FIRST REGULAR SESSION

HOUSE BILL NO. 609

96TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE MOLENDORP.

1237L.02I D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 374.284 and 376.1350, RSMo, and to enact in lieu thereof nine new sections relating to the Show-Me health insurance exchange act.

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

Section A. Sections 374.284 and 376.1350, RSMo, are repealed and nine new sections enacted in lieu thereof, to be known as sections 376.1150, 376.1153, 376.1155, 376.1160, 376.1165, 376.1170, 376.1175, 376.1180, and 376.1350, to read as follows:

376.1150. 1. Sections 376.1150 to 376.1180 shall be known and may be cited as the "Show-Me Health Insurance Exchange Act".

2. The purpose of sections 376.1150 to 376.1180 is to provide for the establishment of a health benefit exchange to facilitate the purchase and sale of qualified health plans in the individual market in this state and to provide for the establishment of a small business health options program (SHOP exchange) to assist qualified small employers in this state in facilitating the enrollment of their employees in qualified health plans offered in the small group market. The intent of the exchange is to reduce the number of uninsured, provide a transparent marketplace, increase competition in the health insurance market, reduce health care costs and portability, provide consumer education, assist individuals with access to programs, premium assistance tax credits, and cost-sharing reductions. The exchange shall conduct extensive consumer outreach to increase the awareness and effectiveness of the exchange which shall include, but is not limited to, print and television advertising and developing a website and toll-free consumer hotline.

3. As used in sections 376.1150 to 376.1180, the following terms shall mean:

EXPLANATION — Matter enclosed in bold-faced brackets **[**thus**]** in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

(1) "Board of trustees" or "board", the Show-Me health insurance board of trustees;

(2) "Catastrophic plan", in general, a health plan not providing a bronze, silver, gold, or platinum level of coverage shall be treated as meeting the requirements of Section 1302(d) of the federal act with respect to any plan year if:

(a) The only individuals who are eligible to enroll in the plan are individuals described in paragraph (c) of this subdivision; and

(b) The plan provides:

a. Except as provided in this subparagraph, the essential health benefits determined under Section 1302(b) of the ACA; except that, the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under Section 1302(c)(1) of the federal act for the plan year, except as provided for in Section 2713 of the Public Health Services Act;

b. Coverage for at least three primary care visits;

(c) Individuals eligible for enrollment:

a. Have not attained the age of thirty years before the beginning of the plan year; or

b. Have a certification in effect for any plan year that the individual is exempt from the requirement under Section 5000A of the Internal Revenue Code of 1986, as amended, by reason of:

(i) Section 5000A(e)(1) of the Internal Revenue Code of 1986, as amended, relating to individuals without affordable coverage; or

(ii) Section 5000A(e)(5) of the Internal Revenue Code of 1986, as amended, relating to individuals with hardships.

If a health carrier or health benefit plan offers a health benefit plan described in this subdivision, such carrier or plan shall only offer the plan in the individual market;

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

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

(5) "Educated health care consumer", an individual who is knowledgeable about the health care system, and has background or experience in making informed decisions regarding health, medical, and scientific matters;

(6) "Exchange", the Show-Me health insurance exchange established under section 376.1153;

(7) "Federal act", the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments thereto, or regulations or guidance issued under such federal acts;

(8) "Health benefit plan", the same meaning as such term is defined in section 376.1350;

(9) "Health carrier" or "carrier", the same meaning as such term is defined in section 376.1350;

(10) "Navigator", the Show-Me health insurance exchange;

(11) "Qualified dental plan", a limited scope dental plan that has been certified in accordance with subsection 5 of section 376.1170;

(12) "Qualified employer", a small employer that elects to make its full-time employees eligible for one or more qualified health plans offered through the SHOP exchange, and at the option of the employer, some or all of its part-time employees, provided that the employer:

(a) Has its principal place of business in this state and elects to provide coverage through the SHOP exchange to all of its eligible employees, wherever employed; or

(b) Elects to provide coverage through the SHOP exchange to all of its eligible employees who are principally employed in this state;

(13) "Qualified health plan", a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in Section 1311(c) of the federal act and section 376.1170;

(14) "Qualified individual", an individual, including a minor, who:

(a) Is seeking to enroll in a qualified health plan offered to individuals through the exchange;

(b) Resides in this state;

(c) At the time of enrollment is not incarcerated, other than incarceration pending the disposition of charges; and

(d) Is and is reasonably expected to be for the entire period for which enrollment is sought a citizen or national of the United States or an alien lawfully present in the United States;

(15) "Secretary", the secretary of the federal Department of Health and Human Services;

(16) "SHOP exchange", the small business health options program established under section 376.1165 and provided through the unified exchange;

(17) "Small employer", an employer that employed an average of not more than fifty employees during the preceding calendar year. For purposes of this subdivision:

(a) All persons treated as a single employer under Section 414(b), (c), (m), or (o) of the Internal Revenue Code of 1986, as amended, shall be treated as a single employer;

(b) An employer and any predecessor employer shall be treated as a single employer;

(c) All employees shall be counted, including part-time employees and employees who are not eligible for coverage through the employer;

(d) If an employer was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees which is reasonably expected by such employer to employ on business days in the current calendar year;

(e) An employer that makes enrollment in qualified health plans available to its employees through the SHOP exchange and would cease to be a small employer by reason of an increase in the number of its employees, shall continue to be treated as a small employer for purposes of sections 376.1150 to 376.1180 as long as it continuously makes enrollment through the SHOP exchange available to its employees;

(18) "Unified exchange", for administrative purposes only, an organized and transparent marketplace system for individuals and small employers to purchase health insurance coverage through qualified health and dental plans and obtain health insurance information; except that, a unified exchange shall not combine actuarial and underwriting functions for the individual and small employer market system.

376.1153. 1. There is hereby created the "Show-Me Health Insurance Exchange" as a quasi-governmental agency under the direction of a board of trustees. The purpose of the board of trustees shall be to conduct the business necessary to implement the exchange and to carry out the functions of the exchange in a fair and impartial manner in order to execute a more competitive insurance marketplace. Notwithstanding any provision of law to the contrary, such exchange may transact business, contract, sue and be sued, invest funds and hold cash, securities, and other property, and shall be vested with such other powers as may be necessary or proper to enable it, its officers, employees, and agents to carry out fully and effectively the purposes of sections 376.1150 to 376.1180.

2. The board shall be comprised of the following thirteen members:

(1) The directors, or the directors' designees, of the following departments as ex officio members:

(a) Social services;

(b) Insurance, financial institutions and professional registration, who shall serve as vice-chair;

(c) Mental health;

(d) Health and senior services;

(2) Two members of the house of representatives, one from the majority party and one from the minority party, to be appointed by the speaker of the house;

(3) Two members of the senate, one from the majority party and one from the minority party, to be appointed by the president pro tem of the senate;

(4) The following five members to be appointed by the governor with the advice and consent of the senate:

(a) A licensed health insurance broker;

(b) A licensed health carrier;

(c) A public health consumer advocate for individuals who purchase coverage through the exchange;

(d) A small employer representative; and

(e) An at-large member.

3. One member of the board shall serve as chair, to be elected annually by a majority of the members of the board.

4. The general assembly and department director members of the board shall serve on the board so long as they hold their respective title and position. With the exception of the initial terms, all members of the board appointed by the governor shall serve a three-year term. The initial terms of the appointed board members shall be as follows:

(1) The at-large member shall serve a one-year term;

(2) The small employer and public health consumer advocate members shall serve two-year terms;

(3) The licensed health insurance broker and licensed health insurance carrier shall serve three-year terms.

5. Vacancies for an unexpired term for a member of the general assembly shall be filled by the speaker of the house and president pro tem of the senate. Vacancies for an unexpired term of members appointed by the governor shall be filled by the governor.

6. All members shall be eligible for reappointment.

7. Any individual with a direct financial interest in decisions made by the board, with the exception of consumers and employers whose only interest is to purchase insurance products, are ineligible for board membership.

8. The board shall appoint an executive director for the exchange, who shall have charge of the offices, records, and employees of the plan, subject to the director of the

board. The executive director and the board shall employ such other officers of the quasi-governmental agency as shall be essential to the operation of the exchange.

9. The executive director shall employ such other employees as authorized by the board to conduct the business of the exchange. Employees and officers of the exchange plan shall receive such salaries and necessary expenses and shall be fixed by the board. The board shall take into account salaries paid by health carriers, health benefit plans, and health care providers in establishing appropriate pay schedules for its employees.

10. The board shall have exclusive jurisdiction and control over the funds and property of the exchange. Income of the exchange shall not be considered revenue of the state of Missouri. The assets of the exchange shall be exempt from state, county, municipal, and other political subdivision taxes.

11. All moneys received by or belonging to the exchange shall be paid to the executive director and promptly deposited by the executive director to the credit of the exchange in one or more banks or trust companies or other financial institutions as selected by the board. No such moneys shall be deposited in or be retained by any bank, trust company, or other financial institution which does not have on deposit with and for the board at the time the kind and value of collateral required by sections 30.240 and 30.270 for depositaries of the state treasurer. Such moneys shall be funds of the exchange and shall not be commingled with any funds in the state treasury. The executive director shall be responsible for all funds, securities, and property belonging to the plan and shall be provided with such corporate surety bond for the faithful handling of the same as the board shall require.

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

13. The board shall keep a record of its proceedings, which shall be open to public inspection. The board shall prepare annually and make available a report showing the financial condition of the exchange which shall contain, but not be limited to, a financial balance sheet, a statement of income and disbursements, a detailed statement of investments acquired and disposed of during the year, together with a detailed statement of the annual rates on investment return from all assets and from each type of investment, a listing of all advisors and consultants retained by the board, and such other data as the board shall deem necessary or desirable for a proper understanding of the condition of the plan. The board and exchange shall be subject to the provisions of chapter 610.

14. Members of the board of trustees shall serve without compensation for their services as members of the board, but shall be paid for any necessary expenses incurred in attending meetings of the board or committees thereof or in the performance of other duties authorized by the board.

15. The board shall meet within the state of Missouri not less than once per calendar quarter, at a time set at a previously scheduled meeting or at the request of the chair or any four members of the board acting jointly. Notice of the meeting shall be made public on the exchange website or portal. The board may meet at any time by unanimous consent.

16. Subject to the limitations of law, the board shall formulate and adopt rules for the governing of its own proceedings and for the administration of the plan.

17. No board member or employee of the exchange shall receive any gain or profit from any funds or transaction of the exchange, except for benefits common to all members, if entitled thereto. Any board member or employee accepting any gratuity or compensation for the purpose of influencing his or her action with respect to the investment of the funds of the exchange shall thereby forfeit his or her office and in addition thereto be subject to the penalties prescribed by law.

18. The duties of the board shall also include advising the department on issues relating to health care insurance.

376.1155. 1. The exchange shall:

(1) Facilitate the purchase and sale of qualified health plans;

(2) Provide for the establishment of a unified exchange to assist both individuals who purchase coverage in the individual market and qualified small employers in this state in facilitating the enrollment of their employees in qualified health plans; and

(3) Meet the requirements of sections 376.1150 to 376.1180 and any rules promulgated thereunder.

2. (1) The exchange may contract or enter into a memorandum of understanding with an eligible entity for any or all of its functions described in sections 376.1150 to 376.1180. Notwithstanding any other provision of law to the contrary, an eligible entity includes, but is not limited to, the family support division, the MO HealthNet division, the Missouri consolidated health care plan, or an entity that has experience in individual and small group health insurance markets, but a health carrier or an affiliate of a health carrier shall not be an eligible entity.

(2) Eligible entities may contract with the exchange so that employees or beneficiaries of such entities may be allowed to select qualified health plans through the exchange.

(3) The exchange may contract with the department for the certificate of health plans as qualified health plans and their recertification and decertification.

(4) A contracted entity of the exchange shall not be eligible to offer a qualified health benefit plan through the exchange.

3. The exchange may enter into information-sharing agreements with federal and state agencies and other state exchanges to carry out its responsibilities under sections 376.1150 to 376.1180, provided such agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all state and federal laws and regulations.

376.1160. 1. Beginning on or before January 1, 2014, the exchange shall make qualified health plans and qualified dental plans available to qualified individuals and qualified employers. Nothing in sections 376.1150 to 376.1180 shall prohibit qualified individuals or qualified employers from purchasing any health benefit plan and qualified dental plans outside the exchange. The exchange shall not make available any health benefit plan or qualified dental plans that is not a qualified health plan.

2. The exchange shall allow a health carrier or health benefit plan to offer a plan that provides limited scope dental benefits meeting the requirements of Section 9832(c)(2)(A) of the Internal Revenue Code of 1986, as amended, through the exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of Section 1302(b)(1)(J) of the federal act.

3. Neither the exchange nor a health carrier or health benefit plan offering health benefit plans through the exchange may charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable under the standards of Section 36B(c)(2)(C) of the Internal Revenue Code of 1986, as amended.

376.1165. The exchange shall:

(1) Implement procedures for the certification, recertification, and decertification, consistent with the guidelines developed by the Secretary under Section 1311(c) of the federal act and section 376.1180, of health benefit plans as qualified health plans;

(2) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

(3) Provide for enrollment periods, as provided under Section 1311(c)(6) of the federal act and additionally on a quarterly basis;

(4) Maintain an internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

(5) Assign a rating to each qualified health plan offered through the exchange in accordance with the criteria developed by the Secretary under Section 1311(c)(3) of the federal act, and determine each qualified health plan's level of coverage in accordance with regulations issued by the Secretary under Section 1302(d)(2)(A) of the federal act;

(6) Use a standardized format for presenting health benefit options in the exchange, including the use of the uniform outline of coverage established under Section 2715 of the federal Public Health Services Act;

(7) In accordance with Section 1413 of the federal act, inform individuals of eligibility requirements for the Medicaid program under Title XIX of the Social Security Act, the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act, or any applicable state or local public program and if through screening of the application by the exchanges, the exchange determines that any individual is eligible for any such program, enroll the individual in such program;

(8) Establish and make available by electronic means:

(a) A calculator to determine the actual cost of coverage after application of any premium tax credit under Section 36B of the Internal Revenue Code of 1986, as amended, and any cost-sharing reduction under Section 1402 of the federal act; and

(b) A consumer tool to calculate out-of-pocket costs of coverage;

(9) Establish a unified exchange serving both the individual and small group markets. Qualified employers in the small group market may access coverage for their employees, which shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the SHOP exchange at the specified level of coverage;

(10) Develop a standardized application for qualified individuals and small employers to use to apply for health benefits through the exchange. Each health carrier or health benefit plan that offers a qualified health benefit plan through the exchange shall use the standard application and shall not use any other application for health benefits;

(11) Subject to Section 1411 of the federal act, grant a certification attesting that, for purposes of the individual responsibility penalty under Section 5000A of the Internal Revenue Code of 1986, as amended, an individual is exempt from the individual responsibility requirement or from the penalty imposed by Section 5000A of the Internal Revenue Code of 1986, as amended, because:

(a) There is no affordable qualified health plan available through the exchange or the individual's employer covering the individual; or

(b) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

(12) Transfer to the federal Secretary of the Treasury the following:

(a) A list of the individuals who are issued a certification under subdivision (10) of this section, including the name and taxpayer identification number of each individual;

(b) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under Section 36B of the Internal Revenue Code of 1986, as amended, because:

a. The employer did not provide minimum essential coverage; or

b. The employer provided the minimum essential coverage, but it was determined under Section 36B(c)(2)(C) of the Internal Revenue Code of 1986, as amended, to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(c) The name and taxpayer identification number of:

a. Each individual who notifies the exchange under Section 1411(b)(4) of the federal act that he or she has changed employers; and

b. Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of such cessation;

(13) Provide to each employer the name of each employee of the employer described in paragraph (b) of subdivision (11) of this section who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

(14) Perform duties required of the exchange by the Secretary or the Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost-sharing, or individual responsibility requirement exemptions;

(15) (a) Establish a navigator program as a function of the exchange operations for the purpose of awarding grants to selected entities to perform and carry out functions of a navigator. Such program shall be subject to the following:

a. Grants awarded by the exchange shall be made from the operational funds of the exchange. Federal funds received by the state to establish the exchange shall not be used for grants. In order to be eligible to receive a grant, an entity shall demonstrate that it has existing relationships or may establish relationships with employers and employees, consumers, or self-employed individuals likely to enroll in a qualified health plan. Entities selected as a navigator shall be qualified in accordance with Section 1311(i) of the federal act and standards developed by the Secretary, and award grants to enable navigators to:

(i) Conduct public education activities to raise awareness of the availability of qualified health plans;

(ii) Distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium tax credits under Section 36B of the Internal Revenue Code of 1986, as amended;

(iii) Facilitate enrollment in qualified health plans;

(iv) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under Section 2793 of the Public Health Services Act, or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health benefit plan, coverage, or a determination under such plan or coverage; and

(v) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange;

b. Entities selected for the navigator program shall:

(i) Be subject to the standards established by the Secretary, licensure requirements, and disclosure of any conflict of interest; and

(ii) Not be a health carrier or health benefit plan, or receive any consideration directly or indirectly from any health carrier or health benefit plan in connection with the enrollment of any qualified individuals or employees of a qualified employer in a qualified health plan;

(b) As part of the navigator program, establish a broker referral network for the purpose of assisting individual and qualified small employers in obtaining health insurance coverage through the unified exchange. The brokers in the broker referral network shall be compensated in a manner appropriate to the health insurance broker industry;

(16) Credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled in accordance with Section 10108 of the federal act and collect the amount credited from the offering employer;

(17) Consult with stakeholders relevant to carrying out the activities required under sections 376.1150 to 376.1180, including but not limited to:

(a) Educated health care consumers who are enrollees in qualified health plans;

(b) Individuals and entities with experience in facilitating enrollment in qualified health plans;

(c) Representatives of small businesses and self-employed individuals;

(d) Advocates for enrolling hard-to-reach populations;

(e) Appropriate eligible entities as identified in section 376.1165;

(f) Health carriers and health benefit plans;

(g) Health care providers, including but not limited to physicians, hospitals, pharmacists, and pharmaceutical manufacturers; and

(h) Others interested in access to affordable quality health care services;

Stakeholder groups formed to provide consultation or guidance to the exchange or its board shall be formed with the advice and consent of the director;

(17) Meet the following financial integrity requirements:

(a) Keep an accurate accounting of all activities, receipts, and expenditures, and annually submit to the Secretary, the governor, and the general assembly a report concerning such accountings;

(b) Fully cooperate with any investigation conducted by the Secretary in accordance with the Secretary's authority under the federal act, and allow the Secretary, in coordination with the Inspector General of the U.S. Department of Health and Human Services, to:

a. Investigate the affairs of the exchange;

b. Examine the properties and records of the exchange; and

c. Require periodic reports in relation to the activities undertaken by the exchange; and

(c) In carrying out its activities under sections 376.1150 to 376.1180, not use any funds intended for the administrative and operational expenses of the exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative and regulatory modifications.

376.1170. 1. In order to foster a competitive exchange marketplace that offers greater consumer choice, it is presumed to be in the best interest of qualified individuals and qualified employers for the exchange to certify health plans that meet the requirements of the federal act and meet standards established by the exchange in order for the health plan to participate in the exchange. The exchange shall establish a transparent objective process for disapproval of certification for a health plan and decertifying a qualified health benefit plan that is determined not to be in the best interest to be offered through the exchange. The exchange shall establish an appeals process for health carriers and health benefit plans to appeal a decertification decision or the denial of certification as a qualified health plan.

2. The exchange may certify a health benefit plan as a qualified health plan if:

(1) The plan provides the essential health benefits package described in Section 1302(a) of the federal act; except that, the plan is not required to provide essential benefits that duplicate the minium benefits of qualified dental plans as provided in subsection 5 of this section if:

(a) The exchange has determined that at least one qualified dental plan is available to supplement the plan's coverage; and

(b) The health carrier makes prominent disclosure at the time it offers the plan, in a form approved by the exchange, that the plan does not provide the full range of essential pediatric benefits and that qualified dental plans providing such benefits and other dental benefits not covered by the plan are offered through the exchange;

(2) The premium rates and contract language have been approved by the director;

(3) The plan provides at least a bronze level of coverage, as determined under subsection 5 of section 376.1175 unless the plan is certified as a qualified catastrophic plan, meets the requirements of the federal act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;

(4) The plan's cost-sharing requirements do not exceed the limits established under Section 1302(c)(1) of the federal act, and if the plan is offered through the SHOP exchange, the plan's deductible does not exceed the limits established under Section 1302(c)(2) of the federal act;

(5) The health carrier offering the plan:

(a) Is licensed and in good standing to offer health insurance coverage in this state;

(b) Offers at least one qualified health plan in the silver level and at least one plan in the gold level through each component of the exchange in which the health carrier participates, where component refers to the SHOP exchange and the exchange for individual coverage;

(c) Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the exchange and without regard to whether the plan is offered directly from the health carrier or through an insurance producer;

(d) Does not charge any cancellation fees or penalties in violation of subsection 3 of section 376.1170; and

(e) Complies with the regulations developed by the Secretary under Section 1311(d) of the federal act and such other requirements as the exchange may establish;

(6) The plan meets the requirements of certification as promulgated by rule and by the Secretary under Section 1322(c) of the federal act, which include but are not limited to minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage, and information on quality measures for health benefit plan performance; and

(7) The exchange determines that making the plan available through the exchange is in the interest of qualified individuals and qualified employers in this state based on

merits of increasing transparency, expanding availability of health care services and providers, and improving health care outcomes for the participants in the exchange.

3. The exchange may promulgate rules regarding standardization of health benefits provided through the exchange and cost-sharing as a means of encouraging competition of qualified health benefit plans offered through the exchange.

4. The exchange shall not exclude a health benefit plan:

(1) On the basis that the plan is a fee-for-service plan;

(2) Through the imposition of premium price controls by the exchange; or

(3) On the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances the exchange determines are inappropriate or too costly.

5. The exchange shall require each health carrier seeking certification of a plan as a qualified health plan to:

(1) Submit a justification for any premium increase before implementation of such increase. The health carrier shall prominently post the information on its internet website. The exchange shall take such information, along with the information and the recommendations provided to the exchange by the director under Section 2794(b) of the Public Health Services Act, into consideration when determining whether to allow the health carrier to make plans available through the exchange;

(2) (a) Make available to the public, in the format described in paragraph (b) of this subdivision, and submit to the exchange, the Secretary, and the director accurate and timely disclosure of the following:

a. Claims payment policies and practices;

b. Periodic financial disclosures;

c. Data on enrollment;

d. Data on disenrollment;

e. Data on the number of claims that are denied;

f. Data on rating practices;

g. Information on cost-sharing and payments with respect to any out-of-network coverage;

h. Information on enrollee and participant rights under Title I of the federal act; and

i. Other information as determined appropriate by the Secretary.

(b) The information required in paragraph (a) of this subdivision shall be provided in plain language, as such term is defined in Section 1311(e)(3)(B) of the federal act;

(3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, such information shall be made available to the individual through an internet website and through other means for individuals without access to the internet;

(4) Promptly notify affected individuals of price and benefit changes, or other changes in circumstance that could materially impact enrollment or coverage; and

(5) Provide timely updates regarding the plan's provider network, including the addition of new providers or the withdrawal of an existing provider through the publicly accessible internet website selected by the exchange as the most appropriate way to disseminate the information.

6. The exchange shall not exempt any health carrier seeking certification of a qualified health plan, regardless of the type or size of the health carrier, from state licensure or solvency requirements and shall apply the criteria of this section in a manner that assures a level playing field between or among health carriers participating in the exchange.

7. (1) The provisions of sections 376.1150 to 376.1180 that are applicable to qualified health plans shall also apply to the extent relevant to qualified dental plans, except as modified in accordance with the provisions of subdivisions (2) to (4) of this subsection or by regulations adopted by the exchange.

(2) The health carrier shall be licensed to offer dental coverage, but need not be licensed to offer other health benefits.

(3) The plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage and shall include, at a minimum, the essential pediatric dental benefits prescribed by the Secretary under Section 1302(b)(1)(J) of the federal act, and such other dental benefits as the exchange or the Secretary may specify by regulation.

(4) Health carriers may jointly offer a comprehensive plan through the exchange in which the dental benefits are provided by a health carrier through a qualified dental plan and the other benefits are provided by a health carrier through a qualified health plan, provided that the plans are priced separately and are also made available for purchase separately at the same price. Nothing in this section shall be construed as prohibiting a health carrier or health benefit plan from offering a discounted rate on a qualified dental plan when purchased jointly with a qualified health plan.

8. The director shall determine whether a health plan seeking certification or recertification as a qualified health plan meets all the requirements related to licensure and solvency. The exchange shall determine whether such a health benefit plan meets all or other requirements of a qualified health plan.

9. In an effort to facilitate efficient coordination between the exchange and the director, the exchange may develop additional responsibilities for the director relating to health plan certification and decertification.

376.1175. 1. Federal funding for direct costs related to the development and operation of the exchange through 2014, the first year of operation, shall be provided under federal law.

2. A budget for the exchange shall be prepared by the governor and submitted to the general assembly annually for approval.

3. The exchange shall charge assessments or user fees to health carriers and health benefit plans, whether or not they are participating in the exchange for each policyholder of an individual health insurance policy issued in this state, for each employee covered under a small employer policy issued in this state and may otherwise generate funding necessary to support its operations provided under sections 376.1150 to 376.1180. Any assessments or fees charged to health carriers or health benefit plans shall be limited to the minimum amount necessary to pay for the administrative and capital costs and expenses that have been approved in the annual budget process, with consideration of other available funding sources. Services performed by the exchange on behalf of other state programs or federal programs shall not be funded with assessments or user fees collected from health carriers or health benefit plans.

4. Any unexpended finding by the exchange shall be used for further exchange operations or returned to health carriers and health benefit plans as a credit for future imposed assessments or fees.

5. The exchange shall publish the average costs of licensing, regulatory fees, taxes, carrier assessments, and any other payments required by the exchange, and the administrative costs of the exchange, on an internet website to educate consumers on such costs.

376.1180. 1. (1) The board may promulgate rules for the administration and implementation of sections 376.1150 to 376.1180.

(2) The exchange may promulgate rules to implement the provisions of sections 376.1150 to 376.1180. Rules promulgated under this subdivision shall not conflict with or prevent the application of rules promulgated by the Secretary under the federal act.

(3) Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in sections 376.1150 to 376.1180 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. Sections 376.1150 to 376.1180 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, 2011, shall be invalid and void.

2. Nothing in sections 376.1150 to 376.1180 and no action taken by the exchange under sections 376.1150 to 376.1180 shall be construed to preempt or supersede the authority of the director to regulate the business of insurance within this state. Except as expressly provided to the contrary in sections 376.1150 to 376.1180, all health carriers offering qualified health plans in this state shall comply fully with all applicable health insurance laws of this state and regulations adopted and orders issued by the director.

3. If the specific provisions of the federal act regarding the establishment and implementation of a state exchange are declared unconstitutional or otherwise declared invalid, sections 376.1150 to 376.1180 shall become null and void and be unenforceable in this state.

376.1350. For purposes of sections 376.1350 to 376.1390, the following terms mean:

(1) "Adverse determination", a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the payment for the requested service is therefore denied, reduced or terminated;

(2) "Ambulatory review", utilization review of health care services performed or provided in an outpatient setting;

(3) "Case management", a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions;

(4) "Certification", a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness;

(5) "Clinical peer", a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review;

(6) "Clinical review criteria", the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by the health carrier to determine the necessity and appropriateness of health care services;

(7) "Concurrent review", utilization review conducted during a patient's hospital stay or course of treatment;

(8) "Covered benefit" or "benefit", a health care service that an enrollee is entitled under the terms of a health benefit plan;

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

(10) "Discharge planning", the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility;

(11) "Drug", any substance prescribed by a licensed health care provider acting within the scope of the provider's license and that is intended for use in the diagnosis, mitigation, treatment or prevention of disease. The term includes only those substances that are approved by the FDA for at least one indication;

(12) "Emergency medical condition", the sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:

(a) Placing the person's health in significant jeopardy;

(b) Serious impairment to a bodily function;

(c) Serious dysfunction of any bodily organ or part;

(d) Inadequately controlled pain; or

(e) With respect to a pregnant woman who is having contractions:

a. That there is inadequate time to effect a safe transfer to another hospital before delivery; or

b. That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child;

(13) "Emergency service", a health care item or service furnished or required to evaluate and treat an emergency medical condition, which may include, but shall not be limited to, health care services that are provided in a licensed hospital's emergency facility by an appropriate provider;

(14) "Enrollee", a policyholder, subscriber, covered person or other individual participating in a health benefit plan;

(15) "FDA", the federal Food and Drug Administration;

(16) "Facility", an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings;

(17) "Grievance", a written complaint submitted by or on behalf of an enrollee regarding the:

(a) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(b) Claims payment, handling or reimbursement for health care services; or

(c) Matters pertaining to the contractual relationship between an enrollee and a health carrier;

(18) "Health benefit plan", a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services**[**; except that, health benefit plan shall not include any coverage pursuant to liability insurance policy, workers' compensation insurance policy, or medical payments insurance issued as a supplement to a liability policy**] . Health benefit plan:**

(a) Does not include the following coverage:

a. Coverage only for accident or disability income insurance, or any combination thereof;

b. Coverage issued as a supplement to liability insurance;

c. Liability insurance, including general liability insurance and automobile liability insurance;

d. Workers' compensation or similar insurance;

e. Automobile medical payment insurance;

f. Credit-only insurance;

g. Coverage for on-site medical clinics; or

h. Other similar insurance coverage, specified in federal regulations issued under Public Law 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits;

(b) Does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

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 scope benefits specified in federal regulations issued under Public Law 104-191;

(c) Does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

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

b. Hospital indemnity or other fixed indemnity insurance;

(d) Does not include the following if offered as a separate policy, certificate, or contract of insurance:

a. Medicare supplemental health insurance as defined in 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, Civil Health and Medical Program of the Uniformed Services (CHAMPUS); or

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

(19) "Health care professional", a physician or other health care practitioner licensed, accredited or certified by the state of Missouri to perform specified health services consistent with state law;

(20) "Health care provider" or "provider", a health care professional or a facility;

(21) "Health care service", a service for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease;

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

(23) "Health indemnity plan", a health benefit plan that is not a managed care plan;

(24) "Managed care plan", a health benefit plan that either requires an enrollee to use, or creates incentives, including financial incentives, for an enrollee to use, health care providers managed, owned, under contract with or employed by the health carrier;

(25) "Participating provider", a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than coinsurance, co-payments or deductibles, directly or indirectly from the health carrier;

(26) "Peer-reviewed medical literature", a published scientific study in a journal or other publication in which original manuscripts have been published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts, and that has been determined by the International Committee of Medical Journal Editors to have met the uniform requirements for manuscripts submitted to biomedical journals or is published in a journal specified by the United States Department of Health and Human Services pursuant to Section 1861(t)(2)(B) of the Social Security Act, as amended, as acceptable peer-reviewed medical literature. Peer-reviewed medical literature shall not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier;

(27) "Person", an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing;

(28) "Prospective review", utilization review conducted prior to an admission or a course of treatment;

(29) "Retrospective review", utilization review of medical necessity that is conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment;

(30) "Second opinion", an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service;

(31) "Stabilize", with respect to an emergency medical condition, that no material deterioration of the condition is likely to result or occur before an individual may be transferred;

(32) "Standard reference compendia":

(a) The American Hospital Formulary Service-Drug Information; or

(b) The United States Pharmacopoeia-Drug Information;

(33) "Utilization review", a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services,

procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review. Utilization review shall not include elective requests for clarification of coverage;

(34) "Utilization review organization", a utilization review agent as defined in section 374.500.

[374.284. The department of insurance, financial institutions and professional registration shall create an advisory committee to be known as the "Health Insurance Advisory Committee". This committee shall be a voluntary committee comprised of representatives of the insurance industry, provider groups and the public. The committee shall consist of at least, but not limited to, one member representing each of the following areas: small group insurance, managed care, doctors of medicine, doctors of osteopathy, pharmacists, dentists and public members representing self-employed workers and the elderly. This committee shall meet to discuss and advise the department on issues relating to health care insurance.**]**

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