FIRST REGULAR SESSION

HOUSE BILL NO. 700

97TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE BARNES.

0714L.02I D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 208.146, 208.151, 208.631, 208.659, 376.961, 376.962, 376.964, 376.966, 376.968, 376.970, and 376.973, RSMo, and to enact in lieu thereof fifteen new sections relating to the Show-Me transformation act.

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

Section A. Sections 208.146, 208.151, 208.631, 208.659, 376.961, 376.962, 376.964, 376.966, 376.968, 376.970, and 376.973, RSMo, are repealed and fifteen new sections enacted in lieu thereof, to be known as sections 208.151, 208.631, 208.659, 208.990, 208.995, 208.997, 208.998, 376.961, 376.962, 376.964, 376.966, 376.968, 376.970, 376.973, and 1, to read as follows:

208.151. 1. Medical assistance on behalf of needy persons shall be known as "MO HealthNet". For the purpose of paying MO HealthNet benefits and to comply with Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. Section 301, et seq.) as amended, the following needy persons shall be eligible to receive MO HealthNet benefits to the extent and in the manner hereinafter provided:

(1) All participants receiving state supplemental payments for the aged, blind and disabled;

(2) All participants receiving aid to families with dependent children benefits, including all persons under nineteen years of age who would be classified as dependent children except for the requirements of subdivision (1) of subsection 1 of section 208.040. Participants eligible under this subdivision who are participating in drug court, as defined in section 478.001, shall have their eligibility automatically extended sixty days from the time their dependent child is

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

removed from the custody of the participant, subject to approval of the Centers for Medicare and Medicaid Services;

(3) All participants receiving blind pension benefits;

(4) All persons who would be determined to be eligible for old age assistance benefits, permanent and total disability benefits, or aid to the blind benefits under the eligibility standards in effect December 31, 1973, or less restrictive standards as established by rule of the family support division, who are sixty-five years of age or over and are patients in state institutions for mental diseases or tuberculosis;

(5) All persons under the age of twenty-one years who would be eligible for aid to families with dependent children except for the requirements of subdivision (2) of subsection 1 of section 208.040, and who are residing in an intermediate care facility, or receiving active treatment as inpatients in psychiatric facilities or programs, as defined in 42 U.S.C. 1396d, as amended;

(6) All persons under the age of twenty-one years who would be eligible for aid to families with dependent children benefits except for the requirement of deprivation of parental support as provided for in subdivision (2) of subsection 1 of section 208.040;

(7) All persons eligible to receive nursing care benefits;

(8) All participants receiving family foster home or nonprofit private child-care institution care, subsidized adoption benefits and parental school care wherein state funds are used as partial or full payment for such care;

(9) All persons who were participants receiving old age assistance benefits, aid to the permanently and totally disabled, or aid to the blind benefits on December 31, 1973, and who continue to meet the eligibility requirements, except income, for these assistance categories, but who are no longer receiving such benefits because of the implementation of Title XVI of the federal Social Security Act, as amended;

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

(11) Pregnant women who meet the requirements for aid to families with dependent children, except for the existence of a dependent child who is deprived of parental support as provided for in subdivision (2) of subsection 1 of section 208.040;

(12) Pregnant women or infants under one year of age, or both, whose family income does not exceed an income eligibility standard equal to one hundred eighty-five percent of the federal poverty level as established and amended by the federal Department of Health and Human Services, or its successor agency;

(13) Children who have attained one year of age but have not attained six years of age who are eligible for medical assistance under 6401 of P.L. 101-239 (Omnibus Budget

Reconciliation Act of 1989). The family support division shall use an income eligibility standard equal to one hundred thirty-three percent of the federal poverty level established by the Department of Health and Human Services, or its successor agency;

(14) Children who have attained six years of age but have not attained nineteen years of age. For children who have attained six years of age but have not attained nineteen years of age, the family support division shall use an income assessment methodology which provides for eligibility when family income is equal to or less than equal to one hundred percent of the federal poverty level established by the Department of Health and Human Services, or its successor agency. As necessary to provide MO HealthNet coverage under this subdivision, the department of social services may revise the state MO HealthNet plan to extend coverage under 42 U.S.C. 1396a (a)(10)(A)(i)(III) to children who have attained six years of age but have not attained nineteen years of age as permitted by paragraph (2) of subsection (n) of 42 U.S.C. 1396d using a more liberal income assessment methodology as authorized by paragraph (2) of subsection (r) of 42 U.S.C. 1396a;

(15) The family support division shall not establish a resource eligibility standard in assessing eligibility for persons under subdivision (12), (13) or (14) of this subsection. The MO HealthNet division shall define the amount and scope of benefits which are available to individuals eligible under each of the subdivisions (12), (13), and (14) of this subsection, in accordance with the requirements of federal law and regulations promulgated thereunder;

(16) Notwithstanding any other provisions of law to the contrary, ambulatory prenatal care shall be made available to pregnant women during a period of presumptive eligibility pursuant to 42 U.S.C. Section 1396r-1, as amended;

(17) A child born to a woman eligible for and receiving MO HealthNet benefits under this section on the date of the child's birth shall be deemed to have applied for MO HealthNet benefits and to have been found eligible for such assistance under such plan on the date of such birth and to remain eligible for such assistance for a period of time determined in accordance with applicable federal and state law and regulations so long as the child is a member of the woman's household and either the woman remains eligible for such assistance or for children born on or after January 1, 1991, the woman would remain eligible for such assistance if she were still pregnant. Upon notification of such child's birth, the family support division shall assign a MO HealthNet eligibility identification number to the child so that claims may be submitted and paid under such child's identification number;

(18) Pregnant women and children eligible for MO HealthNet benefits pursuant to subdivision (12), (13) or (14) of this subsection shall not as a condition of eligibility for MO HealthNet benefits be required to apply for aid to families with dependent children. The family support division shall utilize an application for eligibility for such persons which eliminates

information requirements other than those necessary to apply for MO HealthNet benefits. The division shall provide such application forms to applicants whose preliminary income information indicates that they are ineligible for aid to families with dependent children. Applicants for MO HealthNet benefits under subdivision (12), (13) or (14) of this subsection shall be informed of the aid to families with dependent children program and that they are entitled to apply for such benefits. Any forms utilized by the family support division for assessing eligibility under this chapter shall be as simple as practicable;

(19) Subject to appropriations necessary to recruit and train such staff, the family support division shall provide one or more full-time, permanent eligibility specialists to process applications for MO HealthNet benefits at the site of a health care provider, if the health care provider requests the placement of such eligibility specialists and reimburses the division for the expenses including but not limited to salaries, benefits, travel, training, telephone, supplies, and equipment of such eligibility specialists. The division may provide a health care provider with a part-time or temporary eligibility specialist at the site of a health care provider if the health care provider requests the placement of such an eligibility specialist and reimburses the division for the expenses, including but not limited to the salary, benefits, travel, training, telephone, supplies, and equipment, of such an eligibility specialist. The division may seek to employ such eligibility specialists who are otherwise qualified for such positions and who are current or former welfare participants. The division may consider training such current or former welfare participants as eligibility specialists for this program;

(20) Pregnant women who are eligible for, have applied for and have received MO HealthNet benefits under subdivision (2), (10), (11) or (12) of this subsection shall continue to be considered eligible for all pregnancy-related and postpartum MO HealthNet benefits provided under section 208.152 until the end of the sixty-day period beginning on the last day of their pregnancy;

(21) Case management services for pregnant women and young children at risk shall be a covered service. To the greatest extent possible, and in compliance with federal law and regulations, the department of health and senior services shall provide case management services to pregnant women by contract or agreement with the department of social services through local health departments organized under the provisions of chapter 192 or chapter 205 or a city health department operated under a city charter or a combined city-county health department or other department of health and senior services designees. To the greatest extent possible the department of social services and the department of health and senior services shall mutually coordinate all services for pregnant women and children with the crippled children's program, the prevention of intellectual disability and developmental disability program and the prenatal care program administered by the department of health and senior services. The department of

social services shall by regulation establish the methodology for reimbursement for case management services provided by the department of health and senior services. For purposes of this section, the term "case management" shall mean those activities of local public health personnel to identify prospective MO HealthNet-eligible high-risk mothers and enroll them in the state's MO HealthNet program, refer them to local physicians or local health departments who provide prenatal care under physician protocol and who participate in the MO HealthNet program for prenatal care and to ensure that said high-risk mothers receive support from all private and public programs for which they are eligible and shall not include involvement in any MO HealthNet prepaid, case-managed programs;

(22) By January 1, 1988, the department of social services and the department of health and senior services shall study all significant aspects of presumptive eligibility for pregnant women and submit a joint report on the subject, including projected costs and the time needed for implementation, to the general assembly. The department of social services, at the direction of the general assembly, may implement presumptive eligibility by regulation promulgated pursuant to chapter 207;

(23) All participants who would be eligible for aid to families with dependent children benefits except for the requirements of paragraph (d) of subdivision (1) of section 208.150;

(24) (a) All persons who would be determined to be eligible for old age assistance benefits under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C. Section 1396a(f), or less restrictive methodologies as contained in the MO HealthNet state plan as of January 1, 2005; except that, on or after July 1, 2005, less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), may be used to change the income limit if authorized by annual appropriation;

(b) All persons who would be determined to be eligible for aid to the blind benefits under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C. Section 1396a(f), or less restrictive methodologies as contained in the MO HealthNet state plan as of January 1, 2005, except that less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), shall be used to raise the income limit to one hundred percent of the federal poverty level;

(c) All persons who would be determined to be eligible for permanent and total disability benefits under the eligibility standards in effect December 31, 1973, as authorized by 42 U.S.C. 1396a(f); or less restrictive methodologies as contained in the MO HealthNet state plan as of January 1, 2005; except that, on or after July 1, 2005, less restrictive income methodologies, as authorized in 42 U.S.C. Section 1396a(r)(2), may be used to change the income limit if authorized by annual appropriations. Eligibility standards for permanent and total disability benefits shall not be limited by age;

(25) Persons who have been diagnosed with breast or cervical cancer and who are eligible for coverage pursuant to 42 U.S.C. 1396a (a)(10)(A)(ii)(XVIII). Such persons shall be eligible during a period of presumptive eligibility in accordance with 42 U.S.C. 1396r-1;

(26) Persons who are **[**independent foster care adolescents, as defined in 42 U.S.C. Section 1396d, or who are within reasonable categories of such adolescents who are under twenty-one years of age as specified by the state, are eligible for coverage under 42 U.S.C. Section 1396a (a)(10)(A)(ii)(XVII) without regard to income or assets**] in foster care under the responsibility of the state of Missouri on the date such persons attain the age of eighteen years, without regard to income or assets, are eligible for coverage if such persons:**

(a) Are less than twenty-six years of age;

(b) Are not eligible for coverage under another mandatory coverage group; and

(c) Were covered by Medicaid while they were in such foster care.

2. Beginning July 1, 2014, eligibility for MO HealthNet benefits shall be affected as follows:

(1) Persons eligible under subdivisions (3) and (25) of subsection 1 of this section shall no longer be eligible for MO HealthNet benefits as provided in this section;

(2) Eligibility of pregnant women under subdivision (12) of subsection 1 of this section shall be limited to those women whose family income does not exceed one hundred thirty-three percent of the federal poverty level as established and amended by the United State Department of Health and Human Services, or its successor agency;

(3) Beginning October 1, 2019, infants under one year of age who are eligible under subdivision (12) of subsection 1 of this section shall be limited to those infants whose family income does not exceed one hundred thirty-three percent of the federal poverty level as established and amended by the United States Department of Health and Human Services, or its successor agency;

(4) The changes in eligibility under subdivisions (1) to (3) of this subsection shall not take place unless and until:

(a) There are health insurance premium tax credits under Section 36B of the Internal Revenue Code of 1986, as amended, available to persons through the purchase of a health insurance plan in a health care exchange, whether federally facilitated, state-based, or operated on a partnership basis; and

(b) Eligibility of persons set out in subsection 3 of section 208.995 has been approved by the United States Department of Health and Human Services and has been implemented by the department; and

(c) The United States Department of Health and Human Services grants the required waivers and state plan amendments to implement this subsection; and

(d) Beginning October 1, 2019, sections 208.631 to 208.658 shall no longer be in effect. Such change in eligibility shall not take place unless and until for a six-month period preceding the discontinuance of benefits under sections 208.631 to 208.658 there are health insurance premium tax credits available for children and family coverage under Section 36B of the Internal Revenue Code of 1986, as amended, available to persons through the purchase of a health insurance plan in a health care exchange, whether federally facilitated, state-based, or operated on a partnership basis which have been in place for a six-month period; and

(e) The department shall inform participants six months prior to coverage being discontinued under paragraph (d) of this subdivision as to the possibility of insurance coverage through the purchase of a subsidized health insurance plan available through a health care exchange.

[2.**]** **3.** Rules and regulations to implement this section shall be promulgated in accordance with section 431.064 and 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, 2002, shall be invalid and void.

[3.**]** **4.** After December 31, 1973, and before April 1, 1990, any family eligible for assistance pursuant to 42 U.S.C. 601, et seq., as amended, in at least three of the last six months immediately preceding the month in which such family became ineligible for such assistance because of increased income from employment shall, while a member of such family is employed, remain eligible for MO HealthNet benefits for four calendar months following the month in which such family would otherwise be determined to be ineligible for such assistance because of income and resource limitation. After April 1, 1990, any family receiving aid pursuant to 42 U.S.C. 601, et seq., as amended, in at least three of the six months immediately preceding the month in which such family becomes ineligible for such aid, because of hours of employment or income from employment of the caretaker relative, shall remain eligible for MO HealthNet benefits for six calendar months following the month of such ineligibility as long as such family includes a child as provided in 42 U.S.C. 1396r-6. Each family which has received such medical assistance during the entire six-month period described in this section and which meets reporting requirements and income tests established by the division and continues to include a child as provided in 42 U.S.C. 1396r-6 shall receive MO HealthNet benefits without

fee for an additional six months. The MO HealthNet division may provide by rule and as authorized by annual appropriation the scope of MO HealthNet coverage to be granted to such families.

[4.**]** **5.** When any individual has been determined to be eligible for MO HealthNet benefits, such medical assistance will be made available to him or her for care and services furnished in or after the third month before the month in which he made application for such assistance if such individual was, or upon application would have been, eligible for such assistance at the time such care and services were furnished; provided, further, that such medical expenses remain unpaid.

[5.**]** **6.** The department of social services may apply to the federal Department of Health and Human Services for a MO HealthNet waiver amendment to the Section 1115 demonstration waiver or for any additional MO HealthNet waivers necessary not to exceed one million dollars in additional costs to the state, unless subject to appropriation or directed by statute, but in no event shall such waiver applications or amendments seek to waive the services of a rural health clinic or a federally qualified health center as defined in 42 U.S.C. 1396d(l)(1) and (2) or the payment requirements for such clinics and centers as provided in 42 U.S.C. 1396a(a)(15) and 1396a(bb) unless such waiver application is approved by the oversight committee created in section 208.955. A request for such a waiver so submitted shall only become effective by executive order not sooner than ninety days after the final adjournment of the session of the general assembly to which it is submitted, unless it is disapproved within sixty days of its submission to a regular session by a senate or house resolution adopted by a majority vote of the respective elected members thereof, unless the request for such a waiver is made subject to appropriation or directed by statute.

[6.**]** **7.** Notwithstanding any other provision of law to the contrary, in any given fiscal year, any persons made eligible for MO HealthNet benefits under subdivisions (1) to (22) of subsection 1 of this section shall only be eligible if annual appropriations are made for such eligibility. This subsection shall not apply to classes of individuals listed in 42 U.S.C. Section 1396a(a)(10)(A)(i).

8. The department shall notify any potential exchange-eligible participant who may be eligible for services due to spenddown of their potential ability to qualify for more cost effective private insurance and premium tax credits under Section 36B of the Internal Revenue Code of 1986, as amended, available through the purchase of a health insurance plan in a health care exchange, whether federally facilitated, state-based, or operated on a partnership basis and the benefits that would be potentially covered under such insurance.

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

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

3. Beginning October 1, 2019, sections 208.631 to 208.658 shall no longer be in effect. Such change in eligibility shall not take place unless and until for a six-month period preceding the discontinuance of benefits under sections 208.631 to 208.658 there are health insurance premium tax credits available for children and family coverage under Section 36B of the Internal Revenue Code of 1986, as amended, available to persons through the purchase of a health insurance plan in a health care exchange, whether federally facilitated, state-based, or operated on a partnership basis which have been in place for a six-month period.

4. The department shall inform participants six months prior to coverage being discontinued under subsection 3 of this section as to the possibility of insurance coverage through the purchase of a subsidized health insurance plan available through a health care exchange.

208.659. **1.** The MO HealthNet division shall revise the eligibility requirements for the uninsured women's health program, as established in 13 CSR Section 70-4.090, to include women who are at least eighteen years of age and with a net family income of at or below one hundred eighty-five percent of the federal poverty level. In order to be eligible for such program, the applicant shall not have assets in excess of two hundred and fifty thousand dollars, nor shall the applicant have access to employer-sponsored health insurance. Such change in eligibility requirements shall not result in any change in services provided under the program.

2. Beginning July 1, 2014, the provisions of this section shall no longer be in effect. Such change in eligibility shall not take place unless and until:

(1) For a six-month period preceding the discontinuance of benefits under sections 208.631 to 208.658 there are health insurance premium tax credits available for children and family coverage under Section 36B of the Internal Revenue Code of 1986, as amended, available to persons through the purchase of a health insurance plan in a health care exchange, whether federally facilitated, state-based, or operated on a partnership basis which have been in place for a six-month period; and

(2) Eligibility of persons set out in subsection 3 of section 208.995 has been approved by the United States Department of Health and Human Services and has been implemented by the department.

3. The department shall inform participants six months prior to coverage being discontinued under subsection 2 of this section as to the possibility of insurance coverage through the purchase of a subsidized health insurance plan available through a health care exchange.

208.990. 1. The provisions of this act shall be known and may be cited as the "Show-Me Transformation Act".

2. Notwithstanding any other provisions of law, in order to be eligible for MO HealthNet coverage individuals shall meet eligibility criteria set forth in 42 CFR Part 435, including, but not limited to the requirements that:

(1) The individual is a resident of the state of Missouri;

(2) The individual has a valid Social Security number;

(3) The individual is a citizen of the United States or a qualified alien as described in Section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 8 U.S.C. Section 1641, who has provided satisfactory documentary evidence of qualified alien status which has been verified with the Department of Homeland Security under a declaration required by Section 1137(d) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 that the applicant or beneficiary is an alien in a satisfactory immigration status;

(4) An individual claiming eligibility as a pregnant woman shall verify pregnancy.

3. Notwithstanding any other provisions of law, effective January 1, 2014, the family support division shall conduct an annual review of all MO HealthNet participants' eligibility as provided in 42 CFR Section 435.916.

4. Notwithstanding any other provisions of law, applications for MO HealthNet shall be submitted in accordance with the requirements of 42 CFR Section 435.907 and other applicable federal law. The individual shall provide all required information and documentation necessary to make an eligibility determination or for a purpose directly connected to the administration of the medical assistance program.

5. Notwithstanding any other provisions of law, in order to be eligible for MO HealthNet coverage under section 208.995, individuals shall meet the eligibility requirements set forth in subsection 1 of this section and all other eligibility criteria set forth in 42 CFR Parts 435 and 457, including, but not limited to the requirement that:

(1) The department of social services shall determine the individual's financial eligibility on income based on projected annual household income and family size for the remainder of the current calendar year;

(2) The department of social services shall determine household income for purposes of determining the modified adjusted gross income by including all actually available cash support provided by the person claiming such individual as a tax dependent;

(3) The department of social services shall determine a pregnant woman's household size by counting the pregnant woman plus the number of children she is expected to deliver;

(4) CHIP-eligible children shall be uninsured, shall not have access to affordable insurance, and shall pay the required premium;

(5) An individual claiming eligibility as an uninsured woman shall be uninsured.

6. The MO HealthNet program shall not provide MO HealthNet coverage under subsection 3 of section 208.995 to a parent or other caretaker relative living with a dependent child unless the child is receiving benefits under the MO HealthNet program, the Children's Health Insurance Program (CHIP) under 42 CFR Chapter IV, Subchapter D, or otherwise is enrolled in minimum essential coverage as defined in 42 CFR Section 435.4.

208.995. 1. For purposes of sections 208.990 to 208.998 the following terms mean:

(1) "Caretaker relative", a relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care, which may, but is not required to, be indicated by claiming the child as a tax dependent for federal income tax purposes, and who is one of the following:

(a) The child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece;

(b) The spouse of such parent or relative, even after the marriage is terminated by death or divorce;

(2) "Child" or "children", a person or persons who are under the age of nineteen;

(3) "CHIP-eligible children", children who are eligible for Missouri's children's health insurance program as provided in sections 208.631 to 208.658, including paying the premiums required under sections 208.631 to 208.658;

(4) "Department", the Missouri department of social services, or a division or unit within the department as designated by the department's director;

(5) "MAGI", the individual's modified adjusted gross income as defined in Section 36B(d)(2) of the Internal Revenue Code of 1986, as amended, and:

(a) Any foreign earned income or housing costs;

(b) Tax exempt interest received or accrued by the individual; and

(c) Tax exempt Social Security income;

(6) "MAGI equivalent net income standard", an income eligibility threshold based on modified adjusted gross income that are not less than the effective income eligibility levels that were in effect prior to enactment of Public Law 111-148 and Public Law 111-152;

(7) "Managed care entity", the same meaning as such term is defined in section 376.1450;

(8) "Managed care plan", any plan offered by a managed care entity;

(9) "Medically frail", individuals with:

(a) Serious emotional disturbances;

(b) Disabling mental disorders;

(c) Substance use disorders who are at high risk for significant medical and social costs;

(d) Serious and complex medical conditions; and

(e) Physical or mental disabilities that significantly impair their ability to perform one or more activities of daily living.

2. (1) Effective January 1, 2014, notwithstanding any other provision of law except for subsection 2 of section 208.151 and section 208.630, the following individuals shall be eligible for MO HealthNet coverage as provided in this section:

(a) Individuals covered by MO HealthNet for families as provided in section 208.145;

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

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

(d) Pregnant women as provided in subdivisions (10), (11), and (12) of subsection 1 of section 208.151;

(e) Children under age of one as provided in subdivision (12) of subsection 1 of section 208.151;

(f) Children under age of six as provided in subdivision (13) of subsection 1 of section 208.151;

(g) Children under age of nineteen as provided in subdivision (14) of subsection 1 of section 208.151;

(h) CHIP-eligible children; and

(i) Uninsured women as provided in section 208.659.

(2) Effective January 1, 2014, the department of social services shall determine eligibility for individuals eligible for MO HealthNet under subdivision (1) of this subsection based on the following income eligibility standards, unless and until they are changed under subsection 2 of section 208.151:

(a) For individuals listed in paragraphs (a), (b) and (c) of subdivision (1) of this subsection, the department of social services shall apply the July 16, 1996, Aid to Families with Dependent Children (AFDC) income standard as converted to the MAGI equivalent net income standard;

(b) For individuals listed in paragraphs (d), (f), (g) and (i) of subdivision (1) of this subsection, the department of social services shall apply one hundred thirty-three percent of the federal poverty level converted to the MAGI equivalent net income standard;

(c) For individuals listed in paragraph (h) of subdivision (1) of this subsection, the department of social services shall convert the income eligibility standard set forth in section 208.633 to the MAGI equivalent net income standard;

(d) For individuals listed in paragraph (e) of subdivision (1) of this subsection, the department of social services shall apply one hundred eighty-five percent of the federal poverty level converted to the MAGI equivalent net income standard.

(3) Individuals eligible for MO HealthNet under subdivision (1) of this subsection shall receive all applicable benefits under section 208.152.

3. (1) Effective January 1, 2014, and subject to the receipt of appropriate waivers and approval of state plan amendments, individuals who meet the following qualifications

shall be eligible for the alternative package of MO HealthNet benefits as set forth in subsections 4 and 5 of this section, subject to the other requirements of this section:

(a) Are age nineteen or older and under age sixty-five;

(b) Are not pregnant;

(c) Are not entitled to or enrolled for Medicare benefits under Part A or B of Title XVIII of the Social Security Act;

(d) Are not otherwise eligible for and enrolled for mandatory coverage under Missouri's MO HealthNet program in accordance with 42 CFR Part 435, Subpart B; and

(e) Have household income that is at or below one hundred percent of the federal poverty level for the applicable family size for the applicable year under the MAGI equivalent net income standard.

(2) The department of social services shall immediately seek any necessary waivers from the United States Department of Health and Human Services to implement the provisions of this subsection. The waiver shall:

(a) Promote healthy behavior and reasonable requirements that patients take ownership of their health care by seeking early preventative care in appropriate settings;

(b) Promote the adoption of healthier personal habits, including limiting the impact of unhealthy behaviors as to tobacco use or obesity;

(c) Allow recipients to receive an annual cash incentive to promote responsible behavior and encourage efficient use of health care services.

4. Except for those individuals who meet the definition of medically frail, the individuals eligible for MO HealthNet benefits in subsection 3 of this section shall only receive a package of alternative minimum benefits. The MO HealthNet division of the department of social services shall promulgate regulations to be effective January 1, 2014, that provide an alternative benefit package that complies with the requirements of federal law and subject to limitations as established in regulations of the MO HealthNet division.

5. Except for those participants who meet the definition of medically frail, participants who qualify for coverage under subsections 2 and 3 of this section shall receive covered services through health plans authorized by the department under section 208.998.

6. The department shall provide premium subsidy and other cost supports for individuals eligible for MO HealthNet under subsections 2 and 3 of this section to enroll in employer-provided health plans or other private health plans based on cost-effective principles determined by the department.

7. Individuals eligible for MO HealthNet under subsections 2 and 3 of this section who meet the definition of medically frail shall receive all coverage they are eligible to receive under section 208.152.

8. The department of social services shall establish a screening process in conjunction with the department of mental health and department of health and senior services for determining whether an individual is medically frail.

9. The department of social services or appropriate divisions of the department shall promulgate rules to implement this section. Any rule or portion of a rule, as the 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, 2013, shall be invalid and void.

10. The department of social services shall submit such state plan amendments and waivers to the centers for Medicare and Medicaid services of the United States Department of Health and Human Services as the department determines are necessary to implement this section. The department shall request of the federal government for an enhanced federal funding rate for the persons newly eligible under subsection 3 of this section whereby the federal government agrees to pay the percentages specified in Section 2001 of PL 111-148, as that section existed on March 28, 2012. The provisions of subsections 3 to 8 of this section shall not be implemented unless such waivers and enhanced federal funding rates are granted by the federal government.

11. If the federal funds at the disposal of the state for payments of money benefits to or on behalf of any persons under this section shall at any time become less than ninety percent of the funds necessary or are not appropriated to pay the percentages specified in Section 2001 of Public Law 111-148, as that section existed on March 28, 2010, subsections 3 to 8 of this section shall no longer be effective for the individuals whose benefits are no longer matchable at the specified percentages.

208.997. 1. The MO HealthNet division shall develop and implement the "Health Care Homes Program" as a provider-directed care coordination program for MO HealthNet recipients who are not enrolled in a prepaid MO HealthNet benefits option and who are receiving services on a fee-for-service basis. The health care homes program shall provide payment to primary care clinics for care coordination for people who have complex and chronic medical conditions. Clinics shall meet certain criteria, including but not limited to the following:

(1) The capacity to develop care plans;

(2) Have a dedicated care coordinator; and

(3) Have an adequate number of clients, evaluation mechanisms, and quality improvement processes to qualify for reimbursement.

2. For purposes of this section, "primary care clinic" means a medical clinic designated as the patient's first point of contact for medical care, available twenty-four hours a day, seven days a week, that provides or arranges the patient's comprehensive health care needs, and provides overall integration, coordination, and continuity over time and referrals for specialty care.

3. This section shall be implemented in such a way that it does not conflict with federal requirements for health care home participation by MO HealthNet participants.

4. The department of social services or appropriate divisions of the department may promulgate rules to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2013, shall be invalid and void.

208.998. 1. Except for those individuals who meet the definition of medically frail, individuals who qualify for coverage under subsections 2 and 3 of section 208.995 shall receive covered services through health plans offered by managed care entities which are authorized by the department. Health plans authorized by the department:

(1) Shall resemble commercially available health plans while complying with federal Medicaid requirements;

(2) Shall promote, to the greatest extent possible, opportunity for children and their parents to be covered under the same plan;

(3) May offer plans regionally, statewide or both, but shall ensure that all regions have adequate coverage through managed care contracts;

(4) Shall include cost-sharing for out-patient services as allowed by federal law;

(5) Shall provide incentives to health plans and providers to encourage cost-effective delivery of care; and

(6) May provide multiple plan options and reward participants for choosing a low-cost plan.

2. The department may designate that certain health care services be excluded from such health plans if it is determined cost effective by the department. The department shall establish uniform utilization review protocols to be used by all authorized health plans.

3. The department shall establish the following requirements for contracting with managed care plans:

(1) (a) For managed care plans utilizing capitation arrangements between the managed care plan and providers, the department shall establish the following requirements for contracting with managed care plans under this subdivision:

a. All capitation managed care plans shall be required to submit a blind bid on each of two levels of coverage with the department establishing the levels of coverage and the maximum capitation rate for each level. The department shall not disclose its maximum capitation rate during the initial bidding process. Each bidder shall include all actuarial and other relevant information utilized by the bidder in determining the bidder's capitation rate. The department may establish guidelines for the submission of such actuarial and other information;

b. The capitation managed care plan which submits the lowest bid below the maximum capitation rate established by the department shall be guaranteed participation;

c. Except as provided in item (ii) of subparagraph e. and subparagraph f. of this paragraph, all bids in excess of the maximum capitation rate established by the department shall not be considered;

d. If at least two submit bids which are equal to or less than the maximum capitation rate established by the department, the department shall contract with such plans as required under subparagraph a. of this paragraph and no further bidding shall be required;

e. If less than two, or three if the department elects to include an additional plan, capitation managed care plans submit bids equal to or less than the maximum capitation rate established by the department:

(i) The department shall guarantee participation to the plan or plans which submit bids equal to or less than the maximum capitation rate established by the department;

(ii) For any remaining plan or plans necessary to meet the required number of plans established under subparagraph b. of this paragraph, the department may select such plan or plans with the lowest bid within one hundred twenty-five percent of the maximum capitation rate established by the department or reopen the bidding in accordance with item (ii) of subparagraph f. of this paragraph;

f. If no capitation managed care plans submit a bid equal to or less than the maximum capitation rate established by the department:

(i) The department may select any such plan or plans with the lowest bids within one hundred twenty-five percent of the maximum capitation rate established by the department. If the required number of plans under subparagraph b. of this paragraph

meet the requirements of this paragraph, the department may contract with such plans and no further bidding shall be required; or

(ii) The department may reevaluate and adjust its maximum capitation rate, discard all previous nonconforming bids, disclose to all bidders the adjusted maximum capitation rate established by the department, and open a second bidding process. All bids submitted with the adjusted capitation maximum established by the department shall be otherwise evaluated in accordance with this paragraph.

g. In awarding contracts under this subdivision, the department shall consider the following factors:

(i) Cost to Missouri taxpayers;

(ii) The extent of the network of health care providers offering services within the bidder's plan;

(iii) Additional services offered to recipients under the bidder's plan;

(iv) The bidder's history of providing managed care plans for similar populations in Missouri or other states;

(v) Whether the bidder or an associated company offers an identical or substantially similar plan within a health care exchange in this state; whether federally facilitated, state-based, or operated on a partnership basis; and the bidder, if the bidder offers an identical or similar plan, or the bidder and the associated company, if the bidder has formed a partnership for purposes of its bid, has included in its bid a process by which MO HealthNet recipients who choose its plan will be automatically enrolled in the corresponding plan offered within the health care exchange if the recipient's income increases resulting in the recipient's ineligibility for MO HealthNet benefits; and

(vi) Any other criteria the department deems relevant to ensuring MO HealthNet benefits are provided to recipients in such manner as to save taxpayer money and improve health outcomes of recipients.

(b) If a recipient enrolls in a capitation managed care plan with a capitation rate which is less than the maximum capitation rate established by the department under the bidding process, the recipient shall be eligible to receive a portion of the difference between the plan's capitation rate and the maximum capitation rate established by the department.

(c) For purposes of paragraph (b) of this subdivision, the maximum capitation rate for all participating plans shall be the department's undisclosed maximum capitation rate if the bidding process is not reopened under subparagraph e. or f. of paragraph (a) of this subdivision. If the bidding process is reopened, the maximum capitation rate for all participating plans, including any plans which bid equal to or less than the undisclosed maximum capitation rate, shall be the disclosed adjusted maximum capitation rate;

(2) All managed care bidders shall submit a bid on the levels of coverage established in subsections 8 and 10 of this section;

(3) The department shall select a minimum of three plans from the conforming bids for each region;

(4) The department shall select all of the bidders' plans or none of the bidders' plans; and

(5) The lowest conforming bid in each region shall be accepted by the department.

4. In awarding contracts under this section, the department shall consider the following factors:

(1) Cost to Missouri taxpayers;

(2) The extent of the network of health care providers offering services within the bidder's plan;

(3) Additional services offered to recipients under the bidder's plan;

(4) The managed care entity's history of outcomes and quality of the services offered in Missouri and other states;

(5) The bidder's history of providing managed care plans for similar populations in Missouri and other states;

(6) Whether the bidder or an associated company offers an identical or substantially similar plan within a health insurance marketplace in this state, whether it is federally facilitated, state-based, or operated on a partnership basis; and the bidder, if the bidder offers an identical or similar plan, or the bidder and the associated company, if the bidder has formed a partnership for purposes of its bid, has included in its bid a process by which MO HealthNet recipients who choose its plan will be automatically enrolled in the corresponding plan offered within the health insurance marketplace if the recipient's income increases or another circumstances arises resulting in the recipient's ineligibility for MO HealthNet benefits; and

(7) Any other criteria the department deems relevant to ensuring MO HealthNet benefits are provided to recipients in such manner as to save taxpayer money and improve health outcomes of recipients.

5. If a recipient enrolls in a managed care plan with a capitation rate which is less than the maximum capitation rate established by the department under the bidding process, the recipient shall be eligible to receive a portion of the difference between the plan's capitation rate and the maximum capitation rate established by the department. Any portion received by a participant shall be determined by the department and the department shall ensure a maximum return to taxpayers.

6. All MO HealthNet plans under this subdivision shall provide coverage for the following service unless they are specifically excluded under subsection 2 of this section:

(1) Ambulatory patient services;

(2) Emergency services;

(3) Hospitalization;

(4) Maternity and newborn care;

(5) Mental health and substance use disorders, including behavioral health treatment;

(6) Prescription drugs;

(7) Rehabilitative and habilitative services and devices;

(8) Laboratory services;

(9) Preventive and wellness and chronic disease management;

(10) Pediatric services, including oral and vision care; and

(11) Any other service required by federal law.

7. No MO HealthNet plan shall provide coverage for abortion unless such abortions are certified in writing by a physician to the MO HealthNet agency that, in the physician's professional judgment, the life of the mother would be endangered if the fetus were carried to term.

8. The MO HealthNet program shall provide a high deductible health plan option for uninsured adults between the ages of nineteen and sixty-four with incomes of less than one hundred percent of the federal poverty level. The high deductible plan shall include:

(1) High deductible coverage. After meeting a one thousand dollar deductible, individuals shall be covered for benefits as specified by regulation of the department;

(2) An account of at least one thousand dollars per adult to pay medical costs for the initial deductible funded by the department. The department shall fund such account;

(3) Preventive care, as defined by the department by rule, that is not subject to the deductible and does not require a payment of moneys from the account described in subdivision (2) of this subsection;

(4) A basic benefits package once annual medical costs exceed one thousand dollars;

(5) A minimum deductible of one thousand dollars;

(6) As soon as practicable, the health plan shall establish and maintain a record keeping system for each health care visit or service received by recipients under this subsection. The plan shall require that the recipient's prepaid card number card number be entered or electronic strip be swiped by the health care provider for purposes of maintaining a record of every health care visit or service received by the recipient by such

provider, regardless of any balance on the recipient's card. Such information shall include only the date, provider name, and general description of the visit or service provided. The plan shall maintain a complete history of all health care visits and services for which the recipient's prepaid card is entered or swiped in accordance with this subdivision. If required under the federal Health Insurance Portability and Accountability Act (HIPAA) or other relevant state or federal law or regulation, a recipient shall, as a condition of participation in the prepaid card incentive, be required to provide a written waiver for disclosure of any information required under this subdivision; and

(7) The department shall by rule determine the amount credited to a co-payment prepaid card for a recipient and the percentage of any remaining moneys which may be received by a recipient under subdivision (2) of this subsection; except that, the minimum amounted credited to a co-payment prepaid card shall not be less than forty percent of the minimum deductible required for the high deductible plans under this subsection. No recipient shall be eligible unless such recipient receives a yearly checkup with such recipient's primary care physician.

9. The department shall establish and implement a co-payment cost-sharing program for MO HealthNet recipients not otherwise participating in an option under subsection 8 of this section. Participants shall receive a prepaid card which shall be used to cover the costs of co-payments required under the MO HealthNet program. The department shall require recipients to fund the prepaid card with the maximum cost-share allowed by federal law with the remainder to be funded by the MO HealthNet program. Under this program:

(1) No co-payments shall be imposed for primary care services as defined by the department by rule; and

(2) Recipients shall be eligible to receive a portion of the remaining balance on the card at the end of the coverage year in an amount to be determined by the department by rule. Any such amounts shall be electronically transferred to the recipient's electronic benefit transfer (EBT) card and all such amounts transferred shall be subject to the use requirements and restrictions of EBT cards.

10. All recipients with chronic conditions shall be included in an incentive program for MO HealthNet recipients who obtain specified primary care and preventive services, and who participate or refrain from participation in specified activities to improve the overall health of the recipient. Recipients who complete the requirements of the program shall be eligible to receive an annual cash payment for successful completion of the program. The department shall establish by rule the specific primary care and preventive

services, and activities to be included in the incentive program and the amount of any annual cash payments to recipients.

11. A MO HealthNet recipient shall be eligible for participation in only one of either the high deductible plan under subsection 8 of this section, the co-payment cost-sharing program under subsection 9 of this section, or the incentive program under subsection 10 of this section. No MO HealthNet recipient shall be eligible to combine or otherwise participate in more than one option under subsections 8 to 10 of this section.

12. All cash payments, incentives, or credits paid to or on behalf of a MO HealthNet participant under a program established by the department under this section shall not be deemed to be income to the participant in any means tested benefit program unless otherwise specifically required by law or rule of the department.

13. Managed care entities shall give participants who choose the high deductible plan under subsection 8 of this section or the co-payment cost-sharing program under subsection 9 of this section information notifying the participant that the participant may lose his or her payment if the participant utilizes visits to the emergency department for nonemergency purposes. Such information shall be included on every electronic and paper correspondence between the managed care plan and the participant.

14. The department shall seek all waivers and state plan amendments from the United States Department of Health and Human Services necessary to implement the provisions of this section. The provisions of this section shall not be implemented unless such waivers are granted. If this section is approved in part by the federal government, the department is authorized to proceed on those sections which approval has been granted; except that, any increase in eligibility shall be contingent upon the receipt of all necessary waivers and state plan amendments.

15. The department may promulgate rules to implement this section. Any rule or portion of a rule, as the 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, 2013, shall be invalid and void.

376.961. 1. There is hereby created a nonprofit entity to be known as the "Missouri Health Insurance Pool". All insurers issuing health insurance in this state and insurance arrangements providing health plan benefits in this state shall be members of the pool.

2. Beginning January 1, 2007, the board of directors shall consist of the director of the department of insurance, financial institutions and professional registration or the director's designee, and eight members appointed by the director. Of the initial eight members appointed, three shall serve a three-year term, three shall serve a two-year term, and two shall serve a one-year term. All subsequent appointments to the board shall be for three-year terms. Members of the board shall have a background and experience in health insurance plans or health maintenance organization plans, in health care finance, or as a health care provider or a member of the general public; except that, the director shall not be required to appoint members from each of the categories listed. The director may reappoint members of the board. The director shall fill vacancies on the board in the same manner as appointments are made at the expiration of a member's term and may remove any member of the board for neglect of duty, misfeasance, malfeasance, or nonfeasance in office.

3. Beginning August 28, 2007, the board of directors shall consist of fourteen members. The board shall consist of the director and the eight members described in subsection 2 of this section and shall consist of the following additional five members:

(1) One member from a hospital located in Missouri, appointed by the governor, with the advice and consent of the senate;

(2) Two members of the senate, with one member from the majority party appointed by the president pro tem of the senate and one member of the minority party appointed by the president pro tem of the senate with the concurrence of the minority floor leader of the senate; and

(3) Two members of the house of representatives, with one member from the majority party appointed by the speaker of the house of representatives and one member of the minority party appointed by the speaker of the house of representatives with the concurrence of the minority floor leader of the house of representatives.

4. The members appointed under subsection 3 of this section shall serve in an ex officio capacity. The terms of the members of the board of directors appointed under subsection 3 of this section shall expire on December 31, 2009. On such date, the membership of the board shall revert back to nine members as provided for in subsection 2 of this section.

5. Beginning on August 28, 2013, the board of directors on behalf of the pool, the executive director, and any other employees of the pool shall have the authority to provide assistance or resources to any department, agency, public official, employee, or agent of the federal government for the specific purpose of transitioning individuals enrolled in the pool to coverage outside of the pool beginning on or before January 1, 2014. Such authority does not extend to authorizing the pool to implement, establish, create, administer, or otherwise operate a state-based exchange.

376.962. 1. The board of directors on behalf of the pool shall submit to the director a plan of operation for the pool and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the pool. After notice and hearing, the director shall approve the plan of operation, provided it is determined to be suitable to assure the fair, reasonable and equitable administration of the pool, and it provides for the sharing of pool gains or losses on an equitable proportionate basis. The plan of operation shall become effective upon approval in writing by the director consistent with the date on which the coverage under sections 376.960 to 376.989 becomes available. If the pool fails to submit a suitable plan of operation within one hundred eighty days after the appointment of the board of directors, or at any time thereafter fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this section. Such rules shall continue in force until modified by the director or superseded by a plan submitted by the pool and approved by the director.

2. In its plan, the board of directors of the pool shall:

(1) Establish procedures for the handling and accounting of assets and moneys of the pool;

(2) Select an administering insurer **or third-party administrator** in accordance with section 376.968;

(3) Establish procedures for filling vacancies on the board of directors; **and**

(4) Establish procedures for the collection of assessments from all members to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made. The level of payments shall be established by the board pursuant to the provisions of section 376.973. Assessment shall occur at the end of each calendar year and shall be due and payable within thirty days of receipt of the assessment notice**[**;

(5) Develop and implement a program to publicize the existence of the plan, the eligibility requirements, and procedures for enrollment, and to maintain public awareness of the plan**]**.

3. On or before September 1, 2013, the board shall submit the amendments to the plan of operation as are necessary or suitable to ensure a reasonable transition period to allow for the termination of issuance of policies by the pool.

4. The amendments to the plan of operation submitted by the board shall include all of the requirements outlined in subsection 2 of this section and shall address the transition of individuals covered under the pool to alternative health insurance coverage as it is available after January 1, 2014. The plan of operation shall also address procedures

for finalizing the financial matters of the pool, including assessments, claims expenses, and other matters identified in subsection 2 of this section.

5. The director shall review the plan of operation submitted under subsection 3 of this section and shall promulgate rules to effectuate the transitional plan of operation. Such rule shall be effective no later than October 1, 2013. 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, 2013, shall be invalid and void.

376.964. The board of directors and administering insurers of the pool shall have the general powers and authority granted under the laws of this state to insurance companies licensed to transact health insurance as defined in section 376.960, and, in addition thereto, the specific authority to:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of sections 376.960 to 376.989, including the authority, with the approval of the director, to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

(2) Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against pool members;

(3) Take such legal actions as necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

(4) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas and any other actuarial function appropriate to the operation of the pool. Rates shall not be unreasonable in relation to the coverage provided, the risk experience and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim costs and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices;

(5) Assess members of the pool in accordance with the provisions of this section, and to make advance interim assessments as may be reasonable and necessary for the organizational and interim operating expenses. Any such interim assessments are to be credited as offsets against any regular assessments due following the close of the fiscal year;

(6) **Prior to January 1, 2014,** issue policies of insurance in accordance with the requirements of sections 376.960 to 376.989**. In no event shall new policies of insurance be issued on or after January 1, 2014**;

(7) Appoint, from among members, appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy or other contract design, and any other function within the authority of the pool;

(8) Establish rules, conditions and procedures for reinsuring risks of pool members desiring to issue pool plan coverages in their own name. Such reinsurance facility shall not subject the pool to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers;

(9) Negotiate rates of reimbursement with health care providers on behalf of the association and its members;

(10) Administer separate accounts to separate federally defined eligible individuals and trade act eligible individuals who qualify for plan coverage from the other eligible individuals entitled to pool coverage and apportion the costs of administration among such separate accounts.

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

2. **Prior to January 1, 2014,** the following individual persons shall be eligible for coverage under the pool if they are and continue to be residents of this state:

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

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

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

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

(3) A trade act eligible individual;

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

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

(6) Any person whose health insurance coverage is involuntarily terminated for any reason other than nonpayment of premium or fraud, and who is not otherwise ineligible under subdivision (4) of subsection 3 of this section. If application for pool coverage is made not later

than sixty-three days after the involuntary termination, the effective date of the coverage shall be the date of termination of the previous coverage;

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

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

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

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

(a) This exclusion shall not apply to a person who has such coverage but whose premiums have increased to one hundred fifty percent to two hundred percent of rates established by the board as applicable for individual standard risks;

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

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

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

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

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

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

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

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

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

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

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

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

6. Coverage under the pool shall expire on January 1, 2014.

376.968. The board shall select an insurer **[**or**] ,** insurers**, or third-party administrators** through a competitive bidding process to administer the pool. The board shall evaluate bids submitted based on criteria established by the board which shall include:

(1) The insurer's proven ability to handle individual accident and health insurance;

(2) The efficiency of the insurer's claim-paying procedures;

(3) An estimate of total charges for administering the plan;

(4) The insurer's ability to administer the pool in a cost-efficient manner.

376.970. 1. The administering insurer shall serve for a period of three years subject to removal for cause. At least one year prior to the expiration of each three-year period of service by an administering insurer, the board shall invite all insurers, including the current administering insurer, to submit bids to serve as the administering insurer for the succeeding three-year period. Selection of the administering insurer for the succeeding period shall be made at least six months prior to the end of the current three-year period.

2. The administering insurer shall:

(1) Perform all eligibility and administrative claim-payment functions relating to the pool;

(2) Establish a premium billing procedure for collection of premium from insured persons. Billings shall be made on a period basis as determined by the board;

(3) Perform all necessary functions to assure timely payment of benefits to covered persons under the pool including:

(a) Making available information relating to the proper manner of submitting a claim for benefits to the pool and distributing forms upon which submission shall be made;

(b) Evaluating the eligibility of each claim for payment by the pool;

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

(5) Following the close of each calendar year, determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the board and the department on a form prescribed by the director;

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

3. On or before September 1, 2013, the board shall invite all insurers and third-party administrators, including the current administering insurer, to submit bids to serve as the administering insurer or third-party administrator for the pool. Selection of the administering insurer or third-party administrator shall be made prior to January 1, 2014.

4. Beginning January 1, 2014, the administering insurer or third-party administrator shall:

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

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

(3) Perform all necessary functions to assure timely payment of benefits to covered persons under the pool including:

(a) Making available information relating to the proper manner of submitting a claim for benefits to the pool and distributing forms upon which submission shall be made;

(b) Evaluating the eligibility of each claim for payment by the pool;

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

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

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

376.973. 1. Following the close of each fiscal year, the pool administrator shall determine the net premiums (premiums less administrative expense allowances), the pool expenses of administration and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. Health insurance premiums and benefits paid by an insurance arrangement that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments. The total cost of pool operation shall be the amount by which all program expenses, including pool expenses of administration, incurred losses for the year, and other appropriate losses exceeds all program revenues, including net premiums, investment income, and other appropriate gains.

2. Each insurer's assessment shall be determined by multiplying the total cost of pool operation by a fraction, the numerator of which equals that insurer's premium and subscriber contract charges for health insurance written in the state during the preceding calendar year and the denominator of which equals the total of all premiums, subscriber contract charges written in the state and one hundred ten percent of all claims paid by insurance arrangements in the state during the preceding calendar year; provided, however, that the assessment for each health maintenance organization shall be determined through the application of an equitable formula based upon the value of services provided in the preceding calendar year.

3. Each insurance arrangement's assessment shall be determined by multiplying the total cost of pool operation calculated under subsection 1 of this section by a fraction, the numerator of which equals one hundred ten percent of the benefits paid by that insurance arrangement on behalf of insureds in this state during the preceding calendar year and the denominator of which equals the total of all premiums, subscriber contract charges and one hundred ten percent of all benefits paid by insurance arrangements made on behalf of insureds in this state during the preceding calendar year. Insurance arrangements shall report to the board claims payments made in this state on an annual basis on a form prescribed by the director.

4. If assessments exceed actual losses and administrative expenses of the pool, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" include reserves for incurred but not paid claims.

5. Assessments shall continue until such a time as the executive director of the pool provides notice to the board and director that all claims have been paid.

6. Any assessment funds remaining at the time the executive director provides notice that all claims have been paid shall be deposited in the state general revenue fund.

Section 1. 1. Notwithstanding any other provision of law, beginning July 1, 2014, any MO HealthNet recipient who elects to receive medical coverage through a private health insurance plan instead of through the MO HealthNet program shall be eligible for a private insurance premium subsidy to assist the recipient in paying the costs of such private insurance. The subsidy shall be provided on a sliding scale based on income, with a graduated reduction in subsidy over a period of time not to exceed two years.

2. The department may promulgate rules to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the

grant of rulemaking authority and any rule proposed or adopted after August 28, 2013, shall be invalid and void.

[208.146. 1. The program established under this section shall be known as the "Ticket to Work Health Assurance Program". Subject to appropriations and in accordance with the federal Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA), Public Law 106-170, the medical assistance provided for in section 208.151 may be paid for a person who is employed and who:

(1) Except for earnings, meets the definition of disabled under the Supplemental Security Income Program or meets the definition of an employed individual with a medically improved disability under TWWIIA;

(2) Has earned income, as defined in subsection 2 of this section;

(3) Meets the asset limits in subsection 3 of this section;

(4) Has net income, as defined in subsection 3 of this section, that does not exceed the limit for permanent and totally disabled individuals to receive nonspenddown MO HealthNet under subdivision (24) of subsection 1 of section 208.151; and

(5) Has a gross income of two hundred fifty percent or less of the federal poverty level, excluding any earned income of the worker with a disability between two hundred fifty and three hundred percent of the federal poverty level. For purposes of this subdivision, "gross income" includes all income of the person and the person's spouse that would be considered in determining MO HealthNet eligibility for permanent and totally disabled individuals under subdivision (24) of subsection 1 of section 208.151. Individuals with gross incomes in excess of one hundred percent of the federal poverty level shall pay a premium for participation in accordance with subsection 4 of this section.

2. For income to be considered earned income for purposes of this section, the department of social services shall document that Medicare and Social Security taxes are withheld from such income. Self-employed persons shall provide proof of payment of Medicare and Social Security taxes for income to be considered earned.

3. (1) For purposes of determining eligibility under this section, the available asset limit and the definition of available assets shall be the same as those used to determine MO HealthNet eligibility for permanent and totally disabled individuals under subdivision (24) of subsection 1 of section 208.151 except for:

(a) Medical savings accounts limited to deposits of earned income and earnings on such income while a participant in the program created under this section with a value not to exceed five thousand dollars per year; and

(b) Independent living accounts limited to deposits of earned income and earnings on such income while a participant in the program created under this section with a value not to exceed five thousand dollars per year. For purposes of this section, an "independent living account" means an account established and

maintained to provide savings for transportation, housing, home modification, and personal care services and assistive devices associated with such person's disability.

(2) To determine net income, the following shall be disregarded:

(a) All earned income of the disabled worker;

(b) The first sixty-five dollars and one-half of the remaining earned income of a nondisabled spouse's earned income;

(c) A twenty dollar standard deduction;

(d) Health insurance premiums;

(e) A seventy-five dollar a month standard deduction for the disabled worker's dental and optical insurance when the total dental and optical insurance premiums are less than seventy-five dollars;

(f) All Supplemental Security Income payments, and the first fifty dollars of SSDI payments;

(g) A standard deduction for impairment-related employment expenses equal to one-half of the disabled worker's earned income.

4. Any person whose gross income exceeds one hundred percent of the federal poverty level shall pay a premium for participation in the medical assistance provided in this section. Such premium shall be:

(1) For a person whose gross income is more than one hundred percent but less than one hundred fifty percent of the federal poverty level, four percent of income at one hundred percent of the federal poverty level;

(2) For a person whose gross income equals or exceeds one hundred fifty percent but is less than two hundred percent of the federal poverty level, four percent of income at one hundred fifty percent of the federal poverty level;

(3) For a person whose gross income equals or exceeds two hundred percent but less than two hundred fifty percent of the federal poverty level, five percent of income at two hundred percent of the federal poverty level;

(4) For a person whose gross income equals or exceeds two hundred fifty percent up to and including three hundred percent of the federal poverty level, six percent of income at two hundred fifty percent of the federal poverty level.

5. Recipients of services through this program shall report any change in income or household size within ten days of the occurrence of such change. An increase in premiums resulting from a reported change in income or household size shall be effective with the next premium invoice that is mailed to a person after due process requirements have been met. A decrease in premiums shall be effective the first day of the month immediately following the month in which the change is reported.

6. If an eligible person's employer offers employer-sponsored health insurance and the department of social services determines that it is more cost effective, such person shall participate in the employer-sponsored insurance. The department shall pay such person's portion of the premiums, co-payments, and

any other costs associated with participation in the employer-sponsored health insurance.

7. The provisions of this section shall expire six years after August 28, 2007.**]**

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