

FIRST REGULAR SESSION

SENATE BILL NO. 556

94TH GENERAL ASSEMBLY

INTRODUCED BY SENATORS LOUDON, GIBBONS, SHIELDS, NODLER, RIDGEWAY AND CROWELL.

Read 1st time February 21, 2007, and ordered printed.

TERRY L. SPIELER, Secretary.

0027S.10I

AN ACT

To amend chapter 376, RSMo, by adding thereto seventeen new sections relating to health insurance.

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

Section A. Chapter 376, RSMo, is amended by adding thereto seventeen
2 new sections, to be known as sections 376.1600, 376.1603, 376.1606, 376.1609,
3 376.1612, 376.1615, 376.1618, 376.1621, 376.1624, 376.1627, 376.1630, 376.1633,
4 376.1636, 376.1638, 376.1642, 376.1850, and 376.1852, to read as follows:

**376.1600. As used in sections 376.1600 to 376.1642, unless the
2 context clearly indicates otherwise, the following terms shall mean:**

3 (1) "Administrator", shall have the meaning stated in the Federal
4 Employment Retirement Income Security Act, 29 U.S.C. Section 1002;

5 (2) "Applicant", an individual seeking to participate in the
6 Missouri health insurance exchange;

7 (3) "Carrier" or "health carrier", an entity subject to the
8 insurance laws and regulations of this state that contracts or offers to
9 contract to provide, deliver, arrange for, pay for or reimburse any of
10 the costs of health care services, including a sickness and accident
11 insurance company, a health maintenance organization, a nonprofit
12 hospital and health service corporation, or any other entity providing
13 a plan of health insurance, health benefits or health services; except
14 that such plan shall not include any coverage pursuant to a liability
15 insurance policy, workers' compensation insurance policy, or medical
16 payments insurance issued as a supplement to a liability policy;

17 (4) "Consumer-driven health benefit plan", a health savings
18 account, as defined in 26 U.S.C. Section 223(d), as amended, combined
19 with a high deductible health plan that meets the criteria established

20 in 26 U.S.C. Section 223(c)(2), as amended, and any regulations
21 promulgated thereunder, or a health reimbursement arrangement that
22 meets the requirements of Internal Revenue Code, Notice 2002-45, 2002-
23 2 C.B. 93;

24 (5) "Creditable coverage", continual coverage of an applicant
25 under any of the following health plans, with no lapse in coverage of
26 more than sixty-three days immediately prior to the date of application:

27 (a) An employer sponsored plan;

28 (b) A health benefit plan;

29 (c) Part A or Part B of Title XVIII of the Social Security Act;

30 (d) Title XIX of the Social Security Act, other than coverage
31 consisting solely of benefits under Section 1928 of that Act;

32 (e) Chapter 55 of Title 10 of the United States Code;

33 (f) A medical care program of the Indian Health Service or of a
34 tribal organization;

35 (g) The Missouri health insurance pool established under
36 sections 376.960 to 376.989, or other similarly situated state benefits
37 risk pool;

38 (h) A health plan offered under the Federal Employees Health
39 Benefits Program (FEHBP), Title 5, Chapter 89 of the United States
40 Code;

41 (i) A public health plan as defined by federal regulations
42 authorized by the Public Health Service Act, Section 2701(c)(1)(i), as
43 amended by P.L. 104-191;

44 (j) A health benefit plan under Section 5(e) of the Peace Corps
45 Act, 22 U.S.C. 2504(e); or

46 (k) Any other qualifying coverage required by the Health
47 Insurance Portability and Accountability Act of 1996, as it may be
48 amended, or regulations under that federal act;

49 (6) "COBRA", the Consolidated Omnibus Budget Reconciliation
50 Act of 1985, approved April 7, 1986 (100 Stat. 231; 29 U.S.C. Section 1161
51 et seq.);

52 (7) "Dependent":

53 (a) The spouse of the principal insured; or

54 (b) An individual who is related to the principal insured by
55 birth, marriage, or adoption; and

56 (c) Who also meets the definition of a dependent as set forth in

57 the United States Internal Revenue Code, 26 U.S.C. Section 152;

58 (8) "Director", the director of the department of insurance,
59 financial and professional regulation;

60 (9) "Eligible individual", an individual who meets the
61 requirements of section 376.1624;

62 (10) "Employer", any individual, partnership, association,
63 corporation, business trust, or person or group of persons that:

64 (a) Employs one or more persons in the state; and

65 (b) Files payroll tax information on those persons;

66 (11) "Exchange" the Missouri health insurance exchange
67 established under sections 376.1600 to 376.1642;

68 (12) "Exchange board" or "board", the board authorized under
69 sections 376.1600 to 376.1642 to administer the Missouri health
70 insurance exchange;

71 (13) "Exchange director" the director of the Missouri health
72 insurance exchange appointed by the exchange board under section
73 376.1606;

74 (14) "Federal health coverage tax credit eligible individual", any
75 individual who is eligible for benefits under 26 U.S.C. Section 35(c);

76 (15) "Health benefit plan", "health plan", or "plan", a policy,
77 contract, certificate, or agreement entered into, offered, or issued by
78 a health carrier to provide, deliver, arrange for, pay for, or reimburse
79 any of the costs of health care services; except that, a health benefit
80 plan shall not include any coverage under a plan, policy, contract,
81 certificate, or agreement to provide excepted benefits, which shall
82 consist of any of the following types of benefits, or combinations
83 thereof:

84 (a) Coverage only for only accident, or disability income
85 insurance, or combination thereof;

86 (b) Coverage issued as a supplement to a liability insurance;

87 (c) Liability insurance, including general liability insurance and
88 automobile liability insurance;

89 (d) Workers' compensation or similar insurance;

90 (e) Medical expense and loss of income benefits;

91 (f) Credit-only insurance; and

92 (g) Other similar insurance coverage, specified in regulations
93 promulgated by the director, under which benefits for medical care are

94 secondary or incidental to other insurance benefits;

95 (16) "Insurance producer" a person licensed to sell, solicit, or
96 negotiate insurance in Missouri;

97 (17) "Participating employer plan", a group health plan:

98 (a) That meets the definition of "group health plan" in the federal
99 Employment Retirement Income Security Act, 29 U.S.C. Section 1191b;

100 (b) That is sponsored by an employer; and

101 (c) In which the plan sponsor has entered into an agreement
102 with the Missouri health insurance exchange to offer and administer
103 health insurance benefits for enrollees in the plan;

104 (18) "Participating individual", a person that:

105 (a) Seeks to obtain coverage under benefit plans offered through
106 the exchange; and

107 (b) The exchange has determined to be an eligible individual for
108 purposes of obtaining coverage under participating insurance plans
109 offered through the exchange;

110 (19) "Participating plan" or "participating insurance plan", a
111 health benefit plan offered through the exchange;

112 (20) "Plan year", the period of time during which the insured is
113 covered under a health benefit plan, as stipulated in the contract
114 governing the plan;

115 (21) "Preexisting condition", a medical condition that was present
116 before the effective date of coverage, whether or not any medical
117 advice or treatment was recommended or received regarding the
118 condition. A preexisting condition does not include pregnancy or
119 genetic information, in the absence of a diagnosis of a condition related
120 to the information;

121 (22) "Preexisting condition provision", a provision in a health
122 benefit plan that denies, excludes, or limits benefits for an enrollee for
123 expenses or services relating to a preexisting condition;

124 (23) "Qualified dependent", an individual who qualifies as a
125 dependent as defined in 26 U.S.C. Section 152;

126 (24) "Rate", the premiums or fees charged by a health benefit
127 plan for coverage under the plan;

128 (25) "Resident", a person who is legally domiciled and physically
129 resides on a permanent and full-time basis in a place of permanent
130 habitation in Missouri. A "resident" also includes a person who is a full-

131 time student attending an institution outside of the state.

376.1603. 1. The Missouri health insurance exchange is hereby
2 established. The exchange is created for the purpose of facilitating the
3 availability, choice and adoption of private health insurance plans to
4 eligible individuals and groups as described in sections 376.1600 to
5 376.1642. The Missouri health insurance exchange shall serve as a
6 mechanism through which carriers and insurers can offer policies that
7 combine the best features of the traditional group and non-group
8 insurance markets. The exchange shall serve as a market organizer,
9 providing a single, centralized system facilitating the buying and
10 selling of health insurance. All eligible individuals shall be permitted
11 to obtain health insurance benefits through the exchange, subject to the
12 provisions of sections 376.1600 to 376.1642. Any carrier offering a
13 health benefit plan approved by the director under section 376.1621
14 may offer such plan through the exchange.

15 2. The exchange shall be a body corporate and may sue and be
16 sued, transact business contracts, invest funds, and in addition to the
17 powers and duties described in sections 376.1600 to 376.1642, the
18 exchange shall be vested with such other powers as may be necessary
19 or proper to enable it, its exchange board, its employees, and agents to
20 carry out fully and effectively the purposes of sections 376.1600 to
21 376.1642.

376.1606. 1. There shall be an exchange board, with duties and
2 powers established by sections 376.1600 to 376.1642, that shall govern
3 the exchange. The exchange board is vested with full power, authority
4 and jurisdiction over the exchange. The exchange board may perform
5 all acts necessary or convenient in the administration of the company
6 or in connection with the insurance business to be carried on by the
7 exchange. The exchange board shall be constituted as follows:

8 (1) The director of the department of insurance, financial and
9 professional regulation, ex officio;

10 (2) The director of the department of health and senior services,
11 ex officio;

12 (3) The commissioner of the office of administration, ex officio;
13 and

14 (4) Six members appointed by the governor with the advice and
15 consent of the senate. Of the six members appointed to the exchange

16 board by the governor, one shall be:

17 (a) A member of good standing of the American Academy of
18 Actuaries;

19 (b) A health economist;

20 (c) A person who represent the interests of small business;

21 (d) A representative of a health consumer organization;

22 (e) An employee health benefits plan specialist; and

23 (f) A representative of a licensed health insurance carrier that
24 is not participating in the exchange.

25 2. All appointments shall be for a term of three years, but a
26 person appointed to fill a vacancy shall serve only for the unexpired
27 term. An appointed member of the exchange board shall be eligible for
28 reappointment. From its members, the board shall annually elect a
29 chair and a vice-chair. Each member of the board serving in an ex
30 officio capacity may appoint a designee. The board shall meet at least
31 six times a year, at places and dates determined by the board.

32 3. Members shall serve without pay, but shall be reimbursed for
33 actual expenses necessarily incurred in the performance of their duties.

34 4. Meetings and records of the exchange board shall be subject
35 to the provisions of chapter 610, RSMo. Records containing the name,
36 residence, telephone numbers, or any other identifying information
37 which otherwise identifies a participating individual, are confidential
38 and exempt from the provisions of chapter 610, RSMo.

39 5. The exchange board shall appoint an exchange director who
40 shall serve at the pleasure of the board. The exchange director shall be
41 under the general supervision of the exchange board. The exchange
42 director shall be the chief executive officer of the exchange, and a full
43 time employee of the exchange, and shall be responsible for
44 administering all of the exchange's activities and contracts and
45 supervising all of the exchange's staff. The exchange director shall
46 have proven successful experience as an executive at the general
47 management level in the insurance business. The exchange director
48 shall receive a salary commensurate with the duties of the position.

49 6. No member of the exchange board shall be civilly liable, either
50 jointly or separately, as a result of any act, omission or decision in
51 performance of his duties as specifically required by sections 376.1600
52 to 376.1642. Such immunity shall not attach for any intentional or

53 reckless act affecting the property or rights of any person.

376.1609. The exchange board is authorized to implement and
2 administer the exchange. The goal of the exchange board is to
3 facilitate the purchase of health care insurance products through the
4 exchange at an affordable price by eligible individuals, employers, and
5 groups. For these purposes, the exchange board is authorized and
6 empowered to:

- 7 (1) Administer all of the exchange's activities and contracts;
- 8 (2) Establish procedures for operations of the exchange;
- 9 (3) Prepare an annual budget for the exchange;
- 10 (4) Enter into contracts with public or private entities to carry
11 out the duties of the exchange, including contracts to administer
12 applications, eligibility verification, enrollment, and premium
13 payments for specific groups or populations. Any organization that the
14 exchange board enters into a contract with to administer any of the
15 functions or duties of the exchange shall not be a carrier that offers a
16 participating plan through the exchange. The exchange board shall not
17 have the authority to enter into contracts with healthcare providers;
- 18 (5) Take any legal action necessary or proper on behalf of the
19 exchange;
- 20 (6) Hire or contract with appropriate legal, actuarial,
21 administrative personnel, and other advisors to provide technical
22 assistance in the management and operation of the exchange;
- 23 (7) Establish and execute a line of credit, and establish one or
24 more cash and investment accounts to carry out the duties of the
25 exchange;
- 26 (8) Establish and collect administrative fees from carriers based
27 on the number of persons covered by the plans or plans offered through
28 the exchange by the carrier sufficient to fund the costs of
29 administering the exchange;
- 30 (9) Apply for grants from public and private entities;
- 31 (10) Contract with sponsoring employers of participating
32 employer plans to act as the plan's administrator;
- 33 (11) Establish procedures for the enrollment of eligible
34 individuals, employers, groups, and local government employees;
- 35 (12) Establish and manage a system for collecting premium
36 payments made by, or on behalf of, individuals obtaining health

37 insurance coverage through the exchange, including any premium
38 payments made by enrollees, employers, or other organizations, and
39 transmitting such payments to the chosen plans; and

40 (13) Undertake any other activities necessary to implement the
41 powers and duties set forth in sections 376.1600 to 376.1642.

376.1612. 1. The exchange director shall develop and administer
2 a program that will offer all eligible individuals the opportunity to
3 purchase a health benefit plan through the exchange. Subject to
4 approval by the exchange board, the exchange director shall establish
5 and administer procedures for the effective operation of the exchange,
6 including procedures for:

7 (1) Providing information on the exchange to applicants;

8 (2) Enrolling eligible individuals in the exchange and managing
9 enrollment, including:

10 (a) Creating a standard application form to collect information
11 necessary to determine the eligibility and previous coverage history of
12 an applicant; and

13 (b) Processing any payments for coverage received by the
14 exchange;

15 (3) Preparing and distributing certificate of eligibility forms and
16 enrollment instruction forms to insurance producers and to the general
17 public;

18 (4) The election of coverage by participating individuals from
19 among participating plans, including establishing and administering an
20 annual open enrollment period and providing for coverage elections
21 outside of the annual open enrollment on the occurrence of any
22 qualifying event specified in section 376.1630, including preparing and
23 distributing to participating individuals:

24 (a) Descriptions of the coverage, benefits, limitations, co-
25 payments, and premiums for all participating plans; and

26 (b) Forms and instructions for electing coverage and arranging
27 payment for coverage;

28 (5) Preparing and distributing to participating individuals the
29 following information:

30 (a) Descriptions of the coverage, benefits, limitations, co-
31 payments, and premiums for all participating plans;

32 (b) Forms and instructions for electing coverage and arranging

33 payment for coverage; and

34 (c) Any other information the exchange deems necessary in order
35 for participating individuals to make informed coverage elections;

36 (6) The handling of and accounting for funds received and
37 disbursed by the exchange;

38 (7) Collecting and transmitting to the applicable participating
39 plans all premium payments or contributions made by or on behalf of
40 participating individuals, including developing mechanisms to:

41 (a) Receive and process employer contributions and payroll
42 deductions made by participating individuals, regardless of whether
43 such individuals are enrolled in a participating employer plan;

44 (b) Enable a participating individual to pay any portion of
45 coverage offered through the exchange by electing to assign to the
46 exchange any federal earned income tax credit payments due to the
47 participating individual; and

48 (c) Receive and process any applicable federal or state tax
49 credits or other premium support payments for the health insurance,
50 as may be established by law; and

51 (8) Establishing and administering a website at which
52 individuals and other groups can examine the various health insurance
53 coverage options available through the exchange and which contains
54 a program or programs designed to assist individuals, after inputting
55 basic information about themselves and any covered dependents, in
56 determining the costs of the various health insurance coverage options
57 available to them and which health insurance options provide the best
58 coverages at the least costs for the individuals.

59 2. The exchange director shall publicize the existence of the
60 exchange and disseminate information on eligibility requirements and
61 enrollment procedures for the exchange.

62 3. The exchange director shall establish and maintain accounts
63 for the receipt and disbursement of funds used to manage and operate
64 the exchange, including:

65 (1) A segregated management account for the receipt and
66 disbursement of money allocated to fund the expenses incurred in
67 administering the exchange;

68 (2) A segregated operations account for:

69 (a) The receipt of all premium payments or contributions made

70 by or on behalf of participating individuals; and

71 (b) The disbursement:

72 a. Of premium payments to participating plans; and

73 b. Of commissions or payments to insurance producers and other
74 entities entitled under to receive payments for their services in
75 enrolling eligible individuals or groups in the exchange.

76 4. The exchange director shall have the authority to act as the
77 plan administrator for any participating employer plan, and undertake
78 the obligations required of a plan administrator under federal law for
79 all such participating employer plans.

80 5. The exchange director shall have the authority to hire and
81 supervise staff, as may be determined necessary by the exchange board,
82 for the administration of the exchange.

83 6. The exchange director shall arrange for annual audits of the
84 records and accounts of the exchange by a certified public accountant
85 or firm of certified public accountants. The state auditor shall examine
86 such audits at least once every three years and report to the exchange
87 board and the governor.

88 7. The advisory committee established under subsection 1 of
89 section 376.1621 shall annually review the exchange's administrative
90 budget and issue recommendations to the exchange board with respect
91 to how the exchange can minimize administrative and other transaction
92 costs.

376.1615. The exchange director shall establish and administer
2 at least one service center. A service center established under this
3 section shall provide information on the exchange and the plans offered
4 through the exchange to applicants and enroll eligible individuals
5 seeking to participate in the exchange.

376.1618. 1. All operating expenses of the exchange shall be paid
2 from funds collected by or on behalf of the exchange. The accounts of
3 the exchange are special fund accounts and the money in the accounts
4 are not part of the general revenue fund of Missouri. The state shall
5 not provide general revenue fund appropriations to the exchange and
6 the obligations of the exchange are not a debt of the state or a pledge
7 of the credit of the state. All debts, claims, obligations, and liabilities
8 of the exchange shall be the debts, claims, obligations, and liabilities of
9 the exchange only and not of the state or the state's agencies,

10 instrumentalities, officers, or employees.

11 2. The assets of the exchange shall be exempt from taxation by
12 the state and local government.

 376.1621. 1. The exchange shall offer to participating individuals
2 only plans that have been certified by the director of the department
3 of insurance, financial and professional regulation as eligible to be
4 offered through the exchange. To be able to offer a plan through the
5 exchange described in sections 376.1600 to 376.1642, a carrier must be
6 licensed to issue health insurance in Missouri and be in good standing
7 with the department of insurance, financial and professional
8 regulation. Prior to the exchange's initial open enrollment period, the
9 exchange board shall establish standardized health benefit plans that
10 carriers must offer through the exchange. The development of the plan
11 designs shall be based upon the recommendations of the advisory
12 committee established under this subsection. An advisory committee
13 is hereby established to develop and recommend to the exchange board
14 the types of health benefit plan designs to be offered through the
15 exchange and the criteria for offering such plans. The advisory
16 committee shall be composed of a representative of a health carrier
17 that issues individual health benefit plans in this state, a
18 representative of a health carrier that issues health benefit plans to
19 small employers, an actuary, and three persons from three separate
20 health carriers who are qualified by experience in designing health
21 benefit plans. The advisory committee may solicit oral or written
22 testimony from other interested parties in the furtherance of its
23 duties. The advisory committee established pursuant to this subsection
24 shall report to the exchange board. The types of coverage options and
25 the number of health benefit plan designs to be offered through the
26 exchange shall be based upon the recommendations of the advisory
27 committee. Each carrier, however, may offer any of the following types
28 of plans through the exchange:

29 (1) A consumer-driven health benefit plan, as defined in section
30 376.1600;

31 (2) A limited mandate health insurance policy as described in
32 section 376.995; and

33 (3) An enriched health benefit plan comparable to one of the
34 health benefit plans offered to state employees under chapter 103 or a

35 health benefit plan of similar quality and benefits.

36 2. For each plan year, the exchange shall offer all plans that:

37 (1) Agree to abide by the rules governing plan participation in
38 the exchange; and

39 (2) Have been certified by the director as eligible to be offered
40 through the exchange as of the date established by the exchange for
41 plans to apply to be a participating plan for the specified plan year.

42 3. An offering of a participating plan shall be for a term of at
43 least one year, and may be automatically renewed in the absence of a
44 notice of termination by the plan or notice by the director that the plan
45 is no longer certified as eligible to be offered through the exchange.

46 4. Each plan certified by the exchange board shall contain a
47 detailed description of benefits offered, including maximums,
48 limitations, exclusions, and other benefit limits.

49 5. Carriers shall offer plans through the exchange at standard
50 rates based upon age, geography, health lifestyle considerations, and
51 family composition that are determined to be actuarially sound in the
52 judgment of the director. The rules for participating plans shall also
53 factor in the availability of reimbursement from the direct payment
54 stop loss fund established under section 376.1642.

55 6. The rates determined for the first plan year for which the plan
56 is offered through the exchange may be adjusted by the carrier for
57 subsequent plan years based upon experience and any later
58 modifications to plan benefits, provided that any adjustment in rates
59 shall be made in advance of the plan year for which they will apply and
60 on a basis which, in the judgment of the director, is consistent with the
61 general practice of carriers that issue health benefit plans to large
62 employers.

63 7. The exchange shall not sponsor any insurance or benefit plan,
64 or contract to offer any insurance or benefit plan, as a participating
65 plan that has not first been certified by the director in accordance with
66 the provisions of this section.

67 8. The exchange shall not impose on any participating plan or on
68 any carrier or plan seeking to participate in the exchange, any forms
69 or conditions, including any requirements or agreements with respect
70 to rates or benefits, beyond, or in addition to, those terms and
71 conditions established and imposed by the director in certifying plans

72 under the provisions of this section.

73 9. Before a carrier notifies members of a participating plan of
74 the carrier's intent to discontinue the offering of the participating plan,
75 the carrier shall give one hundred and twenty days written notice of its
76 intent to discontinue the participating plan to the director.

77 10. Each participating plan shall make available to the exchange
78 any reports, data, or other information that the exchange finds
79 reasonably necessary to adequately and effectively perform the
80 functions assigned to it under sections 376.1600 to 376.1642.

81 11. The certification of a plan may be withdrawn after thirty
82 days notice to the carrier and an opportunity for a hearing as provided
83 for in the administrative procedure act of Missouri, chapter 536,
84 RSMo. The director may, however, decline to renew the certification
85 of any carrier at the end of a certification term.

86 12. The exchange shall begin offering health benefit plans
87 approved under this section beginning January 1, 2009.

88 13. The director shall promulgate regulations for certifying plans
89 to participate in the exchange. Any rule or portion of a rule, as that
90 term is defined in section 536.010, RSMo, that is created under the
91 authority delegated in this section shall become effective only if it
92 complies with and is subject to all of the provisions of chapter 536,
93 RSMo, and, if applicable, section 536.028, RSMo. This section and
94 chapter 536, RSMo, are nonseverable and if any of the powers vested
95 with the general assembly pursuant to chapter 536, RSMo, to review, to
96 delay the effective date, or to disapprove and annul a rule are
97 subsequently held unconstitutional, then the grant of rulemaking
98 authority and any rule proposed or adopted after August 28, 2007, shall
99 be invalid and void.

376.1624. 1. An individual shall be considered an "eligible
2 individual" to receive coverage through the exchange if the person
3 meets one or more of the following qualifications:

4 (1) The individual is a resident of Missouri;

5 (2) The individual is not a resident of Missouri, but is employed
6 at least twenty hours a week at a location in Missouri and the
7 individual's employer does not offer a group health insurance plan, or
8 the individual is not eligible to participate in any group health
9 insurance plan offered by the individual's employer;

10 **(3) The individual is enrolled in, or is eligible to enroll in, a**
11 **participating employer plan;**

12 **(4) The individual is self-employed in Missouri, and, if a**
13 **nonresident self-employed individual, the individual's principal place**
14 **of business is in Missouri;**

15 **(5) The individual is a full-time student attending an institution**
16 **of higher education located in Missouri; or**

17 **(6) The individual is a qualified dependent of an individual who**
18 **is eligible to participate in the exchange by meeting one or more of the**
19 **qualifications of this section.**

20 **2. Any individual enrolled in the Missouri health insurance pool**
21 **created under sections 376.960 to 376.989 as of January 1, 2009, shall**
22 **not be eligible to receive coverage through the exchange. If such**
23 **individual ceases to be eligible for coverage under the Missouri health**
24 **insurance pool after January 1, 2009, the individual may be eligible for**
25 **coverage through the exchange if he or she otherwise qualifies under**
26 **the provisions of this section.**

376.1627. 1. Any eligible individual may apply to participate in
2 **the exchange. An employer, a labor union, an educational, professional,**
3 **civic, trade, church, or social organization that has eligible individuals**
4 **as employees or members may apply on behalf of those eligible**
5 **persons. Upon determination by the exchange that an individual is**
6 **eligible in accordance with the provisions of sections 376.1600 to**
7 **376.1642 to participate in the exchange, he or she may enroll, or, when**
8 **applicable, be enrolled by the individual's parent or legal guardian, in**
9 **a participating insurance plan offered through the exchange during the**
10 **next open season period or, when applicable, at such other times as are**
11 **specified in this section.**

12 **2. Subject to the provisions of section 376.1630, from November**
13 **first to November thirtieth of each year, the exchange shall administer**
14 **an open season during which any eligible individual may enroll in any**
15 **health benefit plan offered through the exchange, subject to the**
16 **provisions of section 376.1630, without a waiting period, and may not**
17 **be declined coverage.**

18 **3. An eligible individual may enroll in a health benefit plan**
19 **offered through the exchange, subject to the provisions of section**
20 **376.1630, without a waiting period, and may not be declined coverage,**

21 at a time other than the annual open season for any of the following
22 reasons, provided the individual does so within sixty-three days of the
23 triggering event:

24 (1) The individual loses coverage in an existing health insurance
25 plan due to the death of a spouse, parent, or legal guardian;

26 (2) The individual, or a covered dependent, loses coverage in an
27 existing health insurance plan due to a change in the individual's
28 employment status;

29 (3) The individual, or a covered dependent, loses coverage in an
30 existing health insurance plan because of a divorce, separation, or
31 other change in familial status;

32 (4) The individual loses coverage in an existing health insurance
33 plan because he or she achieves an age at which coverage lapses under
34 that plan;

35 (5) The individual, or a covered dependent, becomes newly
36 eligible by becoming a resident of Missouri or because the individual's
37 place of employment has been changed to Missouri;

38 (6) The individual becomes newly eligible by becoming the
39 spouse or dependent, by reason of birth, adoption, court order, or a
40 change in custody arrangement, of an eligible individual;

41 (7) The individual becomes subject to a court order requiring
42 him or her to provide health insurance coverage to certain dependents,
43 or enters into a new arrangement for the custody of dependents that
44 requires the providing of health insurance for those dependents; or

45 (8) The individual loses coverage in a plan offered through the
46 exchange by reason of the plan terminating participation in the
47 exchange prior to the end of the plan year;

376.1630. The following rules shall govern the imposition by
2 carriers of any preexisting condition provisions and rating surcharges
3 with respect to any participating individual covered by any
4 participating plan:

5 (1) Except as otherwise specified in subdivisions (3) and (4) of
6 this section, during any open season a participating individual who
7 elects to choose a different participating insurance plan or plan option
8 for the next plan year, the individual shall not be subject to any
9 preexisting condition provisions and shall be charged the standard rate
10 of the new participating plan or plan option for persons of the

11 participating individual's age and geographic area. The same shall
12 apply to any election by a participating individual of coverage for any
13 dependent who is also a participating individual;

14 (2) A new participating individual with eighteen months or more
15 of creditable coverage who enrolls in a participating plan shall not be
16 subject to any preexisting condition provisions and shall be charged
17 the applicable age and geography adjusted standard rate for the
18 participating plan;

19 (3) A new participating individual with creditable coverage of
20 between two and seventeen months may enroll in a participating
21 insurance plan, but the participating individual may be subject to one
22 or more preexisting condition provisions, for a period not to exceed
23 twelve months, the number of such months to be reduced by the
24 number of months of creditable coverage, or charged a premium not to
25 exceed one hundred twenty-five percent of the otherwise applicable age
26 and geography adjusted standard rate for the participating insurance
27 plan, or both. Any such rate surcharge shall not be applied during the
28 third or subsequent years of the individual's enrollment in any
29 participating insurance plan;

30 (4) A new participating individual with two months or less of
31 creditable coverage may enroll in a participating insurance plan, but
32 the participating individual may be subject to one or more preexisting
33 condition provisions, for a period not to exceed twelve months, the
34 number of such months to be reduced by the number of months of
35 creditable coverage, or charged a premium not to exceed one hundred
36 fifty percent of the otherwise applicable age and geography adjusted
37 standard rate for the participating insurance plan, or both. Any such
38 rate surcharge shall not be applied during the third or subsequent
39 years of the individual's enrollment in any participating insurance
40 plan;

41 (5) In cases where an individual is enrolled in a plan offered
42 through the exchange as a newly eligible dependent of a participating
43 individual, by reason of birth, adoption, court order or a change in
44 custody arrangement, either during open season or outside of open
45 season in accordance with section 376.1627, a carrier shall not impose
46 any preexisting condition provisions or any change in the rate charged
47 to the participating individual, except for such difference, if any, in the

48 participating insurance plan's standard rates that reflect the addition
49 of a new dependent to the participating individual's coverage;

50 (6) Periods of creditable coverage with respect to an individual
51 shall be established through presentation of certifications or in such
52 other manner as may be specified in federal or state law;

53 (7) For new participating individuals without creditable
54 coverage, or with only limited creditable coverage as set forth in
55 subdivisions (3) and (4) of this section, a carrier may elect to waive the
56 imposition of preexisting condition provisions and instead extend the
57 applicable rate surcharge for an additional year beyond the time
58 provided for in those subdivisions;

59 (8) For purposes of this section, any individual who is a
60 participating individual by reason of enrollment in a participating
61 employer plan shall be deemed to have eighteen months of creditable
62 coverage;

63 (9) For purposes of this section, any federal health coverage tax
64 credit eligible individual shall be deemed to have eighteen months of
65 creditable coverage.

376.1633. 1. Any participating individual may continue to elect
2 coverage under a participating plan in accordance with the rules and
3 procedures of the exchange if:

4 (1) The individual remains an eligible individual; and

5 (2) The individual follows the participating plan's rules
6 regarding cancellation for nonpayment of premiums or fraud.

7 2. A participating individual's coverage under a participating
8 plan may not be canceled or not renewed because of any change in
9 employer or employment status, marital status, health status, age,
10 membership in any organization, or other change that does not affect
11 the individual's eligibility to participate in the exchange.

12 3. A participating individual who is not a resident of Missouri
13 and who ceases to be an eligible individual due to a qualifying event
14 shall remain an eligible individual and shall be considered a
15 participating individual for a period not to exceed thirty-six months
16 from the date of the qualifying event, if:

17 (1) The qualifying event consists of a loss of eligible individual
18 status due to:

19 (a) Voluntary or involuntary termination of employment for
20 reasons other than gross misconduct; or

21 (b) Loss of qualified dependent status for any reason; and

22 (2) The participating individual elects to remain a participating
23 individual and notifies the exchange of this election within sixty-three
24 days of the qualifying event.

 376.1636. 1. Any employer may apply to the exchange to be the
2 sponsor of a participating employer plan.

3 2. Any employer seeking to be the sponsor of a participating
4 employer plan shall, as a condition of participation in the exchange,
5 enter into a binding agreement with the exchange, which, at minimum,
6 shall stipulate that:

7 (1) The sponsoring employer designates the exchange director to
8 be the plan's administrator for the employer's group health plan and
9 the exchange director agrees to undertake the obligations required of
10 a plan administrator under federal law;

11 (2) Only the coverage and benefits offered by participating plans
12 shall constitute the coverage and benefits of the participating employer
13 plan;

14 (3) That any individuals eligible to participate in the exchange
15 by reason of their eligibility for coverage under the employer's
16 participating plan, regardless of whether any such individuals would
17 otherwise qualify as eligible individuals if not enrolled in the
18 participating employer plan, may elect coverage under any
19 participating insurance plan, and that neither the employer nor the
20 exchange shall limit such individuals choice of coverage from among
21 all the participating insurance plans;

22 (4) The employer reserves the right to offer benefits
23 supplemental to the benefits offered through the exchange, but any
24 supplemental benefits offered by the employer shall constitute a
25 separate plan or plans under federal law, for which the exchange
26 director shall not be the plan administrator and for which neither the
27 exchange director nor the exchange shall be responsible in any manner;

28 (5) The employer agrees that, for the term of the agreement, the
29 employer will not offer to individuals eligible to participate in the
30 exchange due to their eligibility for coverage under the employer's
31 participating employer plan any separate or competing group health

32 plan offering the same or substantially similar benefits as those
33 provided by participating plans through the exchange, whether or not
34 any of those individuals would otherwise qualify as eligible individuals
35 absent their enrollment in the participating employer plan;

36 (6) The employer reserves the right to determine the criteria for
37 eligibility, enrollment, and participation in the participating employer
38 plan and the terms and amounts of the employer's contributions to that
39 plan, so long as for the term of the agreement with the exchange, the
40 employer agrees not to alter or amend any criteria or contribution
41 amounts at any time other than during an annual period designated by
42 the exchange for participating employer plans to make such changes in
43 conjunction with the exchange's annual open season;

44 (7) The employer agrees to make available to the exchange
45 director any of the employer's documents, records, or information,
46 including copies of the employer's federal and state tax and wage
47 reports, that the exchange board reasonably determines are necessary
48 for the exchange director to verify:

49 (a) That the employer is in compliance with the terms of its
50 agreement with the exchange governing the employer's sponsorship of
51 a participating employer plan;

52 (b) That the participating employer plan is in compliance with
53 the applicable federal and state laws relating to group health plans,
54 particularly those relating to nondiscrimination in coverage; and

55 (c) The eligibility, under the terms of the employer's plan, of
56 those individuals enrolled in the participating employer plan;

57 (8) The employer agrees to sponsor a cafeteria plan as permitted
58 under 26 U.S.C. Section 125 for all employees eligible for coverage
59 under the employer's participating employee plan.

376.1638. 1. An insurance producer licensed in Missouri may
2 apply to the exchange on behalf of an employer seeking to sponsor a
3 participating employer plan through the exchange. If the exchange
4 enrolls individuals eligible for benefits under the terms of that
5 participating employer plan, then the participating plan chosen by the
6 individual shall pay the insurance producer that applied to the
7 exchange on behalf of that employer the commission provided for in
8 subsection 4 of this section.

9 2. A membership organization, a professional organization, a
10 trade association, or a civic association, may apply to the exchange on
11 behalf of its members seeking enrollment in the exchange as
12 participating individuals. If the exchange enrolls any of those
13 individuals, then the participating plan chosen by the individual shall
14 pay the membership organization the commission provided for in
15 subsection 4 of this section.

16 3. Nothing in this section shall be interpreted to mean that a
17 membership organization that enrolls members in the exchange is
18 licensed as an insurance producer or a membership organization may
19 provide any other services requiring licensure as an insurance
20 producer without first obtaining such a license.

21 4. The director shall determine the amount of the standard
22 commission paid to licensed insurance producers and other qualified
23 entities for enrolling eligible individuals in the exchange. The amount
24 of the commission shall be in an amount the director determines to be
25 reasonable, based on commissions that are paid in the relevant market
26 and other factors the director deems relevant.

376.1642. 1. There is hereby established in the state treasury a
2 fund to be known as the "Direct Payment Stop Loss Fund", to be
3 administered by the director or the department of insurance, financial
4 and professional regulation. Any unexpended balance and any interest
5 in the fund at the end of the biennium shall be exempt from the
6 provisions of section 33.080, RSMo, relating to the transfer of
7 unexpended balances to the general revenue fund. The fund shall
8 consist of appropriations made to it annually by the general assembly
9 and gifts, contributions, grants, or bequests received from federal,
10 private, or other sources. The direct payment stop loss fund shall be
11 a fund from which carriers offering participating plans through the
12 Missouri health insurance exchange may receive reimbursement, to the
13 extent of funds available therefore, for claims paid by such carriers for
14 participating individuals covered under the participating plans issued
15 under sections 376.1600 to 376.1642.

16 2. Commencing January 1, 2009, carriers offering participating
17 plans through the health insurance exchange shall be eligible to receive
18 reimbursement from the direct payment stop loss fund for seventy
19 percent of claims paid between fifty thousand and one hundred

20 thousand dollars in a calendar year for any participating individual
21 covered under a participating plan issued through the health insurance
22 exchange.

23 3. The director shall promulgate rules and regulations setting
24 forth procedures for the operation of the direct payment stop loss fund
25 and the distribution of monies from the fund.

26 4. Claims shall be reported and funds shall be distributed on a
27 calendar year basis. Claims shall be eligible for reimbursement only
28 for the calendar year in which the claims are paid. Once claims paid
29 on behalf of a participating individual reach or exceed one hundred
30 thousand dollars in a given calendar year, no further claims paid on
31 behalf of such participating individual in such calendar year shall be
32 eligible for reimbursement. Claims paid within a calendar year shall
33 be determined by the date of payment rather than date of service or
34 date the claim was incurred. No participating carrier shall delay or
35 defer payment of a claim solely for the purpose of causing the date of
36 payment to fall into a subsequent calendar year. Participating carriers
37 shall not be entitled to any reimbursement on behalf of a participating
38 individual if the claims paid on behalf of that member in a given
39 calendar year do not, in the aggregate, reach the applicable claims
40 threshold. Additionally, claims paid on behalf of a covered member
41 that exceed the claims corridor in a given calendar year shall not be
42 eligible for reimbursement from the fund.

43 5. Each carrier shall submit a request for reimbursement from
44 the stop loss fund on a form prescribed by the director. Such request
45 for reimbursement shall be submitted no later than April first following
46 the end of the calendar year for which the reimbursement request is
47 being made. The director may require carriers to submit such claims
48 data in connection with the reimbursement request as the director
49 deems necessary to enable the director to distribute monies and
50 oversee the operation of the direct payment stop loss fund. The
51 director may require that such data be submitted on a per member,
52 aggregate, or categorical basis.

53 6. The director shall calculate the total claims reimbursement
54 amount for all carriers for the calendar year for which claims are being
55 reported.

56 7. In the event that the total amount requested for
57 reimbursement by all carriers for a calendar year exceeds funds
58 available for distribution for claims paid by all carriers during that
59 same calendar year, the director shall provide for the pro-rata
60 distribution of the available funds. Each carrier shall be eligible to
61 receive only such proportionate amount of the available funds as the
62 individual carrier's total eligible claims paid bears to the total eligible
63 claims paid by all carriers.

64 8. In the event that funds available for distribution for claims
65 paid by all carriers during a calendar year exceeds the total amount
66 requested for reimbursement by all carriers during that same calendar
67 year, any excess funds shall be carried forward and will not affect
68 monies appropriated for the direct payment stop loss fund in the next
69 calendar year.

70 9. Upon the request of the director, each carrier shall be
71 required to furnish such data as the director deems necessary to
72 oversee the operation of the direct payment stop loss fund. Such data
73 shall be furnished in a form prescribed by the director.

74 10. The director may obtain the services of an organization to
75 administer the direct payment stop loss fund. The director shall
76 establish guidelines for the submission of proposals by organizations
77 for the purposes of administering the fund. The director shall make a
78 determination whether to approve, disapprove, or recommend
79 modification to the proposal of an applicant to administer the fund. An
80 organization approved to administer the fund shall submit reports to
81 the director in such form and at times as may be required by the
82 director in order to facilitate evaluation and ensure orderly operation
83 of the fund, including, but not limited to, an annual report of the affairs
84 and operations of the fund, such report to be delivered to the director,
85 the house budget committee chair, and the senate appropriations
86 committee chair. An organization approved to administer the fund
87 shall maintain records in a form prescribed by the director and which
88 shall be available for inspection by or at the request of the
89 director. The director shall determine the amount of compensation to
90 be allocated to an approved organization as payment for fund
91 administration. Compensation shall be payable from the direct
92 payment stop loss fund. An organization approved to administer the

93 fund may be removed by the director and shall cooperate in the orderly
94 transition of services to another approved organization or to the
95 director.

96 11. If the director deems it appropriate for the proper
97 administration of the direct payment stop loss fund, the administrator
98 of the fund, on behalf of and with the prior approval of the director,
99 shall be authorized to purchase stop loss insurance or reinsurance or
100 both from an insurance company licensed to write such type of
101 insurance in this state. Such stop loss insurance or reinsurance may
102 be purchased to the extent of funds available therefore within such
103 funds which are available for purposes of the stop loss fund.

104 12. Beginning January 1, 2010, and annually thereafter, the
105 director shall submit a report to the general assembly evaluating the
106 effectiveness of the direct stop loss fund. The report shall include any
107 recommendations that the director deems relevant. The report,
108 however, shall contain recommendations whether the reinsurance
109 threshold or attachment point delineated in this section shall be
110 lowered and the reinsurance corridor be expanded to lower premium
111 costs and assist carriers with combating adverse selection or whether
112 the threshold should be increased in order to protect the solvency of
113 the fund.

114 13. The director is authorized to promulgate rules and
115 regulations to implement the provisions of this section. Any rule or
116 portion of a rule, as that term is defined in section 536.010, RSMo, that
117 is created under the authority delegated in this section shall become
118 effective only if it complies with and is subject to all of the provisions
119 of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This
120 section and chapter 536, RSMo, are nonseverable and if any of the
121 powers vested with the general assembly pursuant to chapter 536,
122 RSMo, to review, to delay the effective date, or to disapprove and annul
123 a rule are subsequently held unconstitutional, then the grant of
124 rulemaking authority and any rule proposed or adopted after August
125 28, 2007, shall be invalid and void.

376.1850. 1. Each employer in Missouri shall annually file with
2 the director of the department of insurance, financial and professional
3 regulation a form for each employee employed within this state
4 indicating the health insurance coverage status of the employee and

5 the employee's dependents including the source of coverage and the
6 name of the insurer or plan sponsor and, if no coverage is indicated:

7 (1) The employee's election to, in lieu of insurance coverage, post
8 a bond or establish an account in accordance with section 376.1852;

9 (2) The employee's election to apply, or not apply, for coverage
10 through the Missouri health insurance exchange under sections
11 376.1600 to 376.1642; or

12 (3) The employee's election to be considered, or not to be
13 considered, for any publicly financed health insurance program or
14 premium subsidy program administered by Missouri.

15 2. Each form shall be signed by the individual to whom it
16 pertains.

17 3. Each self-employed individual in Missouri shall annually file
18 the same form with the director of the department of insurance,
19 financial and professional regulation.

20 4. The family support division of the department of social
21 services shall annually file the same form with the director on behalf
22 of all individuals receiving benefits under the state's medical assistance
23 program on behalf of needy persons, Title XIX, Public Law 89-97, 1965
24 amendments to the federal Social Security Act, 42 U.S.C. Section 301, et
25 seq; under chapter 208, RSMo, and the health insurance for uninsured
26 children under sections 208.631 to 208.657, RSMo, excepting such
27 individuals as who are also covered by Part A or Part B of Title XVIII
28 of the Social Security Act, 79 Stat. 291; 42 U.S.C. § 1395c, et seq. or
29 1395j, et seq., respectively.

30 5. For purposes of this section, health insurance coverage shall
31 not include any coverage consisting solely of one or more excepted
32 benefits.

33 6. The director shall prepare and distribute such forms. The
34 director shall promulgate rules and regulations to implement the
35 provisions of this section. Any rule or portion of a rule, as that term is
36 defined in section 536.010, RSMo, that is created under the authority
37 delegated in this section shall become effective only if it complies with
38 and is subject to all of the provisions of chapter 536, RSMo, and, if
39 applicable, section 536.028, RSMo. This section and chapter 536, RSMo,
40 are nonseverable and if any of the powers vested with the general
41 assembly pursuant to chapter 536, RSMo, to review, to delay the

42 effective date, or to disapprove and annul a rule are subsequently held
43 unconstitutional, then the grant of rulemaking authority and any rule
44 proposed or adopted after August 28, 2007, shall be invalid and void.

376.1852. 1. On or after January 1, 2009, the following
2 individuals who are twenty-one years of age or older and have not yet
3 attained the age of sixty-five shall offer proof of their ability to pay for
4 medical care for themselves and their dependents:

5 (1) Residents of this state; or

6 (2) Individuals who become residents of Missouri, within 63 days
7 of establishing residency.

8 2. Individuals subject to the requirement in subsection 1 of this
9 section shall be deemed to be in compliance with said requirement if
10 they either:

11 (1) Indicated coverage under any health benefit plan in
12 accordance with section 376.1850; or

13 (2) Demonstrate proof of financial security in accordance with
14 subsection 3 of this section.

15 3. Individuals electing to demonstrate proof of financial security
16 to pay for medical expenditures shall present to the department of
17 revenue, a bond in the amount of ten thousand dollars, or shall deposit
18 with the department of revenue, ten thousand dollars in an escrow
19 account that shall bear interest at a rate determined in accordance
20 with the provisions of section 32.065, RSMo.

21 4. If in any calendar year the director of the department of
22 revenue receives information that an individual subject to the
23 requirement in subsection 1 of this section has defaulted on paying his
24 or her medical bills, has had a judgment rendered against him or her
25 for unpaid hospital or health care provider claims or otherwise has
26 failed to pay for medical claims, the director of the department of
27 revenue shall:

28 (1) Establish an escrow account in the name of said individual;
29 and

30 (2) (a) Retain and deposit in said account all such funds as may
31 be owed to said individual by the state of Missouri, including but not
32 limited to any overpayment by said individual of any taxes imposed by
33 the state of Missouri; or

34 **(b) Obtain an order for the attachment or garnishment of the**
35 **individual's wages to satisfy the requirements of this section; or**

36 **(c) Take action under both paragraphs (a) and (b) of this**
37 **subdivision.**

38 **5. With respect to any escrow account established in accordance**
39 **with this section, either by reason of an individual making the election**
40 **specified in subsection 3 of this section, or by reason of an individual**
41 **being subject to subsection 4 of this section:**

42 **(1) The amount deposited, retained, or collected shall not exceed**
43 **ten thousand dollars in aggregate for any such individual;**

44 **(2) Nothing in this section shall be construed to authorize the**
45 **director of the department of revenue to retain any amount for such**
46 **purposes that otherwise would be paid to a claimant agency or agencies**
47 **of the state of Missouri;**

48 **(3) Monies held in escrow accordance with this section, shall be**
49 **disbursed by the director of the department of revenue only to pay for**
50 **medical claims for healthcare services provided to the individual if the**
51 **individual has defaulted on payment for such services. Any hospital or**
52 **healthcare provider may submit a claim to the director for unpaid**
53 **medical claims from the escrow account. If the amount of moneys held**
54 **in the escrow account are insufficient to pay such medical claims, the**
55 **hospital or healthcare provider may request that the director seek an**
56 **order to garnish the individual's wages. The director shall send the**
57 **individual notice within fifteen days of receiving such claim and the**
58 **individual may request a hearing to contest payment from the escrow**
59 **account or the attachment of wages. If a hearing is not requested**
60 **within fifteen days of receiving the notice, the director may proceed to**
61 **make payment from the escrow account or seek an order for**
62 **attachment of wages, or both. If a hearing is requested, the hearing**
63 **shall be deemed to be a contested case and the procedures applicable**
64 **to the processing of such hearings and determinations shall be those**
65 **established by chapter 536, RSMo. Final decisions of the director of the**
66 **department of revenue under this section shall be subject to review on**
67 **the record by the circuit court under chapter 536, RSMo.**

68 **6. The director of the department of revenue shall close the**
69 **account and remit the remaining funds to the individual within six**
70 **months of receiving notification that the individual has:**

71 **(1) Elected to comply with the requirement in subsection 1 of**
72 **this section by submitting proof of insurance coverage in accordance**
73 **with subdivision (1) of subsection 2 of this section; or**

74 **(2) Is no longer subject to subsection 1 of this section by reason**
75 **of no longer being a resident of Missouri.**

76 **7. If the director of the department of revenue determines that**
77 **an individual for whom an account has been established has not been**
78 **a resident of Missouri for a consecutive period of thirty-six months or**
79 **more, the director of the department of revenue shall close the account**
80 **and remit the remaining funds to the individual, or if the director of**
81 **the department of revenue cannot locate the individual, shall dispose**
82 **of the funds in accordance with the provisions of sections 447.500 to**
83 **447.595, RSMo.**

✓

Bill

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