SECOND REGULAR SESSION

SENATE BILL NO. 608

96TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR WASSON.

Read 1st time January 5, 2012, and ordered printed.

TERRY L. SPIELER, Secretary.

4704S.03I

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 new sections, to be known as sections 376.1600, 376.1603, 376.1606, 376.1609, 376.1612, 376.1615, 376.1618, 376.1621, 376.1624, 376.1627, 376.1630, 376.1633, 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 context clearly indicates otherwise, the following terms shall mean:

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

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

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

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

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

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

(a) An employer sponsored plan;

(b) A health benefit plan;

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

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

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

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

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

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

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

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

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

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

(7) "Dependent":

(a) The spouse of the principal insured; or

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

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

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

(8) "Director", the director of the department of insurance, financial institutions and professional registration;

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

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

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

(b) Files payroll tax information on those persons;

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

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

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

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

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

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

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

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

(d) Workers' compensation or similar insurance;

(e) Medical expense and loss of income benefits;

(f) Credit-only insurance; and

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

secondary or incidental to other insurance benefits;

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

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

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

(b) That is sponsored by an employer; and

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

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

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

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

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

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

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

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

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

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

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

time student attending an institution outside of the state.

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

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

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

(1) The director of the department of insurance, financial institutions and professional registration, ex officio;

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

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

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

board by the governor, one shall be:

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

(b) A health economist;

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

(d) A representative of a health consumer organization;

(e) An employee health benefits plan specialist; and

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

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

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

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

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

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

reckless act affecting the property or rights of any person.

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

(1) Administer all of the exchange's activities and contracts;

(2) Establish procedures for operations of the exchange;

(3) Prepare an annual budget for the exchange;

(4) Enter into contracts with public or private entities to carry out the duties of the exchange, including contracts to administer applications, eligibility verification, enrollment, and premium payments for specific groups or populations. Any organization that the exchange board enters into a contract with to administer any of the functions or duties of the exchange shall not be a carrier that offers a participating plan through the exchange. The exchange board shall not have the authority to enter into contracts with healthcare providers;

(5) Take any legal action necessary or proper on behalf of the exchange;

(6) Hire or contract with appropriate legal, actuarial, administrative personnel, and other advisors to provide technical assistance in the management and operation of the exchange;

(7) Establish and execute a line of credit, and establish one or more cash and investment accounts to carry out the duties of the exchange;

(8) Establish and collect administrative fees from carriers based on the number of persons covered by the plans or plans offered through the exchange by the carrier sufficient to fund the costs of administering the exchange;

(9) Apply for grants from public and private entities;

(10) Contract with sponsoring employers of participating employer plans to act as the plan's administrator;

(11) Establish procedures for the enrollment of eligible individuals, employers, groups, and local government employees;

(12) Establish and manage a system for collecting premium payments made by, or on behalf of, individuals obtaining health

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

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

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

(1) Providing information on the exchange to applicants;

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

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

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

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

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

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

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

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

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

(b) Forms and instructions for electing coverage and arranging

payment for coverage; and

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

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

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

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

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

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

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

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

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

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

(2) A segregated operations account for:

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

by or on behalf of participating individuals; and

(b) The disbursement:

a. Of premium payments to participating plans; and

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

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

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

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

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

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

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

instrumentalities, officers, or employees.

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

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

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

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

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

health benefit plan of similar quality and benefits.

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

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

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

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

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

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

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

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

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

under the provisions of this section.

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

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

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

12. The exchange shall begin offering health benefit plans approved under this section beginning January 1, 2013.

13. The director shall promulgate regulations for certifying plans to participate in the exchange. Any rule or portion of a rule, as that term is defined in section 536.010 that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2012, shall be invalid and void.

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

(1) The individual is a resident of Missouri;

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

(3) The individual is enrolled in, or is eligible to enroll in, a

participating employer plan;

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

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

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

2. Any individual enrolled in the Missouri health insurance pool created under sections 376.960 to 376.989 as of January 1, 2014, shall not be eligible to receive coverage through the exchange. If such individual ceases to be eligible for coverage under the Missouri health insurance pool after January 1, 2014, the individual may be eligible for coverage through the exchange if he or she otherwise qualifies under the provisions of this section.

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

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

3. An eligible individual may enroll in a health benefit plan offered through the exchange, subject to the provisions of section 376.1630, without a waiting period, and may not be declined coverage, at a time other than the annual open season for any of the following

reasons, provided the individual does so within sixty-three days of the triggering event:

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

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

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

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

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

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

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

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

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

(1) Except as otherwise specified in subdivisions (3) and (4) of this section, during any open season a participating individual who elects to choose a different participating insurance plan or plan option for the next plan year, the individual shall not be subject to any preexisting condition provisions and shall be charged the standard rate of the new participating plan or plan option for persons of the participating individual's age and geographic area. The same shall

apply to any election by a participating individual of coverage for any dependent who is also a participating individual;

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

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

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

(5) In cases where an individual is enrolled in a plan offered through the exchange as a newly eligible dependent of a participating individual, by reason of birth, adoption, court order, or a change in custody arrangement, either during open season or outside of open season in accordance with section 376.1627, a carrier shall not impose any preexisting condition provisions or any change in the rate charged to the participating individual, except for such difference, if any, in the participating insurance plan's standard rates that reflect the addition

of a new dependent to the participating individual's coverage;

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

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

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

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

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

(1) The individual remains an eligible individual; and

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) The employer agrees that, for the term of the agreement, the employer will not offer to individuals eligible to participate in the exchange due to their eligibility for coverage under the employer's participating employer plan any separate or competing group health plan offering the same or substantially similar benefits as those provided by participating plans through the exchange, whether or not

any of those individuals would otherwise qualify as eligible individuals absent their enrollment in the participating employer plan;

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

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

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

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

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

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

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

2. A membership organization, a professional organization, a trade association, or a civic association, may apply to the exchange on behalf of its members seeking enrollment in the exchange as

participating individuals. If the exchange enrolls any of those individuals, then the participating plan chosen by the individual shall pay the membership organization the commission provided for in subsection 4 of this section.

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

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

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

2. Commencing January 1, 2014, carriers offering participating plans through the health insurance exchange shall be eligible to receive reimbursement from the direct payment stop loss fund for seventy percent of claims paid between fifty thousand and one hundred thousand dollars in a calendar year for any participating individual covered under a participating plan issued through the health insurance exchange.

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

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

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

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

7. In the event that the total amount requested for reimbursement by all carriers for a calendar year exceeds funds available for distribution for claims paid by all carriers during that same calendar year, the director shall provide for the pro-rata

distribution of the available funds. Each carrier shall be eligible to receive only such proportionate amount of the available funds as the individual carrier's total eligible claims paid bears to the total eligible claims paid by all carriers.

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

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

10. The director may obtain the services of an organization to administer the direct payment stop loss fund. The director shall establish guidelines for the submission of proposals by organizations for the purposes of administering the fund. The director shall make a determination whether to approve, disapprove, or recommend modification to the proposal of an applicant to administer the fund. An organization approved to administer the fund shall submit reports to the director in such form and at times as may be required by the director in order to facilitate evaluation and ensure orderly operation of the fund, including, but not limited to, an annual report of the affairs and operations of the fund, such report to be delivered to the director, the house budget committee chair, and the senate appropriations committee chair. An organization approved to administer the fund shall maintain records in a form prescribed by the director and which shall be available for inspection by or at the request of the director. The director shall determine the amount of compensation to be allocated to an approved organization as payment for fund administration. Compensation shall be payable from the direct payment stop loss fund. An organization approved to administer the fund may be removed by the director and shall cooperate in the orderly transition of services to another approved organization or to the director.

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

12. Beginning January 1, 2015, and annually thereafter, the director shall submit a report to the general assembly evaluating the effectiveness of the direct stop loss fund. The report shall include any recommendations that the director deems relevant. The report, however, shall contain recommendations whether the reinsurance threshold or attachment point delineated in this section shall be lowered and the reinsurance corridor be expanded to lower premium costs and assist carriers with combating adverse selection or whether the threshold should be increased in order to protect the solvency of the fund.

13. The director is authorized to promulgate rules and regulations to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010 that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2012, shall be invalid and void.

376.1850. 1. Each employer in Missouri shall annually file with the director of the department of insurance, financial institutions and professional registration a form for each employee employed within this state indicating the health insurance coverage status of the employee and the employee's dependents including the source of coverage and the name of the insurer or plan sponsor and, if no coverage is indicated:

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

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

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

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

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

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

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

6. The director shall prepare and distribute such forms. The director shall promulgate rules and regulations to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010 that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking

authority and any rule proposed or adopted after August 28, 2012, shall be invalid and void.

376.1852. 1. On or after January 1, 2014, the following individuals who are twenty-one years of age or older and have not yet attained the age of sixty-five shall offer proof of their ability to pay for medical care for themselves and their dependents:

(1) Residents of this state; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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