SECOND REGULAR SESSION

[P E R F E C T E D**]**

SENATE SUBSTITUTE FOR

SENATE COMMITTEE SUBSTITUTE FOR

SENATE BILL NO. 885

90TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR MATHEWSON.

Offered April 25, 2000.

Senate Substitute adopted, April 25, 2000.

Taken up for Perfection April 25, 2000. Bill declared Perfected and Ordered Printed, as amended.

TERRY L. SPIELER, Secretary.

3801S.07P

AN ACT

To repeal sections 103.085 and 103.136, RSMo 1994, and sections 103.003 and 103.008, RSMo Supp. 1999, relating to health plan for state employees, and to enact in lieu thereof six new sections relating to the same subject.

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

Section A. Sections 103.085 and 103.136, RSMo 1994, and sections 103.003 and 103.008, RSMo Supp. 1999, are repealed and six new sections enacted in lieu thereof, to be known as sections 103.003, 103.008, 103.081, 103.085, 103.136 and 1, to read as follows:

103.003. As used in sections 103.003 to 103.175, the following terms mean:

(1) "Actuarial reserves", the necessary funding required to pay all the medical expenses for services provided to members of the plan but for which the claims have not yet been received by the claims administrator;

(2) "Actuary", a member of the American Academy of Actuaries or who is an enrolled actuary under the Employee Retirement Income Security Act of 1974;

(3) "Agency", a state-sponsored institution of higher learning, political subdivision or governmental entity or instrumentality;

(4) "Alternative delivery health care program", a plan of covered benefits that pays medical expenses through an alternate mechanism rather than on a fee-for-service basis. This includes,

EXPLANATION--Matter enclosed in bold-faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

but is not limited to, health maintenance organizations and preferred provider organizations, all of which shall include chiropractic physicians licensed under chapter 331, RSMo, in the provider networks or organizations;

(5) "Board", the board of trustees of the Missouri consolidated health care plan;

(6) "Claims administrator", an agency contracted to process medical claims submitted from providers or members of the plan and their dependents;

(7) "Coordination of benefits", to work with another group-sponsored health care plan which also covers a member of the plan to ensure that both plans pay their appropriate amount of the health care expenses incurred by the member;

(8) "Covered benefits", a schedule of covered services, including chiropractic services, which are payable under the plan;

(9) "Employee", any person employed full time by the state or a participating member agency, or a person eligible for coverage by a state-sponsored retirement system or a retirement system sponsored by a participating member agency of the plan;

(10) "Evidence of good health", medical information supplied by a potential member of the plan that is reviewed to determine the financial risk the person represents to the plan and the corresponding determination of whether or not he or she should be accepted into the plan;

(11) "Health care plan", any group medical benefit plan providing coverage on an expense-incurred basis, any HMO, any group service or indemnity contract issued by a health plan of any type or description;

(12) "Medical benefits coverages" shall include services provided by chiropractic physicians as well as physicians licensed under chapter 334, RSMo;

(13) "Medical expenses", costs for services performed by a provider and covered under the plan;

(14) "Missouri consolidated health care plan benefit fund account", the benefit trust fund account containing all payroll deductions, payments, and income from all sources for the plan;

(15) "Officer", an elected official of the state of Missouri;

(16) "Participating member agency", a state-sponsored institution of higher learning, political subdivision or governmental entity **[**or instrumentality**]** that has elected to join the plan and has been accepted by the board;

(17) "Plan year", a twelve-month period designated by the board which is used to calculate the annual rate categories and the appropriate coverage;

(18) "Provider", a physician, hospital, pharmacist, psychologist, chiropractic physician or other licensed practitioner who or which provides health care services within the respective scope of practice of such practitioner pursuant to state law and regulation;

(19) "Retiree", a person who is not an employee and is receiving or is entitled to receive an annuity benefit from a state-sponsored retirement system or a retirement system of a

participating member agency of the plan or becomes eligible for retirement benefits because of service with a participating member agency.

103.008. 1. The general administration and the responsibility for the proper operation of the plan is vested in a board of trustees of **[**eleven**]** **thirteen** persons, as follows: the director of the department of health, the director of the department of insurance, the commissioner of the state office of administration serving ex officio, one member of the senate **from the majority party** appointed by the president pro tem of the senate **and one member of the senate from the minority party appointed by the president pro tem of the senate with the concurrence of the minority floor leader of the senate**, one member of the house of representatives **from the majority party** appointed by the speaker of the house of representatives **and one member of the house of representatives from 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**, and six members appointed by the governor with the advice and consent of the senate. Of the six members appointed by the governor, three shall be citizens of the state of Missouri who are not members of the plan, but who are familiar with medical issues. The remaining three members shall be members of the plan and may be selected from any state agency or any participating member agency.

2. Except for the legislative members, the director of the department of health, the director of the department of insurance, and the commissioner of the office of administration, trustees shall be chosen for terms of four years from the first day of January next following their election or appointment. Any vacancies occurring in the office of trustee shall be filled in the same manner the office was filled previously.

103.081. The board shall develop and submit to the general assembly by September 1, 2000, a plan to offer to state employees located in counties in which HMO coverage is not available, a medical benefits plan for calendar year 2001 with benefits coverage substantially identical to HMO benefits coverage, at a cost to employees not to exceed the average cost to employees for HMO coverage in counties where such coverage is available.

103.085. Except as otherwise provided by sections 103.003 to 103.175, medical benefits coverage as provided by sections 103.003 to 103.175 shall terminate when the member ceases to be an active employee; except persons receiving or entitled to receive an annuity or retirement benefit or disability benefit or the spouse of or unemancipated children of deceased persons receiving or entitled to receive an annuity or retirement benefit or disability benefit from the state, participating member agency, institution, political subdivision or governmental entity may elect to continue coverage, provided the individuals to be covered have been continuously covered for **[**the**]** **health care** benefits **[**under sections 103.003 to 103.175 for at least the shorter of**]**:

(1) **[**Two years prior to the date of death or disability of the member or his**]** **Under a**

separate group or individual policy for the six-month period immediately preceding the member's date of death or disability or eligibility for normal or early retirement; or

(2) **Pursuant to sections 103.003 to 103.175, since the effective date of the most recent open enrollment period prior to the member's date of death or disability or eligibility for normal or early retirement; or**

(3) From the initial date of eligibility for the benefits provided by sections 103.003 to 103.175.

Cost for coverage continued **[**under**] pursuant to** this section shall be determined by the board. If an eligible person does not elect to continue the coverage within thirty-one days of the first day of the month following the date on which the eligible person ceases to be an employee, he **or she** may not later elect to be covered **[**under**] pursuant to** this section.

103.136. Any participating member agency terminating its coverage under the plan will not be eligible for participation in the plan for a period of two years after its termination date **[**except by a majority vote of the board**]**.

Section 1. Due to the differences between the appropriations process and the current contract methodology used by the board, the general assembly hereby recommends that the board, with respect to health care provider contracts, implement a plan year based upon a fiscal year beginning 1 October rather than the calendar year period currently employed by the board.

?