

SECOND REGULAR SESSION

SENATE BILL NO. 1071

99TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR WIELAND.

Read 1st time February 28, 2018, and ordered printed.

ADRIANE D. CROUSE, Secretary.

6610S.01I

AN ACT

To repeal sections 376.960, 376.961, 376.962, 376.964, 376.966, 376.970, and 376.987, RSMo, and to enact in lieu thereof sixteen new sections relating to the Missouri reinsurance plan.

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

Section A. Sections 376.960, 376.961, 376.962, 376.964, 376.966, 376.970, and 376.987, RSMo, are repealed and sixteen new sections enacted in lieu thereof, to be known as sections 374.900, 374.905, 374.910, 374.915, 374.920, 374.925, 374.930, 374.935, 374.960, 376.960, 376.961, 376.962, 376.964, 376.966, 376.970, and 376.987, to read as follows:

374.900. 1. Sections 374.900 to 374.960 shall be known as the "Missouri Reinsurance Plan".

2. For the purposes of sections 374.900 to 374.960, the following terms shall mean:

(1) "Affordable Care Act", the federal Patient Protection and Affordable Health Care Act, as defined in section 376.1186;

(2) "Attachment point", an amount as provided in subdivision (2) of subsection 2 of section 374.910;

(3) "Benefit year", the calendar year for which an eligible health carrier provides coverage through an individual health insurance coverage;

(4) "Board", the board of directors of the reinsurance pool established under sections 376.960 to 376.989;

(5) "Coinsurance rate", the rate as provided in subdivision (3) of subsection 2 of section 374.910;

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

16 (6) "Department", the Missouri department of insurance, financial
17 institutions and professional registration;

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

20 (8) "Eligible health carrier", any of the following entities that
21 offer individual health plans, incur claims costs for individual health
22 plans, and incur claims costs for an individual enrollee's covered
23 benefits in the applicable benefit year:

24 (a) An insurance company licensed under section 375.014 to offer,
25 sell, or issue a policy of accident and sickness insurance as defined in
26 section 376.773;

27 (b) A nonprofit health service plan corporation operating under
28 section 354.090; or

29 (c) A health maintenance organization as defined in section
30 354.400;

31 (9) "Individual health plan", as defined in section 376.450;

32 (10) "Individual market", as defined in section 376.450;

33 (11) "Missouri reinsurance plan" or "plan", the state-based
34 reinsurance program authorized under section 374.910 and sections
35 376.960 to 376.989;

36 (12) "Payment parameters", the attachment point, reinsurance
37 cap, and coinsurance rate for the plan;

38 (13) "Reinsurance cap", the threshold amount as provided in
39 subdivision (4) of subsection 2 of section 374.910;

40 (14) "Reinsurance payments", an amount paid by the department
41 to an eligible health carrier under the plan.

 374.905. The director shall require eligible health carriers to
2 calculate the premium amount the eligible health carrier would have
3 charged for the benefit year if the Missouri reinsurance plan had not
4 been established. The eligible health carrier shall submit this
5 information as part of its rate filing. The director shall consider this
6 information as part of the rate review.

 374.910. 1. The department shall be Missouri's reinsurance entity
2 to monitor the board. The department shall:

3 (1) Have the authority to apply for any available federal funding
4 for the plan. The department shall notify the chairs and ranking
5 minority members of the legislative committees with jurisdiction over

6 health and senior services and insurance within ten days of receiving
7 any federal funds;

8 (2) Collect or access data from an eligible health carrier that is
9 necessary to determine reinsurance payments, according to the date
10 requirements under subdivision (3) of subsection 5 of this section;

11 (3) For each applicable benefit year, notify eligible health
12 carriers of reinsurance payments to be made for the applicable benefit
13 year no later than June thirtieth of the year following the applicable
14 benefit year;

15 (4) On a quarterly basis during the applicable benefit year,
16 provide each eligible health carrier with the calculation of total
17 reinsurance payment requests; and

18 (5) By August fifteenth of the year following the applicable
19 benefit year, disburse all applicable reinsurance payments to an
20 eligible health carrier.

21 2. The board shall design and adjust the payment parameters to
22 ensure the payment parameters:

23 (1) Will stabilize or reduce premium rates in the individual
24 market;

25 (2) Will increase participation in the individual market;

26 (3) Will improve access to health care providers and services for
27 those in the individual market;

28 (4) Mitigate the impact high-risk individuals have on premium
29 rates in the individual market;

30 (5) Take into account any federal funding available for the plan;
31 and

32 (6) Take into account the total amount available to fund the plan.

33 3. (1) The board shall determine the payment parameters for the
34 next benefit year by January fifteenth of the year before the applicable
35 benefit year.

36 (2) If the amount in the Missouri reinsurance fund established
37 under section 374.920 is not anticipated to be adequate to fully fund the
38 approved payment parameters as of July first of the year before the
39 applicable benefit year, the director shall assess, under the provisions
40 of sections 376.960 to 376.989, to each insurer any additional funds due
41 that exceed available reinsurance funds. The director shall permit an
42 eligible health carrier to revise an applicable rate filing based on the

43 final payment parameters for the next benefit year.

44 4. Each reinsurance payment shall be calculated with respect to
45 an eligible health carrier's incurred claims costs for an individual
46 enrollee's covered benefits in the applicable benefit year. If the claims
47 costs do not exceed the attachment point, the reinsurance payment is
48 zero dollars. If the claims costs exceed the attachment point, the
49 reinsurance payment shall be calculated as the product of the
50 coinsurance rate and the lesser of the claims costs minus the
51 attachment point or the reinsurance cap minus the attachment
52 point. The board shall ensure that reinsurance payments made to
53 eligible health carriers do not exceed the total amount paid by the
54 eligible health carrier for an eligible claim.

55 5. (1) An eligible health carrier may request reinsurance
56 payments from the department when the eligible health carrier meets
57 the requirements of this subsection and subsection 4 of this section.

58 (2) An eligible health carrier shall make requests for reinsurance
59 payments in accordance with any requirements established by the
60 department.

61 (3) An eligible health carrier shall provide the department with
62 access to the data within the dedicated data environment established
63 by the eligible health carrier under the federal risk adjustment
64 program under 42 U.S.C. Section 18063. Eligible health carriers shall
65 submit an attestation to the department asserting compliance with the
66 dedicated data environments, data requirements, establishment and
67 usage of masked enrollee identification numbers, and data submission
68 deadlines.

69 (4) An eligible health carrier shall provide the access described
70 in subdivision (3) of this section for the applicable benefit year by April
71 thirtieth of each year following the applicable benefit year.

72 (5) An eligible health carrier shall maintain documents and
73 records, whether paper, electronic, or in other media, sufficient to
74 substantiate the requests for reinsurance payments made under this
75 section for a period of at least six years. An eligible health carrier
76 shall also make those documents and records available upon request
77 from the director for the purposes of verification, investigation, audit,
78 or other review of reinsurance payment requests.

79 (6) The department shall have an eligible health carrier audited

80 to assess the health carrier's compliance with the requirements of this
81 section when there is evidence of noncompliance. The eligible health
82 carrier shall ensure that its contractors, subcontractors, or agents
83 cooperate with any audit under this section. If an audit results in a
84 proposed finding of material weakness or significant deficiency with
85 respect to compliance with any requirement of this section, the eligible
86 health carrier may provide a response to the proposed finding within
87 thirty days. Within thirty days of the issuance of a final audit report
88 that includes a finding of material weakness or significant deficiency,
89 the eligible health carrier shall:

- 90 (a) Provide a written corrective action plan to the department
91 for approval;
92 (b) Implement the approved plan; and
93 (c) Provide the department with written documentation that the
94 eligible health carrier has taken corrective action.

374.915. 1. The department shall keep an accounting for each
2 benefit year that illustrates:

- 3 (1) Funds appropriated for reinsurance payments and
4 administrative and operational expenses related to the administration
5 of the plan;
6 (2) Requests for reinsurance payments received from eligible
7 health carriers;
8 (3) Reinsurance payments made to eligible health carriers; and
9 (4) Administrative and operational expenses incurred for the
10 plan.

11 2. The director shall make available to the public a report
12 summarizing the plan operations for each benefit year by posting the
13 summary on the department's web page and making the summary
14 otherwise available by November first of the year following the
15 applicable benefit year or sixty calendar days following the final
16 disbursement of reinsurance payments for the applicable benefit year,
17 whichever is later.

18 3. (1) The department shall engage and cooperate with an
19 independent certified public accountant or certified public accountant
20 firm licensed or permitted to perform an audit for each benefit year of
21 the plan. The audit shall, at a minimum:

- 22 (a) Assess compliance with the requirements of sections 374.905

23 to 374.920; and

24 (b) Identify any material weaknesses or significant deficiencies
25 and address manners in which to correct any such weaknesses or
26 deficiencies.

27 (2) The department, after receiving the completed audit, shall:

28 (a) Provide the director with the results of the audit;

29 (b) Identify to the director any material weaknesses or
30 significant deficiencies identified in the audit and address, in writing,
31 how the department intends to correct any such weakness or
32 deficiency, in compliance with subsection 4 of this section; and

33 (c) Make public the results of the audit, to the extent that the
34 audit contains government data that is public, including any material
35 weaknesses or significant deficiencies and how the department intends
36 to correct any such weakness or deficiency, by posting the audit results
37 on the department web page and making the audit results otherwise
38 available.

39 4. (1) If an audit results in a finding of material weakness or
40 significant deficiency with respect to compliance by the department
41 with any requirement under sections 374.905 to 374.920, the department
42 shall:

43 (a) Create a written corrective action plan to be approved by the
44 director within sixty days of the completed audit;

45 (b) Implement the corrective action plan; and

46 (c) Record written documentation of the corrective actions
47 taken.

48 (2) By December first of each year, the department shall submit
49 a report to the standing committees of the legislature having
50 jurisdiction over health and senior services and insurance regarding
51 any finding of material weakness or significant deficiency found in an
52 audit.

374.920. 1. There is hereby created in the state treasury the
2 "Missouri Reinsurance Fund", which shall consist of moneys collected
3 under sections 374.900 to 374.960. The state treasurer shall be
4 custodian of the fund. In accordance with sections 30.170 and 30.180,
5 the state treasurer may approve disbursements. The fund shall be a
6 dedicated fund and, upon appropriation, moneys in the fund shall be
7 used solely for the administration of sections 374.900 to 374.960 and

8 376.960 to 376.989.

9 2. Notwithstanding the provisions of section 33.080 to the
10 contrary, any moneys remaining in the fund at the end of the biennium
11 shall not revert to the credit of the general revenue fund.

12 3. The state treasurer shall invest moneys in the fund in the
13 same manner as other funds are invested. Any interest and moneys
14 earned on such investments shall be credited to the fund.

374.925. 1. The director shall apply to the Secretary of Health
2 and Human Services under 42 U.S.C. Section 18052 for a state
3 innovation waiver to implement the Missouri reinsurance plan for
4 benefit years beginning January 1, 2019, and future years, to maximize
5 federal funding for the plan. The waiver application shall clearly state
6 the implementation of sections 376.960 to 376.989 is contingent on
7 approval of the waiver request.

8 2. In developing the waiver application, the director shall
9 consult with the director of the department of health and senior
10 services.

11 3. The director shall submit the waiver application to the
12 Secretary of Health and Human Services on or before June 15, 2019.

374.930. A state department that incurs administrative costs to
2 implement any provision of sections 374.900 to 374.960 or sections
3 376.960 to 376.989 that does not receive an appropriation for
4 administrative costs of this act shall implement the act within the
5 limits of existing appropriations.

374.935. If the state innovation waiver request in section 374.925
2 is not approved, the department shall not administer the plan nor
3 provide reinsurance payments to the eligible health carriers.

374.960. The department may promulgate rules for the
2 implementation of sections 374.900 to 374.960 and 376.960 to
3 376.989. Any rule or portion of a rule, as that term is defined in section
4 536.010, that is created under the authority delegated in this section
5 shall become effective only if it complies with and is subject to all of
6 the provisions of chapter 536, and, if applicable, section 536.028. This
7 section and chapter 536 are nonseverable, and if any of the powers
8 vested with the general assembly pursuant to chapter 536 to review, to
9 delay the effective date, or to disapprove and annul a rule are
10 subsequently held unconstitutional, then the grant of rulemaking

11 **authority and any rule proposed or adopted after August 28, 2018, shall**
12 **be invalid and void.**

376.960. As used in sections 376.960 to 376.989, the following terms
2 mean:

- 3 (1) "Benefit plan", the coverages to be offered by the pool to eligible
4 persons pursuant to the provisions of section 376.986;
- 5 (2) "Board", the board of directors of the pool;
- 6 (3) "Church plan", a plan as defined in Section 3(33) of the Employee
7 Retirement Income Security Act of 1974, as amended;
- 8 (4) "Creditable coverage", with respect to an individual:
- 9 (a) Coverage of the individual provided under any of the following:
- 10 a. A group health plan;
- 11 b. Health insurance coverage;
- 12 c. Part A or Part B of Title XVIII of the Social Security Act;
- 13 d. Title XIX of the Social Security Act, other than coverage consisting
14 solely of benefits under Section 1928;
- 15 e. Chapter 55 of Title 10, United States Code;
- 16 f. A medical care program of the Indian Health Service or of a tribal
17 organization;
- 18 g. A state health benefits risk pool;
- 19 h. A health plan offered under Chapter 89 of Title 5, United States Code;
- 20 i. A public health plan as defined in federal regulations; or
- 21 j. A health benefit plan under Section 5(e) of the Peace Corps Act, 22
22 U.S.C. 2504(e);
- 23 (b) Creditable coverage does not include coverage consisting solely of
24 excepted benefits;
- 25 (5) "Department", the Missouri department of insurance, financial
26 institutions and professional registration;
- 27 (6) "Dependent", a resident spouse or resident unmarried child under the
28 age of nineteen years, a child who is a student under the age of twenty-five years
29 and who is financially dependent upon the parent, or a child of any age who is
30 disabled and dependent upon the parent;
- 31 (7) "Director", the director of the Missouri department of insurance,
32 financial institutions and professional registration;
- 33 (8) "Excepted benefits":
- 34 (a) Coverage only for accident, including accidental death and

35 dismemberment, insurance;

36 (b) Coverage only for disability income insurance;

37 (c) Coverage issued as a supplement to liability insurance;

38 (d) Liability insurance, including general liability insurance and

39 automobile liability insurance;

40 (e) Workers' compensation or similar insurance;

41 (f) Automobile medical payment insurance;

42 (g) Credit-only insurance;

43 (h) Coverage for on-site medical clinics;

44 (i) Other similar insurance coverage, as approved by the director, under

45 which benefits for medical care are secondary or incidental to other insurance

46 benefits;

47 (j) If provided under a separate policy, certificate or contract of insurance,

48 any of the following:

49 a. Limited scope dental or vision benefits;

50 b. Benefits for long-term care, nursing home care, home health care,

51 community-based care, or any combination thereof;

52 c. Other similar, limited benefits as specified by the director;

53 (k) If provided under a separate policy, certificate or contract of insurance,

54 any of the following:

55 a. Coverage only for a specified disease or illness;

56 b. Hospital indemnity or other fixed indemnity insurance;

57 (l) If offered as a separate policy, certificate or contract of insurance, any

58 of the following:

59 a. Medicare supplemental coverage (as defined under Section 1882(g)(1)

60 of the Social Security Act);

61 b. Coverage supplemental to the coverage provided under Chapter 55 of

62 Title 10, United States Code;

63 c. Similar supplemental coverage provided to coverage under a group

64 health plan;

65 (9) "Federally defined eligible individual", an individual:

66 (a) For whom, as of the date on which the individual seeks coverage

67 through the pool, the aggregate of the periods of creditable coverage as defined

68 in this section is eighteen or more months and whose most recent prior creditable

69 coverage was under a group health plan, governmental plan, church plan, or

70 health insurance coverage offered in connection with any such plan;

71 (b) Who is not eligible for coverage under a group health plan, Part A or
72 Part B of Title XVIII of the Social Security Act, or state plan under Title XIX of
73 such act or any successor program, and who does not have other health insurance
74 coverage;

75 (c) With respect to whom the most recent coverage within the period of
76 aggregate creditable coverage was not terminated because of nonpayment of
77 premiums or fraud;

78 (d) Who, if offered the option of continuation coverage under COBRA
79 continuation provision or under a similar state program, both elected and
80 exhausted the continuation coverage;

81 (10) "Governmental plan", a plan as defined in Section 3(32) of the
82 Employee Retirement Income Security Act of 1974 and any federal governmental
83 plan;

84 (11) "Group health plan", an employee welfare benefit plan as defined in
85 Section 3(1) of the Employee Retirement Income Security Act of 1974 and Public
86 Law 104-191 to the extent that the plan provides medical care and including
87 items and services paid for as medical care to employees or their dependents as
88 defined under the terms of the plan directly or through insurance, reimbursement
89 or otherwise, but not including excepted benefits;

90 (12) "Health insurance", any hospital and medical expense incurred policy,
91 nonprofit health care service for benefits other than through an insurer, nonprofit
92 health care service plan contract, health maintenance organization subscriber
93 contract, preferred provider arrangement or contract, or any other similar
94 contract or agreement for the provisions of health care benefits. The term "health
95 insurance" does not include accident, fixed indemnity, limited benefit or credit
96 insurance, coverage issued as a supplement to liability insurance, insurance
97 arising out of a workers' compensation or similar law, automobile
98 medical-payment insurance, or insurance under which benefits are payable with
99 or without regard to fault and which is statutorily required to be contained in any
100 liability insurance policy or equivalent self-insurance;

101 (13) "Health maintenance organization", any person which undertakes to
102 provide or arrange for basic and supplemental health care services to enrollees
103 on a prepaid basis, or which meets the requirements of section 1301 of the United
104 States Public Health Service Act;

105 (14) "Hospital", a place devoted primarily to the maintenance and
106 operation of facilities for the diagnosis, treatment or care for not less than

107 twenty-four hours in any week of three or more nonrelated individuals suffering
108 from illness, disease, injury, deformity or other abnormal physical condition; or
109 a place devoted primarily to provide medical or nursing care for three or more
110 nonrelated individuals for not less than twenty-four hours in any week. The term
111 "hospital" does not include convalescent, nursing, shelter or boarding homes, as
112 defined in chapter 198;

113 (15) "Insurance arrangement", any plan, program, contract or other
114 arrangement under which one or more employers, unions or other organizations
115 provide to their employees or members, either directly or indirectly through a
116 trust or third party administration, health care services or benefits other than
117 through an insurer;

118 (16) "Insured", any individual resident of this state who is eligible to
119 receive benefits from any insurer or insurance arrangement, as defined in this
120 section;

121 (17) "Insurer", any insurance company authorized to transact health
122 insurance business in this state, any nonprofit health care service plan act, or
123 any health maintenance organization;

124 (18) "Medical care", amounts paid for:

125 (a) The diagnosis, care, mitigation, treatment, or prevention of disease,
126 or amounts paid for the purpose of affecting any structure or function of the body;

127 (b) Transportation primarily for and essential to medical care referred to
128 in paragraph (a) of this subdivision; and

129 (c) Insurance covering medical care referred to in paragraphs (a) and (b)
130 of this subdivision;

131 (19) "Medicare", coverage under both part A and part B of Title XVIII of
132 the Social Security Act, 42 U.S.C. 1395 et seq., as amended;

133 (20) "Member", all insurers and insurance arrangements participating in
134 the pool;

135 (21) "Physician", physicians and surgeons licensed under chapter 334 or
136 by state board of healing arts in the state of Missouri;

137 (22) "Plan of operation", the plan of operation of the pool, including
138 articles, bylaws and operating rules, adopted by the board pursuant to the
139 provisions of sections 376.961, 376.962 and 376.964;

140 (23) "Pool", the state [health insurance] **reinsurance** pool created in
141 sections 376.961, 376.962 and 376.964;

142 (24) "Resident", an individual who has been legally domiciled in this state

143 for a period of at least thirty days, except that for a federally defined eligible
144 individual, there shall not be a thirty-day requirement;

145 (25) "Significant break in coverage", a period of sixty-three consecutive
146 days during all of which the individual does not have any creditable coverage,
147 except that neither a waiting period nor an affiliation period is taken into account
148 in determining a significant break in coverage;

149 (26) "Trade act eligible individual", an individual who is eligible for the
150 federal health coverage tax credit under the Trade Act of 2002, Public Law
151 107-210.

376.961. 1. There is hereby created a nonprofit entity to be known as the
2 "Missouri [Health Insurance] **Reinsurance** Pool". All insurers issuing health
3 insurance in this state and insurance arrangements providing health plan
4 benefits in this state shall be members of the pool.

5 2. Beginning January 1, [2007] **2019**, the board of directors shall consist
6 of the director of the department of insurance, financial institutions and
7 professional registration or the director's designee, and eight members appointed
8 by the director. Of the initial eight members appointed, three shall serve a
9 three-year term, three shall serve a two-year term, and two shall serve a one-year
10 term. All subsequent appointments to the board shall be for three-year
11 terms. Members of the board shall have a background and experience in health
12 insurance plans or health maintenance organization plans, in health care finance,
13 or as a health care provider or a member of the general public; except that, the
14 director shall not be required to appoint members from each of the categories
15 listed. The director may reappoint members of the board. The director shall fill
16 vacancies on the board in the same manner as appointments are made at the
17 expiration of a member's term and may remove any member of the board for
18 neglect of duty, misfeasance, malfeasance, or nonfeasance in office.

19 3. Beginning August 28, [2007] **2019**, the board of directors shall consist
20 of fourteen members. The board shall consist of the director and the eight
21 members described in subsection 2 of this section and shall consist of the
22 following additional five members:

23 (1) One member from a hospital located in Missouri, appointed by the
24 governor, with the advice and consent of the senate;

25 (2) Two members of the senate, with one member from the majority party
26 appointed by the president pro tem of the senate and one member of the minority
27 party appointed by the president pro tem of the senate with the concurrence of

28 the minority floor leader of the senate; and

29 (3) Two members of the house of representatives, with one member from
30 the majority party appointed by the speaker of the house of representatives and
31 one member of the minority party appointed by the speaker of the house of
32 representatives with the concurrence of the minority floor leader of the house of
33 representatives.

34 4. The members appointed under subsection 3 of this section shall serve
35 in an ex officio capacity. The terms of the members of the board of directors
36 appointed under subsection 3 of this section shall expire on December 31, [2009]
37 **2021**. On such date, the membership of the board shall revert back to nine
38 members as provided for in subsection 2 of this section.

39 5. Beginning on August 28, [2013] **2019**, the board of directors, on behalf
40 of the pool, the executive director, and any other employees of the pool, shall have
41 the authority to provide assistance or resources to any department, agency, public
42 official, employee, or agent of the federal government for the specific purpose of
43 transitioning individuals enrolled in the pool to coverage outside of the pool
44 [beginning on or before January 1, 2014]. Such authority does not extend to
45 authorizing the pool to implement, establish, create, administer, or otherwise
46 operate a state-based exchange.

376.962. 1. The board of directors on behalf of the pool shall submit to
2 the director a plan of operation for the pool and any amendments thereto
3 necessary or suitable to assure the fair, reasonable and equitable administration
4 of the pool. After notice and hearing, the director shall approve the plan of
5 operation, provided it is determined to be suitable to assure the fair, reasonable
6 and equitable administration of the pool, and it provides for the sharing of pool
7 gains or losses on an equitable proportionate basis. The plan of operation shall
8 become effective upon approval in writing by the director consistent with the date
9 on which the coverage under sections 376.960 to 376.989 becomes available. If
10 the pool fails to submit a suitable plan of operation within one hundred eighty
11 days after the appointment of the board of directors, or at any time thereafter
12 fails to submit suitable amendments to the plan, the director shall, after notice
13 and hearing, adopt and promulgate such reasonable rules as are necessary or
14 advisable to effectuate the provisions of this section. Such rules shall continue
15 in force until modified by the director or superseded by a plan submitted by the
16 pool and approved by the director.

17 2. In its plan, the board of directors of the pool shall:

18 (1) Establish procedures for the handling and accounting of assets and
19 moneys of the pool;

20 (2) Select an administering insurer or third-party administrator in
21 accordance with section 376.968;

22 (3) Establish procedures for filling vacancies on the board of directors; and

23 (4) Establish procedures for the collection of assessments, **required in**
24 **addition to any funds received under the provisions of section 374.900**
25 **to 374.960**, from all members to provide for claims paid under the plan and for
26 administrative expenses incurred or estimated to be incurred during the period
27 for which the assessment is made. The level of payments shall be established by
28 the board pursuant to the provisions of section 376.973. Assessment shall occur
29 at the end of each calendar year and shall be due and payable within thirty days
30 of receipt of the assessment notice.

31 [3. On or before September 1, 2013, the board shall submit the
32 amendments to the plan of operation as are necessary or suitable to ensure a
33 reasonable transition period to allow for the termination of issuance of policies
34 by the pool.

35 4. The amendments to the plan of operation submitted by the board shall
36 include all of the requirements outlined in subsection 2 of this section and shall
37 address the transition of individuals covered under the pool to alternative health
38 insurance coverage as it is available after January 1, 2014. The plan of operation
39 shall also address procedures for finalizing the financial matters of the pool,
40 including assessments, claims expenses, and other matters identified in
41 subsection 2 of this section.

42 5. The director shall review the plan of operation submitted under
43 subsection 3 of this section and shall promulgate rules to effectuate the
44 transitional plan of operation. Such rules shall be effective no later than October
45 1, 2013. Any rule or portion of a rule, as that term is defined in section 536.010,
46 that is created under the authority delegated in this section shall become effective
47 only if it complies with and is subject to all of the provisions of chapter 536 and,
48 if applicable, section 536.028. This section and chapter 536 are nonseverable and
49 if any of the powers vested with the general assembly pursuant to chapter 536 to
50 review, to delay the effective date, or to disapprove and annul a rule are
51 subsequently held unconstitutional, then the grant of rulemaking authority and
52 any rule proposed or adopted after August 28, 2013, shall be invalid and void.]

376.964. The board of directors and administering insurers of the pool

2 shall have the general powers and authority granted under the laws of this state
3 to insurance companies licensed to transact health insurance as defined in section
4 376.960, and, in addition thereto, the specific authority to:

5 (1) Enter into contracts as are necessary or proper to carry out the
6 provisions and purposes of sections 376.960 to 376.989, including the authority,
7 with the approval of the director, to enter into contracts with similar pools of
8 other states for the joint performance of common administrative functions, or with
9 persons or other organizations for the performance of administrative functions;

10 (2) Sue or be sued, including taking any legal actions necessary or proper
11 for recovery of any assessments for, on behalf of, or against pool members;

12 (3) Take such legal actions as necessary to avoid the payment of improper
13 claims against the pool or the coverage provided by or through the pool;

14 (4) Establish appropriate rates, rate schedules, rate adjustments, expense
15 allowances, agents' referral fees, claim reserve formulas and any other actuarial
16 function appropriate to the operation of the pool. Rates shall not be unreasonable
17 in relation to the coverage provided, the risk experience and expenses of
18 providing the coverage. Rates and rate schedules may be adjusted for appropriate
19 risk factors such as age and area variation in claim costs and shall take into
20 consideration appropriate risk factors in accordance with established actuarial
21 and underwriting practices;

22 (5) Assess members of the pool in accordance with the provisions of this
23 section, and to make advance interim assessments as may be reasonable and
24 necessary for the organizational and interim operating expenses. Any such
25 interim assessments are to be credited as offsets against any regular assessments
26 due following the close of the fiscal year;

27 (6) [Prior to January 1, 2014,] Issue policies of insurance in accordance
28 with the requirements of sections 376.960 to 376.989[. In no event shall new
29 policies of insurance be issued on or after January 1, 2014];

30 (7) Appoint, from among members, appropriate legal, actuarial and other
31 committees as necessary to provide technical assistance in the operation of the
32 pool, policy or other contract design, and any other function within the authority
33 of the pool;

34 (8) Establish rules, conditions and procedures for reinsuring risks of pool
35 members desiring to issue pool plan coverages in their own name. Such
36 reinsurance facility shall not subject the pool to any of the capital or surplus
37 requirements, if any, otherwise applicable to reinsurers;

38 (9) Negotiate rates of reimbursement with health care providers on behalf
39 of the association and its members;

40 (10) Administer separate accounts to separate federally defined eligible
41 individuals and trade act eligible individuals who qualify for plan coverage from
42 the other eligible individuals entitled to pool coverage and apportion the costs of
43 administration among such separate accounts.

376.966. 1. No employee shall involuntarily lose his or her group coverage
2 by decision of his or her employer on the grounds that such employee may
3 subsequently enroll in the pool. The department shall have authority to
4 promulgate rules and regulations to enforce this subsection.

5 2. [Prior to January 1, 2014,] The following individual persons shall be
6 eligible for coverage under the pool if they are and continue to be residents of this
7 state:

8 (1) An individual person who provides evidence of the following:

9 (a) A notice of rejection or refusal to issue substantially similar health
10 insurance for health reasons by at least two insurers; or

11 (b) A refusal by an insurer to issue health insurance except at a rate
12 exceeding the plan rate for substantially similar health insurance;

13 (2) A federally defined eligible individual who has not experienced a
14 significant break in coverage;

15 (3) A trade act eligible individual;

16 (4) Each resident dependent of a person who is eligible for plan coverage;

17 (5) Any person, regardless of age, that can be claimed as a dependent of
18 a trade act eligible individual on such trade act eligible individual's tax filing;

19 (6) Any person whose health insurance coverage is involuntarily
20 terminated for any reason other than nonpayment of premium or fraud, and who
21 is not otherwise ineligible under subdivision (4) of subsection 3 of this section. If
22 application for pool coverage is made not later than sixty-three days after the
23 involuntary termination, the effective date of the coverage shall be the date of
24 termination of the previous coverage;

25 (7) Any person whose premiums for health insurance coverage have
26 increased above the rate established by the board under paragraph (a) of
27 subdivision (1) of subsection 3 of this section;

28 (8) Any person currently insured who would have qualified as a federally
29 defined eligible individual or a trade act eligible individual between the effective
30 date of the federal Health Insurance Portability and Accountability Act of 1996,

31 Public Law 104-191 and the effective date of this act.

32 3. The following individual persons shall not be eligible for coverage under
33 the pool:

34 (1) Persons who have, on the date of issue of coverage by the pool, or
35 obtain coverage under health insurance or an insurance arrangement
36 substantially similar to or more comprehensive than a plan policy, or would be
37 eligible to have coverage if the person elected to obtain it, except that:

38 (a) This exclusion shall not apply to a person who has such coverage but
39 whose premiums have increased to one hundred fifty percent to two hundred
40 percent of rates established by the board as applicable for individual standard
41 risks;

42 (b) A person may maintain other coverage for the period of time the
43 person is satisfying any preexisting condition waiting period under a pool policy;
44 and

45 (c) A person may maintain plan coverage for the period of time the person
46 is satisfying a preexisting condition waiting period under another health
47 insurance policy intended to replace the pool policy;

48 (2) Any person who is at the time of pool application receiving health care
49 benefits under section 208.151;

50 (3) Any person having terminated coverage in the pool unless twelve
51 months have elapsed since such termination, unless such person is a federally
52 defined eligible individual;

53 (4) Any person on whose behalf the pool has paid out one million dollars
54 in benefits;

55 (5) Inmates or residents of public institutions, unless such person is a
56 federally defined eligible individual, and persons eligible for public programs;

57 (6) Any person whose medical condition which precludes other insurance
58 coverage is directly due to alcohol or drug abuse or self-inflicted injury, unless
59 such person is a federally defined eligible individual or a trade act eligible
60 individual;

61 (7) Any person who is eligible for Medicare coverage.

62 4. Any person who ceases to meet the eligibility requirements of this
63 section may be terminated at the end of such person's policy period.

64 5. If an insurer issues one or more of the following or takes any other
65 action based wholly or partially on medical underwriting considerations which is
66 likely to render any person eligible for pool coverage, the insurer shall notify all

67 persons affected of the existence of the pool, as well as the eligibility
68 requirements and methods of applying for pool coverage:

- 69 (1) A notice of rejection or cancellation of coverage;
70 (2) A notice of reduction or limitation of coverage, including restrictive
71 riders, if the effect of the reduction or limitation is to substantially reduce
72 coverage compared to the coverage available to a person considered a standard
73 risk for the type of coverage provided by the plan.

74 [6. Coverage under the pool shall expire on January 1, 2014.]

376.970. 1. The administering insurer shall serve for a period of three
2 years subject to removal for cause. At least one year prior to the expiration of
3 each three-year period of service by an administering insurer, the board shall
4 invite all insurers, including the current administering insurer, to submit bids
5 to serve as the administering insurer for the succeeding three-year
6 period. Selection of the administering insurer for the succeeding period shall be
7 made at least six months prior to the end of the current three-year period.

8 2. The administering insurer shall:

9 (1) Perform all eligibility and administrative claim-payment functions
10 relating to the pool;

11 (2) Establish a premium billing procedure for collection of premium from
12 insured persons. Billings shall be made on a period basis as determined by the
13 board;

14 (3) Perform all necessary functions to assure timely payment of benefits
15 to covered persons under the pool including:

16 (a) Making available information relating to the proper manner of
17 submitting a claim for benefits to the pool and distributing forms upon which
18 submission shall be made;

19 (b) Evaluating the eligibility of each claim for payment by the pool;

20 (4) Submit regular reports to the board regarding the operation of the
21 pool. The frequency, content and form of the report shall be determined by the
22 board;

23 (5) Following the close of each calendar year, determine net written and
24 earned premiums, the expense of administration, and the paid and incurred
25 losses for the year and report this information to the board and the department
26 on a form prescribed by the director;

27 (6) Be paid as provided in the plan of operation for its expenses incurred
28 in the performance of its services.

29 [3. On or before September 1, 2013, the board shall invite all insurers and
30 third-party administrators, including the current administering insurer, to
31 submit bids to serve as the administering insurer or third-party administrator for
32 the pool. Selection of the administering insurer or third-party administrator
33 shall be made prior to January 1, 2014.

34 4. Beginning January 1, 2014, the administering insurer or third-party
35 administrator shall:

36 (1) Submit to the board and director a detailed plan outlining the winding
37 down of operations of the pool. The plan shall be submitted no later than
38 January 31, 2014, and shall be updated quarterly thereafter;

39 (2) Perform all administrative claim-payment functions relating to the
40 pool;

41 (3) Perform all necessary functions to assure timely payment of benefits
42 to covered persons under the pool including:

43 (a) Making available information relating to the proper manner of
44 submitting a claim for benefits to the pool and distributing forms upon which
45 submission shall be made;

46 (b) Evaluating the eligibility of each claim for payment by the pool;

47 (4) Submit regular reports to the board regarding the operation of the
48 pool. The frequency, content and form of the report shall be determined by the
49 board;

50 (5) Following the close of each calendar year, determine the expense of
51 administration, and the paid and incurred losses for the year, and report such
52 information to the board and department on a form prescribed by the director;

53 (6) Be paid as provided in the plan of operation for its expenses incurred
54 in the performance of its services.]

376.987. 1. The board shall offer to all eligible persons for pool coverage
2 under section 376.966 the option of receiving health insurance coverage through
3 a high-deductible health plan and the establishment of a health savings account.
4 In order for a qualified individual to obtain a high-deductible health plan through
5 the pool, such individual shall present evidence, in a manner prescribed by
6 regulation, to the board that he or she has established a health savings account
7 in compliance with 26 U.S.C. Section 223, and any amendments and regulations
8 promulgated thereto.

9 2. As used in this section, the term "health savings account" shall have
10 the same meaning ascribed to it as in 26 U.S.C. Section 223(d), as amended. The

11 term "high-deductible health plan" shall mean a policy or contract of health
12 insurance or health care plan that meets the criteria established in 26 U.S.C.
13 Section 223(c)(2), as amended, and any regulations promulgated thereunder.

14 3. The board is authorized to promulgate rules and regulations for the
15 administration and implementation of this section. Any rule or portion of a rule,
16 as that term is defined in section 536.010, that is created under the authority
17 delegated in this section shall become effective only if it complies with and is
18 subject to all of the provisions of chapter 536 and, if applicable, section
19 536.028. This section and chapter 536 are nonseverable and if any of the powers
20 vested with the general assembly pursuant to chapter 536 to review, to delay the
21 effective date, or to disapprove and annul a rule are subsequently held
22 unconstitutional, then the grant of rulemaking authority and any rule proposed
23 or adopted after August 28, [2007] **2019**, shall be invalid and void.

✓

Bill

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