The second regular session of the 99th Missouri General Assembly adjourned at 6:00 p.m. on May 18, 2018. To say it was an interesting year would be an understatement. Likely because it is an election year, the legislature seemed more comfortable moving legislation forward than it did in 2017. More bills than usual received hearings, were voted out of committee, and received floor debate. This kept interest groups busy tracking numerous issues and made it more difficult to derail unsatisfactory bills. For better or worse, pushing an increasing number of bills has become more common over the past few years, and it results in larger bills with multiple moving pieces as session nears its end.

In addition to the General Assembly’s legislative functions, they also dealt with increasing friction from the executive branch. There wasn’t much collaboration between the two branches of government to begin with, but things became downright adversarial once the House of Representatives formed a special committee to investigate potential wrongdoing by the Governor. Despite numerous calls to step down, the Governor stayed in office throughout the session. He eventually announced his resignation in late May, and signed a number of bills into law on his last day in office.

The General Assembly introduced 2,253 bills and resolutions this year, and that very well may be a record. We monitored many of them; even the ones that only peripherally affected the practice of medicine. A few of our priorities made it to the Governor’s desk. And more importantly, we were fairly successful in keeping the efforts of our adversaries in check. The Governor has until July 14 to sign or veto legislation. Generally, bills that passed the legislature and are signed by the Governor will go into effect on August 28. We have noted the bills that have already been signed into law. The General Assembly will reconvene in mid-September to consider overturning any vetoed bills.
providers for any health care services that the carrier has authorized the patient to seek out-of-network, as long as the patient’s plan does not already include an out-of-network benefit.

The final major section of the bill dealt with surprise billing. This wasn’t an issue we expected to tackle this session, but the need to enact some level of consumer protection was an overriding concern in the Senate. No other section of the bill demanded as much of our time as the prohibition against surprise billing.

The new law only applies to patients who present at an in-network facility with an emergency medical condition, and applies to out-of-network physician services provided to them until they are discharged. Physicians may choose to send a claim for charges to the patient’s insurance company within 120 days of providing the service. Within 45 days of receiving that claim, the insurance company must offer to pay the physician a reasonable reimbursement rate. If the physician participates in any other networks offered by that insurer, the reimbursement offer will be the amount from the network that has the highest reimbursement.

If an agreement is not reached in the negotiation period, the law requires the Department of Insurance to ensure access to an arbitration process. The arbitrator is restricted to determining the reimbursement in a range between 120% of Medicare and 70% of usual and customary rate as determined by an independent database, and the arbitrator must take certain factors into account, such as the physician’s skill and training, the physician’s usual charge for the service, and the complexity of the case.

All in all, we believe we have passed a solid insurance reform law. With the exception of the surprise billing provision, the law will go into effect on August 28, 2018. The surprise billing section takes effect on January 1, 2019. We would be remiss if we didn’t mention the hard work and dedication of Sen. Bob Onder, MD, Sen. Jill Schupp, Rep. Mike Henderson, and Sen. Paul Wieland, in assisting us in making sure these important reforms got done this year.
Two major changes to physician supervision of mid-level practitioners passed this year. The first is a result of a longtime effort by the advanced practice registered nurses (APRNs) to increase the geographic proximity rule. This rule, which was jointly promulgated by the Board of Healing Arts and the Board of Nursing, dictates the maximum distance they can practice from their collaborating physician. Fifty miles has been the law for a long time. During the legislative session, the two boards agreed to expand the rule to seventy-five miles, which extends coverage to underserved areas of the state, like the Bootheel. The second change reduces the number of mid-levels a physician can supervise from nine to six. Instead of being allowed to supervise three each of assistant physicians (APs), APRNs, and physician assistants (PAs), physicians will be able to supervise or collaborate with a maximum of six mid-levels in any combination. So, if you wish, you could supervise four APs, one APRN, and one PA, for example.

In order to clean up some confusing areas of law, a few changes were made to Missouri’s first-in-the-nation assistant physician (AP) practice act. Eligibility for licensure was simplified so that a license could be attained up to three years from the date of medical school graduation or passage of Step 2 of the USMLE, whichever is later. The previous standard for eligibility was confusing to both applicants and the Board of Healing Arts, which is responsible for issuing licenses. In addition, overburdensome rules regarding supervising physician chart review, CME hours, and license fees were modified. An onerous section of law that voided AP licenses after six months if the AP was not in a collaborative agreement was repealed. A section that requires insurance companies to reimburse for AP services also was included.

Curbing the supply of opioids through prescribing limitations and enforcement actions only addresses a portion of the complex opioid epidemic. Increasing access to treatment must also be addressed. The Improved Access to Treatment for Opioid Addiction Act (IATOA) included a number of provisions to bolster the state’s ability to provide treatment. It allows mid-level providers to prescribe a thirty-day supply of buprenorphine for substance abuse treatment under the direction of a supervising physician. It requires insurers to offer coverage for medication-assisted-treatments, and eliminates the exclusion of chemical dependency from the definition of mental health condition. This effectively mandates coverage for addiction. It increases the availability of addiction resources to mid-level providers in rural areas of the state, and loosens some supervisory requirements in order to enhance access to treatment.

This was one of many bills that sought to address the opioid epidemic in the state. It limits certain initial prescriptions of opioids to no more than a seven-day supply for the treatment of acute pain. Prior to prescribing the opioid, a physician must consult with the patient regarding the quantity of the
opioid and the patient’s option to fill the prescription in a lesser quantity, as well as inform the patient of the risks associated with the prescribed opioid. While the legislation does place restrictions on prescriptions, it still allows physicians to use their own professional judgment to determine the best course of treatment for their patients. If the physician believes more than a seven-day supply is required to treat the patient, they must make a notation to that effect in the patient’s chart. This legislation will not apply to prescriptions for a patient who is currently undergoing treatment for cancer, is receiving hospice care or palliative care, is a resident of a long-term care facility, or is receiving treatment for substance abuse or opioid dependence.

DRUG TAKE BACK PROGRAM
SB 826

This popular provision made it across the finish line in three separate bills. The legislation allows unused controlled substances to be accepted from the public through collection receptacles provided through drug take back programs sponsored by a DEA-authorized collector (like Walgreens, CVS, law enforcement agencies, etc.). The public can deposit their unused prescription drugs in the receptacles regardless of whether or not the authorized collector originally dispensed the drug. Improving public access to secure drug disposal boxes is an easy way to safely dispose of unused opioids and other prescription drugs that would otherwise sit in medicine cabinets and risk being abused or diverted. The legislation also requires the Department of Health and Senior Services (DHSS) to develop an education and awareness program about drug disposal by August 2019. All three of the bills containing this provision await approval from the Governor.

LOW-DOSE MAMMOGRAPHY
HB 1252
Rep. Dean Plocher

This bill passed with overwhelming support in both the House and the Senate. It specifies that the current insurance mandate regarding “low-dose mammography screening” shall also include digital mammography and breast tomosynthesis. Currently, women age 40 to 49 are eligible for a mammogram every two years, and women age 50 and over are eligible annually. At the request of the Missouri Radiological Society, MSMA worked with the bill sponsor to add an amendment to update the statute so that all women age 40 and older are now eligible for covered annual screenings. This bill has already been approved by the Governor.

GENERIC SUBSTITUTIONS
By Amendment to SB 826
Rep. Mike Stephens

This bill allows more flexibility for pharmacists when dispensing prescriptions. The language permits a pharmacist who receives a prescription for a brand name product to select a less expensive generically equivalent product unless the patient specifically requests the brand name drug, or the physician indicates that substitution is prohibited. In other words, rather than sign a “dispense as written” line on the prescription pad, a physician will need to write “dispense as written,” “DAW,” or “do not substitute” on the script. The bill doesn’t affect prescriptions that are called into the pharmacy.
While we certainly appreciate outside-the-box thinking when it comes to addressing the state’s opioid epidemic, this proposed legislation likely would have created more problems than it solved. It would have created a prescription drug abuse registry - somewhat modeled after the Missouri Problem Gambling Registry - where patients could submit their own names for inclusion in the registry if they believe themselves to be at risk of abusing prescription medications. The more we studied the bill, the more concerns we had with it. One problem was the casual way in which a person could have listed themselves on the registry. It seemed far easier to get onto the registry than to get off it, and there were few mechanisms for verifying the identity of participants, and whether they were submitting their own name. Our second concern was the lack of physician immunity. While we were able to make some helpful changes to the bill in committee, it ultimately did not pass.

These bills would have extended the duration of short-term insurance policies from six months to one year. These plans have generally been marketed as gap insurance, tailor made for people in between jobs or some other short-term break in their coverage. They are much cheaper than comprehensive policies, which makes them very attractive to younger, healthier patients. Increasing their duration would make them even more attractive. In the past, the problem with these short-term policies was that they didn’t meet ACA standards, so enrollees would end up paying a tax penalty at the end of the year. Now, without the individual mandate penalties to tamp down enthusiasm for the plans, their popularity is certain to skyrocket. However, these plans are not required to cover any essential health benefits, including prescription drugs or emergency services. Although they have skimpy premiums, the deductibles are large and coinsurance is an oft-included feature. Most importantly, they don’t cover any

PHARMACY VACCINATIONS
By Amendment to SB 826
Rep. Mike Stephens

This language lowered the minimum age of patients who can receive immunizations at a pharmacy under a written protocol authorized by a physician. Pharmacists will now be able to give statutorily allowed vaccinations to patients as young as seven in accordance with Centers for Disease Control recommendations. No new immunizations were allowed, and with the exception of viral influenza, only three vaccinations are on the CDC schedule for those between the ages of seven and twelve. So, clearly the impetus here was to allow retail pharmacies to increase the number of potential patients who can receive an annual flu shot from them. The language also contains a requirement that all pharmacy-administered vaccinations be entered into the state’s ShowMeVax database, which allows physicians to track a patient’s immunization history.

PRESCRIPTION BENEFITS MANAGERS
By Amendment to SB 826
Rep. Lynn Morris

This bill prohibits the use of gag clauses by pharmacy benefits managers (PBMs) against pharmacists. Pharmacists had been prohibited from informing patients that their prescriptions would be cheaper if purchased outside of their PBM’s coverage. In addition, PBMs will not be able to retrieve or “clawback” the difference between the cash and covered prices of medications from the pharmacist.

BILLS THAT PASSED, CONTINUED

DRUG ABUSE REGISTRY
HB 2209
Rep. Jay Barnes

SHORT-TERM HEALTH INSURANCE
HB 1589 & SB 860

BILLS MSMA HELPED DEFEAT

PHARMACY VACCINATIONS
By Amendment to SB 826
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preexisting conditions. So even if a patient discovers they have cancer during the policy’s term, if tests show the cancer was present before the policy went into effect … well, that patient is out of luck. We worked to have comprehensive disclosure language included with these policies, but even that wasn’t enough to save them. The language was attached to a few bills late in the session, but there was too much opposition in the Senate for them to survive being purged.

**MOTORCYCLE HELMET REPEAL**
HB 2158 & SB 556

We butted heads again this year with a group of motorcyclists who argue that they should not have to wear helmets while riding on the state’s roads and highways. Like last year, this bill would have limited the statewide helmet mandate to riders under 18 years of age and to those who have been issued an instruction permit. Fully qualified operators 18 and older would be allowed to ride helmetless as long as they could provide proof of a $1 million medical payment insurance policy. The bill was passed out of the House without much opposition, but ran into trouble in the Senate. The language was removed from several bills during the last week of session.

**DIRECT ACCESS PHYSICAL THERAPY**
HB 2090
Rep. David Gregory

This bill would have allowed access to physical therapy services without a physician’s prescription. We found this troublesome because physical therapists cannot diagnose. Even though they claim to have received some “training,” state law expressly prohibits it. That being the case, they are not allowed to differentiate a lower back strain from a slipped disc from a spinal fracture. Being able to offer differential diagnoses is important prior to receiving physical therapy services, and we have always maintained that allowing direct access PT fragments patient care and may have dire consequences for some patients. This bill received a solitary committee hearing and quietly vanished.

**APRN INDEPENDENT PRACTICE**
HB 1502
Rep. Hannah Kelly

The advanced practice registered nurses (APRNs) made a push for independent licensure again this year. Rather than ask for immediate independence, their bill called for APRNs to work in collaboration with a physician for two years. Once the two years were done, so was the collaboration, and an APRN would be able to practice independently. This is similar to a law passed recently in Illinois. This bill received a solitary committee vote in the House.

**RADIOLOGY TECHNICIANS**
SB 926 & HB 2468

This bill would have required licensure for people who perform radiologic imaging or therapy and aren't already licensed by another board. The Board of Healing Arts would have been tasked with creating five new licensure categories and scopes of practice, including x-ray machine operators, radiation therapists, and radiographers. An alternative licensure path to be determined by the Board would be allowed for rural areas of the state, where a licensed individual might be hard to find. This language was added to a couple of bills late in the session, but was deemed too controversial to advance any further. We appreciated the teamwork of the Missouri Academy of Family Physicians while working on this issue.

**BOARD OF HEALING ARTS**
HB 2548
Rep. Jered Taylor

Last summer, the Governor appointed a commission to look into the composition of the state’s boards and licensing authorities, and determine whether some of them should be pared back. One of the suggestions from that commission was to allow the Governor to appoint non-physicians to the Board of Healing Arts. More specifically, the legislation introduced in accordance with the commission’s recommendations opened up spots on the board for all the other professions that the board licenses. So, an anesthesiology assistant, an athletic
trainer, a perfusionist, a physical therapist, a physician assistant, and a respiratory care therapist would all have a seat on the Board of Healing Arts. Which means they could discipline physicians, and that idea left us less than thrilled. The bill received a hearing in the House and was voted down in committee. Another boards and commissions bill passed this year, but it did not contain composition changes to the Board of Healing Arts.

FUND SWEEP
HB 2708
Rep. Deb Lavender

It seems that every year a bill is introduced that would allow the state to sweep funds from the accounts of the professional boards. There is already some statutory authority for sweeps whenever the accounts reach a certain threshold. But some legislators see that money and just start drooling. So we end up opposing bills that change the way in which the General Assembly can take money from the Board of Healing Arts (and the other boards, too). That’s your money. Your fees are used to support the competent practice of medicine in the state. If that account is swept and used for some other purpose, it amounts to a tax on physicians. This year, there was an effort to use your licensure fees to support the Governor’s misguided anti-physician prescription monitoring program. That made it even more reprehensible. This bill received a hearing and the issue was discussed on the House floor late in the session, but we were never seriously threatened by it. As long as the state’s purse strings are tight, this will continue to be an issue we have to deal with.

OPIOID DIRECTIVE
HB 1927
Rep. Becky Ruth

Yet another bill seeking to put a dent in the opioid crisis. This bill was modeled after provisions already in place in a couple of other states. A red flag goes up every time we see a bill that requires physician’s offices to hand out and procure a patient’s signature on yet another form. This legislation would have allowed patients to voluntarily opt out of all opioid treatment. Patients can already do this now verbally, but the bill would have allowed them to make their requests known on a standardized form. Every physician that treated the patient would have presumably needed to have the patient sign a separate form and keep it in the patient’s medical record. One major concern we had was that the bill would have allowed the patient to revoke the directive at any time, even verbally, which would create many liability issues for physicians. We understand what the sponsor was trying to achieve, but this legislation would have been an administrative headache for physicians and medical group managers.

WORKER’S COMPENSATION FEE SCHEDULE
SB 601
Sen. Dave Schatz

This bill would have removed the requirement that charges in workers’ compensation cases be “fair and reasonable,” along with the prohibition that medical professionals not charge any more than what is considered usual and customary for similar services under commercial insurance. In lieu of the present system, it gave broad authority to the Division of Workers’ Compensation to create an undefined fee schedule - a blank slate on which to create whatever type of fee schedule it wants. The only parameters were that the schedule had to promote health care cost containment and efficiency, and ensure availability of necessary care and treatment. Missouri is in the minority here; 43 states have some kind of workers’ compensation fee schedule. Most are tied to Medicare fees, and some to commercial insurance rates. This bill did neither, and if it passed we’d pretty much be at the mercy of whatever the Division decided physicians should be paid for workers’ compensation patients. Increased delays in treatment and reduction in quality of care are other byproducts of fee schedules. It has often been noted that higher physician rates get injured workers back on the job more quickly than artificial price fixing. And that helps everyone - the employee, the employer, and the caregiver. There was overwhelming opposition to this bill, which received a hearing way back in February, then disappeared.
This legislation has struggled for years to get the attention and support it deserves in the Capitol. This was one of a number of bills that would have created a statewide ban on texting while driving. Our present law allows drivers over 21 years of age to text and drive, despite a lack of scientific evidence to support an age of prohibition. Only two other states don’t currently outlaw this behavior, and the other 47 states have a complete ban on texting and driving. We expect the bill to be proposed once again next year.

MENTAL HEALTH PARITY
HB 2384
Rep. Jay Barnes

This bill would have prohibited insurance companies from imposing certain treatment limits on mental health benefits in a more stringent manner than they are applied to surgical or medical benefits. There was a lot of support for this bill in committee, but the insurance companies were able to stall until time ran out, and it never received any floor debate.

NEEDLE EXCHANGE
HB 1620
Rep. Holly Rehder

This bill would have authorized the creation of needle/syringe exchange programs in the state. Syringe services programs offer sterile syringes and various other health and prevention options for people who inject drugs. The programs are operational in many states (including a few already operating in Missouri), and while controversial among Missouri legislators, they have been proven to reduce the risk of spreading or contracting blood borne infections among drug users. They also offer a gateway for providing additional substance abuse treatment to participants. This bill would have exempted any entity registered with DHSS from state statutes prohibiting the distribution, delivery, or sale of drug paraphernalia. The legislation proved too controversial to pass this year, but we expect to see another run at it next year.

We joined a broad coalition of healthcare organizations to support this legislation, which would have put an end to teen tanning bed use in Missouri. Under current state law, a child under 17 years of age must obtain parental consent before they can use a tanning bed or other tanning device. This legislation would have prohibited anyone under the age of 18 from using a tanning bed. It also would have required a trained employee to be present at a tanning facility during operating hours to assist customers and offer information about proper tanning device usage. Though countless dermatologists and skin cancer survivors offered compelling testimony in support of the legislation, several vocal legislators felt that the bill would infringe upon the personal freedom of their constituents and the bill did not pass.

INSURER DIRECTORIES
HB 2612
Rep. Charlie Davis

This bill would have required insurance companies to keep their online provider directories for each of their plans up-to-date and easily available to policyholders. Directories would be required to contain a number of searchable categories, so patients could more easily find in-network providers. In addition, they would have had to inform the public of the criteria they used to build each of their networks and provide a means by which people could notify the carrier that their online directory is out-of-date. They would have to audit a sample of their provider directories for accuracy and report the finding to the Department of Insurance. If a policyholder reasonably relied on inaccurate information contained in a network’s provider directory, the insurer would have to provide coverage and pay for the resulting out-of-network services.

INSURANCE APPEALS
HB 1718
Rep. Bill White

When an insurance company denies a claim, the patient has to maneuver through a three-tiered appeals process within the Department of Insurance. The first tier
requires the carrier to do an investigation within ten days and give written notification. If the service is denied a second time, the next tier requires a review of the claim by a grievance advisory panel. If it’s denied a third time, the Department of Insurance has to refer the grievance to an external independent review organization. This bill would have required insurance companies to reimburse the state for the cost of the independent review organizations for third tier reviews in which their denial is overturned. That seemed pretty fair to us. After all, the insurers would only need to pay up if they wrongly denied a particular claim three times. And why should the Department of Insurance be on the hook for their mistakes? Yet, the huge insurance companies opposed the bill and it never resurfaced after its committee hearing in the House.

**PHYSICIAN-OWNED PHYSICAL THERAPY**

HB 1652  
Rep. Robert Cornejo

Once upon a time, the federal Stark law banned physician ownership of physical therapy as a conflict of interest. Missouri followed along and passed a companion bill soon thereafter to prohibit such business arrangements. Then the feds reversed course and declared physical therapy to be an ancillary service, and those are exempted from Stark. The state never made a corresponding change. We’re the only state that doesn’t allow physicians to own physical therapy services. Allowing physicians to own and offer in-house PT services streamlines coordination of care and is more convenient for the patient. It received a hearing, but never came out of committee.

**JOINT & SEVERAL LIABILITY**

SB 678  
Sen. Bill Eigel

This language would have moved Missouri from a modified joint and several liability state to one that recognizes several liability only. Presently, if a defendant is found to be at least 51% at fault in a lawsuit, they can be held responsible for 100% of the plaintiff’s recovery. Pure several liability would make defendants only liable for their own percentage of fault. So a defendant who is 65% at fault pays 65% of the damages. That’s a much more reasonable way to determine damages as a percentage of fault. As you can imagine, the trial attorneys disliked this bill greatly, and like the other tort bills this session, it failed to pass the finish line.

**PUNITIVE DAMAGES**

HB 2434  
Rep. Bill White

Of all the tort bills we supported, this one was the closest to passing. The bill would have increased the burden of proof for proving punitive damages in medical malpractice cases. Presently, plaintiff’s attorneys only need show some type of willful or wanton conduct. The language of this bill sought to replace that and require lawyers to show that there was some malicious conduct, or conduct that intentionally caused harm. This is a higher bar, and it is more in line with the purpose of punitive damages - to punish outrageous intentional conduct. This short bill was viable until the last day of session as part of a broader tort reform effort. Unfortunately, it didn’t receive the final vote it needed.

**MATERNAL MORTALITY REVIEW BOARD**

HB 2303  
Rep. Sarah Unsicker

This bill would have created a statutory Missouri Maternal Mortality Review Board. The board would have conducted reviews of pregnancy-related deaths, pregnancy-associated deaths, and incidents of severe maternal morbidity in the state to identify factors associated with the deaths and incidents. After the reviews were completed, the Board would have made recommendations for system changes to improve health care services for women in the state and would have submitted an annual report on maternal mortality. This legislation didn’t make it far in the legislative process, but we predict it will be introduced again next year.

**MAINTENANCE OF CERTIFICATION**

HB 2355  
Rep. Keith Frederick, DO

A few years ago, we were able to restrict the Board of Healing Arts from mandating maintenance of certification in licensure requirements. This bill would
have extended that premise to hospitals and health carriers; not allowing them to discriminate against physicians based on maintenance of certification. It wasn’t referred until late in session and never really got off the ground.

**PRESCRIPTION DRUG MONITORING PROGRAM**

HB 1619 & SB 762  

It was a quiet year for prescription drug monitoring program (PDMP) legislation. Rep. Rehder and Sen. Schatz continued to carry the torch for a statewide PDMP, but the bill ran into the same obstacles in the legislature that have been present for the past several years. We expect the legislature will pick up the issue again next year but until then, the St. Louis County PDMP continues to cover almost 80% of the state’s patients and 92% of the state’s prescribers. We continue to advocate that comprehensive PDMPs like the one in St. Louis are effective tools for physicians to use to combat the opioid epidemic and improve treatment for patients with substance abuse disorders.

**GOOD BILLS THAT DIED, CONTINUED**

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**LOOKING TOWARD 2019**

This *Legislative Review* does not detail all the issues that we followed during the 2018 legislative session, but it does give a description of the ones on which we spent much of our time and political capital. In all, we tracked more than 400 bills this year. Many of the bills that did not pass will be reincarnated next year. Speaking of next year, the 2019 legislative session gets under way on January 9, 2019. We have much to do between now and then to ensure physicians have another successful session.

As you know, 2018 is an election year. Please take the time to get to know the candidates who are running for office in your local races. Make sure they know that there’s a physician in their district they can reach out to when complicated healthcare issues cross their desk. We know from experience: they’d much rather hear from their hometown physician than from your lobbyists. Let us know which legislators you have good relationships with, so we can ask you to contact them when we need help.

Your lobbyists would like to thank all the physicians who reached out to us with questions and concerns during the session, those who made calls and sent emails when we asked, and those who volunteered as Physician of the Day in the Capitol.

To those who asked, “What can I do to help?” The best way to help in the interim is to persuade your physician colleagues to join MSMA. No other medical association has the broad shoulders of MSMA - we represent all physicians regardless of specialty. There is strength in numbers, and at no other time has the practice of medicine been under siege to the degree it is today. Managed care, scope of practice, tort reform, public health, licensing and education, antitrust, pharmaceuticals, government interference with the practice of medicine - no other association tackles all these issues on your behalf. So find out if your physician friends are members and ask them to add their voice to the fight.

As we reflect on the past year, we are reminded of the pride we take in representing Missouri’s physicians in Jefferson City. We are honored to speak on your behalf, and we appreciate the ability to represent your professional interests at the Capitol. Thank you, and bring on 2019!
Between January 9 and May 17, 2019, MSMA needs volunteers to be “Physician of the Day” in the Capitol. Would you consider helping us? Plan to spend a day in Jefferson City as the Legislature’s physician. One physician per day is needed every Tuesday, Wednesday, and Thursday during the legislative session. Plan to arrive in the Capitol around 9:00 or 9:30 a.m., and stay until 2:00 or 3:00 p.m. (except Thursdays, when the House and Senate typically adjourn around noon).

NEW FEATURE: Some of our medical students have expressed an interest in shadowing the Physician of the Day. If you are willing to allow a student to shadow you, please check the box at the bottom of the sign-up sheet at www.msma.org/physician-of-the-day. To decline, just leave the box unchecked.

Contact MSMA’s Heidi Geisbuhler at 800-869-6762 or heidi@msma.org. She will coordinate, provide instructions, and offer available dates.

PLAN AHEAD!
Volunteer to spend a day in the Capitol as MSMA’s Physician of the Day in 2019!

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Join hundreds of your physician peers who belong to the Missouri Medical Political Action Committee

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- If you have any questions, please contact MMPAC at 800-869-6762

Contributions or gifts to MMPAC are not deductible as charitable contributions for Federal income tax purposes. MMPAC is a separate segregated fund established by the MSMA. Contributions to MMPAC can be made on either personal or corporate checks. Your corporation must have a corporate resolution regarding PAC donations if your contribution is made from a corporate account. Contributions are not limited to the suggested amount. MSMA will not favor or disadvantage anyone based upon the amounts of or failure to make PAC contributions.

On the Cover & Inside
The Missouri Veterans Memorial, dedicated in 1991, mirrors the north side of the Missouri Capitol, overlooks the Missouri River, and consists of a fountain, colonnade, reflecting pool, waterfall, and a Flag plaza honoring veterans of over two centuries of wars. Inside, the south Capitol pediment, carved out of Tennessee limestone, shows an enthroned female figure representing the state, with her left arm resting upon the shield with the state motto, while the other supports a document of civil rights. She is accompanied by a youthful figure with a winged ball, the “Spirit of Progress.” To the right, a masculine figure representing agriculture drives a pair of yoked oxen. To the left, Hermes, a symbol of commerce, guides a pair of harnessed horses, the “Steeds of Industry.”

Photos by Lizabeth Fleenor.