SECOND REGULAR SESSION

SENATE COMMITTEE SUBSTITUTE FOR

SENATE BILLS NOS. 1063 & 827

91ST GENERAL ASSEMBLY

Reported from the Committee on Insurance and Housing, March 21, 2002, with recommendation that the Senate Committee Substitute do pass.

TERRY L. SPIELER, Secretary.

3935S.06C

AN ACT

To repeal section 192.667, RSMo, and to enact in lieu thereof seventeen new sections relating to health care cost containment measures, with penalty provisions.

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

Section A. Section 192.667, RSMo, is repealed and seventeen new sections enacted in lieu thereof, to be known as sections 192.667, 192.668, 192.1050, 192.1053, 192.1056, 192.1059, 192.1062, 334.113, 376.429, 376.1575, 376.1578, 376.1581, 376.1584, 376.1587, 376.1590, 376.1593 and 376.1600, to read as follows:

192.667. 1. All health care providers shall at least annually provide to the department charge data as required by the department. All hospitals shall at least annually provide patient abstract data and financial data as required by the department. Hospitals as defined in section 197.020, RSMo, shall report patient abstract data for outpatients and inpatients. Within one year of August 28, 1992, ambulatory surgical centers as defined in section 197.200, RSMo, shall provide patient abstract data to the department. The department shall specify by rule the types of information which shall be submitted and the method of submission.

2. The department shall not require the resubmission of data which has been submitted to the department of health and senior services or the department of social services under any other provision of law. The department of health and senior services shall accept data submitted by associations or related organizations on behalf of health care providers by entering into binding agreements negotiated with such associations or related organizations to obtain data required pursuant to section 192.665 and this section. A health care provider shall submit the required information to the department of health and senior services:

(1) If the provider does not submit the required data through such associations or related

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

organizations;

(2) If no binding agreement has been reached within ninety days of August 28, 1992, between the department of health and senior services and such associations or related organizations; or

(3) If a binding agreement has expired for more than ninety days.

3. Information**, including any information which identifies any individual health care provider data,** obtained by the department under the provisions of section 192.665 and this section shall **[**not**]** be **[**public information**] available to the public in the format of a public use data file, as defined by rules promulgated by the department. The public use data file shall not include any information which could identify a specific patient or physician. Any information obtained by the department pursuant to the provisions of section 192.665 and this section which is disclosed to the public in the form of a public use data file shall comply with any applicable federal or state laws regarding patient privacy**. Reports and studies prepared by the department based upon such information shall be public information and may identify individual health care providers. The department of health and senior services may authorize the use of the data by other research organizations pursuant to the provisions of section 192.067. The department shall not use or release any information provided under section 192.665 and this section which would enable any person to determine any health care provider's negotiated discounts with specific preferred provider organizations or other managed care organizations. The department shall not release data in a form which could be used to identify a patient. Any violation of this subsection is a class A misdemeanor.

4. The department shall undertake a reasonable number of studies and publish information, including at least an annual consumer guide, in collaboration with health care providers, business coalitions and consumers based upon the information obtained pursuant to the provisions of section 192.665 and this section. The department shall allow all health care providers and associations and related organizations who have submitted data which will be used in any report to review and comment on the report prior to its publication or release for general use. The department shall include any comments of a health care provider, at the option of the provider, and associations and related organizations in the publication if the department does not change the publication based upon those comments. The report shall be made available to the public for a reasonable charge.

5. Any health care provider which continually and substantially, as these terms are defined by rule, fails to comply with the provisions of this section shall not be allowed to participate in any program administered by the state or to receive any moneys from the state.

6. A hospital, as defined in section 197.020, RSMo, aggrieved by the department's determination of ineligibility for state moneys pursuant to subsection 5 of this section may appeal

as provided in section 197.071, RSMo. An ambulatory surgical center as defined in section 197.200, RSMo, aggrieved by the department's determination of ineligibility for state moneys pursuant to subsection 5 of this section may appeal as provided in section 197.221, RSMo.

7. No rule or portion of a rule promulgated under the authority of section 192.665 and this section shall become effective unless it has been promulgated pursuant to the provisions of section 536.024, RSMo.

192.668. 1. Within one year of August 28, 2002, all hospitals, as defined in section 197.020, RSMo, and all ambulatory surgical centers, as defined in section 197.200, RSMo, shall provide prospective pricing information regarding their most common health care services to the department. The pricing data shall be submitted in a format that is understandable to lay persons so that consumers can compare prices of future health care purchases. The format prescribed by the department shall be used regardless of whether the pricing format differs from the current pricing practices of the entities regulated by this section.

2. Information obtained by the department pursuant to this section shall be public information. Any information which is released to the public shall not individually identify a patient and shall comply with all federal and state laws regarding patient privacy.

3. The department shall specify by rule the types of information which shall be submitted, and the method of submission. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2002, shall be invalid and void.

192.1050. The purpose of sections 192.1050 to 192.1062 is to ensure that nonprofit hospitals provide the communities they serve with benefits in keeping with the charitable purpose for which they were established and in recognition of the advantages the nonprofit hospitals enjoy. Public recognition of their unique status has led to favorable tax treatment by the federal and state government. In exchange, nonprofit hospitals assume a social obligation to provide community benefits and charity care in the public interest. To make nonprofit hospitals more accountable to the public, significant public benefit would be derived if nonprofit hospitals reviewed and reaffirmed periodically their commitment to assist in meeting their communities'

health care needs by identifying, documenting and assessing the benefits provided to the communities which they serve. In order to determine whether nonprofit hospitals are properly meeting their obligations to the communities that they serve, it is imperative that nonprofit hospitals, in conjunction with the department of health and senior services, evaluate the level of community benefits and charity care that they provide. State oversight of how nonprofit hospitals provide such benefits will assure appropriate use of the resources of nonprofit hospitals.

192.1053. As used in sections 192.1050 to 192.1062, the following terms shall mean:

(1) "Charity care", health care a nonprofit hospital provides pursuant to a policy approved by its governing board to a patient who, after an investigation of the circumstances surrounding the patient's ability to pay, including nonqualification for a public program, is determined by the hospital to be unable to pay all or a portion of the hospital's normal billed charges. "Charity care" does not include any amount above the hospital's fixed and variable cost or any of the following:

(a) Care provided to patients for which a public program or public or private grant funds pay for any of the charges for the care;

(b) Contractual adjustments in the provision of health care services below normal billed charges;

(c) Differences between a nonprofit hospital's charges and payments received for health care services provided to the nonprofit hospital's employees, to public employees or to prisoners;

(d) Nonprofit hospital charges associated with health care services for which a hospital reduces normal billed charges as a courtesy;

(e) Bad debts;

(2) "Community", the service areas or patient populations for which the hospital provides health care services and charity care;

(3) "Community benefit", the unreimbursed cost of a nonprofit hospital of providing charity care, government-sponsored indigent health care, donations, education, government-sponsored program services, research and subsidized health services. The term does not include the cost to the nonprofit hospital of paying any taxes or other governmental assessments;

(4) "Community benefits plan", the written document prepared for annual submission to the department that shall include, but shall not be limited to, a description of the activities that the nonprofit hospital has undertaken in order to address identified community and charity care needs within its mission and financial capacity, and the process by which the hospital developed the plan in consultation

with the community;

(5) "Department", the department of health and senior services;

(6) "Donations", the unreimbursed costs of providing cash and in-kind services and gifts, including facilities, education, equipment, personnel, and programs, to other nonprofit or public clinics, hospitals, or health care organizations;

(7) "Government-sponsored indigent health care", the unreimbursed cost to a nonprofit hospital of providing health care services to recipients of Medicaid and other federal, state or local indigent health care programs, eligibility for which is based upon financial need;

(8) "Mission statement", a nonprofit hospital's primary objectives for operation as adopted by its governing body;

(9) "Nonprofit hospital", a hospital, as defined by section 197.020, RSMo, organized as a nonprofit corporation under the laws of this state or any state or country and has been determined to be exempt from taxation under the United States Internal Revenue Code.

192.1056. 1. Every nonprofit hospital shall, by January 1, 2004, and annually thereafter, adopt a community benefits plan evaluating the health needs of the community serviced by the nonprofit hospital, that includes, but is not limited to, a process for consulting with community groups and local government officials in the identification and prioritization of community needs that the nonprofit hospital can address directly, in collaboration with others, or through other organizational arrangement. The community benefits plan developed by the nonprofit hospital shall set forth the nonprofit hospital's goals and objectives for providing community benefits that include charity care and government sponsored indigent care and may include lower charges for services as compared to other hospitals. The community benefit plan shall also include:

(1) Mechanisms to evaluate the plan's effectiveness;

(2) Measurable objectives to be achieved within a specific time frame; and

(3) A budget for the plan.

2. Beginning April 1, 2004, and annually thereafter, every nonprofit hospital shall submit a community benefits plan report to the department. The nonprofit hospital shall, to the extent practicable, assign and report the economic value of community benefits, charity care and government-sponsored indigent health care provided in furtherance of its plan. Information provided in the report shall be calculated in accordance with generally accepted accounting standards. The community benefits plan reports filed by the nonprofit hospital shall be made available to the public by the department. Hospitals under the common control of a

single corporation or another entity may file a consolidated community benefits plan.

3. The department may assess a civil penalty against a nonprofit hospital that fails to submit a community benefits plan report pursuant to this section. The penalty may not exceed two hundred dollars for each day a report is delinquent after the date on which the plan is due. No penalty may be assessed against a nonprofit hospital until ten business days have elapsed after written notification to the nonprofit hospital of the failure to file a report.

192.1059. The department shall prepare and submit a report to the general assembly by December 1, 2004, and annually thereafter. The report shall include, but not be limited to, the following:

(1) The identification of all nonprofit hospitals that did not file plans on a timely basis;

(2) A statement regarding the most prevalent characteristics of plans in terms of identifying and emphasizing community needs;

(3) Recommendations for standardization of plan formats, and recommendations regarding community benefits and community priorities that should be emphasized. These recommendations shall be developed after consultation with representatives of the nonprofit hospitals, local governments and communities;

(4) The amount of charity care, as defined by section 192.1053, provided by nonprofit hospitals;

(5) The amount of government-sponsored indigent health care, as defined by section 192.1053, provided by nonprofit hospitals;

(6) The dollar amount of the nonprofit hospital's charity care and community benefits provided; and

(7) Recommendations for developing a minimum charity care/community benefit standard to be used to determine a nonprofit hospital's eligibility for:

(a) Receiving appropriations from the healthy families trust fund and any subaccounts for the care of indigents;

(b) Accessing tax exempt bonds through the Missouri health and education facilities authority pursuant to sections 360.010 to 360.140, RSMo; and

(c) Receiving appropriations from the Missouri disproportionate share hospital program for the care of Medicaid and indigent patients.

192.1062. 1. The department shall promulgate rules and regulations necessary to effectuate sections 192.1050 to 192.1062.

2. The department of health and senior services shall promulgate rules and regulations establishing a minimum standard for the provision of charity care and community benefits by nonprofit hospitals in Missouri. The standard established by

the department shall approximate the financial benefits received by nonprofit hospitals in relation to the level of community benefits and charity care the nonprofit hospitals provide. In formulating the standard, the department shall study other state programs which establish community benefit levels. Specifically, the department shall study the Texas charity care statute and the community benefit program established in California. The department shall also consider the community benefit plans submitted by the nonprofit hospitals when formulating the minimum standard. The standard developed by the department shall be used to determine a nonprofit hospital's eligibility to:

(1) Borrow funds from the Missouri Health and Educational Facilities Authority pursuant to sections 360.010 to 360.140, RSMo;

(2) Receive appropriations from the healthy families trust fund and any subaccounts established thereunder for the care of indigents; and

(3) Receive appropriations from the Missouri disproportionate share hospital program for the care of Medicaid and indigent patients.

3. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2002, shall be invalid and void.

334.113. 1. As used in this section, a "covenant not to compete" means an agreement or part of a contract of employment in which the covenantee agrees for a specific period of time and within a particular area to refrain from competition with the covenantor.

2. A covenant not to compete is not enforceable if it is ancillary to or part of an otherwise enforceable agreement with a not-for-profit hospital organized under chapter 81, 82, 96, 205, 206 or 355, RSMo.

3. Except as provided in subsection 2 of this section, a covenant not to compete is enforceable against a person licensed as a physician by the Missouri state board of registration for the healing arts pursuant to this chapter if it is ancillary to or part of an otherwise enforceable agreement with a health carrier as defined in section 376.1350, RSMo, at the time the agreement is made to the extent that it contains limitations as to time, geographical area, and scope of activity to be restrained that are reasonable and do not impose a greater restraint than is necessary to protect the

goodwill or other business interest of the physician.

4. A covenant entered into pursuant to this section shall:

(1) Not deny the physician access to a list of his patients whom he had seen or treated within one year of termination of the contract or employment;

(2) Provide access to medical records of the physician's patients upon authorization of the patient and any copies of medical records for a reasonable fee pursuant to section 191.227, RSMo;

(3) Provide that any access to a list of patients or to patients' medical records after termination of the contract or employment shall be provided in the format that such records are maintained except by mutual consent of the parties to the contract;

(4) Provide for a buy out of the covenant by the physician at a reasonable price or, at the option of either party, as determined by a mutually agreed upon arbitrator whose decision shall be binding on the parties or, in the case of an inability to agree, an arbitrator of the court whose decision shall be binding on the parties; and

(5) Permit the physician to provide continuing care and treatment to a specific patient or patients during the course of an acute illness even after the contract or employment has been terminated.

5. This section applies to a covenant entered into on or after August 28, 2002.

376.429. 1. All health benefit plans, as defined in section 376.1350, that are delivered, issued for delivery, continued or renewed on or after August 28, 2002, and providing coverage to any resident of this state shall provide coverage for routine patient care costs as defined in subsection 7 of this section incurred as the result of phase III or IV of a clinical trial that is approved by an entity listed in subsection 4 of this section and is undertaken for the purposes of the prevention, early detection, or treatment of cancer.

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

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

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

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

(2) An NIH Cooperative Group or Center as defined in subsection 7 of this section;

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

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

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

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

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

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

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

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

(3) "Routine patient care costs", shall include coverage for reasonable and medically necessary services needed to administer the drug or device under evaluation in the clinical trial. Routine patient care costs include all items and services that are

otherwise generally available to a qualified individual that are provided in the clinical trial except:

(a) The investigational item or service itself;

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

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

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

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

376.1575. 1. The general assembly takes notice of the increasing number of legislative proposals for mandating certain health coverages, whether such proposals mandate payments for certain providers of health care or mandate the offering of health coverages by health carriers as a component of individual or group policies. Improved access to these health care services to segments of the population who desire them may provide social and health consequences that are beneficial and in the public interest.

2. The general assembly also takes notice of the fact that the cost ramifications of expanding health coverages is resulting in a growing public concern. The way that the coverages are structured and the steps taken to create incentives to provide cost-effective services or to take advantage of features of services that offset costs can significantly affect the cost of mandating particular coverages.

3. The general assembly hereby finds and declares the following:

(1) The merits of a particular coverage mandate must be balanced against a variety of consequences that may go far beyond the immediate effect upon the cost of insurance coverage;

(2) A systematic review of legislation proposing mandated or mandatorily offered health coverage that explores all ramifications of the proposed legislation will assist the general assembly determining whether mandating a particular coverage or offering is in the public interest.

376.1578. As used in sections 376.1575 to 376.1596, unless otherwise specifically provided, the following terms shall mean:

(1) "Appropriate committees of the general assembly" or "committees", standing committees of the Missouri state senate and house of representatives that have

jurisdiction over issues that regulate health carriers, health care facilities, health care providers, or health care services;

(2) "Health carrier" or "carrier" shall have the same meaning as ascribed in section 376.1350;

(3) "Mandated health benefit", "mandated benefit", or "benefit", coverage or offering required by law to be provided by a health carrier to:

(a) Cover a specific health care service or services;

(b) Cover treatment of a specific condition or conditions; or

(c) Contract, pay, or reimburse specific categories of health care providers for specific services; a mandated option is not a mandated health benefit;

(4) "Mandated benefit review commission", the commission established pursuant to section 376.1581.

376.1581. 1. There is hereby established a commission to be known as the "Mandated Benefit Review Commission" within the department of insurance. The commission shall consist of the following members:

(1) The director of the department of insurance, who shall serve in a nonvoting, advisory capacity;

(2) The director of the department of health and senior services, who shall serve in a nonvoting, advisory capacity;

(3) Two members of the Missouri house of representatives, one from each major political party represented in the house of representatives, appointed by the speaker of the house who shall serve in a nonvoting, advisory capacity;

(4) Two members of the senate, one from each major political party represented in the senate, appointed by the president pro tem of the senate who shall serve in a nonvoting, advisory capacity;

(5) One member representing the interests of employers having more than one hundred employees, appointed by the governor with the advice and consent of the senate;

(6) One member representing the interests of employers having less than one hundred employees, appointed by the governor with the advice and consent of the senate;

(7) Two individual purchasers of health insurance policies appointed by the governor with the advice and consent of the senate; and

(8) Two employees that pay a percentage of their health insurance sponsored by their employers, appointed by the governor with the advice and consent of the senate.

2. Members appointed by the governor shall serve for four-year terms and until

their successors are appointed. Provided, however, that the terms of half of the six original appointees shall be for two years. Other members, except legislative members, shall serve for as long as they hold the position which made them eligible for appointment. Legislative members shall serve during their current term of office but may be reappointed.

3. Members of the commission shall not be compensated for their services, but shall be reimbursed for actual and necessary expenses incurred in the performance of their duties. The office of administration and the departments of health and insurance shall provide such support as the commission requires to aid it in the performance of its duties. The commission may consult with experts from the health research, biostatistics, actuarial science and other areas the commission deems appropriate.

4. The members appointed by the governor shall be residents of Missouri. Any vacancy on the commission shall be filled in the same manner as the original appointment.

5. The commission shall be established by October 1, 2002.

376.1584. 1. After the mandated benefit review commission has been established pursuant to section 376.1581, the commission shall review all existing state health care mandates and issue a report to the president pro tem of the senate, the speaker of the house of representatives, and the respective committees in both houses which handle health and insurance issues. The commission shall review the projected costs of all existing state and federal mandated benefits. The report shall state the costs of all current state and federal mandated benefits and recommend to the general assembly which mandated benefits should be repealed from state law.

2. The commission shall submit the list of the proposed deletions of state mandated benefits to the general assembly no later than the tenth legislative day of the session beginning in January, 2004. Notwithstanding any provision of law to the contrary, upon submittal, the general assembly may by resolution implement the recommendations of the mandated benefit review commission. The resolution shall contain all the recommendations of the commission.

376.1587. Whenever a legislative measure containing a mandated health benefit is proposed, the appropriate committee of the general assembly having jurisdiction over the proposal shall hold a public hearing and determine the level of support for the proposal among the members of the committee. If there is support for the proposed mandate among a majority of the members of the committee, the committee may refer the proposal to the mandated benefit review commission for review and evaluation pursuant to sections 376.1590 and 376.1593. Once a review and evaluation

has been completed, the committee shall review the findings of the mandated benefit review commission. A proposed mandate may not be enacted into law unless review and evaluation pursuant to sections 376.1590 and 376.1593 has been completed.

376.1590. Every proposed legislative measure that mandates a health insurance coverage, whether by requiring payment for certain providers or by requiring an offering of a health insurance coverage by an insurer or health carrier as a component of individual or group health insurance policies, shall be accompanied by a report prepared by the mandated benefit review commission that assesses both the social and financial effects of the coverage in the manner provided in section 376.1593, including the efficacy of the treatment or service proposed.

376.1593. Upon referral of a mandated health benefit proposal from the appropriate committee of the general assembly having jurisdiction over the proposal, the mandated benefit review committee shall conduct a review and evaluation of the mandated health benefit proposal and shall report to the committee in a timely manner. The report must include, at the minimum and to the extent that information is available, the following:

(1) The social impact of mandating the benefit, including:

(a) The extent to which the treatment or service is utilized by a significant portion of the population;

(b) The extent to which the treatment or service is available to the population;

(c) The extent to which insurance coverage for this treatment or service is already available;

(d) If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatment;

(e) If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment;

(f) The level of public demand and the level of demand from providers for the treatment or service;

(g) The level of public demand and the level of demand from the providers for individual or group insurance coverage of the treatment or service;

(h) The level of interest in and the extent to which collective bargaining organizations are negotiating privately for inclusion of this coverage in group contracts;

(i) The likelihood of achieving the objectives of meeting a consumer need as evidenced by the experience of other states;

(j) The relevant findings of the state health planning agency or the appropriate

health system agency relating to the social impact of the mandated benefit;

(k) The alternatives to meeting the identified need;

(l) Whether the benefit is a medical or a broader social need and whether it is consistent with the role of health insurance and the concept of managed care;

(m) The impact of any social stigma attached to the benefit upon the market;

(n) The impact of this benefit on the availability of other benefits currently being offered;

(o) The impact of the benefit as it relates to employers shifting to self-insured plans and the extent to which the benefit is currently being offered by employers with self-insured plans; and

(p) The impact of making the benefit applicable to the state employee health insurance program established pursuant to chapter 103, RSMo;

(2) The financial impact of mandating the benefit, including:

(a) The extent to which the proposed insurance coverage would increase or decrease the cost of the treatment or service over the next five years;

(b) The extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next five years;

(c) The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service;

(d) The methods that will be instituted to manage the utilization and costs of the proposed mandate;

(e) The extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next five years;

(f) The extent to which insurance coverage of the health care service or provider may be reasonably expected to increase or decrease the insurance premium and administrative expenses of policyholders;

(g) The impact of indirect costs, which are costs other than premiums and administrative costs, on the question of the costs and benefits of coverage;

(h) The impact of this coverage on the total cost of health care, including potential benefits and savings to insurers and employers because the proposed mandated treatment or service prevents disease or illness or leads to the early detection and treatment of disease or illness that is less costly than treatment or service for later stages of a disease or illness;

(i) The effects of mandating the benefit on the cost of health care, particularly the premium and administrative expenses and indirect costs, to employers and employees, including the financial impact on small employers, medium-sized employers and large employers; and

(j) The effect of the proposed mandate on cost-shifting between private and public payors of health care coverage and on the overall cost of the health care delivery system in this state;

(3) The medical efficacy of mandating the benefit, including:

(a) The contribution of the benefit to the quality of patient care and the health status of the population, including the results of any research demonstrating the medical efficacy of the treatment or service compared to alternatives or not providing the treatment or service; and

(b) If the legislation seeks to mandate coverage of an additional class of practitioners:

a. The results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered; and

b. The methods of the appropriate professional organization that assure clinical proficiency; and

(4) The effects of balancing the social, economic and medical efficacy considerations, including:

(a) The extent to which the need for coverage outweighs the costs of mandating the benefit for all policyholders;

(b) The extent to which the problem of coverage may be solved by mandating the availability of the coverage as an option for policyholders; and

(c) The cumulative impact of mandating this benefit in combination with existing mandates on the costs and availability of coverage.

376.1600. 1. Beginning September 1, 2002, the "Missouri Health Care Cost Antitrust Task Force" is hereby established. The task force shall consist of the following members:

(1) The director of the department of insurance, or the designee of the director;

(2) The attorney general, or the designee of the attorney general;

(3) The director of the department of health and senior services, or the designee of the director;

(4) A member representing the interests of hospitals, appointed by the governor, with the advice and consent of the senate;

(5) A member representing the interests of health carriers, as defined in section 376.1350, appointed by the governor, with the advice and consent of the senate; and

(6) Two members representing the interests of health care consumers, appointed by the governor, with the advice and consent of the senate.

2. Members of the task force who are appointed by the governor shall be

appointed with the advice and consent of the senate. No member of the task force shall receive compensation for the performance of duties related to the task force but shall be reimbursed for reasonable and necessary expenses incurred in the performance of such duties.

3. The department of insurance shall convene, organize and provide support services for the task force.

4. The task force shall conduct a study of the current status of market concentration of health care plans and hospitals in this state. The task force shall study the effect of how the consolidation of health carriers and hospitals in Missouri has translated into higher costs for health care consumers. The task force shall also study whether such consolidation has decreased access to health care consumers in various regions of the state. At the completion of the study, the task force shall submit a report of the findings of the study and recommendations for changes to the governor, the speaker of the house of representatives and the president pro tem of the senate. The report shall include recommendations for possible legislative proposals which would help ensure that there is competition amongst Missouri's health carriers and hospitals and to ensure that such market forces provide an environment for affordable health care for Missouri's citizens. The report required by this section shall be submitted no later than April 1, 2003.