

FIRST REGULAR SESSION

HOUSE BILL NO. 748

95TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES ERVIN (Sponsor), FLOOK, BRANDOM, FUNDERBURK, DUSENBERG, RUESTMAN, NIEVES, JONES (89), WILSON (119), WOOD AND BIVINS (Co-sponsors).

1573L.01I

D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 376.960, 376.966, and 376.986, RSMo, and to enact in lieu thereof four new sections relating to the Missouri high risk health insurance pool.

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

Section A. Sections 376.960, 376.966, and 376.986, RSMo, are repealed and four new
2 sections enacted in lieu thereof, to be known as sections 376.960, 376.966, 376.986, and
3 376.988, to read as follows:

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

- 2 (1) "Benefit plan", the coverages to be offered by the pool to eligible persons pursuant
3 to the provisions of section 376.986;
- 4 (2) "Board", the board of directors of the pool;
- 5 (3) "Church plan", a plan as defined in Section 3(33) of the Employee Retirement
6 Income Security Act of 1974, as amended;
- 7 (4) "Creditable coverage", with respect to an individual:
 - 8 (a) Coverage of the individual provided under any of the following:
 - 9 a. A group health plan;
 - 10 b. Health insurance coverage;
 - 11 c. Part A or Part B of Title XVIII of the Social Security Act;
 - 12 d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits
13 under Section 1928;
 - 14 e. Chapter 55 of Title 10, United States Code;
 - 15 f. A medical care program of the Indian Health Service or of a tribal organization;

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.

- 16 g. A state health benefits risk pool;
- 17 h. A health plan offered under Chapter 89 of Title 5, United States Code;
- 18 i. A public health plan as defined in federal regulations; or
- 19 j. A health benefit plan under Section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e);
- 20 (b) Creditable coverage does not include coverage consisting solely of excepted benefits;
- 21 (5) "Department", the Missouri department of insurance, financial institutions and
- 22 professional registration;
- 23 (6) "Dependent", a resident spouse or resident unmarried child under the age of nineteen
- 24 years, a child who is a student under the age of twenty-five years and who is financially
- 25 dependent upon the parent, or a child of any age who is disabled and dependent upon the parent;
- 26 (7) "Director", the director of the Missouri department of insurance, financial institutions
- 27 and professional registration;
- 28 (8) "Excepted benefits":
- 29 (a) Coverage only for accident, including accidental death and dismemberment,
- 30 insurance;
- 31 (b) Coverage only for disability income insurance;
- 32 (c) Coverage issued as a supplement to liability insurance;
- 33 (d) Liability insurance, including general liability insurance and automobile liability
- 34 insurance;
- 35 (e) Workers' compensation or similar insurance;
- 36 (f) Automobile medical payment insurance;
- 37 (g) Credit-only insurance;
- 38 (h) Coverage for on-site medical clinics;
- 39 (i) Other similar insurance coverage, as approved by the director, under which benefits
- 40 for medical care are secondary or incidental to other insurance benefits;
- 41 (j) If provided under a separate policy, certificate or contract of insurance, any of the
- 42 following:
- 43 a. Limited scope dental or vision benefits;
- 44 b. Benefits for long-term care, nursing home care, home health care, community-based
- 45 care, or any combination thereof;
- 46 c. Other similar, limited benefits as specified by the director;
- 47 (k) If provided under a separate policy, certificate or contract of insurance, any of the
- 48 following:
- 49 a. Coverage only for a specified disease or illness;
- 50 b. Hospital indemnity or other fixed indemnity insurance;

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

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

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

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

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

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

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

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

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

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

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

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

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

90 (14) "Hospital", a place devoted primarily to the maintenance and operation of facilities
91 for the diagnosis, treatment or care for not less than twenty-four hours in any week of three or
92 more nonrelated individuals suffering from illness, disease, injury, deformity or other abnormal
93 physical condition; or a place devoted primarily to provide medical or nursing care for three or
94 more nonrelated individuals for not less than twenty-four hours in any week. The term "hospital"
95 does not include convalescent, nursing, shelter or boarding homes, as defined in chapter 198,
96 RSMo;

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

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

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

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

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

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

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

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

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

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

117 (22) "Plan of operation", the plan of operation of the pool, including articles, bylaws and
118 operating rules, adopted by the board pursuant to the provisions of sections 376.961, 376.962 and
119 376.964;

120 (23) "Pool", the state health insurance pool created in sections 376.961, 376.962 and
121 376.964;

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

125 (25) "Significant break in coverage", a period of sixty-three consecutive days during all
126 of which the individual does not have any creditable coverage, except that neither a waiting
127 period nor an affiliation period is taken into account in determining a significant break in
128 coverage. **As used in this subdivision, "waiting period" and "affiliation period" shall have**
129 **the same meaning as such terms are defined in section 376.450;**

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

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. The following individual persons shall be eligible for coverage under the pool if they
6 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 **(9) Any person who has exhausted his or her maximum in benefits from a health**
31 **insurer.**

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

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

37 (a) This exclusion shall not apply to a person who has such coverage but whose
38 premiums have increased to [one hundred fifty percent to] **beyond the eligibility limit set by**
39 **the board. The board shall not set the eligibility limit in excess of** two hundred percent of
40 rates established by the board as applicable for individual standard risks[. After December 31,
41 2009, this exclusion shall not apply to a person who has such coverage but whose premiums have
42 increased to three hundred percent or more of rates established by the board as applicable for
43 individual standard risks];

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

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

49 **(d) Such exclusion shall not apply to a federally defined eligible individual;**

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

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

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

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

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

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

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

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

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

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

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

 376.986. 1. The pool shall offer major medical expense coverage to every person
2 eligible for coverage under section 376.966 **and shall offer other health plans that the board**
3 **determines to be in the best interest of the individuals covered under the pool, including**
4 **but not limited to dental and vision coverage, and limited mandate plans or other similar**
5 **flexible benefit plans.** The coverage to be issued by the pool and its schedule of benefits,
6 exclusions and other limitations, shall be established by the board with the advice and
7 recommendations of the pool members, and such plan of pool coverage shall be submitted to the
8 director for approval. The pool shall also offer coverage for drugs and supplies requiring a
9 medical prescription and coverage for patient education services, to be provided at the direction
10 of a physician, encompassing the provision of information, therapy, programs, or other services
11 on an inpatient or outpatient basis, designed to restrict, control, or otherwise cause remission of
12 the covered condition, illness or defect.

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

18 3. The pool shall establish premium rates for pool coverage as provided in subsection
19 4 of this section. Separate schedules of premium rates based on age, sex, **family size**, and
20 geographical location may apply for individual risks. Premium rates and schedules shall be
21 submitted to the director for approval prior to use.

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

32 (1) For federally defined eligible individuals and trade act eligible individuals, rates shall
33 be equal to the percent of rates applicable to individual standard risks actuarially determined to
34 be sufficient to recover the sum of the cost of benefits paid under the pool for federally defined
35 and trade act eligible individuals plus the proportion of the pool's administrative expense
36 applicable to federally defined and trade act eligible individuals enrolled for pool coverage,
37 provided that such rates shall not exceed one hundred [fifty] **twenty-five** percent of rates
38 applicable to individual standard risks; and

39 (2) For all other individuals covered under the pool, one hundred [fifty] **twenty-five**
40 percent of rates applicable to individual standard risks.

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

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

53 terminated. **The board may establish a premium rate load to allow enrollees to buy down**
54 **creditable coverage.**

55 7. No preexisting condition exclusion shall be applied to the following:

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

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

61 8. Benefits otherwise payable under pool coverage shall be reduced by all amounts paid
62 or payable through any other health insurance, or insurance arrangement, and by all hospital and
63 medical expense benefits paid or payable under any workers' compensation coverage, automobile
64 medical payment or liability insurance whether provided on the basis of fault or nonfault, and
65 by any hospital or medical benefits paid or payable under or provided pursuant to any state or
66 federal law or program except Medicaid. The insurer or the pool shall have a cause of action
67 against an eligible person for the recovery of the amount of benefits paid which are not for
68 covered expenses. Benefits due from the pool may be reduced or refused as a setoff against any
69 amount recoverable under this subsection.

70 9. Medical expenses shall include expenses for comparable benefits for those who rely
71 solely on spiritual means through prayer for healing.

72 **10. Subject to appropriations, the pool shall establish a premium assistance**
73 **program for qualified individuals under section 376.966. Under the program:**

74 (1) **An individual shall be eligible for premium assistance if the individual qualifies**
75 **for coverage under the pool and the individual's income does not exceed the income**
76 **eligibility level established by the pool for the premium assistance program;**

77 (2) **Premium assistance shall be available for a qualified individual who is employed**
78 **if such qualified individual's employer or the qualified individual, or both, contribute their**
79 **respective shares of the required premium. If the employer of a qualified individual does**
80 **not participate, the qualified individual, or such employed qualified individual and such**
81 **individual's qualified spouse, may directly enroll in the premium assistance program;**

82 (3) **Premium assistance shall be provided based on a sliding income scale to be**
83 **established by the pool;**

84 (4) **Any cost-sharing requirements, such as deductibles, co-payments, or co-**
85 **insurance, shall be established by the pool.**

86 **11. In providing coverage to enrollees under the health insurance pool and**
87 **payments to providers for providing health care services to enrollees under the pool, the**
88 **board shall take into consideration the special needs of Missouri's Tier I Safety Net**

89 providers so that they are not disproportionately impacted by rules promulgated by the
90 board as it implements the provisions of sections 376.960 to 376.990.

376.988. All agents and brokers selling or renewing Missouri health insurance pool
2 policies shall receive a five percent commission upon approval of a new application or
3 renewal of coverage under a health insurance pool policy.

✓