plan and the current American Cancer Society guidelines for all cancer screenings or notify enrollees at intervals consistent with current American Cancer Society guidelines of cancer screenings which are covered by the enrollees' health benefit

plans. The notice shall be delivered by mail unless the enrollee and health carrier have agreed on another method of notification; and

(3) Include coverage for services related to diagnosis, treatment and appropriate management of osteoporosis when such services are provided by a person licensed to practice medicine and surgery in this state, for individuals with a condition or medical history for which bone mass measurement is medically indicated for such individual. In determining whether testing or treatment is medically appropriate, due consideration shall be given to peer-reviewed medical literature. A policy, provision, contract, plan or agreement may apply to such services the same deductibles, coinsurance and other limitations as apply to other covered services; and

(4) If the health benefit plan also provides coverage for pharmaceutical benefits, provide coverage for contraceptives either at no charge or at the same level of deductible, coinsurance or co-payment as any other covered drug.

No such deductible, coinsurance or co-payment shall be greater than any drug on the health benefit plan's formulary. As used in this section, "contraceptive" shall include all prescription drugs and devices approved by the federal Food and Drug Administration for use as a contraceptive, but shall exclude all drugs and devices that are intended to induce an abortion, as defined in section 188.015, which shall be subject to section 376.805. Nothing in this subdivision shall be construed to exclude coverage for prescription contraceptive drugs or devices ordered by a health care provider with prescriptive authority for reasons other than contraceptive or abortion purposes.

2. For the purposes of this section, "health carrier" and "health benefit plan" shall have the same meaning as defined in section 376.1350.

3. The provisions of this section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policies **[**~~of six months or less duration~~**] having a duration of less than one year**, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

4. Notwithstanding the provisions of subdivision (4) of subsection 1 of this section to the contrary:

(1) Any health carrier shall offer and issue to any person or entity purchasing a health benefit plan, a health benefit plan that excludes coverage for contraceptives if the use or provision of such contraceptives is contrary to the moral, ethical or religious beliefs or tenets of such person or entity;

(2) Upon request of an enrollee who is a member of a group health benefit plan and who states that the use or provision of contraceptives is contrary to his or her moral, ethical or religious beliefs, any health carrier shall issue to or on behalf of such enrollee a policy form that excludes coverage for contraceptives. Any administrative costs to a group health benefit plan associated with such exclusion of coverage not offset by the decreased costs of providing coverage shall be borne by the group policyholder or group plan holder;

(3) Any health carrier which is owned, operated or controlled in substantial part by an entity that is operated pursuant to moral, ethical or religious tenets that are contrary to the use or provision of contraceptives shall be exempt from the provisions of subdivision (4) of subsection 1 of this section. For purposes of this subsection, if new premiums are charged for a contract, plan or policy, it shall be determined to be a new contract, plan or policy.

5. Except for a health carrier that is exempted from providing coverage for contraceptives pursuant to this section, a health carrier shall allow enrollees in a health benefit plan that excludes coverage for contraceptives pursuant to subsection 4 of this section to purchase a health benefit plan that includes coverage for contraceptives.

6. Any health benefit plan issued pursuant to subsection 1 of this section shall provide clear and conspicuous written notice on the enrollment form or any accompanying materials to the enrollment form and the group health benefit plan application and contract:

(1) Whether coverage for contraceptives is or is not included;

(2) That an enrollee who is a member of a group health benefit plan with coverage for contraceptives has the right to exclude coverage for contraceptives if such coverage is contrary to his or her moral, ethical or religious beliefs;

(3) That an enrollee who is a member of a group health benefit plan without coverage for contraceptives has the right to purchase coverage for contraceptives;

(4) Whether an optional rider for elective abortions has been purchased by the group contract holder pursuant to section 376.805; and

(5) That an enrollee who is a member of a group health plan with coverage for elective abortions has the right to exclude and not pay for coverage for elective abortions if such coverage is contrary to his or her moral, ethical, or religious beliefs.

For purposes of this subsection, if new premiums are charged for a contract, plan, or policy, it shall be determined to be a new contract, plan, or policy.

7. Health carriers shall not disclose to the person or entity who purchased the health benefit plan the names of enrollees who exclude coverage for contraceptives in the health benefit plan or who purchase a health benefit plan that includes coverage for contraceptives. Health carriers and the person or entity who purchased the health benefit plan shall not discriminate against an enrollee because the enrollee excluded coverage for contraceptives in the health benefit plan or purchased a health benefit plan that includes coverage for contraceptives.

8. The departments of health and senior services and insurance, financial institutions and professional registration may promulgate rules necessary to implement the provisions of this section. No rule or portion of a rule promulgated pursuant to this section shall become effective unless it has been promulgated pursuant to chapter 536. 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, 2001, shall be invalid and void.

376.1200. 1. Each entity offering individual and group health insurance policies providing coverage on an expense-incurred basis, individual and group service or indemnity type contracts issued by a health services corporation, individual and group service contracts issued by a health maintenance organization, all self-insured group arrangements to the extent not preempted by federal law and all managed health care delivery entities of any type or description, that are delivered, issued for delivery, continued or renewed in this state on or after January 1, 1996, shall offer coverage for the treatment of breast cancer by dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants. The offer of benefits under this section shall be in writing and must be accepted in writing by the individual or group policyholder or contract holder.

2. Such health care service shall not be subject to any greater deductible or co-payment than any other health care service provided by the policy, contract or plan, except that the policy, contract or plan may contain a provision imposing a lifetime benefit maximum of not less than one hundred thousand dollars, for dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants for breast cancer treatment.

3. Benefits may be administered for such health care service through a managed care program of exclusive and/or preferred contractual arrangements with one or more providers rendering such health care service. These contractual arrangements may provide that the provider shall hold the patient harmless for the cost of rendering such health care service if it is subsequently found by the entity authorized to resolve disputes that:

(1) Such care did not qualify under the protocols established for the providing of care for such health care service;

(2) Such care was not medically appropriate; or

(3) The provider otherwise failed to comply with the utilization management or other managed care provision agreed to in any contract between the entity and the provider.

4. The provisions of this section shall not apply to short-term travel, accident-only, limited or specified disease policies, or to short-term nonrenewable policies of **[**~~not more than seven months duration~~**] having a duration less than one year**.

5. Nothing in this section shall prohibit an entity from including all or part of such health care services as standard coverage in its policies, contracts or plans.

376.1215. 1. All individual and group health insurance policies providing coverage on an expense-incurred basis, individual and group service or indemnity type contracts issued by a health services corporation, individual and group service contracts issued by a health maintenance organization and all self-insured group arrangements to the extent not preempted by federal law and all managed health care delivery entities of any type or description shall provide coverage for immunizations of a child from birth to five years of age as provided by department of health and senior services regulations.

2. Such coverage shall not be subject to any deductible or co-payment limits.

3. The contract issued by a health maintenance organization may provide that the benefits required pursuant to this section shall be covered benefits only if the services are rendered by a provider who is designated by and affiliated with the health maintenance organization, except that the health maintenance organization shall, as a condition of participation, comply with the immunization requirements of state or federally funded health programs.

4. This section shall not apply to supplemental insurance policies, including life care contracts, accident-only policies, specified disease policies, hospital policies providing a fixed daily benefit only, Medicare supplement policies, long-term care policies, coverage issued as a supplement to liability insurance, short-term major medical policies **[**~~of six months or less duration~~**] having a duration of less than one year,** and other supplemental policies as determined by the department of insurance, financial institutions and professional registration.

5. The department of health and senior services shall promulgate rules and regulations to determine which immunizations shall be covered by policies, plans or contracts described in this section. No rule or portion of a rule promulgated under the authority of this section shall become effective unless it has been promulgated pursuant to the provisions of section 536.024.

6. No health care provider shall charge more than one hundred percent of the reasonable and customary charges for providing any immunization.

376.1218. 1. Any health carrier or health benefit plan that offers or issues health benefit plans, other than Medicaid health benefit plans, which are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2006, shall provide coverage for early intervention services described in this section that are delivered by early intervention specialists who are health care professionals licensed by the state of Missouri and acting within the scope of their professions for children from birth to age three identified by the Part C early intervention system as eligible for services under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section 1431, et seq. Such coverage shall be limited to three thousand dollars for each covered child per policy per calendar year, with a maximum of nine thousand dollars per child.

2. As used in this section, "health carrier" and "health benefit plan" shall have the same meaning as such terms are defined in section 376.1350.

3. In the event that any health benefit plan is found not to be required to provide coverage under subsection 1 of this section because of preemption by a federal law, including but not limited to the act commonly known as ERISA contained in Title 29 of the United States Code, or in the event that subsection 1 of this section is found to be unconstitutional, then the lead agency shall be responsible for payment and provision of any benefit provided under this section.

4. For purposes of this section, "early intervention services" means medically necessary speech and language therapy, occupational therapy, physical therapy, and assistive technology devices for children from birth to age three who are identified by the Part C early intervention system as eligible for services under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section 1431, et seq. Early intervention services shall include services under an active individualized family service plan that enhance functional ability without effecting a cure. An individualized family service plan is a written plan for providing early intervention services to an eligible child and the child's family that is adopted in accordance with 20 U.S.C. Section 1436. The Part C early intervention system, on behalf of its contracted regional Part C early intervention system centers and providers, shall be considered the rendering provider of services for purposes of this section.

5. No payment made for specified early intervention services shall be applied by the health carrier or health benefit plan against any maximum lifetime aggregate specified in the policy or health benefit plan if the carrier opts to satisfy its obligations under this section under subdivision (2) of subsection 7 of this section. A health benefit plan shall be billed at the applicable Medicaid rate at the time the covered benefit is delivered, and the health benefit plan shall pay the Part C early intervention system at such rate for benefits covered by this section. Services under the Part C early intervention system shall be delivered as prescribed by the individualized family service plan and an electronic claim filed in accordance with the carrier's or plan's standard format. Beginning January 1, 2007, such claims' payments shall be made in accordance with the provisions of sections 376.383 and 376.384.

6. The health care service required by this section shall not be subject to any greater deductible, co-payment, or coinsurance than other similar health care services provided by the health benefit plan.

7. (1) Subject to the provisions of this section, payments made during a calendar year by a health carrier or group of carriers affiliated by or under common ownership or control to the Part C early intervention system for services provided to children covered by the Part C early intervention system shall not exceed one-half of one percent of the direct written premium for health benefit plans as reported to the department of insurance, financial institutions and professional registration on the health carrier's most recently filed annual financial statement.

(2) In lieu of reimbursing claims under this section, a carrier or group of carriers affiliated by or under common ownership or control may, on behalf of all of the carrier's or carriers' health benefit plan or plans providing coverage under this section, directly pay the Part C early intervention system by January thirty-first of the calendar year an amount equal to one-half of one percent of the direct written premium for health benefit plans as reported to the department of insurance, financial institutions and professional registration on the health carrier's most recently filed annual financial statement, or five hundred thousand dollars, whichever is less, and such payment shall constitute full and complete satisfaction of the health benefit plan's obligation for the calendar year. Nothing in this subsection shall require a health carrier or health benefit plan providing coverage under this section to amend or modify any provision of an existing policy or plan relating to the payment or reimbursement of claims by the health carrier or health benefit plan.

8. This section shall not apply to a supplemental insurance policy, including a life care contract, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, hospitalization-surgical care policy, policy that is individually underwritten or provides such coverage for specific individuals and members of their families, long-term care policy, or short-term major medical policies **[**~~of six months or less duration~~**] having a duration of less than one year**.

9. Except for health carriers or health benefit plans making payments under subdivision (2) of subsection 7 of this section, the department of insurance, financial institutions and professional registration shall collect data related to the number of children receiving private insurance coverage under this section and the total amount of moneys paid on behalf of such children by private health carriers or health benefit plans. The department shall report to the general assembly regarding the department's findings no later than January 30, 2007, and annually thereafter.

10. Notwithstanding the provisions of section 23.253 to the contrary, the provisions of this section shall not sunset.

376.1219. 1. Each policy issued by an entity offering individual and group health insurance which provides coverage on an expense-incurred basis, individual and group health service or indemnity type contracts issued by a nonprofit corporation, individual and group service contracts issued by a health maintenance organization, all self-insured group health arrangements to the extent not preempted by federal law, and all health care plans provided by managed health care delivery entities of any type or description, that are delivered, issued for delivery, continued or renewed in this state on or after September 1, 1997, shall provide coverage for formula and low protein modified food products recommended by a physician for the treatment of a patient with phenylketonuria or any inherited disease of amino and organic acids who is covered under the policy, contract, or plan and who is less than six years of age.

2. For purposes of this section, "low protein modified food products" means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a physician for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

3. The coverage required by this section may be subject to the same deductible for similar health care services provided by the policy, contract, or plan as well as a reasonable coinsurance or co-payment on the part of the insured, which shall not be greater than fifty percent of the cost of the formula and food products, and may be subject to an annual benefit maximum of not less than five thousand dollars per covered child. Nothing in this section shall prohibit a carrier from using individual case management or from contracting with vendors of the formula and food products.

4. This section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, **short-term major medical policies having a duration of less than one year,** or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

376.1220. 1. Each policy issued by an entity offering individual and group health insurance which provides coverage on an expense-incurred basis, individual or group health service, or indemnity contracts issued by a nonprofit corporation, individual and group service contracts issued by a health maintenance organization, all self-insured group health arrangements to the extent not preempted by federal law, and all health care plans provided by

managed health care delivery entities of any type or description that are delivered, issued for delivery, continued or renewed in this state shall provide coverage for newborn hearing screening, necessary rescreening, audiological assessment and follow-up, and initial amplification.

2. The health care service required by this section shall not be subject to any greater deductible or co-payment than other similar health care services provided by the policy, contract or plan.

3. This section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policies **[**~~of six months or less duration~~**] having a duration of less than one year**, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

4. Coverage for newborn hearing screening and any necessary rescreening and audiological assessment shall be provided to newborns eligible for medical assistance pursuant to section 208.151, and the children's health program pursuant to sections 208.631 to 208.660, with payment for the newborn hearing screening required in section 191.925, and any necessary rescreening, audiological assessment and follow-up, and amplification as described in section 191.928.

376.1224. 1. For purposes of this section, the following terms shall mean:

(1) "Applied behavior analysis", the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior;

(2) "Autism service provider":

(a) Any person, entity, or group that provides diagnostic or treatment services for autism spectrum disorders who is licensed or certified by the state of Missouri; or

(b) Any person who is licensed under chapter 337 as a board-certified behavior analyst by the behavior analyst certification board or licensed under chapter 337 as an assistant board-certified behavior analyst;

(3) "Autism spectrum disorders", a neurobiological disorder, an illness of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association;

(4) "Diagnosis of autism spectrum disorders", medically necessary assessments, evaluations, or tests in order to diagnose whether an individual has an autism spectrum disorder;

(5) "Habilitative or rehabilitative care", professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are necessary to develop the functioning of an individual;

(6) "Health benefit plan", shall have the same meaning ascribed to it as in section 376.1350;

(7) "Health carrier", shall have the same meaning ascribed to it as in section 376.1350;

(8) "Line therapist", an individual who provides supervision of an individual diagnosed with an autism diagnosis and other neurodevelopmental disorders pursuant to the prescribed treatment plan, and implements specific behavioral interventions as outlined in the behavior plan under the direct supervision of a licensed behavior analyst;

(9) "Pharmacy care", medications used to address symptoms of an autism spectrum disorder prescribed by a licensed physician, and any health-related services deemed medically necessary to determine the need or effectiveness of the medications only to the extent that such medications are included in the insured's health benefit plan;

(10) "Psychiatric care", direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices;

(11) "Psychological care", direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices;

(12) "Therapeutic care", services provided by licensed speech therapists, occupational therapists, or physical therapists;

(13) "Treatment for autism spectrum disorders", care prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist, including equipment medically necessary for such care, pursuant to the powers granted under such licensed physician's or licensed psychologist's license, including, but not limited to:

(a) Psychiatric care;

(b) Psychological care;

(c) Habilitative or rehabilitative care, including applied behavior analysis therapy;

(d) Therapeutic care;

(e) Pharmacy care.

2. All group health benefit plans that are delivered, issued for delivery, continued, or renewed on or after January 1, 2011, if written inside the state of Missouri, or written outside the state of Missouri but insuring Missouri residents, shall provide coverage for the diagnosis and treatment of autism spectrum disorders to the extent that such diagnosis and treatment is not already covered by the health benefit plan.

3. With regards to a health benefit plan, a health carrier shall not deny or refuse to issue coverage on, refuse to contract with, or refuse to renew or refuse to reissue or otherwise terminate or restrict coverage on an individual or their dependent because the individual is diagnosed with autism spectrum disorder.

4. (1) Coverage provided under this section is limited to medically necessary treatment that is ordered by the insured's treating licensed physician or licensed psychologist, pursuant to the powers granted under such licensed physician's or licensed psychologist's license, in accordance with a treatment plan.

(2) The treatment plan, upon request by the health benefit plan or health carrier, shall include all elements necessary for the health benefit plan or health carrier to pay claims. Such elements include, but are not limited to, a diagnosis, proposed treatment by type, frequency and duration of treatment, and goals.

(3) Except for inpatient services, if an individual is receiving treatment for an autism spectrum disorder, a health carrier shall have the right to review the treatment plan not more than once every six months unless the health carrier and the individual's treating physician or psychologist agree that a more frequent review is necessary. Any such agreement regarding the right to review a treatment plan more frequently shall only apply to a particular individual being treated for an autism spectrum disorder and shall not apply to all individuals being treated for autism spectrum disorders by a physician or psychologist. The cost of obtaining any review or treatment plan shall be borne by the health benefit plan or health carrier, as applicable.

5. Coverage provided under this section for applied behavior analysis shall be subject to a maximum benefit of forty thousand dollars per calendar year for individuals through eighteen years of age. Such maximum benefit limit may be exceeded, upon prior approval by the health benefit plan, if the provision of applied behavior analysis services beyond the maximum limit is medically necessary for such individual. Payments made by a health carrier on behalf of a covered individual for any care, treatment, intervention, service or item, the provision of which was for the treatment of a health condition unrelated to the covered individual's autism spectrum disorder, shall not be applied toward any maximum benefit established under this subsection. Any coverage required under this section, other than the coverage for applied behavior analysis, shall not be subject to the age and dollar limitations described in this subsection.

6. The maximum benefit limitation for applied behavior analysis described in subsection 5 of this section shall be adjusted by the health carrier at least triennially for inflation to reflect the aggregate increase in the general price level as measured by the Consumer Price Index for All Urban Consumers for the United States, or its successor index, as defined and officially published by the United States Department of Labor, or its successor agency. Beginning January 1, 2012, and annually thereafter, the current value of the maximum benefit limitation for applied behavior analysis coverage adjusted for inflation in accordance with this subsection shall be calculated by the director of the department of insurance, financial institutions and professional registration. The director shall furnish the calculated value to the secretary of state, who shall publish such value in the Missouri Register as soon after each January first as practicable, but it shall otherwise be exempt from the provisions of section 536.021.

7. Subject to the provisions set forth in subdivision (3) of subsection 4 of this section, coverage provided under this section shall not be subject to any limits on the number of visits an individual may make to an autism service provider, except that the maximum total benefit for applied behavior analysis set forth in subsection 5 of this section shall apply to this subsection.

8. This section shall not be construed as limiting benefits which are otherwise available to an individual under a health benefit plan. The health care coverage required by this section shall not be subject to any greater deductible, coinsurance, or co-payment than other physical health care services provided by a health benefit plan. Coverage of services may be subject to other general exclusions and limitations of the contract or benefit plan, not in conflict with the provisions of this section, such as coordination of benefits, exclusions for services provided by family or household members, and utilization review of health care services, including review of medical necessity and care management; however, coverage for treatment under this section shall not be denied on the basis that it is educational or habilitative in nature.

9. To the extent any payments or reimbursements are being made for applied behavior analysis, such payments or reimbursements shall be made to either:

(1) The autism service provider, as defined in this section; or

(2) The entity or group for whom such supervising person, who is certified as a board-certified behavior analyst by the Behavior Analyst Certification Board, works or is associated.

Such payments or reimbursements under this subsection to an autism service provider or a board-certified behavior analyst shall include payments or reimbursements for services provided by a line therapist under the supervision of such provider or behavior analyst if such services provided by the line therapist are included in the treatment plan and are deemed medically necessary.

10. Notwithstanding any other provision of law to the contrary, health carriers shall not be held liable for the actions of line therapists in the performance of their duties.

11. The provisions of this section shall apply to any health care plans issued to employees and their dependents under the Missouri consolidated health care plan established pursuant to chapter 103 that are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2011. The terms "employees" and "health care plans" shall have the same meaning ascribed to them in section 103.003.

12. The provisions of this section shall also apply to the following types of plans that are established, extended, modified, or renewed on or after January 1, 2011:

(1) All self-insured governmental plans, as that term is defined in 29 U.S.C. Section 1002(32);

(2) All self-insured group arrangements, to the extent not preempted by federal law;

(3) All plans provided through a multiple employer welfare arrangement, or plans provided through another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, or any waiver or exception to that act provided under federal law or regulation; and

(4) All self-insured school district health plans.

13. The provisions of this section shall not automatically apply to an individually underwritten health benefit plan, but shall be offered as an option to any such plan.

14. The provisions of this section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policy **[**~~of six months or less duration~~**]** **having a duration of less than one year**, or any other supplemental policy.

15. Any health carrier or other entity subject to the provisions of this section shall not be required to provide reimbursement for the applied behavior analysis delivered to a person insured by such health carrier or other entity to the extent such health carrier or other entity is billed for such services by any Part C early intervention program or any school district for applied behavior analysis rendered to the person covered by such health carrier or other entity. This section shall not be construed as affecting any obligation to provide services to an individual under an individualized family service plan, an individualized education plan, or an individualized service plan. This section shall not be construed as affecting any obligation to provide reimbursement pursuant to section 376.1218.

16. The provisions of sections 376.383, 376.384, and 376.1350 to 376.1399 shall apply to this section.

17. The director of the department of insurance, financial institutions and professional registration shall grant a small employer with a group health plan, as that term is defined in section 379.930, a waiver from the provisions of this section if the small employer demonstrates to the director by actual claims experience over any consecutive twelve-month period that compliance with this section has increased the cost of the health insurance policy by an amount of two and a half percent or greater over the period of a calendar year in premium costs to the small employer.

18. The provisions of this section shall not apply to the Mo HealthNet program as described in chapter 208.

19. (1) By February 1, 2012, and every February first thereafter, the department of insurance, financial institutions and professional registration shall submit a report to the general assembly regarding the implementation of the coverage required under this section. The report shall include, but shall not be limited to, the following:

(a) The total number of insureds diagnosed with autism spectrum disorder;

(b) The total cost of all claims paid out in the immediately preceding calendar year for coverage required by this section;

(c) The cost of such coverage per insured per month; and

(d) The average cost per insured for coverage of applied behavior analysis;

(2) All health carriers and health benefit plans subject to the provisions of this section shall provide the department with the data requested by the department for inclusion in the annual report.

376.1225. 1. All individual and group health insurance policies providing coverage on an expense-incurred basis, individual and group service or indemnity type contracts issued by a nonprofit corporation, individual and group service contracts issued by a health maintenance organization, all self-insured group arrangements to the extent not preempted by federal law and all managed health care delivery entities of any type or description, that are delivered, issued for delivery, continued or renewed on or after August 28, 1998, shall provide coverage for administration of general anesthesia and hospital charges for dental care provided to the following covered persons:

(1) A child under the age of five;

(2) A person who is severely disabled; or

(3) A person who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

2. Each plan as described in this section must provide coverage for administration of general anesthesia and hospital or office charges for treatment rendered by a dentist, regardless of whether the services are provided in a participating hospital or surgical center or office.

3. Nothing in this section shall prevent a health carrier from requiring prior authorization for hospitalization for dental care procedures in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

4. Nothing in this section shall apply to accident-only, dental-only plans or other specified disease, hospital indemnity, Medicare supplement or long-term care policies, or short-term major medical policies **[**~~of six months or less in duration~~**] having a duration of less than one year**.

376.1230. 1. Every policy issued by a health carrier, as defined in section 376.1350, shall provide coverage for chiropractic care delivered by a licensed chiropractor acting within the scope of his or her practice as defined in chapter 331. The coverage shall include initial diagnosis and clinically appropriate and medically necessary services and supplies required to treat the diagnosed disorder, subject to the terms and conditions of the policy. The coverage may be limited to chiropractors within the health carrier's network, and nothing in this section shall be construed to require a health carrier to contract with a chiropractor not in the carrier's network nor shall a carrier be required to reimburse for services rendered by a nonnetwork chiropractor unless prior approval has been obtained from the carrier by the enrollee. An enrollee may access chiropractic care within the network for a total of twenty-six chiropractic physician office visits per policy period, but may be required to provide the health carrier with notice prior to any additional visit as a condition of coverage. A health carrier may require prior authorization or notification before any follow-up diagnostic tests are ordered by a chiropractor or for any office visits for treatment in excess of twenty-six in any policy period. The certificate of coverage for any health benefit plan issued by a health carrier shall clearly state the availability of chiropractic coverage under the policy and any limitations, conditions, and exclusions.

2. A health benefit plan shall provide coverage for treatment of a chiropractic care condition and shall not establish any rate, term, or condition that places a greater financial burden on an insured for access to treatment for a chiropractic care condition than for access to treatment for another physical health condition.

3. The provisions of this section shall not apply to any health plan or contract that is individually underwritten.

4. The provisions of this section shall not apply to benefits provided under the Medicaid program.

5. The provisions of this section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policy **[**~~of six months' or less duration~~**] having a duration of less than one year**, or any other similar supplemental policy.

376.1232. 1. Each health carrier or health benefit plan that offers or issues health benefit plans which are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2010, shall offer coverage for prosthetic devices and services, including original and replacement devices, as prescribed by a physician acting within the scope of his or her practice.

2. For the purposes of this section, "health carrier" and "health benefit plan" shall have the same meaning as defined in section 376.1350.

3. The amount of the benefit for prosthetic devices and services under this section shall be no less than the annual and lifetime benefit maximums applicable to the basic health care services required to be provided under the health benefit plan. If the health benefit plan does not include any annual or lifetime maximums applicable to basic health care services, the amount of the benefit for prosthetic devices and services shall not be subject to an annual or

lifetime maximum benefit level. Any co-payment, coinsurance, deductible, and maximum out-of-pocket amount applied to the benefit for prosthetic devices and services shall be no more than the most common amounts applied to the basic health care services required to be provided under the health benefit plan.

4. The provisions of this section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policies **[**~~of six months or less duration~~**] having a duration of less than one year**, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

376.1235. 1. No health carrier or health benefit plan, as defined in section 376.1350, shall impose a co-payment or coinsurance percentage charged to the insured for services rendered for each date of service by a physical therapist licensed under chapter 334 or an occupational therapist licensed under chapter 324, for services that require a prescription, that is greater than the co-payment or coinsurance percentage charged to the insured for the services of a primary care physician licensed under chapter 334 for an office visit.

2. A health carrier or health benefit plan shall clearly state the availability of physical therapy and occupational therapy coverage under its plan and all related limitations, conditions, and exclusions.

3. Beginning September 1, 2016, the oversight division of the joint committee on legislative research shall perform an actuarial analysis of the cost impact to health carriers, insureds with a health benefit plan, and other private and public payers if the provisions of this section regarding occupational therapy coverage were enacted. By December 31, 2016, the director of the oversight division of the joint committee on legislative research shall submit a report of the actuarial findings prescribed by this section to the speaker, the president pro tem, and the chairpersons of both the house of representatives and senate standing committees having jurisdiction over health insurance matters. If the fiscal note cost estimation is less than the cost of an actuarial analysis, the actuarial analysis requirement shall be waived.

4. This section shall not apply to short-term major medical policies having a duration of less than one year.

376.1237. 1. Each health carrier or health benefit plan that offers or issues health benefit plans which are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2014, and that provides coverage for prescription eye drops shall provide coverage for the refilling of an eye drop prescription prior to the last day of the prescribed dosage period without regard to a coverage restriction for early refill of prescription renewals as long as the prescribing health care provider authorizes such early refill, and the health carrier or the health benefit plan is notified.

2. For the purposes of this section, health carrier and health benefit plan shall have the same meaning as defined in section 376.1350.

3. The coverage required by this section shall not be subject to any greater deductible or co-payment than other similar health care services provided by the health benefit plan.

4. The provisions of this section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policies **[**~~of six months' or less duration~~**] having a duration of less than one year**, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

5. The provisions of this section shall terminate on January 1, 2020.

376.1250. 1. All individual and group health insurance policies providing coverage on an expense-incurred basis, individual and group service or indemnity type contracts issued by a nonprofit corporation, individual and group service contracts issued by a health maintenance organization, all self-insured group arrangements to the extent not preempted by federal law and all managed health care delivery entities of any type or description, that are delivered, issued for delivery, continued or renewed on or after August 28, 1999, and providing coverage to any resident of this state shall provide benefits or coverage for:

(1) A pelvic examination and pap smear for any nonsymptomatic woman covered under such policy or contract, in accordance with the current American Cancer Society guidelines;

(2) A prostate examination and laboratory tests for cancer for any nonsymptomatic man covered under such policy or contract, in accordance with the current American Cancer Society guidelines; and

(3) A colorectal cancer examination and laboratory tests for cancer for any nonsymptomatic person covered under such policy or contract, in accordance with the current American Cancer Society guidelines.

2. Coverage and benefits related to the examinations and tests as required by this section shall be at least as favorable and subject to the same dollar limits, deductible, and co-payments as other covered benefits or services.

3. Nothing in this act shall apply to accident-only, hospital indemnity, Medicare supplement, long-term care, or other limited benefit health insurance policies.

4. The provisions of this section shall not apply to short-term major medical policies **[**~~of six months or less duration~~**] having a duration of less than one year**.

5. The attending physician shall advise the patient of the advantages, disadvantages, and risks, including cancer, associated with breast implantation prior to such operation.

6. Nothing in this section shall alter, impair or otherwise affect claims, rights or remedies available pursuant to law.

376.1253. 1. Each physician attending any patient with a newly diagnosed cancer shall inform the patient that the patient has the right to a referral for a second opinion by an appropriate board-certified specialist prior to any treatment. If no specialist in that specific cancer diagnosis area is in the provider network, a referral shall be made to a nonnetwork specialist in accordance with this section.

2. Each health carrier or health benefit plan, as defined in section 376.1350, that offers or issues health benefit plans which are delivered, issued for delivery, continued or renewed in this state on or after January 1, 2003, shall provide coverage for a second opinion rendered by a specialist in that specific cancer diagnosis area when a patient with a newly diagnosed cancer is referred to such specialist by his or her attending physician. Such coverage shall be subject to the same deductible and coinsurance conditions applied to other specialist referrals and all other terms and conditions applicable to other benefits, including the prior authorization and/or referral authorization requirements as specified in the applicable health insurance policy.

3. The provisions of this section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policies **[**~~of six months' or less duration~~**] having a duration of less than one year**, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

376.1275. 1. Each health carrier or health benefit plan that offers or issues health benefit plans which are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2003, shall include coverage for their members for the cost for human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation. The testing must be performed in a facility which is accredited by the American Association of Blood Banks or its successors, and is licensed under the Clinical Laboratory Improvement Act, 42 U.S.C. Section 263a, as amended, and is accredited by the American Association of Blood Banks or its successors, the College of American Pathologists, the American Society for Histocompatibility and Immunogenetics (ASHI) or any other national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists. At the time of testing, the person being tested must complete and sign an informed consent form which also authorizes the results of the test to be used for participation in the National Marrow Donor Program. The health benefit plan may limit each enrollee to one such testing per lifetime to be reimbursed at a cost of no greater than seventy-five dollars by the health carrier or health benefit plan.

2. For the purposes of this section, "health carrier" and "health benefit plan" shall have the same meaning as defined in section 376.1350.

3. The health care service required by this section shall not be subject to any greater deductible or co-payment than other similar health care services provided by the health benefit plan.

4. The provisions of this section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policies **[**~~of six months' or less duration~~**] having a duration of less than one year**, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

376.1400. 1. Every health insurance carrier offering policies of insurance in this state shall use standardized information for the explanation of benefits given to the health care provider whenever a claim is paid or denied. As used in this section, the term "health insurance carrier" shall have the meaning given to "health

carrier" in section 376.1350. Nothing in this section shall apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, short-term major medical policies **[**~~of six months or less duration~~**]** **having a duration of less than one year**, other limited benefit health insurance policies.

2. The standardized information shall contain the following:

(1) The name of the insured;

(2) The insured's identification number;

(3) The date of service;

(4) Amount of charge;

(5) Explanation for any denial;

(6) The amount paid;

(7) The patient's full name;

(8) The name and address of the insurer; and

(9) The phone number to contact for questions on explanation of benefits.

3. All health insurance carriers shall use the standard explanation of benefits information after January 1, 2002.

376.1550. 1. Notwithstanding any other provision of law to the contrary, each health carrier that offers or issues health benefit plans which are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2005, shall provide coverage for a mental health condition, as defined in this section, and shall comply with the following provisions:

(1) A health benefit plan shall provide coverage for treatment of a mental health condition and shall not establish any rate, term, or condition that places a greater financial burden on an insured for access to treatment for a mental health condition than for access to treatment for a physical health condition. Any deductible or out-of-pocket limits required by a health carrier or health benefit plan shall be comprehensive for coverage of all health conditions, whether mental or physical;

(2) The coverages set forth is this subsection:

(a) May be administered pursuant to a managed care program established by the health carrier; and

(b) May deliver covered services through a system of contractual arrangements with one or more providers, hospitals, nonresidential or residential treatment programs, or other mental health service delivery entities certified by the department of mental health, or accredited by a nationally recognized organization, or licensed by the state of Missouri;

(3) A health benefit plan that does not otherwise provide for management of care under the plan or that does not provide for the same degree of management of care for all health conditions may provide coverage for treatment of mental health conditions through a managed care organization; provided that the managed care organization is in compliance with rules adopted by the department of insurance, financial institutions and professional registration that assure that the system for delivery of treatment for mental health conditions does not diminish or negate the purpose of this section. The rules adopted by the director shall assure that:

(a) Timely and appropriate access to care is available;

(b) The quantity, location, and specialty distribution of health care providers is adequate; and

(c) Administrative or clinical protocols do not serve to reduce access to medically necessary treatment for any insured;

(4) Coverage for treatment for chemical dependency shall comply with sections 376.779, 376.810 to 376.814, and 376.825 to 376.836 and for the purposes of this subdivision the term "health insurance policy" as used in sections 376.779, 376.810 to 376.814, and 376.825 to 376.836, the term "health insurance policy" shall include group coverage.

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

(1) "Chemical dependency", the psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both;

(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) "Mental health condition", any condition or disorder defined by categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders except for chemical dependency;

(5) "Managed care organization", any financing mechanism or system that manages care delivery for its members or subscribers, including health maintenance organizations and any other similar health care delivery system or organization;

(6) "Rate, term, or condition", any lifetime or annual payment limits, deductibles, co-payments, coinsurance, and other cost-sharing requirements, out-of-pocket limits, visit limits, and any other financial component of a health benefit plan that affects the insured.

3. This section shall not apply to a health plan or policy that is individually underwritten or provides such coverage for specific individuals and members of their families pursuant to section 376.779, sections 376.810 to 376.814, and sections 376.825 to 376.836, a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, hospitalization-surgical care policy, short-term major medical policies **[**~~of six months or less duration~~**] having a duration of less than one year**, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

4. Notwithstanding any other provision of law to the contrary, all health insurance policies that cover state employees, including the Missouri consolidated health care plan, shall include coverage for mental illness. Multiyear group policies need not comply until the expiration of their current multiyear term unless the policyholder elects to comply before that time.

5. The provisions of this section shall not be violated if the insurer decides to apply different limits or exclude entirely from coverage the following:

(1) Marital, family, educational, or training services unless medically necessary and clinically appropriate;

(2) Services rendered or billed by a school or halfway house;

(3) Care that is custodial in nature;

(4) Services and supplies that are not immediately nor clinically appropriate; or

(5) Treatments that are considered experimental.

6. The director shall grant a policyholder a waiver from the provisions of this section if the policyholder demonstrates to the director by actual experience over any consecutive twenty-four-month period that compliance with this section has increased the cost of the health insurance policy by an amount that results in a two percent increase in premium costs to the policyholder. The director shall promulgate rules establishing a procedure and appropriate standards for making such a demonstration. 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, 2004, shall be invalid and void.

376.1900. 1. As used in this section, the following terms shall mean:

(1) "Electronic visit", or "e-visit", an online electronic medical evaluation and management service completed using a secured web-based or similar electronic-based communications network for a single patient encounter. An electronic visit shall be initiated by a patient or by the guardian of a patient with the health care provider, be completed using a federal Health Insurance Portability and Accountability Act (HIPAA)-compliant online connection, and include a permanent record of the electronic visit;

(2) "Health benefit plan" shall have the same meaning ascribed to it in section 376.1350;

(3) "Health care provider" shall have the same meaning ascribed to it in section 376.1350;

(4) "Health care service", a service for the diagnosis, prevention, treatment, cure or relief of a physical or mental health condition, illness, injury or disease;

(5) "Health carrier" shall have the same meaning ascribed to it in section 376.1350;

(6) "Telehealth" shall have the same meaning ascribed to it in section 208.670.

2. Each health carrier or health benefit plan that offers or issues health benefit plans which are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2014, shall not deny coverage for a health care service on the basis that the health care service is provided through telehealth if the same service would be covered if provided through face-to-face diagnosis, consultation, or treatment.

3. A health carrier may not exclude an otherwise covered health care service from coverage solely because the service is provided through telehealth rather than face-to-face consultation or contact between a health care provider and a patient.

4. A health carrier shall not be required to reimburse a telehealth provider or a consulting provider for site origination fees or costs for the provision of telehealth services; however, subject to correct coding, a health carrier shall reimburse a health care provider for the diagnosis, consultation, or treatment of an insured or enrollee when the

health care service is delivered through telehealth on the same basis that the health carrier covers the service when it is delivered in person.

5. A health care service provided through telehealth shall not be subject to any greater deductible, co-payment, or coinsurance amount than would be applicable if the same health care service was provided through face-to-face diagnosis, consultation, or treatment.

6. A health carrier shall not impose upon any person receiving benefits under this section any co-payment, coinsurance, or deductible amount, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services that is not equally imposed upon all terms and services covered under the policy, contract, or health benefit plan.

7. Nothing in this section shall preclude a health carrier from undertaking utilization review to determine the appropriateness of telehealth as a means of delivering a health care service, provided that the determinations shall be made in the same manner as those regarding the same service when it is delivered in person.

8. A health carrier or health benefit plan may limit coverage for health care services that are provided through telehealth to health care providers that are in a network approved by the plan or the health carrier.

9. Nothing in this section shall be construed to require a health care provider to be physically present with a patient where the patient is located unless the health care provider who is providing health care services by means of telehealth determines that the presence of a health care provider is necessary.

10. The provisions of this section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policies **[**~~of six months' or less duration~~**] having a duration of less than one year**, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration."; and

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

On motion of Representative Hill, **House Amendment No. 3** was adopted.

Representative Dogan offered **House Amendment No. 4**.

House Amendment No. 4

AMEND House Committee Bill No. 10, Page 2, Section 208.690, Line 22, by inserting immediately after said section and line the following:

"**208.1070. 1. For purposes of this section, the term "long-acting reversible contraceptive (LARC)" shall include, but not be limited to, intrauterine devices (IUDs) and birth control implants.**

2. Notwithstanding any other provision of law, any LARC that is prescribed to and obtained for a MO HealthNet participant may be transferred to another MO HealthNet participant if the LARC was not delivered to, implanted in, or used on the original MO HealthNet participant to whom the LARC was prescribed. In order to be transferred to another MO HealthNet participant under the provisions of this section, the LARC shall:

(1) Be in the original, unopened package;

(2) Have been in the possession of the health care provider for at least twelve weeks. The provisions of this subdivision may be waived upon the written consent of the original MO HealthNet participant to whom the LARC was prescribed;

(3) Not have left the possession of the health care provider who originally prescribed the LARC; and

(4) Be medically appropriate and not contraindicated for the MO HealthNet participant to whom the LARC is being transferred."; and

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

House Amendment No. 4 was withdrawn.

On motion of Representative Wiemann, the title of **HCB 10, as amended**, was agreed to.

On motion of Representative Wiemann, **HCB 10, as amended**, was ordered perfected and printed.

PERFECTION OF HOUSE BILLS

HCS HB 219, relating to private probation services for misdemeanor offenders, was taken up by Representative Hill.

Representative Hill offered **House Amendment No. 1**.

House Amendment No. 1

AMEND House Committee Substitute for House Bill No. 219, Page 1, Section 559.600, Line 14, by inserting after the word "**entity.**" the following:

"**A drug test is positive if drug presence is at or above the cutoff concentration or negative if no drug is detected or if drug presence is below the cutoff concentration.**"; and

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

On motion of Representative Hill, **House Amendment No. 1** was adopted.

Representative Walker (74) offered **House Amendment No. 2**.

House Amendment No. 2

AMEND House Committee Substitute for House Bill No. 219, Page 1, Section A, Line 2, by inserting immediately after said line the following:

"**478.004. 1. As used in this section, "medication-assisted treatment" means the use of pharmacological medications, in combination with counseling and behavioral therapies, to provide a whole patient approach to the treatment of substance use disorders.**

2. If a drug court or veterans court participant requires treatment for opioid or other substance misuse or dependence, a drug court or veterans court shall not prohibit such participant from participating in and receiving medication-assisted treatment under the care of a physician licensed in this state to practice medicine. A drug court or veterans court participant shall not be required to refrain from using medication-assisted treatment as a term or condition of successful completion of the drug court program.

3. A drug court or veterans court participant assigned to a treatment program for opioid or other substance misuse or dependence shall not be in violation of the terms or conditions of the drug court or veterans court on the basis of his or her participation in medication-assisted treatment under the care of a physician licensed in this state to practice medicine.

487.200. 1. As used in this section, "medication-assisted treatment" means the use of pharmacological medications, in combination with counseling and behavioral therapies, to provide a whole patient approach to the treatment of substance use disorders.

2. If a family court participant requires treatment for opioid or other substance misuse or dependence, a family court shall not prohibit such participant from participating in and receiving medication-assisted treatment under the care of a physician licensed in this state to practice medicine. A family court participant shall not be required to refrain from using medication-assisted treatment as a term or condition of successful completion of the family court program.

3. A family court participant assigned to a treatment program for opioid or other substance misuse or dependence shall not be in violation of the terms or conditions of the family court on the basis of his or her participation in medication-assisted treatment under the care of a physician licensed in this state to practice medicine."; and

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

Representative Schroer raised a point of order that **House Amendment No. 2** goes beyond the scope of the bill.

The point of order was withdrawn.

On motion of Representative Walker (74), **House Amendment No. 2** was adopted.

On motion of Representative Hill, the title of **HCS HB 219, as amended**, was agreed to.

On motion of Representative Hill, **HCS HB 219, as amended**, was adopted.

On motion of Representative Hill, **HCS HB 219, as amended**, was ordered perfected and printed.

HCS HB 324, relating to truant pupils, was taken up by Representative Neely.

On motion of Representative Neely, the title of **HCS HB 324** was agreed to.

On motion of Representative Neely, **HCS HB 324** was adopted.

On motion of Representative Neely, **HCS HB 324** was ordered perfected and printed.

Representative Taylor assumed the Chair.

THIRD READING OF HOUSE CONCURRENT RESOLUTIONS

HCR 9, relating to Joachim Creek in Jefferson and St. Francois Counties, was taken up by Representative Gannon.

On motion of Representative Gannon, **HCR 9** was read the third time and passed by the following vote:

AYES: 135

Adams	Anders	Anderson	Arthur	Austin
Bahr	Bangert	Baringer	Barnes 28	Basye
Beard	Beck	Berry	Black	Brattin
Brown 27	Brown 94	Burnett	Burns	Butler
Carpenter	Chipman	Christofanelli	Cierpiot	Conway 104
Corlew	Cornejo	Crawford	Curtis	Curtman
Davis	Dogan	Dohrman	Dunn	Eggleston
Ellebracht	Ellington	Engler	Fitzpatrick	Fitzwater 144
Fitzwater 49	Francis	Franks Jr	Frederick	Gannon

Gray	Green	Gregory	Grier	Haahr
Haefner	Hannegan	Harris	Helms	Henderson
Higdon	Hill	Houghton	Houx	Hubrecht
Johnson	Justus	Kelley 127	Kelly 141	Kendrick
Kolkmeyer	Korman	Lant	Lauer	Lavender
Lichtenegger	Love	Lynch	Mathews	Matthiesen
McCaherty	McCann Beatty	McCreery	McGaugh	McGee
Meredith 71	Merideth 80	Messenger	Miller	Mitten
Morgan	Morris	Mosley	Muntzel	Newman
Nichols	Peters	Pfautsch	Pierson Jr	Pietzman
Pike	Plocher	Quade	Razer	Redmon
Rehder	Reiboldt	Reisch	Remole	Rhoads
Roberts	Roden	Roeber	Rone	Ross
Rowland 29	Runions	Ruth	Schroer	Shaul 113
Shumake	Smith 85	Smith 163	Sommer	Spencer
Stacy	Stephens 128	Stevens 46	Swan	Tate
Taylor	Trent	Unsicker	Walker 3	Walker 74
Wessels	White	Wiemann	Wood	Mr. Speaker

NOES: 004

Hurst	Marshall	Moon	Pogue

PRESENT: 000

ABSENT WITH LEAVE: 023

Alferman	Andrews	Barnes 60	Bernskoetter	Bondon
Brown 57	Conway 10	Cookson	Cross	DeGroot
Evans	Fraker	Franklin	Hansen	Kidd
May	McDaniel	Neely	Phillips	Rowland 155
Shull 16	Vescovo	Wilson		

VACANCIES: 001

Representative Taylor declared the bill passed.

HCS HCRs 32 & 33, relating to the designation of Total Eclipse Day in Missouri, was taken up by Representative Francis.

Representative McGaugh offered **House Amendment No. 1**.

House Amendment No. 1

AMEND House Committee Substitute for House Concurrent Resolution Nos. 32 & 33, Page 1, Line 14, by inserting immediately after the word "Chillicothe," the words "Richmond, Carrollton,"; and

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

Representative Corlew offered **House Amendment No. 1 to House Amendment No. 1**.

House Amendment No. 1
to
House Amendment No. 1

AMEND House Amendment No. 1 to House Committee Substitute for House Concurrent Resolution Nos. 32 & 33, Page 1, Line 1, by inserting immediately after the word "Line" the following:

"13, by inserting immediately after the word "over" the words "many cities and counties in Missouri including"; and

Further amend said bill, page, and section, Line"; and

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

On motion of Representative Corlew, **House Amendment No. 1 to House Amendment No. 1** was adopted.

Representative Roberts offered **House Amendment No. 2 to House Amendment No. 1**.

House Amendment No. 2
to
House Amendment No. 1

AMEND House Amendment No. 1 to House Committee Substitute for House Concurrent Resolution Nos. 32 & 33, Page 1, Line 2, by inserting immediately after the word "Carrollton," the following:

"St. Louis City, Sullivan, St. Clair, Pacific, Blue Springs, Velda Village Hills, Owensville, Belle, Vienna, Westphalia, Linn, Affton,"; and

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

On motion of Representative Roberts, **House Amendment No. 2 to House Amendment No. 1** was adopted.

On motion of Representative McGaugh, **House Amendment No. 1, as amended**, was adopted.

On motion of Representative Francis, the title of **HCS HCRs 32 & 33, as amended**, was agreed to.

On motion of Representative Francis, **HCS HCRs 32 & 33, as amended**, was adopted.

On motion of Representative Francis, **HCS HCRs 32 & 33, as amended**, was read the third time and passed by the following vote:

AYES: 140

Adams	Alferman	Anders	Anderson	Arthur
Austin	Bahr	Bangert	Baringer	Barnes 28
Basye	Beard	Beck	Bernskoetter	Berry
Black	Bondon	Brattin	Brown 27	Brown 94
Burnett	Burns	Butler	Carpenter	Chipman

Christofanelli	Conway 10	Conway 104	Corlew	Cornejo
Crawford	Cross	Curtis	Curtman	Davis
DeGroot	Dogan	Dohrman	Dunn	Eggleston
Engler	Evans	Fitzpatrick	Fitzwater 144	Fraker
Francis	Franks Jr	Frederick	Gannon	Gray
Green	Gregory	Grier	Haahr	Haefner
Hannegan	Hansen	Harris	Helms	Henderson
Higdon	Hill	Houghton	Houx	Hubrecht
Hurst	Johnson	Justus	Kelley 127	Kelly 141
Kendrick	Korman	Lant	Lauer	Lavender
Lichtenegger	Love	Lynch	Marshall	Matthiesen
McCaherty	McCann Beatty	McCreery	McGaugh	McGee
Meredith 71	Merideth 80	Messenger	Miller	Mitten
Moon	Morgan	Morris	Mosley	Muntzel
Neely	Newman	Nichols	Peters	Pfautsch
Pierson Jr	Pietzman	Pike	Quade	Razer
Rehder	Reiboldt	Reisch	Remole	Rhoads
Roberts	Roden	Roeber	Rone	Ross
Rowland 29	Runions	Schroer	Shaul 113	Shull 16
Shumake	Smith 85	Smith 163	Sommer	Spencer
Stacy	Stephens 128	Stevens 46	Swan	Tate
Taylor	Trent	Unsicker	Vescovo	Walker 3
Wessels	White	Wiemann	Wood	Mr. Speaker

NOES: 002

Ellington Pogue

PRESENT: 000

ABSENT WITH LEAVE: 020

Andrews	Barnes 60	Brown 57	Cierpiot	Cookson
Ellebracht	Fitzwater 49	Franklin	Kidd	Kolkmeyer
Mathews	May	McDaniel	Phillips	Plocher
Redmon	Rowland 155	Ruth	Walker 74	Wilson

VACANCIES: 001

Representative Taylor declared the bill passed.

PERFECTION OF HOUSE BILLS

HCS HB 670, relating to gifted education, was taken up by Representative Sommer.

Representative Pfautsch offered **House Amendment No. 1**.

House Amendment No. 1

AMEND House Committee Substitute for House Bill No. 670, Page 1, Section 162.720, Line 15, by inserting immediately after said line the following:

"**162.722. 1. Each school district shall establish a policy, approved by the board of education of the district, that allows acceleration for students who demonstrate:**

(1) Advanced performance or potential for advanced performance; and

(2) The social and emotional readiness for acceleration.

2. The policy shall allow, for students described in this section, at least the following types of acceleration:

(1) Subject acceleration; and

(2) Whole grade acceleration."; and

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

On motion of Representative Pfautsch, **House Amendment No. 1** was adopted.

On motion of Representative Sommer, the title of **HCS HB 670, as amended**, was agreed to.

On motion of Representative Sommer, **HCS HB 670, as amended**, was adopted.

On motion of Representative Sommer, **HCS HB 670, as amended**, was ordered perfected and printed.

HCS HB 746, relating to residential mortgage loan brokers, was taken up by Representative Crawford.

Representative Crawford offered **House Amendment No. 1**.

House Amendment No. 1

AMEND House Committee Substitute for House Bill No. 746, Page 2, Section 443.812, Line 25, by inserting the word "**residential**" before the words "**mortgage loan brokers**"; and

Further amend said bill, page and section, Line 35, by deleting the words "**county of Cole**" and inserting in lieu thereof the words "**circuit court of Cole County**"; and

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

On motion of Representative Crawford, **House Amendment No. 1** was adopted.

On motion of Representative Crawford, the title of **HCS HB 746, as amended**, was agreed to.

On motion of Representative Crawford, **HCS HB 746, as amended**, was adopted.

On motion of Representative Crawford, **HCS HB 746, as amended**, was ordered perfected and printed.

HB 824, relating to autocycles, was taken up by Representative Reiboldt.

Representative Brattin offered **House Amendment No. 1**.

House Amendment No. 1

AMEND House Bill No. 824, Page 1, Section 304.005, Line 13, by inserting after all of said section and line the following:

"304.170. 1. No vehicle operated upon the highways of this state shall have a width, including load, in excess of one hundred two inches, except clearance lights, rearview mirrors or other accessories required by federal, state or city law or regulation. Provided however, a recreational vehicle as defined in section 700.010 may exceed the foregoing width limits if the appurtenances on such recreational vehicle extend no further than the rearview mirrors. Such mirrors may only extend the distance necessary to provide the required field of view before the appurtenances were attached.

2. No vehicle operated upon the interstate highway system or upon any route designated by the chief engineer of the state transportation department shall have a height, including load, in excess of fourteen feet. On all other highways, no vehicle shall have a height, including load, in excess of thirteen and one-half feet, except that any vehicle or combination of vehicles transporting automobiles or other motor vehicles may have a height, including load, of not more than fourteen feet.

3. No single motor vehicle operated upon the highways of this state shall have a length, including load, in excess of forty-five feet, except as otherwise provided in this section.

4. No bus, recreational motor vehicle or trackless trolley coach operated upon the highways of this state shall have a length in excess of forty-five feet, except that such vehicles may exceed the forty-five feet length when such excess length is caused by the projection of a front safety bumper or a rear safety bumper or both. Such safety bumper shall not cause the length of the bus or recreational motor vehicle to exceed the forty-five feet length limit by more than one foot in the front and one foot in the rear.

The term "safety bumper" means any device which may be fitted on an existing bumper or which replaces the bumper and is so constructed, treated, or manufactured that it absorbs energy upon impact.

5. No combination of truck-tractor and semitrailer or truck-tractor equipped with dromedary and semitrailer operated upon the highways of this state shall have a length, including load, in excess of sixty feet; except that in order to comply with the provisions of Title 23 of the United States Code (Public Law 97-424), no combination of truck-tractor and semitrailer or truck-tractor equipped with dromedary and semitrailer operated upon the interstate highway system of this state shall have an overall length, including load, in excess of the length of the truck-tractor plus the semitrailer or truck-tractor equipped with dromedary and semitrailer. The length of such semitrailer shall not exceed fifty-three feet.

6. In order to comply with the provisions of Title 23 of the United States Code (Public Law 97-424), no combination of truck-tractor, semitrailer and trailer operated upon the interstate highway system of this state shall have an overall length, including load, in excess of the length of the truck-tractor plus the semitrailer and trailer, neither of which semitrailer or trailer shall exceed twenty-eight feet in length, except that any existing semitrailer or trailer up to twenty-eight and one-half feet in length actually and lawfully operated on December 1, 1982, within a sixty-five foot overall length limit in any state, may continue to be operated upon the interstate highways of this state. On those primary highways not designated by the state highways and transportation commission as provided in subsection 10 of this section, no combination of truck-tractor, semitrailer and trailer shall have an overall length, including load, in excess of sixty-five feet; provided, however, the state highways and transportation commission may designate additional routes for such sixty-five foot combinations.

7. Automobile transporters, boat transporters, truck-trailer boat transporter combinations, stinger-steered combination automobile transporters and stinger-steered combination boat transporters having a length not in excess of seventy-five feet may be operated on the interstate highways of this state and such other highways as may be designated by the highways and transportation commission for the operation of such vehicles plus a distance not to exceed ten miles from such interstate or designated highway. All length provisions regarding automobile or boat transporters, truck-trailer boat transporter combinations and stinger-steered combinations shall include a semitrailer length not to exceed fifty-three feet and are exclusive of front and rear overhang, which shall be no greater than a three-foot front overhang and no greater than a four-foot rear overhang.

8. Driveaway saddlemount combinations having a length not in excess of ninety-seven feet may be operated on the interstate highways of this state and such other highways as may be designated by the highways and transportation commission for the operation of such vehicles plus a distance not to exceed ten miles from such

interstate or designated highway. Saddlemount combinations must comply with the safety requirements of Section 393.71 of Title 49 of the Code of Federal Regulations and may contain no more than three saddlemounted vehicles and one fullmount.

9. No truck-tractor semitrailer-semitrailer combination vehicles operated upon the interstate and designated primary highway system of this state shall have a semitrailer length in excess of twenty-eight feet or twenty-eight and one-half feet if the semitrailer was in actual and lawful operation in any state on December 1, 1982, operating in a truck-tractor semitrailer-semitrailer combination. The B-train assembly is excluded from the measurement of semitrailer length when used between the first and second semitrailer of a truck-tractor semitrailer-semitrailer combination, except that when there is no semitrailer mounted to the B-train assembly, it shall be included in the length measurement of the semitrailer.

10. The highways and transportation commission is authorized to designate routes on the state highway system other than the interstate system over which those combinations of vehicles of the lengths specified in subsections 5, 6, 7, 8 and 9 of this section may be operated. Combinations of vehicles operated under the provisions of subsections 5, 6, 7, 8 and 9 of this section may be operated at a distance not to exceed ten miles from the interstate system and such routes as designated under the provisions of this subsection.

11. Except as provided in subsections 5, 6, 7, 8, 9 and 10 of this section, no other combination of vehicles operated upon the primary or interstate highways of this state plus a distance of ten miles from a primary or interstate highway shall have an overall length, unladen or with load, in excess of sixty-five feet or in excess of fifty-five feet on any other highway, except the state highways and transportation commission may designate additional routes for use by sixty-five foot combinations, seventy-five foot stinger-steered combinations or seventy-five foot saddlemount combinations. Any vehicle or combination of vehicles transporting automobiles, boats or other motor vehicles may carry a load which extends no more than three feet beyond the front and four feet beyond the rear of the transporting vehicle or combination of vehicles.

12. (1) Except as hereinafter provided, these restrictions shall not apply to agricultural implements operating occasionally on the highways for short distances including tractor parades for fund-raising activities or special events, provided the tractors are driven by licensed drivers during daylight hours only and with the approval of the superintendent of the Missouri state highway patrol; or to self-propelled hay-hauling equipment or to implements of husbandry, or to the movement of farm products as defined in section 400.9-102 or to vehicles temporarily transporting agricultural implements or implements of husbandry or road-making machinery, or road materials or towing for repair purposes vehicles that have become disabled upon the highways; or to implement dealers delivering or moving farm machinery for repairs on any state highway other than the interstate system.

(2) Implements of husbandry and vehicles transporting such machinery or equipment and the movement of farm products as defined in section 400.9-102 may be operated occasionally for short distances on state highways when operated between the hours of sunrise and sunset by a driver licensed as an operator or chauffeur.

(3) Notwithstanding any other provision of law to the contrary, agricultural machinery and implements may be operated on state highways between the hours of sunset and sunrise for agricultural purposes provided such vehicles are equipped with lighting meeting the requirements of section 307.115.

13. As used in this chapter the term "implements of husbandry" means all self-propelled machinery operated at speeds of less than thirty miles per hour, specifically designed for, or especially adapted to be capable of, incidental over-the-road and primary offroad usage and used exclusively for the application of commercial plant food materials or agricultural chemicals, and not specifically designed or intended for transportation of such chemicals and materials.

14. Sludge disposal units may be operated on all state highways other than the interstate system. Such units shall not exceed one hundred thirty-eight inches in width and may be equipped with over-width tires. Such units shall observe all axle weight limits. The chief engineer of the state transportation department shall issue special permits for the movement of such disposal units and may by such permits restrict the movements to specified routes, days and hours."; and

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

On motion of Representative Brattin, **House Amendment No. 1** was adopted.

On motion of Representative Reiboldt, the title of **HB 824, as amended**, relating to transportation safety, was agreed to.

On motion of Representative Reiboldt, **HB 824, as amended**, was ordered perfected and printed.

HCS HB 384, relating to confiscation of animals, was taken up by Representative Anderson.

Representative Lavender offered **House Amendment No. 1**.

House Amendment No. 1

AMEND House Committee Substitute for House Bill No. 384, Page 1, Section 578.018 in the first instance, Line 1, by deleting the phrase "**[**~~public health official or~~**]**" and inserting in lieu thereof the phrase "public health official or"; and

Further amend said bill, page and section, Line 13, by deleting all of said line and inserting in lieu thereof the following:

"animal control authority, or an animal shelter. If no"; and

Further amend said bill and section, Page 3, Line 76, by inserting after all of said line the following:

"**8. The provisions of this section shall not apply to any animal of the canine species.**"; and

Further amend said bill and page, Section 578.030, Lines 4-6, by deleting all of said lines and inserting in lieu thereof the words "to 578.050."; and

Further amend said bill, page and section, Lines 8-9, by deleting the words "**in accordance with the provisions of section 578.018**"; and

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

Representative Lavender moved that **House Amendment No. 1** be adopted.

Which motion was defeated.

On motion of Representative Anderson, the title of **HCS HB 384** was agreed to.

On motion of Representative Anderson, **HCS HB 384** was adopted.

On motion of Representative Anderson, **HCS HB 384** was ordered perfected and printed.

HCS HB 1116, relating to the use of bags to package purchased goods, was taken up by Representative Shaul (113).

Speaker Pro Tem Haahr resumed the Chair.

Representative Matthiesen assumed the Chair.

Representative Nichols offered **House Amendment No. 1**.

House Amendment No. 1

AMEND House Committee Substitute for House Bill No. 1116, Page 1, Section 260.283, Line 10, by inserting after the word "**any**" the word "**recyclable**"; and

Further amend said bill, page and section, Line 12, by inserting after the phrase "**Made of**" the word "**recyclable**"; and

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

Representative Nichols moved that **House Amendment No. 1** be adopted.

Which motion was defeated.

Representative McGaugh offered **House Amendment No. 2**.

House Amendment No. 2

AMEND House Committee Substitute for House Bill No. 1116, Page 1, Section A, Line 2, by inserting immediately after said line the following:

"192.300. **1.** The county commissions **[**~~and~~**] with the concurrence of** 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~~**] with the concurrence of** 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 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. Notwithstanding the provisions of subsection 1 of this section, in the event of an emergency, a county commission or the county health center board may make and promulgate any orders, ordinances, rules, or regulations in order to protect public health, safety, or welfare, but the 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."; and

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

Representative Austin moved the previous question.

Which motion was adopted by the following vote:

AYES: 086

Alferman	Anderson	Austin	Bahr	Basye
Beard	Bernskoetter	Berry	Black	Bondon
Brattin	Brown 94	Christofanelli	Cierpiot	Conway 104
Cornejo	Crawford	Cross	Curtman	Davis
Dohrman	Eggleston	Fitzpatrick	Fraker	Francis
Frederick	Gannon	Gregory	Grier	Haahr
Hannegan	Hansen	Helms	Henderson	Hill
Houghton	Houx	Hubrecht	Hurst	Johnson
Justus	Kelley 127	Kelly 141	Korman	Lant
Lauer	Love	Lynch	Marshall	Mathews
Matthiesen	McCaherty	McGaugh	Messenger	Moon
Morris	Neely	Pfautsch	Pietzman	Pike
Plocher	Pogue	Redmon	Rehder	Reiboldt
Reisch	Roden	Roeber	Rone	Ross
Ruth	Shaul 113	Shumake	Smith 163	Sommer
Spencer	Stacy	Swan	Tate	Taylor
Trent	Vescovo	Walker 3	White	Wood
Mr. Speaker				

NOES: 039

Adams	Anders	Arthur	Bangert	Baringer
Barnes 28	Beck	Brown 27	Burns	Conway 10
Dunn	Ellebracht	Franks Jr	Green	Harris
Kendrick	Lavender	McCann Beatty	McCreery	McGee
Meredith 71	Merideth 80	Mitten	Morgan	Mosley
Newman	Nichols	Peters	Pierson Jr	Quade
Razer	Roberts	Rowland 29	Runions	Smith 85
Stevens 46	Unsicker	Walker 74	Wessels	

PRESENT: 000

ABSENT WITH LEAVE: 037

Andrews	Barnes 60	Brown 57	Burnett	Butler
Carpenter	Chipman	Cookson	Corlew	Curtis
DeGroot	Dogan	Ellington	Engler	Evans
Fitzwater 144	Fitzwater 49	Franklin	Gray	Haefner
Higdon	Kidd	Kolkmeyer	Lichtenegger	May
McDaniel	Miller	Muntzel	Phillips	Remole
Rhoads	Rowland 155	Schroer	Shull 16	Stephens 128
Wiemann	Wilson			

VACANCIES: 001

Representative McGaugh moved that **House Amendment No. 2** be adopted.

Which motion was defeated by the following vote, the ayes and noes having been demanded pursuant to Article III, Section 26 of the Constitution:

AYES: 031

Austin	Bernskoetter	Black	Brattin	Conway 10
Crawford	Fraker	Houghton	Johnson	Kelly 141
Korman	Love	Marshall	McGaugh	Meredith 71

Miller	Neely	Nichols	Pietzman	Redmon
Rehder	Reiboldt	Rhoads	Roberts	Ross
Rowland 29	Spencer	Stacy	Tate	Vescovo
Wood				

NOES: 103

Adams	Alferman	Anders	Anderson	Arthur
Bahr	Bangert	Baringer	Barnes 28	Basye
Beard	Beck	Berry	Bondon	Brown 27
Brown 94	Burns	Carpenter	Christofanelli	Conway 104
Cornejo	Cross	Curtis	Curtman	Davis
DeGroot	Dogan	Dohrman	Dunn	Eggleston
Ellebracht	Ellington	Fitzpatrick	Fitzwater 49	Francis
Franklin	Franks Jr	Frederick	Gannon	Gray
Green	Gregory	Haahr	Haefner	Hannegan
Hansen	Harris	Helms	Henderson	Hill
Houx	Hubrecht	Hurst	Justus	Kendrick
Lant	Lauer	Lavender	Lynch	Mathews
Matthiesen	McCaherty	McCann Beatty	McCreery	McGee
Merideth 80	Messenger	Mitten	Moon	Morgan
Morris	Mosley	Newman	Peters	Pfautsch
Pierson Jr	Pike	Plocher	Pogue	Quade
Razer	Reisch	Roeber	Rone	Runions
Ruth	Schroer	Shaul 113	Shumake	Smith 85
Smith 163	Sommer	Stevens 46	Swan	Taylor
Trent	Unsicker	Walker 3	Walker 74	Wessels
White	Wiemann	Mr. Speaker		

PRESENT: 003

Grier	Kelley 127	Roden

ABSENT WITH LEAVE: 025

Andrews	Barnes 60	Brown 57	Burnett	Butler
Chipman	Cierpiot	Cookson	Corlew	Engler
Evans	Fitzwater 144	Higdon	Kidd	Kolkmeyer
Lichtenegger	May	McDaniel	Muntzel	Phillips
Remole	Rowland 155	Shull 16	Stephens 128	Wilson

VACANCIES: 001

On motion of Representative Shaul (113), the title of **HCS HB 1116** was agreed to.

On motion of Representative Shaul (113), **HCS HB 1116** was adopted.

On motion of Representative Shaul (113), **HCS HB 1116** was ordered perfected and printed.

HCS HB 380, relating to certain violations in municipal court, was taken up by Representative Plocher.

Representative Plocher offered **House Amendment No. 1**.

House Amendment No. 1

AMEND House Committee Substitute for House Bill No. 380, Page 3, Section 479.354, Lines 1-3, by inserting immediately before each instance of the word "**summons**" the words "**notice to appear in court, citation, or**"; and

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

On motion of Representative Plocher, **House Amendment No. 1** was adopted.

Representative Spencer offered **House Amendment No. 2**.

House Amendment No. 2

AMEND House Committee Substitute for House Bill No. 380, Page 1, Section A, Line 3, by inserting after all of said section and line the following

"**302.335. 1. Except as otherwise provided in subsection 2 of this section, any motorist charged with a traffic violation in this state or any county or municipality of this state shall receive notification, in person, within twenty-four hours of the violation from a law enforcement officer employed by the law enforcement agency issuing the violation.**

2. The in-person notification requirement of subsection 1 of this section shall not apply to:

(1) Parking tickets;

(2) Violations under section 577.060;

(3) Incidents requiring further investigation; or

(4) Any other situation in which in-person notification is not possible.

304.288. 1. As used in this section "automated traffic enforcement system" means a camera or optical device designed to record images that depict the motor vehicle, the motor vehicle operator, the license plate of the motor vehicle, or other images to establish evidence that the motor vehicle or its operator is not in compliance with a state law, ordinance, order, or other provision which is designated as a traffic infraction.

2. Beginning on the effective date of this section, no county, city, town, village, municipality, state agency, or other political subdivision of this state may enact, adopt, or enforce, or authorize any other entity to enact, adopt, or enforce, any law, ordinance, regulation, order, or other provision that authorizes the use of an automated traffic enforcement system or systems to establish evidence that a motor vehicle or its operator has not paid any user fee or is not in compliance with traffic signals, traffic speeds, or other traffic laws, ordinances, rules, or regulations on any public street, road, or highway within this state or to impose or collect any civil or criminal fine, fee, user fee, or penalty for any such noncompliance, except as permitted under subsection 3 of this section.

3. Any county, city, town, village, municipality, state agency, or other political subdivision of this state that has an automated traffic enforcement system installation or maintenance contract with a company or entity on the effective date of this section shall arrange to complete or terminate the contract within one year after the effective date of this section. The provisions of subsection 2 of this section shall apply to the county, city, town, village, municipality, state agency, or other political subdivision after the termination or completion of such installation or maintenance contracts.

4. Notwithstanding any other provision of law to the contrary, no county, city, town, village, municipality, state agency, or political subdivision shall be exempted from the provisions of this section except by explicit reference to, or modification of, this section.

5. This section shall not apply to any data or information recorded at weigh stations managed by the department of transportation or the highway patrol."; and

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

On motion of Representative Spencer, **House Amendment No. 2** was adopted.

Representative Nichols offered **House Amendment No. 3**.

House Amendment No. 3

AMEND House Committee Substitute for House Bill No. 380, Page 2, Section 479.020, Line 41, by inserting immediately after all of said section and line the following:

"479.350. For purposes of sections 479.350 to 479.372, the following terms mean:

(1) "Annual general operating revenue", revenue that can be used to pay any bill or obligation of a county, city, town, or village, including general sales tax; general use tax; general property tax; fees from licenses and permits; unrestricted user fees; fines, court costs, bond forfeitures, and penalties. Annual general operating revenue does not include designated sales or use taxes; restricted user fees; grant funds; funds expended by a political subdivision for technological assistance in collecting, storing, and disseminating criminal history record information and facilitating criminal identification activities for the purpose of sharing criminal justice-related information among political subdivisions; or other revenue designated for a specific purpose;

(2) "Court costs", costs, fees, or surcharges which are retained by a county, city, town, or village upon a finding of guilty or plea of guilty, and shall exclude any costs, fees, or surcharges disbursed to the state or other entities by a county, city, town, or village and any certified costs, not including fines added to the annual real estate tax bill or a special tax bill under section 67.398, 67.402, or 67.451;

(3) "Minor traffic violation", a municipal or county traffic ordinance violation prosecuted that does not involve an accident or injury, that does not involve the operation of a commercial motor vehicle, and for which no points are assessed by the department of revenue or the department of revenue is authorized to assess one to four points to a person's driving record upon conviction. Minor traffic violation shall include amended charges for any minor traffic violation. Minor traffic violation shall exclude a violation for exceeding the speed limit by more than nineteen miles per hour or a violation occurring within a construction zone or school zone**[**~~;~~

~~(4) "Municipal ordinance violation", a municipal or county ordinance violation prosecuted for which penalties are authorized by statute under sections 64.160, 64.200, 64.295, 64.487, 64.690, 64.895, 67.398, 71.285, 89.120, and 89.490. Municipal ordinance violation shall include amended charges for municipal ordinance violations~~**]**.";

and

Further amend said bill and page, Section 479.353, Lines 1-10, by deleting all of said lines and inserting in lieu thereof the following:

"479.353. **1.** Notwithstanding any **[**~~provisions~~**] provision of law** to the contrary, the following conditions shall apply to minor traffic violations **[**~~and municipal ordinance violations~~**]**:

(1) The court shall not assess a fine, if combined with the amount of court costs, totaling in excess of**[**~~:~~

~~(a)~~**]** two hundred twenty-five dollars **[**~~for minor traffic violations; and~~

~~(b) For municipal ordinance violations committed within a twelve-month period beginning with the first violation: two hundred dollars for the first municipal ordinance violation, two hundred seventy-five dollars for the second municipal ordinance violation, three hundred fifty dollars for the third municipal ordinance violation, and four hundred fifty dollars for the fourth and any subsequent municipal ordinance violations~~**]**;";

and

Further amend said bill, Page 3, Section 479.354, Line 3, by inserting immediately after all of said section and line the following:

"479.359. 1. Every county, city, town, and village shall annually calculate the percentage of its annual general operating revenue received from fines, bond forfeitures, and court costs for **[**~~municipal ordinance violations and~~**]** minor traffic violations, including amended charges for any **[**~~municipal ordinance violations and~~**]** minor traffic violations, whether the violation was prosecuted in municipal court, associate circuit court, or circuit court, occurring within the county, city, town, or village. If the percentage is more than thirty percent, the excess amount shall be sent to the director of the department of revenue. The director of the department of revenue shall set forth by rule a procedure whereby excess revenues as set forth in this section shall be sent to the department of revenue. The department of revenue shall distribute these moneys annually to the schools of the county in the same manner that proceeds of all fines collected for any breach of the penal laws of this state are distributed.

2. Beginning January 1, 2016, the percentage specified in subsection 1 of this section shall be reduced from thirty percent to twenty percent, unless any county, city, town, or village has a fiscal year beginning on any date other than January first, in which case the reduction shall begin on the first day of the immediately following fiscal year except that any county with a charter form of government and with more than nine hundred fifty thousand inhabitants and any city, town, or village with boundaries found within such county shall be reduced from thirty percent to twelve and one-half percent.

3. An addendum to the annual financial report submitted to the state auditor under section 105.145 by the county, city, town, or village that has chosen to have a municipal court division shall contain an accounting of:

(1) Annual general operating revenue **[**~~as defined in section 479.350~~**]**;

(2) The total revenues from fines, bond forfeitures, and court costs for **[**~~municipal ordinance violations and~~**]** minor traffic violations occurring within the county, city, town, or village, including amended charges from any **[**~~municipal ordinance violations and~~**]** minor traffic violations;

(3) The percent of annual general operating revenue from fines, bond forfeitures, and court costs for **[**~~municipal ordinance violations and~~**]** minor traffic violations occurring within the county, city, town, or village, including amended charges from any charged **[**~~municipal ordinance violations and~~**]** minor traffic violation, charged in the municipal court of that county, city, town, or village; and

(4) Said addendum shall be certified and signed by a representative with knowledge of the subject matter as to the accuracy of the addendum contents, under oath and under the penalty of perjury, and witnessed by a notary public.

4. On or before December 31, 2015, the state auditor shall set forth by rule a procedure for including the addendum information required by this section. The rule shall also allow reasonable opportunity for demonstration of compliance without unduly burdensome calculations.

479.368. 1. (1) Except for county sales taxes deposited in the county sales tax trust fund as defined in section 66.620, any county, city, town, or village failing to timely file the required addendums or remit the required excess revenues, if applicable, after the time period provided by the notice by the director of the department of revenue or any final determination on excess revenue by the court in a judicial proceeding, whichever is later, shall not receive from that date any amount of moneys to which the county, city, town, or village would otherwise be entitled to receive from revenues from local sales tax as defined in section 32.085.

(2) If any county, city, town, or village has failed to timely file the required addendums, the director of the department of revenue shall hold any moneys the noncompliant city, town, village, or county would otherwise be entitled to from local sales tax as defined in section 32.085 until a determination is made by the director of revenue that the noncompliant city, town, village, or county has come into compliance with the provisions of sections 479.359 and 479.360.

(3) If any county, city, town, or village has failed to remit the required excess revenue to the director of the department of revenue such general local sales tax revenues shall be distributed as provided in subsection 1 of section 479.359 by the director of the department of revenue in the amount of excess revenues that the county, city, town, or village failed to remit.

Upon a noncompliant city, town, village, or county coming into compliance with the provisions of sections 479.359 and 479.360, the director of the department of revenue shall disburse any remaining balance of funds held under this subsection after satisfaction of amounts due under section 479.359. Moneys held by the director of the department of revenue under this subsection shall not be deemed to be state funds and shall not be commingled with any funds of the state.

2. (1) Any city, town, village, or county that participates in the distribution of local sales tax in sections 66.600 to 66.630 and fails to timely file the required addendums or remit the required excess revenues, if applicable, after the time period provided by the notice by the director of the department of revenue or any final determination on excess revenue by the court in a judicial proceeding, whichever is later, shall not receive any amount of moneys to which said city, town, village, or county would otherwise be entitled under sections 66.600 to 66.630. The director of the department of revenue shall notify the county to which the duties of the director have been delegated under section 66.601 of any noncompliant city, town, village, or county and the county shall remit to the director of the department of revenue any moneys to which said city, town, village, or county would otherwise be entitled. No disbursements to the noncompliant city, town, village, or county shall be permitted until a determination is made by the director of revenue that the noncompliant city, town, village, or county has come into compliance with the provisions of sections 479.359 and 479.360.

(2) If such county, city, town, or village has failed to timely file the required addendums, the director of the department of revenue shall hold any moneys the noncompliant city, town, village, or county would otherwise be entitled to under sections 66.600 to 66.630 until a determination is made by the director of revenue that the noncompliant city, town, village, or county has come into compliance with the provisions of sections 479.359 and 479.360.

(3) If any county, city, town, or village has failed to remit the required excess revenue to the director of the department of revenue, the director shall distribute such moneys the county, city, town, or village would otherwise be entitled to under sections 66.600 to 66.630 in the amount of excess revenues that the city, town, village, or county failed to remit as provided in subsection 1 of section 479.359.

Upon a noncompliant city, town, village, or county coming into compliance with the provisions of sections 479.359 and 479.360, the director of the department of revenue shall disburse any remaining balance of funds held under this subsection after satisfaction of amounts due under section 479.359 and shall notify the county to which the duties of the director have been delegated under section 66.601 that such compliant city, town, village, or county is entitled to distributions under sections 66.600 to 66.630. If a noncompliant city, town, village, or county becomes disincorporated, any moneys held by the director of the department of revenue shall be distributed to the schools of the county in the same manner that proceeds of all penalties, forfeitures, and fines collected for any breach of the penal laws of the state are distributed. Moneys held by the director of the department of revenue under this subsection shall not be deemed to be state funds and shall not be commingled with any funds of the state.

3. In addition to the provisions of subsection 1 of this section, any county that fails to remit the required excess revenue as required by section 479.359 shall have an election upon the question of disincorporation under Article VI, Section 5 of the Constitution of Missouri, and any such city, town, or village that fails to remit the required excess revenue as required by section 479.359 shall have an election upon the question of disincorporation according to the following procedure:

(1) The election upon the question of disincorporation of such city, town, or village shall be held on the next general election day, as defined by section 115.121;

(2) The director of the department of revenue shall notify the election authorities responsible for conducting the election according to the terms of section 115.125 and the county governing body in which the city, town, or village is located not later than 5:00 p.m. on the tenth Tuesday prior to the election of the amount of the excess revenues due;

(3) The question shall be submitted to the voters of such city, town, or village in substantially the following form:

The city/town/village of ..... has kept more revenue from fines, bond forfeitures, and court costs for **[**~~municipal ordinance violations and~~**]** minor traffic violations than is permitted by state law and failed to remit those revenues to the county school fund. Shall the city/town/village of ..... be dissolved?

[ ] YES **[ ]** NO

(4) Upon notification by the director of the department of revenue, the county governing body in which the city, town, or village is located shall give notice of the election for eight consecutive weeks prior to the election by publication in a newspaper of general circulation published in the city, town, or village, or if there is no such newspaper in the city, town, or village, then in the newspaper in the county published nearest the city, town, or village; and

(5) Upon the affirmative vote of a majority of those persons voting on the question, the county governing body shall disincorporate the city, town, or village."; and

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

Representative Nichols moved that **House Amendment No. 3** be adopted.

Which motion was defeated.

Representative McGaugh offered **House Amendment No. 4**.

House Amendment No. 4

AMEND House Committee Substitute for House Bill No. 380, Page 3, Section 479.354, Line 3, by inserting immediately after said line the following:

"488.2250. 1. For all appeal transcripts of testimony given **[**~~or proceedings in any circuit court~~**]**, the court reporter shall receive the sum of three dollars and fifty cents per legal page for the preparation of a paper and an electronic version of the transcript.

2. In criminal cases where an appeal is taken by the defendant and it appears to the satisfaction of the court that the defendant is unable to pay the costs of the transcript for the purpose of perfecting the appeal, the court reporter shall receive a fee of two dollars and sixty cents per legal page for the preparation of a paper and an electronic version of the transcript.

3. Any judge, in his or her discretion, may order a transcript of all or any part of the evidence or oral proceedings and the court reporter shall receive the sum of two dollars and sixty cents per legal page for the preparation of a paper and an electronic version of the transcript.

4. For purposes of this section, a legal page, other than the first page and the final page of the transcript, shall be twenty-five lines, approximately eight and one-half inches by eleven inches in size, with the left-hand margin of approximately one and one-half inches, and with the right-hand margin of approximately one-half inch.

5. Notwithstanding any law to the contrary, the payment of court reporter's fees provided in subsections 2 and 3 of this section shall be made by the state upon a voucher approved by the court. The cost to prepare all other transcripts of testimony or proceedings shall be borne by the party requesting their preparation and production, who shall reimburse the court reporter **[**~~the sum provided in subsection 1 of this section~~**]**."; and

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

Speaker Richardson resumed the Chair.

On motion of Representative McGaugh, **House Amendment No. 4** was adopted.

On motion of Representative Plocher, the title of **HCS HB 380, as amended**, relating to judicial proceedings, was agreed to.

On motion of Representative Plocher, **HCS HB 380, as amended**, was adopted.

On motion of Representative Plocher, **HCS HB 380, as amended**, was ordered perfected and printed.

HCS HB 886, relating to retirement of higher education employees, was taken up by Representative Black.

Representative Black offered **House Amendment No. 1**.

House Amendment No. 1

AMEND House Committee Substitute for House Bill No. 886, Page 2, Section 104.1205, Lines 33 and 34, by deleting the following:

"**, but shall not contribute less than two percent of his or her pay**"; and

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

On motion of Representative Black, **House Amendment No. 1** was adopted.

On motion of Representative Black, the title of **HCS HB 886, as amended**, was agreed to.

On motion of Representative Black, **HCS HB 886, as amended**, was adopted.

On motion of Representative Black, **HCS HB 886, as amended**, was ordered perfected and printed.

HCS HBs 960, 962 & 828, relating to a social innovation grant program, was taken up by Representative Mathews.

On motion of Representative Mathews, the title of **HCS HBs 960, 962 & 828** was agreed to.

On motion of Representative Mathews, **HCS HBs 960, 962 & 828** was adopted.

On motion of Representative Mathews, **HCS HBs 960, 962 & 828** was ordered perfected and printed.

HB 743, relating to the Crime Victims' Compensation Fund, was taken up by Representative Conway (104).

Representative Conway (104) offered **House Amendment No. 1**.

House Amendment No. 1

AMEND House Bill No. 743, Page 1, Section 595.045, Lines 14-15, by deleting the phrase "**[**~~two hundred fifty thousand~~**]**" and inserting in lieu thereof the following:

"**at least** two hundred fifty thousand **dollars but no more than**"; and

Further amend said bill and section, Page 3, Line 59, by deleting all of said line and inserting in lieu thereof the following:

"A or B felony; **fifty-five dollars upon a plea of guilty or a finding of guilt for a class C felony;** forty-six dollars upon a plea of guilty or finding of guilt for a class **[**~~C or~~**]** D **or E** felony;" and

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

On motion of Representative Conway (104), **House Amendment No. 1** was adopted.

Representative Peters offered **House Amendment No. 2**.

House Amendment No. 2

AMEND House Bill No. 743, Page 1, Section A, Line 2, by inserting after all of said section and line the following:

"595.030. 1. No compensation shall be paid unless the claimant has incurred an out-of-pocket loss of at least fifty dollars or has lost two continuous weeks of earnings or support from gainful employment. "Out-of-pocket loss" shall mean unreimbursed or unreimbursable expenses or indebtedness reasonably incurred:

(1) For medical care or other services, including psychiatric, psychological or counseling expenses, necessary as a result of the crime upon which the claim is based, except that the amount paid for psychiatric, psychological or counseling expenses per eligible claim shall not exceed two thousand five hundred dollars; or

(2) As a result of personal property being seized in an investigation by law enforcement.

Compensation paid for an out-of-pocket loss under this subdivision shall be in an amount equal to the loss sustained, but shall not exceed two hundred fifty dollars.

2. No compensation shall be paid unless the department of public safety finds that a crime was committed, that such crime directly resulted in personal physical injury to, or the death of, the victim, and that police records show that such crime was promptly reported to the proper authorities. In no case may compensation be paid if the police records show that such report was made more than forty-eight hours after the occurrence of such crime, unless the department of public safety finds that the report to the police was delayed for good cause. If the victim is under eighteen years of age such report may be made by the victim's parent, guardian or custodian; by a physician, a nurse, or hospital emergency room personnel; by the children's division personnel; or by any other member of the victim's family. In the case of a sexual offense, filing a report of the offense to the proper authorities may include, but not be limited to, the filing of the report of the forensic examination by the appropriate medical provider, as defined in section 595.220, with the prosecuting attorney of the county in which the alleged incident occurred.

3. No compensation shall be paid for medical care if the service provider is not a medical provider as that term is defined in section 595.027, and the individual providing the medical care is not licensed by the state of Missouri or the state in which the medical care is provided.

4. No compensation shall be paid for psychiatric treatment or other counseling services, including psychotherapy, unless the service provider is a:

(1) Physician licensed pursuant to chapter 334 or licensed to practice medicine in the state in which the service is provided;

(2) Psychologist licensed pursuant to chapter 337 or licensed to practice psychology in the state in which the service is provided;

(3) Clinical social worker licensed pursuant to chapter 337;

(4) Professional counselor licensed pursuant to chapter 337; or

(5) Board-certified psychiatric-mental health clinical nurse specialist or board certified psychiatric-mental health nurse practitioner licensed under chapter 335 or licensed in the state in which the service is provided.

5. Any compensation paid pursuant to sections 595.010 to 595.075 for death or personal injury shall be in an amount not exceeding out-of-pocket loss, together with loss of earnings or support from gainful employment, not to exceed four hundred dollars per week, resulting from such injury or death. In the event of death of the victim, **a claim for** an award may be made for reasonable and necessary expenses actually incurred for preparation and burial not to exceed five thousand dollars **by the funeral home or a relative of the victim**.

6. Any compensation for loss of earnings or support from gainful employment shall be in an amount equal to the actual loss sustained not to exceed four hundred dollars per week; provided, however, that no award pursuant to sections 595.010 to 595.075 shall exceed twenty-five thousand dollars. If two or more persons are entitled to compensation as a result of the death of a person which is the direct result of a crime or in the case of a sexual assault, the compensation shall be apportioned by the department of public safety among the claimants in proportion to their loss.

7. The method and timing of the payment of any compensation pursuant to sections 595.010 to 595.075 shall be determined by the department.

8. The department shall have the authority to negotiate the costs of medical care or other services directly with the providers of the care or services on behalf of any victim receiving compensation pursuant to sections 595.010 to 595.075."; and

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

On motion of Representative Peters, **House Amendment No. 2** was adopted.

On motion of Representative Conway (104), the title of **HB 743, as amended**, relating to governmental compensation funds, was agreed to.

On motion of Representative Conway (104), **HB 743, as amended**, was ordered perfected and printed.

THIRD READING OF HOUSE BILLS

HCS HB 144, relating to the designated health care decision-maker act, was taken up by Representative McGaugh.

On motion of Representative McGaugh, **HCS HB 144** was read the third time and passed by the following vote:

AYES: 127

Adams	Alferman	Anders	Anderson	Arthur
Austin	Bangert	Baringer	Barnes 28	Basye
Beard	Beck	Bernskoetter	Berry	Black
Brattin	Brown 27	Brown 94	Burnett	Burns
Butler	Carpenter	Christofanelli	Conway 10	Conway 104
Corlew	Cornejo	Crawford	Curtis	Curtman
Davis	DeGroot	Dogan	Dohrman	Dunn
Eggleston	Ellebracht	Engler	Fitzpatrick	Fitzwater 49
Fraker	Francis	Franks Jr	Frederick	Gannon
Gray	Gregory	Grier	Haahr	Haefner
Hannegan	Harris	Helms	Henderson	Hill
Houghton	Houx	Justus	Kelley 127	Kelly 141
Kendrick	Korman	Lant	Lauer	Lavender
Lichtenegger	Love	Lynch	Marshall	Mathews
Matthiesen	McCaherty	McCann Beatty	McCreery	McGaugh
McGee	Meredith 71	Merideth 80	Messenger	Miller
Mitten	Morgan	Morris	Mosley	Newman
Nichols	Peters	Pfautsch	Pierson Jr	Pietzman
Pike	Plocher	Quade	Razer	Redmon
Rehder	Reiboldt	Reisch	Remole	Roberts
Roden	Roeber	Rone	Ross	Rowland 29
Runions	Ruth	Shaul 113	Shull 16	Shumake
Smith 163	Sommer	Stacy	Stephens 128	Stevens 46
Swan	Tate	Taylor	Trent	Unsicker
Vescovo	Walker 3	Wessels	White	Wiemann
Wood	Mr. Speaker			

NOES: 005

Bondon	Hubrecht	Hurst	Moon	Pogue

PRESENT: 000

ABSENT WITH LEAVE: 030

Andrews	Bahr	Barnes 60	Brown 57	Chipman
Cierpiot	Cookson	Cross	Ellington	Evans
Fitzwater 144	Franklin	Green	Hansen	Higdon
Johnson	Kidd	Kolkmeyer	May	McDaniel

Muntzel	Neely	Phillips	Rhoads	Rowland 155
Schroer	Smith 85	Spencer	Walker 74	Wilson

VACANCIES: 001

Speaker Richardson declared the bill passed.

MESSAGES FROM THE SENATE

Mr. Speaker: I am instructed by the Senate to inform the House of Representatives that the Senate has taken up and passed **HB 34**.

Mr. Speaker: I am instructed by the Senate to inform the House of Representatives that the Senate has taken up and passed **SCS HB 51** entitled:

An act to repeal section 214.160, RSMo, and to enact in lieu thereof one new section relating to cemetery funds.

In which the concurrence of the House is respectfully requested.

REFERRAL OF HOUSE BILLS

The following House Bills were referred to the Committee indicated:

SCS HB 51 - Fiscal Review
HB 1073 - Insurance Policy

REFERRAL OF SENATE CONCURRENT RESOLUTIONS

The following Senate Concurrent Resolutions were referred to the Committee indicated:

SCR 4 - Special Committee on Government Oversight
SCR 9 - Special Committee on Government Oversight
SCR 14 - Special Committee on Government Oversight
SCR 21 - Special Committee on Government Oversight

REFERRAL OF SENATE BILLS

The following Senate Bills were referred to the Committee indicated:

SS SB 22 - Budget
SB 65 - General Laws
SS SCS SB 74 - Insurance Policy
SCS SB 88 - Judiciary
SB 99 - Judiciary
SB 225 - Transportation
SCS SB 240 - Workforce Development
SB 299 - General Laws

SCS SBs 300 & 306 - Elementary and Secondary Education
SB 332 - General Laws
SCS SB 334 - Insurance Policy
SCS SB 355 - Transportation
SB 394 - Pensions
SCS SB 404 - Special Committee on Small Business
SCS SB 405 - Local Government
SB 434 - Elementary and Secondary Education
SB 478 - Special Committee on Government Oversight
SB 501 - Health and Mental Health Policy

COMMITTEE REPORTS

Committee on General Laws, Chairman Cornejo reporting:

Mr. Speaker: Your Committee on General Laws, to which was referred **HB 246**, begs leave to report it has examined the same and recommends that it **Do Pass**, and pursuant to Rule 24(25)(c) be referred to the Committee on Rules - Legislative Oversight by the following vote:

Ayes (9): Arthur, Basye, Carpenter, Cornejo, Cross, Evans, Mathews, Merideth (80) and Roeber

Noes (1): McCreery

Absent (3): Anderson, Schroer and Taylor

Mr. Speaker: Your Committee on General Laws, to which was referred **HB 555**, begs leave to report it has examined the same and recommends that it **Do Pass with House Committee Substitute**, and pursuant to Rule 24(25)(c) be referred to the Committee on Rules - Legislative Oversight by the following vote:

Ayes (7): Basye, Cornejo, Cross, Evans, Mathews, Roeber and Schroer

Noes (4): Arthur, Carpenter, McCreery and Merideth (80)

Absent (2): Anderson and Taylor

Mr. Speaker: Your Committee on General Laws, to which was referred **HB 585**, begs leave to report it has examined the same and recommends that it **Do Pass**, and pursuant to Rule 24(25)(c) be referred to the Committee on Rules - Legislative Oversight by the following vote:

Ayes (9): Basye, Carpenter, Cornejo, Cross, Evans, Mathews, Merideth (80), Roeber and Schroer

Noes (2): Arthur and McCreery

Absent (2): Anderson and Taylor

Mr. Speaker: Your Committee on General Laws, to which was referred **HB 732**, begs leave to report it has examined the same and recommends that it **Do Pass**, and pursuant to Rule 24(25)(c) be referred to the Committee on Rules - Legislative Oversight by the following vote:

Ayes (11): Arthur, Basye, Carpenter, Cornejo, Cross, Evans, Mathews, McCreery, Merideth (80), Roeber and Schroer

Noes (0)

Absent (2): Anderson and Taylor

Mr. Speaker: Your Committee on General Laws, to which was referred **HB 1141**, begs leave to report it has examined the same and recommends that it **Do Pass with House Committee Substitute**, and pursuant to Rule 24(25)(c) be referred to the Committee on Rules - Legislative Oversight by the following vote:

Ayes (11): Arthur, Basye, Carpenter, Cornejo, Cross, Evans, Mathews, McCreery, Merideth (80), Roeber and Schroer

Noes (0)

Absent (2): Anderson and Taylor

Committee on Judiciary, Chairman McGaugh reporting:

Mr. Speaker: Your Committee on Judiciary, to which was referred **HB 73**, begs leave to report it has examined the same and recommends that it **Do Pass**, and pursuant to Rule 24(25)(c) be referred to the Committee on Rules - Legislative Oversight by the following vote:

Ayes (7): Beard, Corlew, Ellebracht, Gregory, Marshall, McGaugh and White

Noes (1): Mitten

Absent (3): DeGroot, Roberts and Toalson Reisch

Mr. Speaker: Your Committee on Judiciary, to which was referred **HB 945**, begs leave to report it has examined the same and recommends that it **Do Pass**, and pursuant to Rule 24(25)(c) be referred to the Committee on Rules - Legislative Oversight by the following vote:

Ayes (7): Beard, Corlew, DeGroot, Ellebracht, Gregory, McGaugh and White

Noes (3): Marshall, Mitten and Roberts

Absent (1): Toalson Reisch

Mr. Speaker: Your Committee on Judiciary, to which was referred **HB 1112**, begs leave to report it has examined the same and recommends that it **Do Pass**, and pursuant to Rule 24(25)(c) be referred to the Committee on Rules - Legislative Oversight by the following vote:

Ayes (10): Beard, Corlew, DeGroot, Ellebracht, Gregory, Marshall, McGaugh, Mitten, Roberts and White

Noes (0)

Absent (1): Toalson Reisch

Special Committee on Government Oversight, Chairman Brattin reporting:

Mr. Speaker: Your Special Committee on Government Oversight, to which was referred **HB 985**, begs leave to report it has examined the same and recommends that it **Do Pass with House Committee Substitute**, and pursuant to Rule 24(25)(b) be referred to the Committee on Rules - Administrative Oversight by the following vote:

Ayes (7): Bangert, Barnes (28), Brattin, Fitzwater (144), Merideth (80), Messenger and Toalson Reisch

Noes (3): Christofanelli, Moon and Taylor

Absent (3): Brown (57), Hill and Mitten

Committee on Transportation, Chairman Reiboldt reporting:

Mr. Speaker: Your Committee on Transportation, to which was referred **SB 222**, begs leave to report it has examined the same and recommends that it **Do Pass**, and pursuant to Rule 24(25)(b) be referred to the Committee on Rules - Administrative Oversight by the following vote:

Ayes (9): Burns, Corlew, Hurst, Kolkmeyer, Korman, Reiboldt, Runions, Ruth and Tate

Noes (0)

Absent (2): Cornejo and May

Mr. Speaker: Your Committee on Transportation, to which was referred **SCS SB 322**, begs leave to report it has examined the same and recommends that it **Do Pass**, and pursuant to Rule 24(25)(b) be referred to the Committee on Rules - Administrative Oversight by the following vote:

Ayes (9): Burns, Corlew, Hurst, Kolkmeyer, Korman, Reiboldt, Runions, Ruth and Tate

Noes (0)

Absent (2): Cornejo and May

Mr. Speaker: Your Committee on Transportation, to which was referred **SB 503**, begs leave to report it has examined the same and recommends that it **Do Pass**, and pursuant to Rule 24(25)(b) be referred to the Committee on Rules - Administrative Oversight by the following vote:

Ayes (9): Burns, Corlew, Hurst, Kolkmeyer, Korman, Reiboldt, Runions, Ruth and Tate

Noes (0)

Absent (2): Cornejo and May

Committee on Veterans, Chairman Davis reporting:

Mr. Speaker: Your Committee on Veterans, to which was referred **SCS SB 279**, begs leave to report it has examined the same and recommends that it **Do Pass**, and pursuant to Rule 24(25)(c) be referred to the Committee on Rules - Legislative Oversight by the following vote:

Ayes (7): Barnes (28), Davis, Dohrman, Gray, Kelley (127), Lynch and Pike

Noes (0)

Absent (6): Beck, Brattin, Conway (10), Shumake, Tate and Wilson

Committee on Rules - Legislative Oversight, Chairman Rhoads reporting:

Mr. Speaker: Your Committee on Rules - Legislative Oversight, to which was referred **HR 398**, begs leave to report it has examined the same and recommends that it **Do Pass** by the following vote:

Ayes (13): Bondon, Brown (94), Butler, Curtis, Dogan, Eggleston, Fitzwater (49), Haahr, Lavender, Rhoads, Rone, Shull (16) and Shumake

Noes (1): Wessels

Absent (0)

Mr. Speaker: Your Committee on Rules - Legislative Oversight, to which was referred **HCB 1**, begs leave to report it has examined the same and recommends that it **Do Pass** by the following vote:

Ayes (9): Bondon, Brown (94), Dogan, Eggleston, Fitzwater (49), Rhoads, Rone, Shull (16) and Shumake

Noes (3): Butler, Lavender and Wessels

Absent (2): Curtis and Haahr

Mr. Speaker: Your Committee on Rules - Legislative Oversight, to which was referred **HCB 7**, begs leave to report it has examined the same and recommends that it **Do Pass** by the following vote:

Ayes (12): Bondon, Brown (94), Butler, Dogan, Eggleston, Fitzwater (49), Lavender, Rhoads, Rone, Shull (16), Shumake and Wessels

Noes (0)

Absent (2): Curtis and Haahr

Mr. Speaker: Your Committee on Rules - Legislative Oversight, to which was referred **HCS HCB 8**, begs leave to report it has examined the same and recommends that it **Do Pass** by the following vote:

Ayes (10): Bondon, Brown (94), Butler, Dogan, Eggleston, Fitzwater (49), Rhoads, Rone, Shull (16) and Shumake

Noes (2): Lavender and Wessels

Absent (2): Curtis and Haahr

Mr. Speaker: Your Committee on Rules - Legislative Oversight, to which was referred **HCB 9**, begs leave to report it has examined the same and recommends that it **Do Pass** by the following vote:

Ayes (10): Bondon, Brown (94), Butler, Dogan, Eggleston, Fitzwater (49), Rhoads, Rone, Shull (16) and Shumake

Noes (2): Lavender and Wessels

Absent (2): Curtis and Haahr

Mr. Speaker: Your Committee on Rules - Legislative Oversight, to which was referred **HB 458**, begs leave to report it has examined the same and recommends that it **Do Pass** by the following vote:

Ayes (10): Bondon, Brown (94), Dogan, Eggleston, Fitzwater (49), Haahr, Rhoads, Rone, Shull (16) and Shumake

Noes (4): Butler, Curtis, Lavender and Wessels

Absent (0)

Mr. Speaker: Your Committee on Rules - Legislative Oversight, to which was referred **HCS HBs 551 & 919**, begs leave to report it has examined the same and recommends that it **Do Pass** by the following vote:

Ayes (12): Bondon, Brown (94), Butler, Dogan, Eggleston, Fitzwater (49), Lavender, Rhoads, Rone, Shull (16), Shumake and Wessels

Noes (0)

Absent (2): Curtis and Haahr

Mr. Speaker: Your Committee on Rules - Legislative Oversight, to which was referred **HB 630**, begs leave to report it has examined the same and recommends that it **Do Pass** by the following vote:

Ayes (9): Bondon, Dogan, Eggleston, Fitzwater (49), Haahr, Rhoads, Rone, Shull (16) and Shumake

Noes (4): Butler, Curtis, Lavender and Wessels

Absent (1): Brown (94)

Mr. Speaker: Your Committee on Rules - Legislative Oversight, to which was referred **HB 632**, begs leave to report it has examined the same and recommends that it **Do Pass** by the following vote:

Ayes (12): Bondon, Brown (94), Butler, Curtis, Dogan, Eggleston, Fitzwater (49), Haahr, Rhoads, Rone, Shull (16) and Shumake

Noes (2): Lavender and Wessels

Absent (0)

Mr. Speaker: Your Committee on Rules - Legislative Oversight, to which was referred **SS SB 182**, begs leave to report it has examined the same and recommends that it **Do Pass** by the following vote:

Ayes (11): Bondon, Brown (94), Curtis, Dogan, Eggleston, Fitzwater (49), Haahr, Rhoads, Rone, Shull (16) and Shumake

Noes (3): Butler, Lavender and Wessels

Absent (0)

The following members' presence was noted: Brown (57), Cookson, and McDaniel.

ADJOURNMENT

On motion of Representative Austin, the House adjourned until 10:00 a.m., Thursday, April 20, 2017.

COMMITTEE HEARINGS

CHILDREN AND FAMILIES
Thursday, April 20, 2017, 12:00 PM or upon adjournment (whichever is later), South Gallery.
Executive session will be held: SS SCS SB 160
Executive session may be held on any matter referred to the committee.

CHILDREN AND FAMILIES
Tuesday, April 25, 2017, 5:00 PM or upon evening recess/adjournment (whichever is later), House Hearing Room 7.
Public hearing will be held: SS SCS SB 160
Executive session may be held on any matter referred to the committee.
CANCELLED

CONSENT AND HOUSE PROCEDURE
Thursday, April 20, 2017, 9:00 AM, House Hearing Room 7.
Executive session will be held: SB 50, SCS SB 229, SB 194
Executive session may be held on any matter referred to the committee.

CORRECTIONS AND PUBLIC INSTITUTIONS
Thursday, April 20, 2017, 8:30 AM, House Hearing Room 1.
Public hearing will be held: SCS SB 421
Executive session will be held: SCS SB 421
Executive session may be held on any matter referred to the committee.

CRIME PREVENTION AND PUBLIC SAFETY
Tuesday, April 25, 2017, 8:00 AM, House Hearing Room 5.
Public hearing will be held: SB 25, SCS SB 84, SB 282
Executive session may be held on any matter referred to the committee.

FISCAL REVIEW
Thursday, April 20, 2017, 8:30 AM, House Hearing Room 6.
Executive session may be held on any matter referred to the committee.

FISCAL REVIEW
Thursday, April 27, 2017, 8:30 AM, House Hearing Room 6.
Executive session may be held on any matter referred to the committee.

INSURANCE POLICY
Tuesday, April 25, 2017, 12:00 PM or upon morning adjournment (whichever is later), House Hearing Room 4.
Public hearing will be held: SS SCS SB 74, SCS SB 334, HB 1073
Executive session may be held on any matter referred to the committee.

JOINT COMMITTEE ON EDUCATION
Monday, May 1, 2017, 12:30 PM, Senate Committee Room 2.
Executive session may be held on any matter referred to the committee.
1. Department of Elementary and Secondary Education (DESE) will present a draft state response to the federal Every Student Succeeds Act (ESSA).
2. Elections of JCED Chair and Co-Chair.
3. Discuss possible JCED interim projects.

JOINT COMMITTEE ON PUBLIC EMPLOYEE RETIREMENT
Thursday, April 27, 2017, 9:00 AM, House Hearing Room 7.
Executive session may be held on any matter referred to the committee.
Second quarter meeting.

PENSIONS
Monday, April 24, 2017, upon conclusion of afternoon session, House Hearing Room 1.
Public hearing will be held: SB 394
Executive session will be held: SCS SB 309
Executive session may be held on any matter referred to the committee.

SUBCOMMITTEE ON CORRECTIONS WORKFORCE ENVIRONMENT AND CONDUCT
Thursday, April 20, 2017, 8:45 AM or upon adjournment of the Corrections and Public Institutions Committee meeting, House Hearing Room 1.
Executive session may be held on any matter referred to the committee.
The subcommittee will hear testimony from the Director of the Department of Corrections.

HOUSE CALENDAR

FIFTY-NINTH DAY, THURSDAY, APRIL 20, 2017

HOUSE JOINT RESOLUTIONS FOR PERFECTION

HCS HJR 29 - Dohrman
HJR 2 - Shumake
HJR 18 - Moon

HOUSE COMMITTEE BILLS FOR PERFECTION

HCB 2 - Reiboldt
HCB 1 - McGaugh
HCB 7 - Fitzwater (144)

HCS HCB 8 - McGaugh
HCB 9 - McGaugh

HOUSE BILLS FOR PERFECTION

HB 459 - Kolkmeyer
HB 463 - Kolkmeyer
HB 39 - Higdon
HB 182 - Hurst
HCS HB 326 - Miller
HB 358 - Bahr
HCS HB 415 - McGaugh
HB 426 - Cornejo
HCS HBs 908 & 757 - Lichtenegger
HB 708 - Hill
HB 56 - Love
HB 110 - Davis
HCS HB 574 - Davis
HCS HB 677 - Rowland (155)
HB 738 - Kolkmeyer
HB 799 - Lauer
HCS HB 890 - Mathews
HB 114 - McGaugh
HB 301 - Hill
HB 305 - Pike
HB 322 - Neely
HCS HB 379 - Plocher
HCS HB 436 - Hill
HCS HB 608 - Anderson
HB 705 - Cross
HCS HB 754 - Schroer
HCS HB 827 - DeGroot
HB 889 - Rehder
HCS HB 136 - Spencer
HCS HB 351 - McGaugh
HB 352 - Eggleston
HB 603 - Rone
HB 897 - Houghton
HB 102 - Swan
HB 257 - Pfautsch
HCS HB 291 - Crawford
HB 356 - Bahr
HCS HB 432 - Conway (10)
HCS HB 611 - Carpenter
HCS HB 717 - Curtman

HB 723 - Walker (3)
HB 899 - Brown (57)
HB 1008 - Kelly (141)
HB 187 - Swan
HCS HB 226 - Hubrecht
HB 254 - Swan
HB 268 - Brattin
HCS HB 405 - Hubrecht
HCS HB 642 - Kelly (141)
HCS HB 696 - Kelly (141)
HB 768 - Lant
HB 790 - Wiemann
HB 794 - Walker (3)
HCS HB 878 - Dogan
HB 888 - Basye
HB 906 - DeGroot
HCS HB 957 - Rhoads
HCS#2 HBs 48, 69, 495 & 589 - Lichtenegger
HB 287 - Beard
HB 457 - Swan
HB 665 - Walker (3)
HB 761 - Barnes (60)
HB 486 - Dunn
HB 397 - Nichols
HCS HBs 1007 & 937 - Evans
HB 637 - Helms

HOUSE CONCURRENT RESOLUTIONS FOR THIRD READING

HCR 17 - Hubrecht
HCR 48 - Kidd
HCR 7 - Morris
HCR 20 - Kidd
HCR 36 - Walker (74)
HCR 30 - May

HOUSE BILLS FOR THIRD READING

HB 401 - McDaniel
HCS HB 654 - Rowland (155)
HCS HB 306 - Berry
HCS HB 619 - Dogan
HCS HB 162 - Eggleston
HB 97 - Swan
HCS HB 293 - Higdon

HOUSE BILLS FOR THIRD READING - CONSENT

HCS HB 914 - Kidd

SENATE BILLS FOR THIRD READING - CONSENT

SCS SB 52, E.C. - Frederick

(04/18/2017)

SB 411 - Tate
SB 329 - Kolkmeyer

SENATE BILLS FOR THIRD READING

SB 8, E.C. - Rhoads
SB 64 - Alferman
HCS SS SCS SB 66, (Fiscal Review 4/18/17) - Fitzwater (49)
SB 45 - Corlew
SCS SB 108 - Davis
HCS SB 111 - Crawford
SB 486 - Bernskoetter
SS#2 SCS SB 43, (Fiscal Review 4/18/17) - McGaugh
SS SB 182 - Vescovo

HOUSE BILLS WITH SENATE AMENDMENTS

SCS HCS HB 50 - Roeber
SCS HCS HB 14 - Fitzpatrick
SCS HB 51, (Fiscal Review 4/19/17) - Andrews

BILLS CARRYING REQUEST MESSAGES

SS HCS HBs 90 & 68, as amended (request Senate recede/grant conference) - Rehder

HOUSE RESOLUTIONS

HR 11 - Peters

ACTIONS PURSUANT TO ARTICLE IV, SECTION 27

HCS HB 2001 - Fitzpatrick
CCS SCS HCS HB 2002 - Fitzpatrick
CCS SCS HCS HB 2003 - Fitzpatrick
CCS SCS HCS HB 2004 - Fitzpatrick

CCS SCS HCS HB 2005 - Fitzpatrick
CCS SCS HCS HB 2006 - Fitzpatrick
CCS SCS HCS HB 2007 - Fitzpatrick
CCS SCS HCS HB 2008 - Fitzpatrick
CCS SCS HCS HB 2009 - Fitzpatrick
CCS SCS HCS HB 2010 - Fitzpatrick
CCS SCS HCS HB 2011 - Fitzpatrick
CCS SCS HCS HB 2012 - Fitzpatrick
HCS HB 2013 - Fitzpatrick
SCS HCS HB 2017 - Fitzpatrick
SS SCS HCS HB 2018 - Fitzpatrick