

FIRST REGULAR SESSION

HOUSE BILL NO. 1039

97TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES FRANKLIN (Sponsor), GUERNSEY, WOOD, LYNCH, MORRIS, NEELY, DAVIS, HICKS, FLANIGAN, MILLER, MUNTZEL, REMOLE, HAEFNER, ENTLICHER, MCGAUGH, CONWAY (104), LICHTENEGGER, DOHRMAN, PIKE, WALKER, LAIR, PHILLIPS AND SHULL (Co-sponsors).

2228L.02I

D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 208.146, 376.961, 376.962, 376.964, 376.966, 376.968, 376.970, and 376.973, RSMo, and to enact in lieu thereof eleven new sections relating to the Show-Me transformation act.

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

Section A. Sections 208.146, 376.961, 376.962, 376.964, 376.966, 376.968, 376.970, and 376.973, RSMo, are repealed and eleven new sections enacted in lieu thereof, to be known as sections 208.998, 376.961, 376.962, 376.964, 376.966, 376.968, 376.970, 376.973, 1, 2, and 3, to read as follows:

208.998. 1. All individuals who receive MO HealthNet benefits shall receive covered services through health plans offered by managed care entities which are authorized by the department. Health plans authorized by the department:

(1) Shall resemble commercially available health plans while complying with federal Medicaid requirements;

(2) Shall promote, to the greatest extent possible, opportunity for children and their parents to be covered under the same plan;

(3) Shall offer at least one statewide plan and may offer plans regionally only if there is at least one statewide plan offered. The department shall ensure that all regions have adequate coverage through managed care contracts;

(4) Shall include cost-sharing for out-patient services as allowed by federal law;

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.

12 **(5) Shall provide incentives to health plans and providers to encourage cost-**
13 **effective delivery of care;**

14 **(6) May provide multiple plan options and reward participants for choosing a low-**
15 **cost plan; and**

16 **(7) May be offered by hospitals or health care systems. Such hospitals and health**
17 **care systems shall be permitted to bid to provide health services as a health plan under the**
18 **MO HealthNet program.**

19 **2. The department may designate that certain health care services be excluded from**
20 **such health plans if it is determined cost effective by the department. The department shall**
21 **establish uniform utilization review protocols to be used by all authorized health plans.**

22 **3. The department shall establish the following requirements for contracting with**
23 **managed care plans:**

24 **(1) (a) For managed care plans utilizing capitation arrangements between the**
25 **managed care plan and providers, the department shall establish the following**
26 **requirements for contracting with managed care plans under this subdivision:**

27 **a. All capitation managed care plans shall be required to submit a blind bid on each**
28 **of two levels of coverage with the department establishing the levels of coverage and the**
29 **maximum capitation rate for each level. The department shall not disclose its maximum**
30 **capitation rate during the initial bidding process. Each bidder shall include all actuarial**
31 **and other relevant information utilized by the bidder in determining the bidder's**
32 **capitation rate. The department may establish guidelines for the submission of such**
33 **actuarial and other information;**

34 **b. The capitation managed care plan which submits the lowest bid below the**
35 **maximum capitation rate established by the department shall be guaranteed participation;**

36 **c. Except as provided in item (ii) of subparagraph e. and subparagraph f. of this**
37 **paragraph, all bids in excess of the maximum capitation rate established by the department**
38 **shall not be considered;**

39 **d. If at least two submit bids which are equal to or less than the maximum**
40 **capitation rate established by the department, the department shall contract with such**
41 **plans as required under subparagraph a. of this paragraph and no further bidding shall**
42 **be required;**

43 **e. If less than two, or three if the department elects to include an additional plan,**
44 **capitation managed care plans submit bids equal to or less than the maximum capitation**
45 **rate established by the department:**

46 **(i) The department shall guarantee participation to the plan or plans which submit**
47 **bids equal to or less than the maximum capitation rate established by the department;**

48 (ii) For any remaining plan or plans necessary to meet the required number of
49 plans established under subparagraph b. of this paragraph, the department may select
50 such plan or plans with the lowest bid within one hundred twenty-five percent of the
51 maximum capitation rate established by the department or reopen the bidding in
52 accordance with item (ii) of subparagraph f. of this paragraph;

53 f. If no capitation managed care plans submit a bid equal to or less than the
54 maximum capitation rate established by the department:

55 (i) The department may select any such plan or plans with the lowest bids within
56 one hundred twenty-five percent of the maximum capitation rate established by the
57 department. If the required number of plans under subparagraph b. of this paragraph
58 meet the requirements of this paragraph, the department may contract with such plans and
59 no further bidding shall be required; or

60 (ii) The department may reevaluate and adjust its maximum capitation rate,
61 discard all previous nonconforming bids, disclose to all bidders the adjusted maximum
62 capitation rate established by the department, and open a second bidding process. All bids
63 submitted with the adjusted capitation maximum established by the department shall be
64 otherwise evaluated in accordance with this paragraph.

65 g. In awarding contracts under this subdivision, the department shall consider the
66 following factors:

67 (i) Cost to Missouri taxpayers;

68 (ii) The extent of the network of health care providers offering services within the
69 bidder's plan;

70 (iii) Additional services offered to recipients under the bidder's plan;

71 (iv) The bidder's history of providing managed care plans for similar populations
72 in Missouri or other states;

73 (v) Whether the bidder or an associated company offers an identical or
74 substantially similar plan within a health care exchange in this state; whether federally
75 facilitated, state-based, or operated on a partnership basis; and the bidder, if the bidder
76 offers an identical or similar plan, or the bidder and the associated company, if the bidder
77 has formed a partnership for purposes of its bid, has included in its bid a process by which
78 MO HealthNet recipients who choose its plan will be automatically enrolled in the
79 corresponding plan offered within the health care exchange if the recipient's income
80 increases resulting in the recipient's ineligibility for MO HealthNet benefits; and

81 (vi) Any other criteria the department deems relevant to ensuring MO HealthNet
82 benefits are provided to recipients in such manner as to save taxpayer money and improve
83 health outcomes of recipients.

84 (b) If a recipient enrolls in a capitation managed care plan with a capitation rate
85 which is less than the maximum capitation rate established by the department under the
86 bidding process, the recipient shall be eligible to receive a portion of the difference between
87 the plan's capitation rate and the maximum capitation rate established by the department.

88 (c) For purposes of paragraph (b) of this subdivision, the maximum capitation rate
89 for all participating plans shall be the department's undisclosed maximum capitation rate
90 if the bidding process is not reopened under subparagraph e. or f. of paragraph (a) of this
91 subdivision. If the bidding process is reopened, the maximum capitation rate for all
92 participating plans, including any plans which bid equal to or less than the undisclosed
93 maximum capitation rate, shall be the disclosed adjusted maximum capitation rate;

94 (2) All managed care bidders shall submit a bid on the levels of coverage
95 established in subsections 8 and 10 of this section;

96 (3) The department shall select a minimum of three plans from the conforming bids
97 for statewide plans and for each region, if applicable;

98 (4) The department shall select all of the bidders' plans or none of the bidders'
99 plans; and

100 (5) The lowest conforming bid for statewide plans and in each region, if applicable,
101 shall be accepted by the department.

102 4. In awarding contracts under this section, the department shall consider the
103 following factors:

104 (1) Cost to Missouri taxpayers;

105 (2) The extent of the network of health care providers offering services within the
106 bidder's plan;

107 (3) Additional services offered to recipients under the bidder's plan;

108 (4) The managed care entity's history of outcomes and quality of the services
109 offered in Missouri and other states;

110 (5) The bidder's history of providing managed care plans for similar populations
111 in Missouri and other states;

112 (6) Whether the bidder or an associated company offers an identical or substantially
113 similar plan within a health insurance marketplace in this state, whether it is federally
114 facilitated, state-based, or operated on a partnership basis; and the bidder, if the bidder
115 offers an identical or similar plan, or the bidder and the associated company, if the bidder
116 has formed a partnership for purposes of its bid, has included in its bid a process by which
117 MO HealthNet recipients who choose its plan will be automatically enrolled in the
118 corresponding plan offered within the health insurance marketplace if the recipient's

119 **income increases or another circumstances arises resulting in the recipient's ineligibility**
120 **for MO HealthNet benefits; and**

121 **(7) Any other criteria the department deems relevant to ensuring MO HealthNet**
122 **benefits are provided to recipients in such manner as to save taxpayer money and improve**
123 **health outcomes of recipients.**

124 **5. If a recipient enrolls in a managed care plan with a capitation rate which is less**
125 **than the maximum capitation rate established by the department under the bidding**
126 **process, the recipient shall be eligible to receive a portion of the difference between the**
127 **plan's capitation rate and the maximum capitation rate established by the department.**
128 **Any portion received by a participant shall be determined by the department and the**
129 **department shall ensure a maximum return to taxpayers.**

130 **6. All MO HealthNet plans under this subdivision shall provide coverage for the**
131 **following service unless they are specifically excluded under subsection 2 of this section:**

132 **(1) Ambulatory patient services;**

133 **(2) Emergency services;**

134 **(3) Hospitalization;**

135 **(4) Maternity and newborn care;**

136 **(5) Mental health and substance use disorders, including behavioral health**
137 **treatment;**

138 **(6) Prescription drugs;**

139 **(7) Rehabilitative and habilitative services and devices;**

140 **(8) Laboratory services;**

141 **(9) Preventive and wellness and chronic disease management;**

142 **(10) Pediatric services, including oral and vision care;**

143 **(11) Health care counselor services, as described in subsection 10 of this section;**

144 **and**

145 **(12) Any other service required by federal law.**

146 **7. No MO HealthNet plan shall provide coverage for abortion unless such abortions**
147 **are certified in writing by a physician to the MO HealthNet agency that, in the physician's**
148 **professional judgment, the life of the mother would be endangered if the fetus were carried**
149 **to term.**

150 **8. The MO HealthNet program shall provide a high deductible health plan option**
151 **for uninsured adults between the ages of nineteen and sixty-four with incomes of less than**
152 **one hundred percent of the federal poverty level. The high deductible plan shall include:**

153 **(1) High deductible coverage. After meeting a one thousand dollar deductible,**
154 **individuals shall be covered for benefits as specified by regulation of the department;**

- 155 **(2) An account of at least one thousand dollars per adult to pay medical costs for**
156 **the initial deductible funded by the department. The department shall fund such account;**
- 157 **(3) Preventive care, as defined by the department by rule, that is not subject to the**
158 **deductible and does not require a payment of moneys from the account described in**
159 **subdivision (2) of this subsection;**
- 160 **(4) A basic benefits package once annual medical costs exceed one thousand**
161 **dollars;**
- 162 **(5) A minimum deductible of one thousand dollars;**
- 163 **(6) As soon as practicable, the health plan shall establish and maintain a record**
164 **keeping system for each health care visit or service received by recipients under this**
165 **subsection. The plan shall require that the recipient's prepaid card number card number**
166 **be entered or electronic strip be swiped by the health care provider for purposes of**
167 **maintaining a record of every health care visit or service received by the recipient by such**
168 **provider, regardless of any balance on the recipient's card. Such information shall include**
169 **only the date, provider name, and general description of the visit or service provided. The**
170 **plan shall maintain a complete history of all health care visits and services for which the**
171 **recipient's prepaid card is entered or swiped in accordance with this subdivision. If**
172 **required under the federal Health Insurance Portability and Accountability Act (HIPAA)**
173 **or other relevant state or federal law or regulation, a recipient shall, as a condition of**
174 **participation in the prepaid card incentive, be required to provide a written waiver for**
175 **disclosure of any information required under this subdivision; and**
- 176 **(7) The department shall by rule determine the amount credited to a co-payment**
177 **prepaid card for a recipient and the percentage of any remaining moneys which may be**
178 **received by a recipient under subdivision (2) of this subsection; except that, the minimum**
179 **amounted credited to a co-payment prepaid card shall not be less than forty percent of the**
180 **minimum deductible required for the high deductible plans under this subsection. No**
181 **recipient shall be eligible unless such recipient receives a yearly checkup with such**
182 **recipient's primary care physician.**
- 183 **9. The department shall establish and implement a co-payment cost-sharing**
184 **program for MO HealthNet recipients not otherwise participating in an option under**
185 **subsection 8 of this section. Participants shall receive a prepaid card which shall be used**
186 **to cover the costs of co-payments required under the MO HealthNet program. The**
187 **department shall require recipients to fund the prepaid card with the maximum cost-share**
188 **allowed by federal law with the remainder to be funded by the MO HealthNet program.**
189 **Under this program:**

190 (1) No co-payments shall be imposed for primary care services as defined by the
191 department by rule; and

192 (2) Recipients shall be eligible to receive a portion of the remaining balance on the
193 card at the end of the coverage year in an amount to be determined by the department by
194 rule. Any such amounts shall be electronically transferred to the recipient's electronic
195 benefit transfer (EBT) card and all such amounts transferred shall be subject to the use
196 requirements and restrictions of EBT cards.

197 10. (1) The division shall establish a preventative care incentive program for all
198 MO HealthNet recipients identified by the division as having a chronic condition. The
199 preventative care incentive program shall encourage recipients to follow a medically
200 indicated regimen for treatment and control of such recipients' chronic conditions through
201 utilization of outreach health care navigators to provide assistance and guidance for such
202 recipients. The criteria for the program shall include:

203 (a) Each recipient receives integrated person-centered care and services designed
204 to provide choice, independence, and dignity;

205 (b) Each recipient has a consistent and stable relationship with a care team that is
206 responsible for comprehensive care management and service delivery;

207 (c) The supportive and therapeutic needs of each recipient are addressed in a
208 holistic fashion, using patient-centered primary care and individualized care plans to the
209 extent feasible;

210 (d) Recipients receive appropriate follow-up care when entering and leaving an
211 acute care facility or long-term care setting;

212 (e) Recipients receive assistance in navigating the health care delivery system and
213 accessing support services and statewide resources; and

214 (f) Services and supports are geographically located throughout the state to
215 adequately provide such services and supports.

216 (2) The division shall employ and have available outreach health care navigators
217 throughout the state in sufficient locations and numbers to ensure access to all recipients
218 with chronic conditions as identified by the division.

219 (3) Every hospital that is a provider under the MO HealthNet program shall, as a
220 condition of the hospital's provider contract, agree to allow outreach health care navigators
221 assigned by the division to work at such hospital and provide a workplace for such
222 navigators within the hospital.

223 (4) Primary care providers under the MO HealthNet program shall be team leaders
224 in collaborative arrangements with outreach health care navigators for the design of
225 treatment plans to improve health care outcomes for MO HealthNet recipients with

226 chronic conditions as identified by the division. In the collaborative arrangement, the
227 outreach health care navigator shall be responsible for providing such recipient with
228 assistance, guidance, and monitoring regarding implementation and ongoing compliance
229 with the treatment plan developed for the recipient.

230 (5) For purposes of this section, the following terms shall mean:

231 (a) "Chronic condition", diabetes, hypertension, high cholesterol, heart disease,
232 and other chronic conditions identified by the Centers for Medicare and Medicaid Services
233 (CMS) or the MO HealthNet division;

234 (b) "Outreach health care navigator", an individual who provides information,
235 assistance, tools, and support to enable a recipient to make the best health care decisions
236 in the recipient's particular circumstances and in light of the recipient's needs, lifestyle,
237 combination of conditions and desired outcomes. The MO HealthNet division shall by rule
238 establish competency and quality measures for outreach health care navigators.

239 (5) The division shall seek all necessary federal waivers to implement the provisions
240 of this subsection.

241 11. A MO HealthNet recipient shall be eligible for participation in only one of
242 either the high deductible plan under subsection 8 of this section, the co-payment cost-
243 sharing program under subsection 9 of this section, or the incentive program under
244 subsection 10 of this section. No MO HealthNet recipient shall be eligible to combine or
245 otherwise participate in more than one option under subsections 8 to 10 of this section.

246 12. All incentives or credits paid to or on behalf of a MO HealthNet participant
247 under a program established by the department under this section shall not be deemed to
248 be income to the participant in any means tested benefit program unless otherwise
249 specifically required by law or rule of the department.

250 13. Managed care entities shall give participants who choose the high deductible
251 plan under subsection 8 of this section or the co-payment cost-sharing program under
252 subsection 9 of this section information notifying the participant that the participant may
253 lose his or her payment if the participant utilizes visits to the emergency department for
254 nonemergency purposes. Such information shall be included on every electronic and paper
255 correspondence between the managed care plan and the participant.

256 14. The department shall seek all waivers and state plan amendments from the
257 United States Department of Health and Human Services necessary to implement the
258 provisions of this section. The provisions of this section shall not be implemented unless
259 such waivers are granted. If this section is approved in part by the federal government,
260 the department is authorized to proceed on those sections which approval has been

261 granted; except that, any increase in eligibility shall be contingent upon the receipt of all
262 necessary waivers and state plan amendments.

263 **15. The department may promulgate rules to implement this section. Any rule or**
264 **portion of a rule, as the term is defined in section 536.010, that is created under the**
265 **authority delegated in this section shall become effective only if it complies with and is**
266 **subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This**
267 **section and chapter 536 are nonseverable and if any of the powers vested with the general**
268 **assembly pursuant to chapter 536 to review, to delay the effective date or to disapprove**
269 **and annul a rule are subsequently held unconstitutional, then the grant of rulemaking**
270 **authority and any rule proposed or adopted after August 28, 2013, shall be invalid and**
271 **void.**

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

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

16 3. Beginning August 28, 2007, the board of directors shall consist of fourteen members.
17 The board shall consist of the director and the eight members described in subsection 2 of this
18 section and shall consist of the following additional five members:

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

21 (2) Two members of the senate, with one member from the majority party appointed by
22 the president pro tem of the senate and one member of the minority party appointed by the
23 president pro tem of the senate with the concurrence of the minority floor leader of the senate;
24 and

25 (3) Two members of the house of representatives, with one member from the majority
26 party appointed by the speaker of the house of representatives and one member of the minority
27 party appointed by the speaker of the house of representatives with the concurrence of the
28 minority floor leader of the house of representatives.

29 4. The members appointed under subsection 3 of this section shall serve in an ex officio
30 capacity. The terms of the members of the board of directors appointed under subsection 3 of
31 this section shall expire on December 31, 2009. On such date, the membership of the board shall
32 revert back to nine members as provided for in subsection 2 of this section.

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

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

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

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

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

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

20 (4) Establish procedures for the collection of assessments from all members to provide
21 for claims paid under the plan and for administrative expenses incurred or estimated to be

22 incurred during the period for which the assessment is made. The level of payments shall be
23 established by the board pursuant to the provisions of section 376.973. Assessment shall occur
24 at the end of each calendar year and shall be due and payable within thirty days of receipt of the
25 assessment notice[;

26 (5) Develop and implement a program to publicize the existence of the plan, the
27 eligibility requirements, and procedures for enrollment, and to maintain public awareness of the
28 plan].

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

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

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

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

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

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

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

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

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

25 (6) **Prior to January 1, 2014**, issue policies of insurance in accordance with the
26 requirements of sections 376.960 to 376.989. **In no event shall new policies of insurance be**
27 **issued on or after January 1, 2014;**

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

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

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

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

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

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

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

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

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

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

14 (3) A trade act eligible individual;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

64 **6. Coverage under the pool shall expire on January 1, 2014.**

376.968. The board shall select an insurer [or], insurers, or **third-party administrators**
2 through a competitive bidding process to administer the pool. The board shall evaluate bids
3 submitted based on criteria established by the board which shall include:

4 (1) The insurer's proven ability to handle individual accident and health insurance;

5 (2) The efficiency of the insurer's claim-paying procedures;

6 (3) An estimate of total charges for administering the plan;

7 (4) The insurer's ability to administer the pool in a cost-efficient manner.

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

5 three-year period. Selection of the administering insurer for the succeeding period shall be made
6 at least six months prior to the end of the current three-year period.

7 2. The administering insurer shall:

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

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

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

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

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

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

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

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

24 **3. On or before September 1, 2013, the board shall invite all insurers and third-**
25 **party administrators, including the current administering insurer, to submit bids to serve**
26 **as the administering insurer or third-party administrator for the pool. Selection of the**
27 **administering insurer or third-party administrator shall be made prior to January 1, 2014.**

28 **4. Beginning January 1, 2014, the administering insurer or third-party**
29 **administrator shall:**

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

33 (2) **Perform all administrative claim-payment functions relating to the pool;**

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

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

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

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

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

44 **(6) Be paid as provided in the plan of operation for its expenses incurred in the**
45 **performance of its services.**

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

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

18 3. Each insurance arrangement's assessment shall be determined by multiplying the total
19 cost of pool operation calculated under subsection 1 of this section by a fraction, the numerator
20 of which equals one hundred ten percent of the benefits paid by that insurance arrangement on
21 behalf of insureds in this state during the preceding calendar year and the denominator of which
22 equals the total of all premiums, subscriber contract charges and one hundred ten percent of all
23 benefits paid by insurance arrangements made on behalf of insureds in this state during the
24 preceding calendar year. Insurance arrangements shall report to the board claims payments made
25 in this state on an annual basis on a form prescribed by the director.

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

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

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

Section 1. 1. Notwithstanding any other provision of law, beginning July 1, 2014,
2 **any MO HealthNet recipient who elects to receive medical coverage through a private**
3 **health insurance plan instead of through the MO HealthNet program shall be eligible for**
4 **a private insurance premium subsidy to assist the recipient in paying the costs of such**
5 **private insurance. The subsidy shall be provided on a sliding scale based on income, with**
6 **a graduated reduction in subsidy over a period of time not to exceed two years.**

7 **2. The department may promulgate rules to implement the provisions of this**
8 **section. Any rule or portion of a rule, as that term is defined in section 536.010, that is**
9 **created under the authority delegated in this section shall become effective only if it**
10 **complies with and is subject to all of the provisions of chapter 536 and, if applicable,**
11 **section 536.028. This section and chapter 536 are nonseverable and if any of the powers**
12 **vested with the general assembly pursuant to chapter 536 to review, to delay the effective**
13 **date, or to disapprove and annul a rule are subsequently held unconstitutional, then the**
14 **grant of rulemaking authority and any rule proposed or adopted after August 28, 2013,**
15 **shall be invalid and void.**

Section 2. Under the MO HealthNet program, primary care providers shall be the
2 **team leaders in any collaborative practice arrangements entered into between providers**
3 **under the program.**

Section 3. All electronic cards used by recipients under the MO HealthNet program
2 **shall contain a photograph of the recipient on the front of the electronic card.**

 [208.146. 1. The program established under this section shall be known
2 as the "Ticket to Work Health Assurance Program". Subject to appropriations
3 and in accordance with the federal Ticket to Work and Work Incentives
4 Improvement Act of 1999 (TWWIA), Public Law 106-170, the medical
5 assistance provided for in section 208.151 may be paid for a person who is
6 employed and who:

7 (1) Except for earnings, meets the definition of disabled under the
8 Supplemental Security Income Program or meets the definition of an employed
9 individual with a medically improved disability under TWWIA;

10 (2) Has earned income, as defined in subsection 2 of this section;

11 (3) Meets the asset limits in subsection 3 of this section;

12 (4) Has net income, as defined in subsection 3 of this section, that does
13 not exceed the limit for permanent and totally disabled individuals to receive
14 nonspenddown MO HealthNet under subdivision (24) of subsection 1 of section
15 208.151; and

16 (5) Has a gross income of two hundred fifty percent or less of the federal
17 poverty level, excluding any earned income of the worker with a disability

18 between two hundred fifty and three hundred percent of the federal poverty level.
19 For purposes of this subdivision, "gross income" includes all income of the
20 person and the person's spouse that would be considered in determining MO
21 HealthNet eligibility for permanent and totally disabled individuals under
22 subdivision (24) of subsection 1 of section 208.151. Individuals with gross
23 incomes in excess of one hundred percent of the federal poverty level shall pay
24 a premium for participation in accordance with subsection 4 of this section.

25 2. For income to be considered earned income for purposes of this
26 section, the department of social services shall document that Medicare and
27 Social Security taxes are withheld from such income. Self-employed persons
28 shall provide proof of payment of Medicare and Social Security taxes for income
29 to be considered earned.

30 3. (1) For purposes of determining eligibility under this section, the
31 available asset limit and the definition of available assets shall be the same as
32 those used to determine MO HealthNet eligibility for permanent and totally
33 disabled individuals under subdivision (24) of subsection 1 of section 208.151
34 except for:

35 (a) Medical savings accounts limited to deposits of earned income and
36 earnings on such income while a participant in the program created under this
37 section with a value not to exceed five thousand dollars per year; and

38 (b) Independent living accounts limited to deposits of earned income and
39 earnings on such income while a participant in the program created under this
40 section with a value not to exceed five thousand dollars per year. For purposes
41 of this section, an "independent living account" means an account established and
42 maintained to provide savings for transportation, housing, home modification,
43 and personal care services and assistive devices associated with such person's
44 disability.

45 (2) To determine net income, the following shall be disregarded:

46 (a) All earned income of the disabled worker;

47 (b) The first sixty-five dollars and one-half of the remaining earned
48 income of a nondisabled spouse's earned income;

49 (c) A twenty dollar standard deduction;

50 (d) Health insurance premiums;

51 (e) A seventy-five dollar a month standard deduction for the disabled
52 worker's dental and optical insurance when the total dental and optical insurance
53 premiums are less than seventy-five dollars;

54 (f) All Supplemental Security Income payments, and the first fifty dollars
55 of SSDI payments;

56 (g) A standard deduction for impairment-related employment expenses
57 equal to one-half of the disabled worker's earned income.

58 4. Any person whose gross income exceeds one hundred percent of the
59 federal poverty level shall pay a premium for participation in the medical
60 assistance provided in this section. Such premium shall be:

61 (1) For a person whose gross income is more than one hundred percent
62 but less than one hundred fifty percent of the federal poverty level, four percent
63 of income at one hundred percent of the federal poverty level;

64 (2) For a person whose gross income equals or exceeds one hundred fifty
65 percent but is less than two hundred percent of the federal poverty level, four
66 percent of income at one hundred fifty percent of the federal poverty level;

67 (3) For a person whose gross income equals or exceeds two hundred
68 percent but less than two hundred fifty percent of the federal poverty level, five
69 percent of income at two hundred percent of the federal poverty level;

70 (4) For a person whose gross income equals or exceeds two hundred fifty
71 percent up to and including three hundred percent of the federal poverty level, six
72 percent of income at two hundred fifty percent of the federal poverty level.

73 5. Recipients of services through this program shall report any change in
74 income or household size within ten days of the occurrence of such change. An
75 increase in premiums resulting from a reported change in income or household
76 size shall be effective with the next premium invoice that is mailed to a person
77 after due process requirements have been met. A decrease in premiums shall be
78 effective the first day of the month immediately following the month in which the
79 change is reported.

80 6. If an eligible person's employer offers employer-sponsored health
81 insurance and the department of social services determines that it is more cost
82 effective, such person shall participate in the employer-sponsored insurance. The
83 department shall pay such person's portion of the premiums, co-payments, and
84 any other costs associated with participation in the employer-sponsored health
85 insurance.

86 7. The provisions of this section shall expire six years after August 28,
87 2007.]

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