SB 841

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Path to full text: https://www.senate.mo.gov/26info/pdf-bill/intro/SB841.pdf

PART 1 – QUICK SNAPSHOT

1.1 One-paragraph overview

SB 841 is a large omnibus "health care" bill that touches dozens of different topics: awareness weeks, hospital and hospital-district investments, telemedicine rules, paramedics and epinephrine policies, long-term care inspections, MO HealthNet reimbursement changes (***including a new doula benefit***), Show-Me Healthy Babies tweaks, pharmacy and wholesaler rules, 340B / PBM regulations, anesthesia billing, non-opioid pain coverage, and major reforms to prior authorization in insurance.

It also quietly expands the authority of state health officials to issue standing medical orders ***(including for doula services and prenatal vitamins, and potentially other drugs by rule***), and authorizes the health department to contract directly with affiliates of national public-health associations.

Many individual provisions would likely help patients and families (e.g., reducing prior authorization red tape, recognizing unborn children in Show-Me Healthy Babies, giving more flexibility in non-opioid pain treatment), but they are bundled with expansions of unelected health-bureaucrat power and new Medicaid-style benefits. Overall, it's a classic "Christmas tree" bill: a mix of genuinely good reforms, ideological or bureaucratic creep, and significant process concerns about single-subject and delegation.

Plain-English bottom line: good ideas are buried inside an oversized health-care omnibus that grows state health power, expands MO HealthNet obligations, and opens some doors (by rule) that can be used badly in the future.

1.2 Triage table (fast flags)

- **Single-Subject & Title (Art. III §23):**
    - Title: repeals/enacts 43 sections "relating to health care, with penalty provisions."

    - Functionally a multi-topic omnibus: Medicaid benefits, prior authorization, hospital investing, long-term care inspections, pseudoephedrine, childcare allergy policies, 340B, pharmacy scope, etc. All can be loosely shoved under "health care," but from a citizen-notice perspective, this is clearly **a multi-subject omnibus.**

- **Does it grow government?**
    - Yes, in multiple ways:
        - Adds a new **MO HealthNet doula reimbursement** framework and related rulemaking.
        - Expands MO HealthNet obligations for perinatal / pathology services.
        - Authorizes DHSS to contract with **national public-health affiliates/institutes** as preferred vendors.
        - Broad new **standing-order power** for state medical officers.
        - New policy mandates for child-care facilities (Elijah's Law).
    - Some sections restrain or redirect big players (PBMs, health carriers, prior-auth games), but overall, **state health bureaucracy gains more tools and programs.**
- **Impact on Missouri families (overall): Mixed.**
    - **Helps:** Easier non-opioid pain treatment; less prior-auth red tape; supports Show-Me Healthy Babies and unborn-child coverage; better allergy readiness in schools/childcare; epinephrine access.
    - **Hurts / risk:** More embedded Medicaid-style programming; open-ended standing orders; new conduit for national public-health groups; continued expansion of the health-care administrative state.
- **Alignment with Act for Missouri core beliefs (high-level): Poor/conflicted.**
    - Strengthens recognition of unborn children in Show-Me Healthy Babies.
    - Adds "***pregnant individual***" language and public-health NGO hooks, and creates new state-run doula infrastructure with "community navigation" services. The Show-Me Healthy Babies section still uses the terms "pregnant mother" and "pregnant woman," but the new doula language intentionally shifts to "***pregnant individual.***"
    - Expands rulemaking and standing-order authority in ways that could be turned against pro-life and parental-rights priorities in the future.

- **Initial stance (before deep dive): Oppose**, because (1) clear omnibus structure; (2) serious delegation/standing-order concerns; and (3) government-expansion tradeoffs, even though there are some good pieces.

PART 2 – PURPOSE & PROVISION MAP

2.1 Stated purpose & title

- **Title/purpose:** Repeals 21 existing sections and enacts 43 new ones, "relating to health care, with penalty provisions."
- **What it's really doing:**
    - Uses "health care" as a catch-all to:
        - Adjust hospital / hospital-district investment rules and territorial rules.
        - Rewrite chunks of telemedicine and pharmacy law.
        - Expand the Show-Me Healthy Babies program and related maternal coverage.
        - Create a **Doula Reimbursement Act** within MO HealthNet.
        - Increase pseudoephedrine limits while assessing manufacturer fees for the tracking system.
        - Make the Rx Cares program permanent.
        - Tighten rules on prior authorization and PBM behavior.
- An ordinary citizen reading only the title would have no idea this bill creates a new doula benefit, restructures prior authorization, tweaks pseudoephedrine limits, and sets up new contracting authority with public-health NGOs.

2.2 Provision-by-provision map (grouped)

I'll group provisions by topic and assign the labels [Good], [Mixed], [Concern], or [Bad].

Awareness designations

- **§9.412 – Brain Aneurysm Awareness Month.**
    - Designates September for awareness; harmless symbolic recognition.
    - **Tag:** [No Effect] – No real policy effect; fine as symbolism.
- **§9.418 – Infertility Awareness Week.**

- Defines infertility and encourages events promoting "equitable access to fertility treatments and family-building options, including assisted reproductive technologies, adoption, and surrogacy."
- **Tag:** [Mixed] – Adoption is good; surrogacy / assisted reproductive technologies can raise serious ethical issues (embryo destruction, commodification). But it's only an awareness week, no direct funding or mandates.

Hospital & hospital-district investment and territory

- **§96.192 – City hospital investment authority; tax-dependence threshold raised to 3%.**
  - Allows certain municipal hospitals with <3% revenue from taxes to invest up to 50% of "available funds" in mutual funds, high-grade bonds, and money market instruments; the rest must follow state-treasurer rules.
  - **Tag:** [Mixed] – Gives local hospitals more investment flexibility (could improve stability), but also increases exposure to financial markets with public-connected funds; no explicit added transparency.
- **§96.196 – City hospital authority to operate/lease related facilities outside city; local approval if taking city money.**
  - Mostly a small tweak to which other chapters trigger territorial limits.
  - **Tag:** [Mixed] – Could expand hospital reach; might crowd out smaller providers, but not a major structural change.
- **§206.110 – Hospital district powers; clarifies where districts may operate.**
  - Removes reference to hospitals organized under chapters 96 and 205 from the territory-limit clause; still prohibits district competition in counties where a hospital organized under this chapter already exists (with grandfathering).
  - **Tag:** [Mixed] – Technical, but could shift competitive boundaries subtly.
- **§206.158 – Hospital district investment authority (similar to §96.192) if tax revenue <3%.**
  - **Tag:** [Mixed] – Same tradeoffs as above (flexibility vs. risk with quasi-public money).

School / EMS / childcare allergy & epinephrine policies

- **§§167.627, 167.630, 190.246, 196.990, 321.621, 335.081** (cluster)

- Standardizes “epinephrine delivery device” terminology; clarifies school/EMS/authorized-entity authority to maintain, train on, and administer EpiPens or equivalent devices; sets civil-liability protections and reporting requirements; updates fund language for fire personnel epinephrine programs.
- **Tag:** [Good] – Improves clarity and availability of life-saving allergy treatment with reasonable liability rules; no obvious ideological or surveillance issues.

- **§210.225 – “Elijah’s Law” allergy policies for licensed childcare.**
  - Requires licensed child-care providers, by 2028, to adopt an allergy-prevention and response policy, coordinate with DESE and local health authorities, address confidentiality, and may use model policies from organizations like FARE. DESE must create a model by 2027.
  - **Tag:** [Bad] – Genuine safety concern, but adds paperwork and embeds reliance on national NGOs and state bureaucracies. It could be implemented reasonably or turned into another compliance burden.

Community paramedics

- **§190.098 – Community paramedic services; cross-territory rules; DOH endorsement.**
  - Tightens definitions; requires paramedics to be licensed and complete approved training; lays out MOUs when operating over other ambulance services’ territories; requires DHSS to set standards and issue five-year endorsements.
  - **Tag:** [Bad] – Some good elements (clearer boundaries, quality control); but expands DHSS rulemaking and formalizes another layer of licensing/endorsement.

Telemedicine & prescribing

- **§191.1146 – Physician-patient relationship via telemedicine.**
  - Replaces “interview” with “evaluation”; allows a telemedicine encounter to establish relationship if standard of care doesn’t require in-person exam; requires questionnaires to be part of a broader evaluation and that providers using questionnaires be employed by a licensed business entity; requires reporting back to primary provider if identified.
  - **Tag:** [Bad] – Does tighten standards against pure “questionnaire mills,” but also cements telemedicine business-entity structures and centralization.

- **§334.108 – Telemedicine prescribing rules.**

- Requires a reliable history and, if needed, physical exam; clarifies that telemedicine can't be used alone without an existing relationship unless certain collaborative arrangements exist; forbids prescribing based solely on internet/tele-eval in absence of proper relationship; ensures records are HIPAA-compliant.
- **Tag:** [Good/Mixed] – Generally protective against abusive online prescribing; but reinforces reliance on HIPAA/data-sharing structures.

Standing orders & DHSS contracting

- **§191.708 – Standing orders and recommendations by state medical officers.**
  - Allows the chief medical officers of DHSS, DMH, and MO HealthNet, or physicians acting with their written consent, to issue:
    1. Nonspecific recommendations for **doula services**,
    2. A **standing order for prenatal vitamins**, and
    3. "A medical standing order for any other purpose, other than for controlled substances, that is promulgated by rule" under chapter 536.
  - Provides criminal, civil, and disciplinary immunity for issuing these orders.
  - **Tag:** [Bad] – Prenatal vitamins are fine; nonspecific doula recommendations are possibly concerning. But the "any other purpose" clause, limited only by "not controlled substances" and whatever rules DHSS can push through, gives broad standing-order power to unelected physicians inside agencies. In the wrong hands this could be used for controversial drugs (e.g., chemical-abortion-related items, gender-medicine, etc.) that are not technically "controlled substances."
- **§192.021 – DHSS contracting with national public-health affiliates.**
  - Authorizes DHSS to contract directly with an entity on a "qualified vendor list" consisting of Missouri affiliates of national public-health associations or public-health institutes, for delivering health services or administering grants; requires an annual report to the General Assembly.
  - **Tag:** [Bad] – Formalizes a pipeline between Missouri public health and national public-health organizations, which often carry progressive ideological agendas (equity, gender ideology, etc.). While some contracting is inevitable, narrowing "qualified vendors" to affiliates of national associations gives those external groups special status and influence.

Pseudoephedrine/meth precursor rules

- **§195.417 & §579.060 – Pseudoephedrine limits and manufacturer fees.**
    - Raises the **annual** limit of allowed pseudoephedrine purchase from 43g to 61.2g while keeping daily and 30-day limits the same; retains behind-the-counter and logging requirements; clarifies preemption of local ordinances.
    - Requires **manufacturers** of these products, starting Oct. 1, 2026, to pay monthly fees to the administrator of the real-time electronic pseudoephedrine tracking system, which can set fee levels. DHSS can demand proof of payment.
    - **Tag:** [Mixed] – More flexibility for legitimate consumers (chronic allergy patients) and shifts monitoring costs to manufacturers instead of taxpayers. But higher annual limit plus continuing real-time tracking keeps the surveillance structure in place while potentially increasing diversion risk.

Long-term care & facility inspections

- **§198.022 – Licensing & inspection; accreditation substitution.**
    - Allows DHSS to accept federal/other accreditor survey reports in lieu of state inspections if comparable; requires accredited facilities to provide reports for public posting; if an exempted facility receives a serious Class I violation, it triggers a full state survey.
    - **Tag:** [Mixed] – Could reduce duplicative inspections when accreditation is strong; maintains a backstop via Class I-violation trigger. But, allows federal or other (possible international standards in place of Missouri standards)
- **§198.070 – Abuse/neglect reporting; link with §198.022.**
    - Standard elder-abuse reporting rules; new language ties an exempt facility's class I violations to loss of inspection exemption.
    - **Tag:** [Good/Mixed] – Protects residents; increases state oversight for serious violations.

Show-Me Healthy Babies

- **§208.662 – Show-Me Healthy Babies Program.**
    - Reaffirms a separate CHIP program for "low-income unborn children"; defines eligibility; covers prenatal and pregnancy-related services benefiting the unborn child from conception to birth; extends coverage for the child up to one year after birth; provides pregnancy-related and postpartum coverage for the mother, with a federal-law-linked extension to twelve months postpartum under certain conditions; requires annual cost-benefit reports.

- **Tag:** [Good/Bad] – Good: Strongly affirms the unborn child as a distinct CHIP-eligible person from conception, which aligns with personhood principles. Bad: But it also entrenches a federally tied CHIP/Medicaid structure and potentially broadens state obligations.

MO HealthNet – Doula Reimbursement Act & Pathology

- **§208.149 – Pathologist professional component reimbursement.**
  - Requires MO HealthNet to pay the professional component of clinical pathology services (30% of the Medicare fee schedule) for hospital-based pathologists; payment goes to the hospital if employed or to a third party otherwise.
  - **Tag:** [Bad] – While it helps ensure specialists get paid, it increases MO HealthNet costs at a time when Medicaid expansion is already a budget concern.
- **§§208.1400–208.1425 – "Missouri Doula Reimbursement Act".**
  - Names the act; defines **doulas** and "pregnant individuals" (***Note the use gender-neutral language***); covers six combined prenatal/postpartum sessions, one birth attendance, lactation consults, and up to ten extra "community navigation services" interactions; sets certification and training pathways; requires doulas to enroll as MO HealthNet providers, carry liability insurance, and be reimbursed fee-for-service.
  - **Tag:** [Bad/Concern] –
    - **Good intentions:** Supports mothers through pregnancy and postpartum; could reduce complications and strengthen family support if done well.
    - **Concerns:**
      - Creates a new Medicaid-like benefit and bureaucracy with ongoing rulemaking.
      - Uses "***pregnant individual***" language instead of mother/woman, aligning with gender ideology.
      - "Community navigation services" can become a soft social-work / case-management infrastructure that steers families toward state-approved services and NGOs.

Pharmacy, 340B, Rx Cares, and distribution

- **§338.010 – Practice of pharmacy; vaccine authority.**

- Continues to allow pharmacists to order/administer FDA-approved vaccines (with board rules), **but explicitly excludes** a long list (cholera, monkeypox, polio, smallpox, etc.) and "any vaccine approved after January 1, 2026" unless boards act; clarifies ShowMeVax reporting and emergency-use authority during declared emergencies.
- **Tag:** [Concern] – On one hand, this blocks automatic pharmacist access to future vaccines without state-level review, which is a positive guardrail. On the other hand, it still ties practice to CDC guidance and allows broad emergency-declaration vaccine authority.

- **§338.333 – Licensing of wholesale distributors, out-of-state reciprocity.**
  - Small technical edits to allow reciprocity for out-of-state wholesale distributors / third-party logistics providers with equivalent licensure or NABP accreditation.
  - **Tag:** [Good/Mixed] – Mostly technical; modest interstate facilitation.
- **§338.710 – "Rx Cares for Missouri" program; removes sunset.**
  - Makes the program permanent; continues to bar its funds from being used for a state prescription drug monitoring program; focuses on medication safety/anti-abuse education.
  - **Tag:** [Good] – Keeps an anti-drug-abuse program while expressly **prohibiting** PDMP use of these funds.
- **§376.417 – 340B anti-discrimination rules.**
  - Bars health carriers/PBMs from reimbursing 340B covered entities less, imposing extra fees/conditions, or discriminating in other ways against them because they use 340B; sets civil penalties up to $5,000 per violation per day.
  - **Tag:** [Mixed] – Helps safety-net clinics/hospitals keep 340B savings; but further entangles state law with a complex federal 340B system that is itself prone to abuse and distortions.

Insurance/utilization review/anesthesia /non-opioid coverage

- **§376.1245 – Anesthesia-time payment rules.**
  - Defines anesthesia time units; forbids plans from imposing a time limit or excluding anesthesia time when paying anesthesia services; applies even to excepted benefit plans.
  - **Tag:** [Mixed] –Possibly fairer payment for anesthesiologists; may slightly increase premiums but reduces insurer games.

- **§376.1280 – Non-opioid acute pain coverage.**
    - For patients at elevated risk of opioid misuse, plans may **not**: deny non-opioid drugs in favor of opioids, require trying opioids first, or require higher cost-sharing for non-opioids.
    - **Tag:** [Good] – Fights perverse incentives pushing opioids; aligns with responsibility and life-protecting care.
- **§§376.2100–376.2108 – Prior authorization reforms.**
    - If a carrier is already approving ≥90% of prior-auth requests (per provider/per service or overall) in a 12-month period, it cannot require prior auth for those services; gives hospitals options for exemption via value-based agreements, CMS star ratings ≥3, or ≥91% approval rate; sets carve-outs (pharmacy, imaging above certain dollar thresholds, cosmetic/experimental); allows audits and rescission if approval rates would fall below 90%; requires appeal processes, online portals, and forbids carriers from denying payment after prior authorization except for fraud or nonperformance. Excludes fee-for-service MO HealthNet but includes Medicaid managed-care orgs.
    - **Tag:** [Good/Mixed] – Strongly pro-physician and pro-patient on red-tape reduction. However:
        - Anchors an exemption path to **CMS Five-Star ratings** and "value-based care agreements," which are deeply federal-driven metrics and can carry equity/DEI strings.
        - Still leaves room for carriers to game definitions and audits.

2.3 High-level changes to existing law

In 3–6 bullets:

- **New powers/programs created:**
    - DHSS standing-order authority for broad non-controlled-substance purposes, including doula recommendations.
    - MO HealthNet doula reimbursement infrastructure.
    - Expanded MO HealthNet coverage for pathologists and postpartum mothers in Show-Me Healthy Babies.
    - Allergy-policy mandates for child-care providers (Elijah's Law).
    - Durable prior-auth reform regime and PBM/340B rules.
- **Powers shifted or limited:**

    - PBMs/health carriers lose some leverage against 340B entities and against providers on prior-auth games.
    - Pharmacists' automatic access to future vaccines is constrained (anything new after Jan. 1, 2026 requires rulemaking).
- **Funding/enforcement shifts:**
    - Manufacturers now fund the pseudoephedrine tracking system.
    - Facilities relying on accreditation can skip some inspections but lose that break if they incur serious violations.
    - Rx Cares is made permanent.

PART 3 – CONSTITUTIONAL & PROCESS CHECKS

3.1 Single-Subject & clear-title (Art. III §23)

- **Main subject (as written):** "Health care."
- **Additional subjects/areas tucked in:**
    - Hospital/hospital-district finance and investments.
    - Telemedicine and prescribing.
    - Medicaid/CHIP benefits and reimbursement structures.
    - Pharmacy scope and wholesalers.
    - Epinephrine policies for schools, EMS, fire, and child care.
    - Pseudoephedrine/meth-precursor offenses and manufacturer fees.
    - PBM/340B rules and insurance prior-authorization procedures.
    - Anesthesia billing and non-opioid coverage.
    - Awareness weeks and signage requirements in hospitals.

Even though each of those can be plausibly labelled "health care," this is functionally an omnibus bill with many distinct policy ideas in one vehicle.

- **Riders/barnacles:**
    - Awareness weeks, hospital financing, pseudoephedrine manufacturer fees, Elijah's Law, 340B/PBM disputes, and prior-auth reforms all feel like separate bills stapled together.
- **Title clarity vs. real effects:**

    - "Relating to health care" plus "penalty provisions" is technically broad enough, but from a **citizen fair-notice** standpoint, it hides big policy moves:
        - New doula benefit and standing-order authority.
        - Expanded CHIP/Medicaid benefits.
        - Complex prior-auth and PBM rules.
        - Pseudoephedrine limit changes and manufacturer-fee regime.
- **Original-purpose drift:**
    - Unknown without full history, but the sheer number of subjects suggests the bill either started broad or accreted topics over time.

Conclusion (Art. III §23):

- **Legal:** Probably upheld under Missouri's permissive "relating to" standard.
- **Honesty/fair-notice: Contrary to the spirit** of single-subject and clear-title protections. This is essentially an omnibus health-policy package.

3.2 U.S. & Missouri constitutional rights

- **Right to life / unborn equal protection:**
    - **Positive:** Show-Me Healthy Babies explicitly treats the unborn child as a separate program beneficiary from conception to birth.
    - **Concern:** Expanded standing-order authority and doula infrastructure, if misused, could later be harnessed to route abortion-adjacent services, emergency contraception, or other life-questionable interventions through public-health channels, though current text doesn't explicitly authorize abortion.
- **Religious liberty/conscience:**
    - No explicit protections added. Some mandates (Elijah's Law, allergy policies) could intersect with religious child-care providers; the bill does not build in conscience carve-outs, though the content is medically focused.
- **Free speech / compelled speech:**
    - No direct compelled-speech provisions, apart from required signage in hospital emergency and labor/delivery departments warning that assaulting health-care workers is a crime.
- **Due process/property rights:**
    - New penalties on PBMs and manufacturers, and expanded DHSS and DCI rulemaking, would have to meet general due-process standards; nothing obviously retroactive.

- **Right to bear arms:**
    - No impact.

3.3 Delegation & separation of powers

Major delegation concerns:

- **Standing-order power (§191.708).**
    - Grants internal agency physicians broad authority to issue standing orders "for any other purpose" (except controlled substances), implemented by regulation, with immunity.
    - This is a significant **open-ended delegation** that can be weaponized for contested medical policies without fresh legislative debate.
- **DHSS contracting with national public-health affiliates (§192.021).**
    - Automatically privileges certain NGO types as "qualified vendors," embedding them into state health operations and grant administration.
- **MO HealthNet / doula rules (§§208.1400–208.1425, §208.149).**
    - Substantial rulemaking to define doula training standards, reimbursement schedules, and pathology professional components.
- **Insurance prior-auth & 340B rules (§§376.417, 376.2100–2108).**
    - DCI is empowered to define "similarly situated pharmacy" and set practices that count as discrimination. Carriers/UR entities get audit and determination power under statutes that still leave plenty of discretion.

Net effect: SB 841 **centralizes more power** in statewide executive agencies (DHSS, MO HealthNet, DCI) and in external rating/standard systems (CMS star ratings, national public-health associations), rather than pushing decisions down to families, local communities, or even the legislature.

PART 4 – IMPACT ON MISSOURI FAMILIES

4.1 Economic, tax, and utility impacts

- **MO HealthNet / CHIP costs:**
    - New doula benefit + expanded postpartum coverage + pathology reimbursement = **more ongoing Medicaid/CHIP expense**, tied to federal-matching schemes.
    - Who pays? Ultimately, taxpayers are responsible for both state general revenue and federal debt.

- **Drug and insurance costs:**
    - Pseudoephedrine manufacturer fees likely get baked into product prices; consumers may pay slightly more.
    - Prior-auth reforms and anesthesia/non-opioid rules should reduce wasteful bureaucracy but may raise premiums modestly if carriers can't deny or delay payments as aggressively.
- **Winners vs. losers:**
    - **Winners:**
        - Doulas and certain hospitals/pathologists.
        - 340B hospitals and clinics.
        - Physicians frustrated with prior-auth games; patients needing non-opioid alternatives.
    - **Losers / cost-bearers:**
        - PBMs and health carriers (and thus indirectly employers and premium-payers).
        - Manufacturers of pseudoephedrine products and, ultimately, consumers.

4.2 Family, parental rights, and education

- **Parental authority/childcare:**
    - Elijah's Law imposes allergy policies on licensed child-care providers; primarily medical/safety focused, not ideological, **but increases** DESE/program oversight.
- **Education / DESE:**
    - This bill doesn't expand DESE's broader control over K-12, aside from coordinating allergy policies.
- **Family support:**
    - Show-Me Healthy Babies and doula services could help struggling mothers carry to term and parent safely—potentially reducing abortions and complications.

4.3 Moral & cultural climate

- **Life and unborn child:**
    - Strong Show-Me Healthy Babies language recognizing the unborn child as a covered CHIP recipient is a clear **pro-life signal** within the constraints of current law.
- **Language and worldview:**

- Doula provisions use "***pregnant individual***" rather than mother/woman, implicitly nodding to gender ideology and erasing the reality that pregnancy is female.
- Standing-order power + national public-health NGO contracting could be used to push progressive public-health agendas (equity, reproductive rights, trans medicine) without direct legislative accountability.

PART 5 – ACT FOR MISSOURI CORE PRINCIPLES CHECK

1. **Sanctity of life (from conception)**
   - **Supports:** Show-Me Healthy Babies treating unborn children as program beneficiaries from conception is a major plus.
   - **Risks:** Open-ended standing-order authority could be applied in ways that undercut pro-life protections in the future (e.g., emergency-contraception infrastructure), even if not explicit today.
   - **Verdict: Mixed** – pro-life recognition plus structural tools that could later cut the other way.
2. **Biblical view of limited government**
   - New Medicaid-style benefits, expanded DHSS standing orders, DHSS-NGO contracting, and increased insurance regulation all **grow government's footprint** in health care rather than restraining it.
   - **Verdict: Violates / Mixed**, leaning **violates** due to expansion and delegation.
3. **Property rights & economic liberty**
   - Some gains (reduced prior-auth micromanagement, anti-PBM abuses) help providers operate more freely.
   - But the bill also adds new regulatory and funding mandates (manufacturer fees, 340B penalties, MO HealthNet costs).
   - **Verdict: Mixed.**
4. **Constitutionalism & rule of law**
   - Omnibus structure strains single-subject spirit; title is very generic.
   - Several open-ended delegations (standing orders, DHSS vendor lists, MO HealthNet rules).
   - **Verdict: Violates the spirit** of clean, transparent legislation even if technically compliant.
5. **Right to bear arms**

- No impact.
- **Verdict:** Neutral.

6. **State sovereignty & Tenth Amendment**
    - Deepens reliance on federal programs/metrics: CHIP unborn-child program, 12-month postpartum coverage tied to 42 U.S.C. references, CMS star ratings for prior-auth exemptions, 340B federal drug-pricing framework.
    - **Verdict: Negative** – more entanglement with federal strings.
7. **Nuclear family & parental rights**
    - Some positive support for mothers/babies; no direct attack on parental rights.
    - But "community navigation" structures can subtly insert state-approved intermediaries into family life.
    - **Verdict: Mixed.**
8. **Homeschool freedom & private Christian education**
    - No direct new burdens on homeschools or private Christian schools.
    - **Verdict:** Neutral.
9. **Surveillance, data, and financial control**
    - Pseudoephedrine real-time tracking remains in place; manufacturers now fund it; Rx Cares explicitly barred from PDMP use.
    - Prior-auth portals and ShowMeVax continue data flows, but these precede this bill.
    - **Verdict:** Negative. Not a major new surveillance leap, but the main new risk is expanding public-health power, not new ID systems.

PART 6 – SPECIAL TOPIC TESTS (2025–2026)

1. **Amendment 3 / Personhood & Equal-Protection Test**
    - Show-Me Healthy Babies supports a personhood logic by recognizing unborn children as program beneficiaries.
    - Nothing here directly rolls back pro-abortion constitutional language, nor does it add exceptions.
    - Standing-order and doula infrastructure could be neutral or harmful depending on who controls them later.

- **Net:** Slight **positive** for personhood recognition; no direct help in overturning pro-abortion constitutional language.

2. **Surveillance-State & Digital-Control Test**
    - No new digital ID or financial-control architectures.
    - Continues pseudoephedrine tracking, but that already exists; Rx Cares remains barred from PDMP use.
    - **Net:** No major new surveillance infrastructure; the concern is more about **institutional leverage** via national public-health groups and federal metrics.
3. **Utilities, Energy Policy, Data-Center / Big-User Test**
    - Not implicated.
4. **Federal Money & Strings**
    - Strong reliance on CHIP, Medicaid waivers, 340B, and CMS star ratings.
    - Doula and postpartum expansions are clearly built around federal funding opportunities and conditions.
    - **Net:** Deepens dependence on federal money and policy frameworks.
5. **Globalism / Agenda 21 / Agenda 2030 Signals**
    - No explicit UN/WEF language.
    - But the preference for national public-health affiliates and CMS-style quality metrics continues aligning Missouri with national/international public-health policy currents.

PART 7 – RED FLAGS, AMENDMENT IDEAS & FINAL RECOMMENDATION

7.1 Top red flags (prioritized)

1. **Open-ended standing-order authority**
    - **Location:** §191.708.
    - **Why it matters:** Lets internal agency physicians issue standing medical orders "for any other purpose" (non-controlled substances) via rule, with broad immunity. In the wrong hands, that could be used to push controversial medical interventions statewide without new statutes.
    - **Severity: Critical.**
2. **Preferred pipeline to national public-health NGOs**

- **Location:** §192.021.
- **Why it matters:** Locks in "Missouri affiliates of national public-health associations/institutes" as a qualified vendor list, giving them a privileged position to run programs and grants. Most of those associations are ideologically progressive.
- **Severity: Serious.**

3. **New MO HealthNet doula benefit & "pregnant individual" language**
    - **Location:** §§208.1400–208.1425.
    - **Why it matters:** Expands Medicaid-style benefits and bureaucracy, ***embeds gender-ideology language***, and creates "***community navigation***" structures that can be steered toward whichever social-service worldview dominates state agencies.
    - **Severity: Serious.**
4. **Omnibus structure / fair-notice problem**
    - **Location:** Whole bill; title + 43 sections.
    - **Why it matters:** Bundles many unrelated health-policy items into one bill under a vague "relating to health care" title; ordinary citizens (and many legislators) will not fully appreciate what they are voting for.
    - **Severity: Serious.**
5. **Deepening federal entanglement in state health policy**
    - **Location:** Show-Me Healthy Babies (§208.662), doula act, prior-auth CMS-star criteria (§376.2102), 340B rules (§376.417).
    - **Why it matters:** MO becomes more dependent on CHIP, Medicaid waivers, 340B, and CMS rating systems, making it harder to resist federal policy shifts.
    - **Severity: Moderate–Serious.**

7.2 Possible fixes/amendments

While it is possible, provisions from this legislation could be supported if presented as stand-alone bills. However, this legislation, as written, is beyond fixing. This exemplifies the type of legislation we DO NOT want to see in the Missouri General Assembly.

7.3 Final recommendation

Given:

- The **omnibus** nature.

- The **open-ended standing-order power** for state health officials.
- The privileged role for **national public-health affiliates** in DHSS contracting.
- The expansion of MO HealthNet programs and embedding of gender-ideological language ("pregnant individual").
- Yet acknowledging there are several **good, pro-family, and pro-life-leaning elements** (Show-Me Healthy Babies, non-opioid coverage, prior-auth relief, limits on future vaccines, Rx Cares non-PDMP guardrail),

Act for Missouri STRONGLY OPPOSES SB 841.

Act for Missouri OPPOSES this bill. While we support several individual provisions—especially those that recognize unborn children, protect patients from opioid pressure, and reduce prior-authorization abuse—the bill, as written, is an omnibus package that expands state health bureaucracy, opens dangerous standing-order authority, deepens federal and public-health-NGO entanglement, and violates our preference for transparent, limited, and accountable government. We would encourage legislators to kill SB 841 in its current form.