FIRST REGULAR SESSION

SENATE BILL NO. 566

98TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR SILVEY.

Read 1st time February 26, 2015, and ordered printed.

ADRIANE D. CROUSE, Secretary.

1414S.01I

AN ACT

To repeal sections 148.380, 197.310, 197.315, 197.330, 374.184, 376.960, 376.962, 376.966, 376.973, 376.975, 376.980, 376.984, 376.986, and 376.987, RSMo, and to enact in lieu thereof twenty-eight new sections relating to transformation of the health care market, with an emergency clause, and an effective date for certain sections.

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

Section A. Sections 148.380, 197.310, 197.315, 197.330, 374.184, 376.960, 376.962, 376.966, 376.973, 376.975, 376.980, 376.984, 376.986, and 376.987, RSMo, are repealed and twenty-eight new sections enacted in lieu thereof, to be known as sections 148.380, 191.1020, 191.1021, 191.1022, 191.1025, 191.1028, 191.1030, 197.310, 197.315, 197.330, 374.184, 376.960, 376.962, 376.966, 376.981, 376.983, 376.985, 376.986, 376.987, 376.991, 1, 2, 3, 4, 5, 6, 7, and 8, to read as follows:

148.380. 1. Every such company, on or before the first day of March in each year, shall make a return verified by the affidavit of its president and secretary, or other chief officers, to the director of the department of insurance, financial institutions and professional registration, stating the amount of all direct premiums received by it from policyholders in this state, whether in cash or in notes, during the year ending on the thirty-first day of December, next preceding. Upon receipt of such returns the director of the department of insurance, financial institutions and professional registration shall verify the same and certify the amount of the tax due from the various companies on the basis and at the rate provided in section 148.370, taking into consideration deductions and credits allowed by law, and shall certify the same to the director

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

of revenue together with the amount of the quarterly installments to be made as provided in subsection 2 of this section, on or before the thirtieth day of April of each year.

2. Beginning January 1, 1983, the amount of the tax due for that calendar year and each succeeding calendar year thereafter shall be paid in four approximately equal estimated quarterly installments, and a fifth reconciling installment. The first four installments shall be based upon the tax for the immediately preceding taxable year ending on the thirty-first day of December, next preceding. The quarterly installments shall be made on the first day of March, the first day of June, the first day of September and the first day of December. Immediately after receiving certification from the director of the department of insurance, financial institutions and professional registration of the amount of tax due from the various companies, the director of revenue shall notify and assess each company the amount of taxes on its premiums for the calendar year ending on the thirty-first day of December, next preceding. The director of revenue shall also notify and assess each company the amount of the estimated quarterly installments to be made for the calendar year. If the amount of the actual tax due for any year exceeds the total of the installments made for such year, the balance of the tax due shall be paid on the first day of June of the year following, together with the regular quarterly payment due at that time. If the total amount of the tax actually due is less than the total amount of the installments actually paid, the amount by which the amount paid exceeds the amount due shall be credited against the tax for the following year and deducted from the quarterly installment otherwise due on the first day of June. If the March first quarterly installment made by a company is less than the amount assessed by the director of revenue, the difference will be due on June first, but no interest will accrue to the state on the difference unless the amount paid by the company is less than eighty percent of one-fourth of the total amount of tax assessed by the director of revenue for the immediately preceding taxable year.

3. If the estimated quarterly tax installments are not so paid, the director of revenue shall notify the director of the department of insurance, financial institutions and professional registration who shall thereupon suspend such delinquent company from the further transaction of business in this state until such taxes shall be paid, and such companies shall be subject to the provisions of sections 148.410 to 148.461.

4. Upon receipt of the money the state treasurer shall receipt one-half thereof into the general revenue fund of the state, and one-half thereof to the

credit of the county foreign insurance fund for the purposes set forth in section 148.360. **Beginning in fiscal year 2016 and every fiscal year thereafter, moneys collected under this section in connection with the conduct of business in this state by a health carrier for premiums reported for any health benefit plan insurance products shall be distributed in accordance with section 376.991.**

5. As used in this section, "health benefit plan" and "health carrier" shall have the same meaning as defined in section 376.1350.

191.1020. As used in sections 191.1020 to 191.1030, the following terms shall mean:

(1) "Amount the provider plans to charge", the amount the provider would charge assuming that, in the provision of the planned service, no complications or unexpected events occurred necessitating the provision of any service other than the service or services planned, or of any service or services of increased intensity;

(2) "Comparative quality of care data", data on a provider's performance results on standard quality measures, which are relevant to a patient's current medical condition, adopted by the National Quality Forum (NQF) when available and when NQF measures do not exist, the next level of measures to be considered, to the extent practical, shall be those endorsed by the Ambulatory Quality Alliance (AQA), national accrediting organizations such as the National Committee for Quality Assurance (NCQA), or the Joint Commission and federal agencies;

(3) "Department", the department of insurance, financial institutions and professional registration;

(4) "Estimate of the allowed amount" or "estimated cost", the amount, if any, that the insurer has negotiated with the provider as payment in full for the provision of the ordered or planned service, assuming that, in the provision of the planned service, no complications or unexpected events occurred necessitating the provision of any service other than the service or services planned, or of any service or services of increased intensity, and further assuming that the services would be covered and approved by the patient's insurer, or, if not known, a good faith estimate of the same;

(5) "Estimate of the out-of-pocket amount the patient would be expected to pay for the planned service", the total amount, calculated

using all known payment information in the possession of the insurer and taking into account any known unmet deductible obligation and the particular provisions of the patient's insurance plan, the patient would pay for the planned service, assuming that, in the provision of the planned service, no complications or unexpected events occurred necessitating the provision of any service other than the service or services planned, or of any service or services of increased intensity, and further assuming that the services would be covered and approved by the patient's insurer, and, if there are more than one provider involved in the delivery of the service, a breakdown of the amounts the patient would pay to each provider, or, if not known, a good faith estimate of the same;

(6) "Health care provider" or "provider", the same meaning as such term is defined in section 376.1350 and home health agencies;

(7) "Insurer", the same meaning as the term "health carrier" is defined in section 376.1350;

(8) "Procedure volume", the number of procedures or discharges during the same time period during which the estimate of cost has been calculated;

(9) "Service", any planned treatment, series of treatments, diagnostic test, or surgical procedure.

191.1021. 1. (1) Any health care provider ordering or tentatively planning to provide a health care service shall, upon request, provide to the patient, or if the patient is a minor or incapacitated, to the patient's parent or guardian, for whom such service is ordered or planned, the following:

(a) The patient's diagnosis or diagnoses necessitating such service and the corresponding diagnosis code or codes, or if the provider did not order the services, those diagnoses and codes, if any, reported to the provider; and

(b) The name of the ordered or planned service and the procedure code or codes for the service if it is to be performed by the provider, and if known, for a service a provider is ordering; and

(c) If applicable, the name of the health care facility at which the provider expects the service to be performed or at which the provider plans to perform the service; and

(d) If applicable, the amount the provider plans to charge for the

services to be provided; and

(e) If known, an estimate of the allowed amount under the patient's insurance for the planned service.

(2) The provisions of this subsection shall not apply to health care services delivered on an emergency basis, to requests regarding services to be performed as part of ongoing inpatient care, or to services represented by evaluation and management codes as defined by the Current Procedural Terminology (CPT) Code Set published by the American Medical Association. Providers shall make their usual and customary charges for such evaluation and management services available to prospective patients upon request.

(3) Any health care provider who has not made a good faith effort to comply with the provisions of this subsection shall be subject to discipline or licensure sanction by the appropriate governing board for the health care provider and if such provider is a health care facility, shall be subject to licensure revocation or suspension.

2. (1) An insurer shall, upon request and upon receipt of the information required under subsection 1 of this section, provide to a patient, or if the patient is a minor or incapacitated, to the patient's parent or guardian, the following:

(a) An estimate of the allowed amount the insurer expects will be paid for the provision of the planned or ordered service to the following:

a. The provider of the service; and

b. Any health care facility participating in the provision of the service; and

c. All expected ancillary service providers, if any, participating in the provision of the service. Ancillary service providers shall include, but not be limited to, anesthesia, pathology, and radiology providers; and

(b) An estimate of the out-of-pocket amount the patient would be expected to pay for the planned service;

(c) For hospital services, the name of and code for the diagnosis-related group that would be applicable if the payer for the planned or ordered service were Medicare.

(2) The notification required under this subsection shall be completed within five business days of receipt of the request by the

insurer.

(3) In providing the estimate required in this subsection, the insurer shall clearly indicate that:

(a) The estimated cost is based on the information provided and on assumptions about typical utilization and costs;

(b) Because the estimated cost does not account for all the possible factors that could affect it, the actual amount billed may differ from the estimated cost;

(c) The estimated cost is not a guarantee of insurance coverage;

(d) The patient will be billed at the provider's charge for any service provided that is not a covered benefit under the patient's insurance; and

(e) The patient should contact the insurer for any needed help understanding the insurance benefits for the service planned or ordered.

(4) The provisions of this subsection shall only apply to requests made by patients covered by the insurer and referring to services to be performed by the insurer's participating providers.

(5) Any insurer that has not made a good faith effort to comply with the provisions of this subsection shall be subject to the provisions of section 374.280.

3. The department shall include a link on its website to any organization that provides quality of care data consistent with the provisions of sections 191.1000 to 191.1010 for health care providers upon request of such organization. By January 1, 2016, the department shall provide through its website, or through a link which may be provided by any willing entity, the Medicare fee schedule, by code and provider, for all Missouri Medicare providers, and for each Missouri hospital, the Medicare diagnosis-related-group payment for each code.

4. Nothing in this section shall be construed as preventing a patient from negotiating a fee for services that is less than the insurer's allowed amount. Services provided by a provider for a fee less than the allowed amount shall not be construed as a breach of any provider contract between a provider and insurer. Nothing in this section shall be construed as requiring an insurer to pay a provider more than a negotiated amount for a service or to pay for services provided by a provider not in the insurer's network.

191.1022. Nothing in sections 191.1020 to 191.1022 shall be construed as violating any provider contract provisions with a health carrier that prohibit disclosure of the provider's fee schedule with a health carrier to third parties.

191.1025. 1. For purposes of this section, "insurer" includes the state of Missouri for purposes of the rendering of health care services by providers under a medical assistance program of the state.

2. Programs of insurers that publicly assess and compare the quality and cost efficiency of health care providers shall conform to the following criteria:

(1) The insurers shall retain, at their own expense, the services of a nationally-recognized independent health care quality standard-setting organization to review the plan's programs for consumers that measure, report, and tier providers based on their performance. Such review shall include a comparison to national standards and a report detailing the measures and methodologies used by the health plan. The scope of the review shall encompass all elements described in this section and section 191.1028;

(2) The program measures shall provide performance information that reflects consumers' health needs. Programs shall clearly describe the extent to which they encompass particular areas of care, including primary care and other areas of specialty care;

(3) Performance reporting for consumers shall include both quality and cost efficiency information. While quality information may be reported in the absence of cost efficiency, cost efficiency information shall not be reported without accompanying quality information unless the cost provided is related to a discrete service, diagnostic test, or procedure;

(4) When any individual measures or groups of measures are combined, the individual scores, proportionate weighting, and any other formula used to develop composite scores shall be disclosed. Such disclosure shall be done both when quality measures are combined and when quality and cost efficiency are combined;

(5) Consumers or consumer organizations shall be solicited to provide input on the program, including methods used to determine performance strata;

(6) A clearly defined process for receiving and resolving

consumer complaints shall be a component of any program;

(7) Performance information presented to consumers shall include context, discussion of data limitations, and guidance on how to consider other factors in choosing a provider;

(8) Relevant providers and provider organizations shall be solicited to provide input on the program, including the methods used to determine performance strata;

(9) Providers shall be given reasonable prior notice before their individual performance information is publicly released;

(10) A clearly defined process for providers to request review of their own performance results and the opportunity to present information that supports what they believe to be inaccurate results, within a reasonable time frame, shall be a component of any program. Results determined to be inaccurate after the reconsideration process shall be corrected;

(11) Information about the comparative performance of providers shall be accessible and understandable to consumers and providers;

(12) Information about factors that might limit the usefulness of results shall be publicly disclosed;

(13) Measures used to assess provider performance and the methodology used to calculate scores or determine rankings shall be published and made readily available to the public. Some elements shall be assessed against national standards. Examples of measurement elements that shall be assessed against national standards include: risk and severity adjustment, minimum observations, and statistical standards utilized. Examples of other measurement elements that shall be fully disclosed include: data used, how providers' patients are identified, measure specifications and methodologies, known limitations of the data, and how episodes are defined;

(14) The rationale and methodologies supporting the unit of analysis reported shall be clearly articulated, including a group practice model versus the individual provider;

(15) Sponsors of provider measurement and reporting shall work collaboratively to aggregate data whenever feasible to enhance its consistency, accuracy, and use. Sponsors of provider measurement and reporting shall also work collaboratively to align and harmonize

measures used to promote consistency and reduce the burden of collection. The nature and scope of such efforts shall be publicly reported;

(16) The program shall be regularly evaluated to assess its effectiveness and any unintended consequences;

(17) Measures shall be based on national standards. The primary source shall be measures endorsed by the National Quality Forum (NQF). When non-NQF measures are used because NQF measures do not exist or are unduly burdensome, it shall be with the understanding that they will be replaced by comparable NQF-endorsed measures when available;

(18) Where NQF-endorsed measures do not exist, the next level of measures to be considered, to the extent practical, shall be those endorsed by the AQA, national accrediting organizations such as the NCQA, or the Joint Commission and federal agencies;

(19) Supplemental measures are permitted if they address areas of measurement for which national standards do not yet exist or for which existing national standard measure requirements are unreasonably burdensome on providers or program sponsors. Supplemental measures may be used if they are part of a pilot program to assess the extent to which the measures could fill national gaps in measurement. When supplemental measures are used they shall reasonably adhere to the NQF measure criteria, including importance, scientific acceptability, feasibility and usability, and may include sources such as provider specialty society guidelines.

3. The use by insurers of programs to publicly assess and compare the quality and cost efficiency of health care providers under subsection 2 of this section shall not be a basis for a provider to decline to enter into a provider contract with an insurer. A provider shall not withhold or otherwise obstruct an insurer from using data collected from medical claims or other sources generated by the provider and in possession of the insurer for the purpose of providing plan enrollees, providers, or the public information on the quality and cost efficiency differences in treatments and providers as long as the data is not used in a manner that violates any provisions of the federal Health Insurance Portability and Accountability Act (HIPAA) or antitrust law.

191.1028. 1. Any person who sells or otherwise distributes to the

public health care quality and cost efficiency data for disclosure in comparative format to the public shall identify the measure source or evidence-based science behind the measure and the national consensus, multi-stakeholder, or other peer review process, if any, used to confirm the validity of the data and its analysis as an objective indicator of health care quality.

2. Articles or research studies on the topic of health care quality or cost efficiency that are published in peer-reviewed academic journals or by nonprofit community-based organizations shall be exempt from the requirements of subsection 1 of this section.

3. (1) Upon receipt of a complaint of an alleged violation of this section by a person or entity other than a health carrier, the department of health and senior services shall investigate the complaint and, upon finding that a violation has occurred, shall be authorized to impose a penalty in an amount not to exceed one thousand dollars. The department shall promulgate rules governing its processes for conducting such investigations and levying fines authorized by law.

(2) 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, 2015, shall be invalid and void.

191.1030. All alleged violations of sections 191.1020 to 191.1028 by a health insurer shall be investigated and enforced by the department of insurance, financial institutions and professional registration under the department's powers and responsibilities to enforce the insurance laws of this state in accordance with chapter 374.

197.310. 1. The "Missouri Health Facilities Review Committee" is hereby established. The agency shall provide clerical and administrative support to the committee. The committee may employ additional staff as it deems necessary.

2. The committee shall be composed of:

(1) **[**Two members of the senate appointed by the president pro tem, who shall be from different political parties**]** **One member who is professionally qualified in health insurance plan sales and administration**; and

(2) **[**Two members of the house of representatives appointed by the speaker, who shall be from different political parties**]** **One member who has professionally qualified experience in commercial development, financing, and lending**; and

(3) **[**Five members**]** **Two members with a doctorate of philosophy in economics;**

(4) Two members who are professionally qualified as medical doctors or doctors of osteopathy, but who are not employees of a hospital or consultants to a hospital;

(5) Two members who are professionally experienced in hospital administration, but are not employed by a hospital or as consultants to a hospital;

(6) One member who is a registered nurse, but who is not an employee of a hospital or a consultant to a hospital.

All members shall be appointed by the governor with the advice and consent of the senate, not more than **[**three**]** **five** of whom shall be from the same political party. **All members shall serve four-year terms.**

3. No business of this committee shall be performed without a majority of the full body.

4. **[**The members shall be appointed as soon as possible after September 28, 1979. One of the senate members, one of the house members and three of the members appointed by the governor shall serve until January 1, 1981, and the remaining members shall serve until January 1, 1982. All subsequent members shall be appointed in the manner provided in subsection 2 of this section and shall serve terms of two years.

5.**]** The committee shall elect a chairman at its first meeting which shall be called by the governor. The committee shall meet upon the call of the chairman or the governor.

[6.**]** **5.** The committee shall review and approve or disapprove all applications for a certificate of need made under sections 197.300 to 197.366. It shall issue reasonable rules and regulations governing the submission, review and disposition of applications.

[7.**]** **6.** Members of the committee shall serve without compensation but shall be reimbursed for necessary expenses incurred in the performance of their

duties.

[8.**]** **7.** Notwithstanding the provisions of subsection 4 of section 610.025, the proceedings and records of the facilities review committee shall be subject to the provisions of chapter 610.

197.315. 1. Any person who proposes to develop or offer a new institutional health service within the state must obtain a certificate of need from the committee prior to the time such services are offered.

2. Only those new institutional health services which are found by the committee to be needed shall be granted a certificate of need. Only those new institutional health services which are granted certificates of need shall be offered or developed within the state. No expenditures for new institutional health services in excess of the applicable expenditure minimum shall be made by any person unless a certificate of need has been granted.

3. After October 1, 1980, no state agency charged by statute to license or certify health care facilities shall issue a license to or certify any such facility, or distinct part of such facility, that is developed without obtaining a certificate of need.

4. If any person proposes to develop any new institutional health care service without a certificate of need as required by sections 197.300 to 197.366, the committee shall notify the attorney general, and he shall apply for an injunction or other appropriate legal action in any court of this state against that person.

5. After October 1, 1980, no agency of state government may appropriate or grant funds to or make payment of any funds to any person or health care facility which has not first obtained every certificate of need required pursuant to sections 197.300 to 197.366.

6. A certificate of need shall be issued only for the premises and persons named in the application and is not transferable except by consent of the committee.

7. Project cost increases, due to changes in the project application as approved or due to project change orders, exceeding the initial estimate by more than ten percent shall not be incurred without consent of the committee.

8. Periodic reports to the committee shall be required of any applicant who has been granted a certificate of need until the project has been completed. The committee may order the forfeiture of the certificate of need upon failure of the applicant to file any such report.

9. A certificate of need shall be subject to forfeiture for failure to incur a

capital expenditure on any approved project within six months after the date of the order. The applicant may request an extension from the committee of not more than six additional months based upon substantial expenditure made.

10. **[**Each application for a certificate of need must be accompanied by an application fee.**]** The time of filing commences with the receipt of the application **[**and the application fee. The application fee is one thousand dollars, or one-tenth of one percent of the total cost of the proposed project, whichever is greater. All application fees shall be deposited in the state treasury. Because of the loss of federal funds,**].** The general assembly will appropriate funds to the Missouri health facilities review committee.

11. In determining whether a certificate of need should be granted, no consideration shall be given to the facilities or equipment of any other health care facility located more than a fifteen-mile radius from the applying facility.

12. When a nursing facility shifts from a skilled to an intermediate level of nursing care, it may return to the higher level of care if it meets the licensure requirements, without obtaining a certificate of need.

13. In no event shall a certificate of need be denied because the applicant refuses to provide abortion services or information.

14. A certificate of need shall not be required for the transfer of ownership of an existing and operational health facility in its entirety.

15. A certificate of need may be granted to a facility for an expansion, an addition of services, a new institutional service, or for a new hospital facility which provides for something less than that which was sought in the application.

16. The provisions of this section shall not apply to facilities operated by the state, and appropriation of funds to such facilities by the general assembly shall be deemed in compliance with this section, and such facilities shall be deemed to have received an appropriate certificate of need without payment of any fee or charge.

17. Notwithstanding other provisions of this section, a certificate of need may be issued after July 1, 1983, for an intermediate care facility operated exclusively for the intellectually disabled.

18. To assure the safe, appropriate, and cost-effective transfer of new medical technology throughout the state, a certificate of need shall not be required for the purchase and operation of research equipment that is to be used in a clinical trial that has received written approval from a duly constituted institutional review board of an accredited school of medicine or osteopathy located in Missouri to establish its safety and efficacy and does not increase the

bed complement of the institution in which the equipment is to be located. After the clinical trial has been completed, a certificate of need must be obtained for continued use in such facility.

197.330. 1. The committee shall:

(1) Notify the applicant within fifteen days of the date of filing of an application as to the completeness of such application;

(2) Provide written notification to affected persons located within this state at the beginning of a review. This notification may be given through publication of the review schedule in all newspapers of general circulation in the area to be served;

(3) Hold public hearings on all applications when a request in writing is filed by any affected person within thirty days from the date of publication of the notification of review;

(4) Within one hundred days of the filing of any application for a certificate of need, issue in writing its findings of fact, conclusions of law, and its approval or denial of the certificate of need; provided, that the committee may grant an extension of not more than thirty days on its own initiative or upon the written request of any affected person;

(5) Cause to be served upon the applicant, the respective health system agency, and any affected person who has filed his prior request in writing, a copy of the aforesaid findings, conclusions and decisions;

(6) Consider the needs and circumstances of institutions providing training programs for health personnel;

(7) Provide for the availability, based on demonstrated need, of both medical and osteopathic facilities and services to protect the freedom of patient choice; and

(8) Establish by regulation procedures to review, or grant a waiver from review, nonsubstantive projects. The term "filed" or "filing" as used in this section shall mean delivery to the staff of the health facilities review committee the document or documents the applicant believes constitute an application.

2. Failure by the committee to issue a written decision on an application for a certificate of need within the time required by this section shall constitute approval of and final administrative action on the application, and is subject to appeal pursuant to section 197.335 only on the question of approval by operation of law.

3. For all hearings held by the committee, including all public hearings under subdivision (3) of subsection 1 of this section:

(1) All testimony and other evidence taken during such hearings shall be under oath and subject to the penalty of perjury;

(2) The committee may, upon a majority vote of the committee, subpoena witnesses, and compel the attendance of witnesses, the giving of testimony, and the production of records;

(3) All ex parte communications between members of the committee and any interested party or witness which are related to the subject matter of a hearing shall be prohibited at any time prior to, during, or after such hearing;

(4) The provisions of sections 105.452 to 105.458 regarding conflict of interest shall apply;

(5) In all hearings, there shall be a rebuttable presumption of the need for additional medical services and lower costs for such medical services in the affected region or community. Any party opposing the issuance of a certificate of need shall have the burden of proof to show by clear and convincing evidence that no such need exists or that the new facility will cause a substantial and continuing loss of medical services within the affected region or community;

(6) All hearings before the committee shall be governed by rules to be adopted and prescribed by the committee; except that, in all inquiries or hearings, the committee shall not be bound by the technical rules of evidence. No formality in any proceeding nor in the manner of taking testimony before the committee shall invalidate any decision made by the committee; and

(7) The committee shall have the authority, upon a majority vote of the committee, to assess the costs of court reporting transcription or the issuance of subpoenas to one or both of the parties to the proceedings.

374.184. 1. The director of the department of insurance, financial institutions and professional registration shall prescribe by rule**[**,**]:**

(1) After due consultation with providers of health care or treatment and their respective licensing boards, **[**accident and sickness insurers, health services corporations and health maintenance organizations,**]** and after a public hearing, uniform claim forms for reporting by health care providers. Such prescribed forms shall include but need not be limited to information regarding the medical diagnosis, treatment and prognosis of the patient, together with the details of charges incident to the providing of such care, treatment or services, sufficient for

the purpose of meeting the proof requirements of an accident and sickness insurance or hospital, medical or dental services contract. Such prescribed forms shall be based upon the UB-82 form, with respect to hospital claims, and the HCFA 1500 form, with respect to physician claims, as such forms are modified or amended from time to time by the National Uniform Billing Committee or the federal Health Care Financing Administration**; and**

(2) After due consultation with accident and sickness insurers, health services corporations, health maintenance organizations, and insurance producers, and after a public hearing, uniform application forms.

2. The adoption of any uniform claim forms **or uniform application forms** by the director pursuant to this section shall not preclude an insurer, health services corporation, or health maintenance organization from requesting any necessary additional information in connection with a claims investigation from the claimant, provider of health care or treatment, or certifier of coverage**, or in connection with an application for insurance from the applicant**. The provisions of this section shall not be deemed or construed to apply to electronic claims submission. Insurers and providers may by contract provide for modifications to the uniform billing document where both insurers and providers feel that such modifications streamline claims processing procedures relating to the claims of the insurer involved in such contract modification. However, a refusal by the provider to agree to modification of the uniform billing format shall not be used by the insurer as grounds for refusing to enter into a contract with the provider for reimbursement or payment for health services rendered to an insured of the insurer.

3. Rules adopted or promulgated pursuant to this act shall be subject to notice and hearing as provided in chapter 536. The regulations so adopted shall specify an effective date, which shall not be less than one hundred eighty days after the date of adoption, after which no accident and sickness insurer, health services corporation or health maintenance organization shall require providers of health care or treatment to complete forms differing from those prescribed by the director pursuant to this section, **[**and**]** after which no health care provider shall submit claims except upon such prescribed forms; provided that the provisions of this section shall not preclude the use by any insurer, health services corporation or health maintenance organization of the UB-82 form or the HCFA 1500 form**, and after which no insurer shall require applicants for insurance coverage to complete forms differing from those prescribed**

by the director under this section.

376.960. As used in sections 376.960 to **[**376.989**]** **376.991**, the following terms mean:

(1) "Benefit plan", the coverages to be offered by the pool to eligible persons pursuant to the provisions of section 376.986;

(2) "Board", the board of directors of the pool;

(3) "Church plan", a plan as defined in Section 3(33) of the Employee Retirement Income Security Act of 1974, as amended;

(4) "Creditable coverage", with respect to an individual:

(a) Coverage of the individual provided under any of the following:

a. A group health plan;

b. Health insurance coverage;

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;

e. Chapter 55 of Title 10, United States Code;

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

g. A state health benefits risk pool;

h. A health plan offered under Chapter 89 of Title 5, United States Code;

i. A public health plan as defined in federal regulations; or

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

(b) Creditable coverage does not include coverage consisting solely of excepted benefits;

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

(6) "Dependent", a resident spouse or resident unmarried child under the age of nineteen years, a child who is a student under the age of twenty-five years and who is financially dependent upon the parent, or a child of any age who is disabled and dependent upon the parent;

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

(8) "Excepted benefits":

(a) Coverage only for accident, including accidental death and dismemberment, insurance;

(b) Coverage only for disability income insurance;

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

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

(e) Workers' compensation or similar insurance;

(f) Automobile medical payment insurance;

(g) Credit-only insurance;

(h) Coverage for on-site medical clinics;

(i) Other similar insurance coverage, as approved by the director, under which benefits for medical care are secondary or incidental to other insurance benefits;

(j) If provided under a separate policy, certificate or contract of insurance, any of the following:

a. Limited scope dental or vision benefits;

b. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;

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

(k) If provided under a separate policy, certificate or contract of insurance, any of the following:

a. Coverage only for a specified disease or illness;

b. Hospital indemnity or other fixed indemnity insurance;

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

a. Medicare supplemental coverage (as defined under Section 1882(g)(1) of the Social Security Act);

b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code;

c. Similar supplemental coverage provided to coverage under a group health plan;

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

(a) For whom, as of the date on which the individual seeks coverage through the pool, the aggregate of the periods of creditable coverage as defined in this section is eighteen or more months and whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with any such plan;

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

coverage;

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

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

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

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

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

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

(14) "Hospital", a place devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment or care for not less than twenty-four hours in any week of three or more nonrelated individuals suffering from illness, disease, injury, deformity or other abnormal physical condition; or a place devoted primarily to provide medical or nursing care for three or more nonrelated individuals for not less than twenty-four hours in any week. The term

"hospital" does not include convalescent, nursing, shelter or boarding homes, as defined in chapter 198;

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

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

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

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

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

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

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

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

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

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

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

(23) "Pool", the state health insurance pool created in sections 376.961, 376.962 and 376.964;

(24) "Resident", an individual who has been legally domiciled in this state for a period of at least thirty days, except that for a federally defined eligible individual, there shall not be a thirty-day requirement;

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

in determining a significant break in coverage;

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

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

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

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

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

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

(4) Establish procedures for the collection of assessments from all members to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made. The level of payments shall be established by the board pursuant to the provisions of section 376.973. Assessment shall occur at the end of each calendar year and shall be due and payable within thirty days of receipt of the assessment notice**]**.

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

by the pool.

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

5. The director shall review the plan of operation submitted under subsection 3 of this section and shall promulgate rules to effectuate the transitional plan of operation. Such rules shall be effective no later than October 1, 2013. 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, 2013, shall be invalid and void.

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

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

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

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

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

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

(3) A trade act eligible individual;

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

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

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

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

(8) Any person currently insured who would have qualified as a federally defined eligible individual or a trade act eligible individual between the effective date of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the effective date of this act**;**

(9) Any person who has exhausted his or her maximum in benefits from a health insurer.

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

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

(a) This exclusion shall not apply to a person who has such coverage but whose premiums have increased to **[**one hundred fifty percent to**]** **beyond the eligibility limit set by the board. The board shall not set the eligibility limit in excess of** two hundred percent of rates established by the board as applicable for individual standard risks;

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

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

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

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

(4) Any person on whose behalf the pool has paid out **[**one**]** **two** million dollars in benefits;

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

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

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

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

5. If an insurer issues one or more of the following or takes any other action based wholly or partially on medical underwriting considerations which is likely to render any person eligible for pool coverage, the insurer shall notify all persons affected of the existence of the pool, as well as the eligibility requirements and methods of applying for pool coverage:

(1) A notice of rejection or cancellation of coverage;

(2) A notice of reduction or limitation of coverage, including restrictive riders, if the effect of the reduction or limitation is to substantially reduce coverage compared to the coverage available to a person considered a standard risk for the type of coverage provided by the plan.

6. **When an insurer determines an insured has exhausted eighty-five percent of his or her total lifetime benefits, the insurer shall notify any affected person of the existence of the pool, of the person's eligibility for the pool when all lifetime benefits have been exhausted, and of methods of applying for pool coverage. When any affected person has exhausted one hundred percent of his or her total lifetime benefits, the insurer shall notify the affected person of his or her eligibility for pool coverage and of the methods of applying for such coverage. The insurer shall provide a copy of such notice to the pool with the name and address of such affected person.**

7. Coverage under the pool shall expire on January 1, 2014.

376.981. The pool shall offer individual stop-loss coverage for any insurer licensed providing individual health insurance policies in this state. Such stop-loss coverage, if available, shall be provided by the pool or an insurer licensed by the state to write accident and health insurance on a direct basis. The stop-loss coverage shall cover claim

liability for an insured person in the individual market who becomes uninsurable and any uninsurable dependent of an insured person, if coverage for an uninsurable dependent is requested. The stop-loss insurer shall bear the risk of coverage for such uninsurable persons.

376.983. 1. The pool shall establish a two-year pilot program that offers small employer group stop-loss coverage for health insurers providing health insurance coverage in the small employer group market in the metropolitan statistical area of a home rule city with more than four hundred thousand inhabitants and located in more than one county and in the metropolitan statistical area of a home rule city with more than one hundred fifty-one thousand five hundred but fewer than one hundred fifty-one thousand six hundred inhabitants. The board shall promulgate rules for implementation of the pilot program established under this section.

2. (1) For purposes of this section, small employer shall have the same meaning as such term is defined in section 379.930.

(2) The stop-loss coverage offered under this section may be provided by the pool, an insurer, or an approved reinsurer.

(3) The pool board shall have the authority to set actuarially sound rates to be charged for such stop-loss coverage taking into consideration anticipated tax premium revenue and other available sources of income.

3. To be eligible to purchase small employer group stop-loss coverage under the pool:

(1) The insurer shall not be permitted to purchase small employer group stop-loss coverage from the pool in the aggregate, but shall be required to purchase a separate stop-loss policy for each small employer group policy for which stop-loss coverage is being sought through the pool;

(2) The insurer shall provide the pool with sufficient information, to be determined by the board, establishing a need for the purchase of such stop-loss coverage for a small employer group policy of the insurer. The insurer shall establish to the satisfaction of the pool board at a minimum that the purchase of stop-loss coverage for a small employer group policy will stabilize the standard risk rate for such small employer group policy;

(3) The stop-loss coverage provided through the pool shall cover

claim liability for each individual risk within the small employer group health plan that exceeds the annual individual claim liability threshold under subdivision (4) of this subsection;

(4) Stop-loss coverage criteria shall be established by the pool board with the following minimums:

(a) The stop-loss coverage purchased from the pool shall provide coverage in accordance with paragraphs (c) and (d) of this subdivision for claim risks for individuals insured through a small employer group health plan issued in Missouri that exceeds a per policy year individual claim payments threshold to be set by the board;

(b) The stop-loss coverage purchased from the pool shall provide coverage in accordance with paragraphs (c) and (d) of this subdivision for claim risks for individuals in a small employer group health plan issued in Missouri if individual claim payments for the year exceed an individual claim payments threshold to be set by the board;

(c) An insurer purchasing stop-loss coverage from the pool shall retain a portion of the risk associated with the individual insured through the small employer group (risk corridor) and shall be liable for a portion of such individual's claims. The insurer's retained risk shall not be less than thirty percent of claims within the risk corridor of a policy year claims associated with such individual risk being reinsured. The risk corridor shall be established by the board;

(d) An insurer purchasing stop-loss coverage from the pool shall retain a portion of the risk for the small employer group in the aggregate and shall be liable for that portion of all claims associated with the small employer group. The retained risk shall not be less than an aggregate of one hundred twenty percent of expected claims for the entire small employer group; and

(e) The threshold and risk corridor established in paragraphs (a) to (c) of this subdivision shall be periodically reviewed by the board and may be adjusted for appropriate factors as determined by the board.

4. By January 1, 2018, the board shall submit a report to the general assembly regarding the pilot project established under this section and any recommendations for expanding the program statewide.

5. The board, in conjunction with the department of insurance,

financial institutions and professional registration, may promulgate rules for the administration and implementation 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, 2015, shall be invalid and void.

376.985. 1. Beginning July 1, 2015, the pool shall offer at least two plans for uninsurable individuals eligible under the insure Missouri program established under sections 1 to 8 of this act that meets the criteria of the federal Centers for Medicare and Medicaid for such program. No person related within the second degree of consanguinity or affinity of a statewide officeholder who is working as a lobbyist, consultant, or principal shall be awarded a contract for services under sections 1 to 8 of this act. No entity employing such person or clients of such person or entity shall be awarded a contract for services under sections 1 to 8 of this act. For purposes of this section and section 376.986, an uninsurable individual shall be defined by the eligibility criteria in subsection 2 of section 376.966.

2. Any individual receiving health insurance coverage under the state health insurance pool whose income is less than two hundred twenty-five percent of the federal poverty level may apply for participation in the insure Missouri program. The pool shall provide information to pool participants on how to apply for participation in the insure Missouri program.

3. Subject to available funds, the board may establish a premium subsidy program for low-income persons who are eligible for participation in the high-risk pool in accordance with the premiums established under section 376.986. The program may include incentives designed to encourage and promote healthy lifestyle choices which are appropriate and attainable for such participants, taking into consideration any limitations on lifestyle choices which exist based on the medical conditions and needs of the population served under the

high-risk pool.

376.986. 1. The pool shall offer major medical expense coverage to every person eligible for coverage under section 376.966 **and may offer other health plans that the board determines to be in the best interest of the individuals covered under the pool**. The coverage to be issued by the pool and its schedule of benefits, exclusions and other limitations, shall be established by the board with the advice and recommendations of the pool members, and such plan of pool coverage shall be submitted to the director for approval. The pool shall also offer coverage for drugs and supplies requiring a medical prescription and coverage for patient education services, to be provided at the direction of a physician, encompassing the provision of information, therapy, programs, or other services on an inpatient or outpatient basis, designed to restrict, control, or otherwise cause remission of the covered condition, illness or defect.

2. In establishing the pool coverage the board shall take into consideration the levels of health insurance provided in this state and medical economic factors as may be deemed appropriate, and shall promulgate benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of and commensurate with health insurance provided through a representative number of insurers in this state.

3. The pool shall establish premium rates for pool coverage as provided in **[**subsection**]** **subsections** 4 **and 5** of this section. Separate schedules of premium rates based on age, sex and geographical location may apply for individual risks. Premium rates and schedules shall be submitted to the director for approval prior to use.

4. The pool, with the assistance of the director, shall determine the standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. **[**Initial rates for pool coverage shall not be less than one hundred twenty-five percent of rates established as applicable for individual standard risks.**]** Subject to the limits provided in this subsection, **[**subsequent**]** rates shall be established **in accordance with the premium rate schedule in subsection 5 of this section** to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein. In no event shall pool rates exceed the following:

(1) For federally defined eligible individuals and trade act eligible individuals, rates shall be equal to the percent of rates applicable to individual standard risks actuarially determined to be sufficient to recover the sum of the cost of benefits paid under the pool for federally defined and trade act eligible individuals plus the proportion of the pool's administrative expense applicable to federally defined and trade act eligible individuals enrolled for pool coverage, provided that such rates shall not exceed **[**one hundred fifty**]** **the limits established in subsection 5 of this section, not to exceed two hundred** percent of rates applicable to individual standard risks; and

(2) For all other individuals covered under the pool, **[**one hundred fifty percent of rates**]** **the rate limits established under subsection 5 of this section** applicable to individual standard risks.

5. **Premium rates for pool coverage shall be established in accordance with the following schedule:**

(1) For individuals with incomes of less than three hundred percent of the federal poverty level, a premium rate equal to the standard risk rates;

(2) For individuals with incomes of three hundred percent of the federal poverty level or more, a sliding scale premium rate based on income which is between one hundred and one hundred twenty-five percent of the standard risk rates established by rule.

6. For uninsurable individuals eligible for the insure Missouri program established under sections 1 to 8 of this act, the pool shall offer the coverage required under subsection 1 of section 376.985 to such individuals at the standard risk rates of the pool subject to the following:

(1) The department of social services shall pay all or a portion of the premium for such coverage for an individual in the same manner authorized under the insure Missouri program;

(2) If the premium exceeds the amount paid by the department under this subsection, the individual covered shall be responsible for payment of any premium for such coverage not paid by the department;

(3) For insure Missouri program participants who are eligible for federal participation moneys, the losses covered under the pool for such individuals may, in accordance with the requirements of the federal waiver for such program, exceed the standard risk rates of the pool; and

(4) Premiums shall be certified as actuarially sound in accordance with the requirements established by the federal Centers for Medicare and Medicaid Services.

7. Commission payments for the sale of Missouri health insurance pool policies shall be set by the board. The board shall provide that agents and brokers selling insure Missouri qualified plans comply with the federal Centers for Medicare and Medicaid Services requirements concerning marketing and plan enrollment for insure Missouri program participants eligible for federal participation.

8. Pool coverage established pursuant to this section shall provide an appropriate high and low deductible to be selected by the pool applicant. The deductibles and coinsurance factors may be adjusted annually in accordance with the medical component of the consumer price index.

[6.**]** **9.** Pool coverage shall exclude charges or expenses incurred during the first **[**twelve**]** **six** months following the effective date of coverage as to any condition for which medical advice, care or treatment was recommended or received as to such condition during the six-month period immediately preceding the effective date of coverage. Such preexisting condition exclusions shall be waived to the extent to which similar exclusions, if any, have been satisfied under any prior health insurance coverage which was involuntarily terminated, if application for pool coverage is made not later than sixty-three days following such involuntary termination and, in such case, coverage in the pool shall be effective from the date on which such prior coverage was terminated.

[7.**]** **10.** No preexisting condition exclusion shall be applied to the following:

(1) A federally defined eligible individual who has not experienced a significant gap in coverage; or

(2) A trade act eligible individual who maintained creditable health insurance coverage for an aggregate period of three months prior to loss of employment and who has not experienced a significant gap in coverage since that time.

[8.**]** **11.** Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other health insurance, or insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any

state or federal law or program except Medicaid. The insurer or the pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the pool may be reduced or refused as a setoff against any amount recoverable under this subsection.

[9.**]** **12.** Medical expenses shall include expenses for comparable benefits for those who rely solely on spiritual means through prayer for healing.

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

2. As used in this section, the term "health savings account" shall have the same meaning ascribed to it as in 26 U.S.C. Section 223(d), as amended. The term "high-deductible health plan" shall mean a policy or contract of health insurance or health care plan that meets the criteria established in 26 U.S.C. Section 223(c)(2), as amended, and any regulations promulgated thereunder.

3. **The utilization of high deductible plans and the establishment of health savings accounts or other similar accounts shall be reviewed and reassessed annually by the appropriate legislative committees of the general assembly.**

4. The board is authorized to promulgate rules and regulations for the administration and implementation 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, 2007, shall be invalid and void.

376.991. 1. Notwithstanding any other provision of law to the contrary, beginning January 1, 2016, any premium tax imposed and collected in connection with the conduct of business in this state by a

health carrier for premiums for any health benefit plan insurance shall be distributed to the health insurance pool established under sections 376.960 to 376.991, as follows:

(1) For fiscal years 2016 and 2017, fifty percent of all such premium taxes collected;

(2) For fiscal year 2018 and every fiscal year thereafter, one hundred percent of all such premium taxes collected.

2. For purposes of this section, health benefit plan and health carrier shall have the same meaning as such terms are defined in section 376.1350.

Section 1. 1. As used in sections 1 to 8 of this act, the following terms shall mean:

(1) "Department", the department of social services;

(2) "Health insurance pool" or "pool", the health insurance pool established under sections 376.960 to 376.991;

(3) "Insure Missouri program" or "program", the insure Missouri initiative established in sections 1 to 8 of this act;

(4) "Prevention and wellness services", medically appropriate and age appropriate care that is provided to an individual to prevent and diagnose disease, and promote good health and a healthy lifestyle;

(5) "Qualified plan", any health benefit plan available in the private individual health insurance market or through the health insurance pool established under sections 376.960 to 376.991 that meets the minimum benefit design contained in the federal waiver authorizing the insure Missouri program.

2. There is hereby established within the department of social services the "Insure Missouri Program" to provide health care coverage through the private insurance market to low-income working adults residing in this state. The department shall apply to the United States Department of Health and Human Services for approval of a Section 1115 demonstration waiver to develop and implement the program. Such submitted waiver shall include but not be limited to:

(1) A provision that allows for transitional participation in the program as set forth in subsection 3 of section 6 of this act; and

(2) For uninsurable individuals receiving coverage through the state's health insurance pool, a provision that allows for:

(a) Federal participation moneys to be used to provide such

uninsurable individuals with pool coverage under the program; and

(b) Actuarially sound premium rates for coverage for such individuals that exceed the standard risk rates of the health insurance pool based on the aggregate losses for all such individuals eligible for federal participation moneys.

3. Prior to the submission of an application for a federal waiver under subsection 2 of this section, the department shall submit the proposed application for such waiver to the joint committee on MO HealthNet for the committee's review, recommendations, and approval.

4. The program is not an entitlement program. The maximum enrollment of individuals who may participate in the program is dependent on funding appropriated for the program by the general assembly. Eligibility for the program may be phased in incrementally on the basis of actions taken by the general assembly in the appropriations process.

5. Notwithstanding any other provision of sections 1 to 8 of this act to the contrary, for uninsurable individuals receiving coverage through the state's health insurance pool, such individuals shall be eligible for participation under the program as long as they are otherwise eligible for participation in the program and their incomes do not exceed two hundred twenty-five percent of the federal poverty level.

6. The department shall establish standards for consumer protection, including the following:

(1) Quality of care standards;

(2) A uniform process for participant grievances and appeals;

(3) Standardized reporting concerning provider performance, consumer experience, and cost.

7. The insure Missouri program shall pay one hundred percent of the premium costs for all participants in the program, except for any participant whose balance in his or her insure Missouri account at the end of the plan year exceeds the total annual required contribution amount under subdivision (2) of subsection 2 of section 5 of this act. Any amount in a participant's insure Missouri account at the end of the plan year that exceeds the participant's total annual required contribution amount shall go toward payment of the participant's premium costs under the program.

Section 2. 1. An individual shall be eligible for participation in the program if the individual meets the following requirements:

(1) The individual is at least nineteen years of age and less than sixty-five years of age;

(2) The individual is a United States citizen or qualified legal alien and a resident of Missouri;

(3) The individual has an annual household income of not more than two hundred twenty-five percent of the federal income poverty level;

(4) The individual is not eligible for health insurance coverage through the individual's employer;

(5) The individual has not had health insurance coverage for at least six months;

(6) The individual has household earned income that exceeds the maximum income for eligibility for Temporary Assistance for Needy Families (TANF) benefits.

2. The following individuals shall not be eligible for the program:

(1) An individual who participates in the federal Medicare program, 42 U.S.C. 1395, et seq.;

(2) A pregnant woman for purposes of pregnancy-related services who is eligible for health care coverage under chapter 208;

(3) An individual who has resources or owns assets with a value in excess of two hundred twenty-five thousand dollars.

3. The eligibility requirements specified in subsection 1 of this section are subject to approval for federal financial participation by the United States Department of Health and Human Services.

4. The department shall provide for enrollment with the program through the department's internet website and family support division offices.

Section 3. 1. The program shall include the following medically necessary services in a manner and to the extent determined by the department:

(1) Inpatient hospital services;

(2) Outpatient hospital and ambulatory surgical center services;

(3) Emergency room services;

(4) Physician and advanced practice nurse services;

(5) Federally qualified health center and rural health clinic

services;

(6) Laboratory, radiology, and other diagnostic services;

(7) Prescription drug coverage;

(8) Mental health and substance abuse treatment. The program shall not permit treatment limitations or financial requirements on the coverage of mental health care services or substance abuse services if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions;

(9) Home health services;

(10) Durable medical equipment;

(11) Family planning services:

(a) Including contraceptives and sexually transmitted disease testing, as described in federal Medicaid law, 42 U.S.C. 1396, et seq.; and

(b) Not including abortion or abortifacients, except as required in federal Medicaid law, 42 U.S.C. 1396, et seq.;

(12) Personal care services;

(13) Emergency ground and air transportation services;

(14) Hospice services;

(15) Prevention and wellness services. The program shall, at no cost to the individual, provide payment for at least three hundred dollars of qualifying prevention and wellness services per year for an individual who participates in the program. Any additional prevention and wellness services covered under the program and received by the individual during the year are subject to the deductible and copayment requirements of the program; and

(16) Case management, care coordination, and disease management.

2. The program shall, at no cost to the individual, provide payment for two physician office visits and three hundred dollars of qualifying preventative care services per year for program participants. Any additional physician office visits or preventative care services covered under the program and received a participant during the year shall be subject to the deductible and copayment requirements of the program.

3. The program may include incentives designed to encourage and promote healthy lifestyle choices which are medically appropriate, age appropriate, and attainable for individual participants, taking into

consideration any limitations on lifestyle choices which may exist based on medical conditions and the needs of the population serviced under the program.

Section 4. 1. Every individual who participates in the program shall have an individual insure Missouri account to which payments may be made for the individual's participation in the program by any of the following:

(1) The individual;

(2) An employer;

(3) The state, including any incentive payments contributed by the state;

(4) Any philanthropic or charitable contributor.

2. The minimum funding amount for an individual insure Missouri account is the amount required under section 6 of this act.

3. An individual insure Missouri account shall be used to pay the individual's deductible and copayments for health care services under the program.

4. An individual may make payments to his or her individual insure Missouri account as follows:

(1) An employer withholding or causing to be withheld from an employee's wages or salary, after taxes are deducted from the wages or salary, the individual's contribution under this section and distributed equally throughout the calendar year;

(2) Submission of the individual's contribution under sections 1 to 8 of this act to the department to deposit in the participant's individual insure Missouri account in a manner prescribed by the department;

(3) Another method determined by the department.

5. An employer may make, from moneys not payable by the employer to the employee, not more than fifty percent of an individual's required payment to his or her individual insure Missouri account.

6. Any employer making any contributions for a participant in the insure Missouri program may make such contribution to the employee's individual insure Missouri account or may make such contribution towards the payment of any premiums for coverage of the employee under the program.

Section 5. 1. An individual's participation in the program shall

not begin until an initial payment is made for the individual's participation in the program. A required payment to the program for the individual's participation shall not exceed one-twelfth of the annual payment required under subsection 2 of this section.

2. To participate in the program, an individual shall:

(1) Apply for the program in a manner prescribed by the department. The department may develop and allow a joint application for a household;

(2) If the individual is approved by the department to participate in the program, contribute to an individual insure Missouri account the lesser of the following:

(a) One thousand dollars per year or an amount not to exceed the deductible for the participant's coverage under the program, whichever is greater, less any amounts paid by the individual under:

a. The MO HealthNet program;

b. The children's health insurance program; and

c. The Medicare program, 42 U.S.C. 1395, et seq., as determined by the department; or

(b) Not more than the following applicable percentage of the individual's annual household income per year, less any amounts paid under the MO HealthNet program, the children's health insurance program, and the Medicare program, 42 U.S.C. 1395, et seq., as determined by the department:

a. One percent of the annual household income per year for incomes up to one hundred percent of the federal poverty level;

b. Two percent of the annual household income per year if the individual has an annual household income of more than one hundred percent and not more than one hundred twenty-five percent of the federal poverty level;

c. Three percent of the annual household income per year if the individual has an annual household income of more than one hundred twenty-five percent and not more than one hundred fifty percent of the federal poverty level;

d. Four percent of the annual household income per year if the individual has an annual household income of more than one hundred fifty percent and not more than two hundred percent of the federal poverty level; or

e. Five percent of the annual household income per year if the individual has an annual household income of more than two hundred and not more than two hundred twenty-five percent of the federal poverty level.

3. If the individual's account does not have sufficient funds to pay any deductible or copayments incurred by an individual under the program, the state shall contribute to an individual's account all or any portion of such unmet deductibles and copayments incurred by an individual.

4. If the required payment to the program is not made within ninety days after the required payment date, the individual or individuals shall be terminated from participation in the program. The individual or individuals shall receive written notice before being terminated from the program.

5. If an individual is terminated from the program for fraud or under subsection 4 of this section, the individual shall not reapply for participation in the program within six months of termination.

Section 6. 1. An individual who is approved to participate in the program is eligible for a twelve-month program period unless the individual fails to make the required contribution. An individual who participates in the program without a break in service shall not be refused renewal of participation in the program:

(1) For the sole reason that the program has reached the program's maximum enrollment; or

(2) If the individual is eligible for transitional participation under subsection 3 of this section.

2. If the individual chooses to renew participation in the program, the individual shall complete a renewal application and any necessary documentation, and submit to the insure Missouri program the documentation and application on a form prescribed by the department. At the time of renewal under the program, a participant may change qualified plans for his or her receipt of benefits under the program.

3. If an individual is eligible and participates in the program without a break in service and such individual's income subsequently exceeds the current income limitations for participation in the program, based on appropriations, at the time of such individual's

renewal, but otherwise remains eligible for participation in the program, the individual may choose and shall be eligible for transitional participation in the program; except that, such individual's participation in the program shall terminate if his or her income exceeds two hundred twenty-five percent of the federal poverty level. A transitional participant shall receive coverage under a qualified plan and shall be responsible for the required payments in the same manner established under the program in accordance with sections 1 to 8 of this act.

4. Any moneys remaining in an individual insure Missouri account of a participant who renews participation in the program at the end of the individual's twelve-month program period shall be used to reduce the individual's payments for the subsequent program period.

5. If an individual is no longer eligible for the program, does not renew participation in the program at the end of the program period or is terminated from the program for nonpayment of a required payment, the department shall, as determined by rule and not more than ninety days after the last date of participation in the program, refund to the individual the amount of any balance remaining in the individual insure Missouri account less any outstanding individual obligations under the program.

Section 7. 1. For individuals approved for participation in the program, health care coverage shall be obtained as follows:

(1) An individual approved for participation in the program shall seek health care coverage through a qualified plan available in the private individual health insurance market from insurance agents and brokers; or

(2) If an individual approved for participation in the program is denied coverage under two qualified plans available in the private individual health insurance market, the individual shall receive health care coverage through a qualified plan available in the health insurance pool in accordance with the provisions of sections 376.960 to 376.991 established for such coverage.

2. The deductible for any qualified plan under the program shall not exceed two thousand five hundred dollars.

3. The premium required of the qualified plan shall be certified as actuarially sound in accordance with the requirements established

by the federal Centers for Medicare and Medicaid Services.

4. Commission payments for the sale of qualified plans to individuals under the insure Missouri program shall be set by the department of social services. The insurance agent or broker shall comply with the federal Centers for Medicare and Medicaid Services requirements concerning marketing and plan enrollment for insure Missouri program participants eligible for federal participation.

5. The department of social services, in consultation and coordination with the department of insurance, financial institutions and professional registration and the board of directors for the health insurance pool, shall ensure that individuals approved for participation in the program are able to seek and obtain health insurance coverage under the program through insurance agents and brokers licensed in this state.

6. The department of social services, the department of insurance, financial institutions and professional registration, and the board of directors for the health insurance pool may promulgate rules and/or joint rules 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, 2015, shall be invalid and void.

Section 8. The department of social services shall promulgate rules and regulations for the implementation of sections 1 to 8 of this act. 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, 2015, shall be invalid and void.

[376.973. 1. Following the close of each fiscal year, the pool administrator shall determine the net premiums (premiums less administrative expense allowances), the pool expenses of administration and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. Health insurance premiums and benefits paid by an insurance arrangement that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments. The total cost of pool operation shall be the amount by which all program expenses, including pool expenses of administration, incurred losses for the year, and other appropriate losses exceeds all program revenues, including net premiums, investment income, and other appropriate gains.

2. Each insurer's assessment shall be determined by multiplying the total cost of pool operation by a fraction, the numerator of which equals that insurer's premium and subscriber contract charges for health insurance written in the state during the preceding calendar year and the denominator of which equals the total of all premiums, subscriber contract charges written in the state and one hundred ten percent of all claims paid by insurance arrangements in the state during the preceding calendar year; provided, however, that the assessment for each health maintenance organization shall be determined through the application of an equitable formula based upon the value of services provided in the preceding calendar year.

3. Each insurance arrangement's assessment shall be determined by multiplying the total cost of pool operation calculated under subsection 1 of this section by a fraction, the numerator of which equals one hundred ten percent of the benefits paid by that insurance arrangement on behalf of insureds in this state during the preceding calendar year and the denominator of which equals the total of all premiums, subscriber contract charges and one hundred ten percent of all benefits paid by insurance arrangements made on behalf of insureds in this state during the

preceding calendar year. Insurance arrangements shall report to the board claims payments made in this state on an annual basis on a form prescribed by the director.

4. If assessments exceed actual losses and administrative expenses of the pool, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" include reserves for incurred but not paid claims.

5. Assessments shall continue until such a time as the executive director of the pool provides notice to the board and director that all claims have been paid.

6. Any assessment funds remaining at the time the executive director provides notice that all claims have been paid shall be deposited in the state general revenue fund.**]**

[376.975. Each member's proportion of participation in the pool shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the member with it. Any deficit incurred by the pool shall be recouped by assessments apportioned as provided in subsections 1, 2, and 3 of section 376.973 by the board among members. The amount of assessments incurred by each member of the pool shall be allowed as an offset against certain taxes, and shall be subject to certain limitations, as follows: Each pool member subject to chapter 148 may deduct from premium taxes payable for any calendar year to the state any and all assessments paid for the same year pursuant to sections 376.960 to 376.989. All assessments, for a fiscal year, shall not exceed the net premium tax due and payable by such member in the previous year. If the assessment exceeds any premium tax due or payable in such year, the excess shall be a credit or offset carried forward against any premium tax due or payable in succeeding years until the excess is exhausted.**]**

[376.980. Each pool member exempt from chapter 148 shall be allowed to offset against any sales or use tax on purchases due, paid, or payable in the calendar year in which such assessments are made. Further, such assessment, for any fiscal year, shall not exceed one percent of nongroup premium income, exclusive of

Medicare supplement programs, received in the previous year. If the assessment exceeds the part of any sales tax or use tax due or payable in such year, the excess shall be a credit or offset carried forward against the part of any sales tax or use tax due or payable in succeeding years until the excess is exhausted. The director of revenue, in consultation with the board, shall promulgate and enforce reasonable rules and regulations and prescribe forms for the administration and enforcement of this law.**]**

[376.984. The board may abate or defer, in whole or in part, the assessment of a member if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. In the event an assessment against a member is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessment set forth in subsections 1, 2, and 3 of section 376.973. The member receiving such abatement or deferment shall remain liable to the pool for the deficiency for four years.**]**

Section B. Because immediate action is necessary to ensure adequate provision of health care services to the low-income citizens of this state, the enactment of section 376.985, subsections 6 and 7 of section 376.986 and sections 1 to 8 of section A of this act are deemed necessary for the immediate preservation of the public health, welfare, peace, and safety, and is hereby declared to be an emergency act within the meaning of the constitution, and the enactment of section 376.985, subsections 6 and 7 of section 376.986 and sections 1 to 8 of section A of this act shall be in full force and effect July 1, 2015, or upon its passage and approval, whichever later occurs.

Section C. Sections 148.380, 376.960, 376.966, 376.981, and 376.983, subsections 1 to 5 and 8 to 12 of section 376.986, and section 376.991, and the repeal of sections 376.973, 376.975, 376.980, and 376.984, of section A of this act shall become effective January 1, 2016.

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