FIRST REGULAR SESSION

HOUSE BILL NO. 818

94TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES ERVIN (Sponsor), WILSON (130), BEARDEN, DEMPSEY, JETTON, YATES, HOBBS, RICHARD, ZIMMERMAN, EMERY, BRUNS, PRATT, SCHNEIDER, SUTHERLAND, BAKER (123), COOPER (155), THRELKELD, KUESSNER, GRILL, WELLS, POLLOCK, COOPER (120), SATER, ROBB, ONDER, CUNNINGHAM (145), FAITH, SANDER, THOMSON, NOLTE, WASSON, DAVIS, DIXON, NIEVES, STEVENSON, SELF, KRAUS, GRISAMORE, LEMBKE, DUSENBERG, SCHAD, SMITH (150), QUINN (7), SCHAAF, SCHLOTTACH, MAY, WILSON (119), DETHROW, PORTWOOD, MUNZLINGER, MOORE, FLOOK, DEEKEN, BIVINS, PAGE, PEARCE, FUNDERBURK, RUZICKA AND HOLSMAN (Co-sponsors).

Read 1st time February 8, 2007 and copies ordered printed.

D. ADAM CRUMBLISS, Chief Clerk

1261L.04I

AN ACT

To repeal sections 376.961, 376.962, 376.964, and 376.989, RSMo, and to enact in lieu thereof nineteen new sections relating to portability and accessibility of health insurance.

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

Section A. Sections 376.961, 376.962, 376.964, and 376.989, RSMo, are repealed and nineteen new sections enacted in lieu thereof, to be known as sections 376.961, 376.962, 376.964, 376.967, 376.989, 376.1800, 376.1803, 376.1806, 376.1809, 376.1812, 376.1815, 376.1818, 376.1821, 376.1824, 376.1827, 376.1830, 376.1833, 376.1836, and 376.1839, to read as follows:

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

2. Beginning January 1, 2007, the board of directors shall consist of the director of the department of insurance**, financial institutions and professional registration** or the director's designee, and eight members appointed by the director. Of the initial eight members appointed, three shall serve a three-year term, three shall serve a two-year term, and two shall serve a

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.

one-year term. All subsequent appointments to the board shall be for three-year terms. Members of the board shall have a background and experience in health insurance plans or health maintenance organization plans, in health care finance, or as a health care provider or a member of the general public; except that, the director shall not be required to appoint members from each of the categories listed. The director may reappoint members of the board. The director shall fill vacancies on the board in the same manner as appointments are made at the expiration of a member's term **and may remove any member of the board for neglect of duty, misfeasance, malfeasance, or nonfeasance in office**.

376.962. 1. **Within one hundred eighty days of August 28, 2007,** the board of directors on behalf of the pool shall submit to the director a **proposed revised** plan of operation for the pool and any amendments thereto necessary or suitable to assure the **economical,** fair, reasonable and equitable administration of the pool**, and for the prompt and efficient implementation of the risk transfer mechanisms of the pool in accordance with section 376.967**. After notice and hearing, the director shall approve the plan of operation, provided it is determined to be suitable to assure the fair, reasonable and equitable administration of the pool, and it provides for the sharing of pool gains or losses on an equitable proportionate basis. **Upon approval in writing by the director,** the **revised** plan of operation shall become effective **[**upon approval in writing by the director consistent with the date on which the coverage under sections 376.960 to 376.989 becomes available**] on January 1, 2009, or, at the discretion of the board, a date prior to January 1, 2009, established by the board**. If the pool fails to submit a suitable plan of operation within one hundred eighty days after **[**the appointment of the board of directors**] of August 28, 2007**, or at any time thereafter fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this section. Such rules shall continue in force until modified by the director or superseded by a plan submitted by the pool and approved by the director.

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

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

(2) Select an administering insurer in accordance with section 376.968;

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

(4) Establish procedures for the collection of assessments from all members to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made. The level of payments shall be established by the board pursuant to the provisions of section 376.973. Assessment shall occur

at the end of each calendar year and shall be due and payable within thirty days of receipt of the assessment notice;

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

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

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

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

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

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

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

(6) Issue policies of insurance in accordance with the requirements of sections 376.960 to 376.989;

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

(8) Establish rules, conditions and procedures for reinsuring risks of pool members desiring to issue pool plan coverages in their own name. Such reinsurance facility shall not

subject the pool to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers;

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

2. The board shall file with the director an annual report by March thirty-first summarizing the activities and accounts of the pool in the preceding calendar year, including premiums charged for risks ceded to the reinsurance pool, the expense of administration, the paid and incurred losses for the year and other information as may be requested by the director or determined to be appropriate by the board. The director shall make the report available to the governor, the general assembly, and the public.

376.967. 1. Sections 376.960 to 376.989 shall apply to health insurance plans and insurance arrangements sold in Missouri that provide coverage to individuals or to employers with employees who are engaged in employment in Missouri at least twenty hours a week and the covered dependents of such individuals or employees.

2. Each participating pool member shall have voting rights apportioned according to its respective share of the total number of lives covered by health insurance issued or sponsored by all of the pool members participating in the plan, excluding Medicaid beneficiaries and persons whose coverage consists solely of excepted benefits; except that, no pool members shall have a vote in excess of forty-nine percent of the total vote.

3. The following rules shall govern the pool:

(1) Each pool member may determine on a case-by-case basis and on its own initiative whether to cede a risk to the pool;

(2) The pool shall not impose any rule on any plan member that establishes a minimum or maximum number of individual risks that a pool member may cede to the pool from among any group of risks covered by a plan issued or sponsored by a pool member;

(3) Pool members shall not cede to the pool any risks associated with the provision of coverage of Medicaid benefits or of coverage that consists solely of excepted benefits;

(4) A pool member ceding a risk to the pool shall pay the pool a premium determined by the rules governing the pool, provided that such premium shall be a multiple of the premium charged by the pool member to the insured for the individual risk and that such multiple shall not be less than one. The pool shall have the authority to set and, as from time to time it deems appropriate, change such requirement above the minimum. For purposes of determining the reinsurance premium, the premium charged by the pool member to the insured shall be the actual premium charged for the risk or, if

coverage of the insured is underwritten on a group basis, the premium that would otherwise be charged for the individual risk upon election of COBRA coverage;

(5) A pool member ceding a risk to the pool shall retain a portion of the risk (risk corridor), as determined by rules governing the pool, and shall be liable for that portion of all claims associated with the ceded risk, provided that the retained risk shall not be less than twenty percent of all claims associated with the ceded risk. The pool shall have the authority to set and, from time to time as it deems appropriate, change such requirement above the minimum; and

(6) Each risk ceded to the pool shall be ceded for the lesser of a fixed term of twelve months or until such time as the risk is no longer covered by a health insurance plan issued or sponsored by the ceding pool member. The pool shall not impose any restriction on the number of consecutive times a pool member may cede a specific risk to the pool.

4. No provision of sections 376.960 to 376.989 shall require a pool member to provide or make available coverage under a group or individual comprehensive health insurance plan to any person or group.

5. For purposes of sections 376.960 to 376.989, pool members may require verification of residency or employment, and may require any additional information or documentation, or statements under oath when necessary to determine residency or employment status of a covered individual upon initial application and for the entire term of the policy issued or sponsored by the pool member.

6. Coverage shall cease:

(1) At the end of the twelve-month period for which the risk has been ceded;

(2) On the date a person is no longer a resident or employed in Missouri;

(3) Upon the death of the covered person;

(4) On the date Missouri law requires cancellation of the policy; or

(5) At the pool member's option, thirty days after the pool member makes an inquiry concerning a person's eligibility, or place of residence or employment to which the covered person does not reply or whose reply does not satisfy the pool member that the person is eligible for coverage under a health insurance plan issued or sponsored by the pool member in the state of Missouri.

7. The coverage by the pool of any risk associated with a person who ceases to meet the eligibility requirements of this section shall be terminated at the end of the current policy period for which the necessary premiums have been paid.

8. The provisions of this section shall become effective on January 1, 2009, or the date established by the board under section 376.962.

376.989. Neither the participation in the pool as members, the establishment of rates, forms or procedures, nor any other joint or collective action required or permitted by the provisions of sections 376.960 to 376.989 shall be the basis of any legal action, criminal or civil liability or penalty against the pool**, the pool administrator, the board or any of its members, or pool employees, contractors, or consultants,** or any of its members.

376.1800. Sections 376.1800 to 376.1839 shall be known and may be cited as the "Missouri Health Insurance Portability and Accessibility Act".

376.1803. 1. The governor may, on behalf of the state and in accordance with chapter 355, RSMo, establish a private not-for-profit corporation named the "Missouri Health Insurance Exchange", to carry out the provisions of sections 376.1800 to 376.1839. Before certification by the governor, the exchange shall conduct a public hearing for the purpose of giving all interested parties an opportunity to review and comment upon the articles of incorporation, bylaws and method of operation of the corporation. Notice of the hearing shall be given at least fourteen days prior to the hearing.

2. For the purposes of this chapter, unless the context clearly indicates otherwise, the following terms shall mean:

(1) "Applicant", an individual seeking to participate in the exchange;

(2) "Carrier", any person or organization subject to the authority of the director that provides one or more health benefit plans or insurance in Missouri, and includes an insurer, a hospital and medical services corporation, a fraternal benefit society, a health maintenance organization, or a multiple employer welfare arrangement;

(3) "Creditable coverage", continual coverage of the applicant under any of the following health plans, with no lapse in coverage of more than sixty-three days immediately prior to the date of application:

(a) A group health plan;

(b) Health insurance coverage;

(c) Part A or Part B of Title XVIII of the Social Security Act, 42 U.S.C. Section 1395c et seq. or 1395j et seq., respectively;

(d) Title XIX of the Social Security Act, 42 U.S.C. Section 1396 et seq., other than coverage consisting solely of benefits under Section 1928;

(e) Chapter 55 of Title 10, United States Code (10 U.S.C. Section 1071 et seq.);

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

(g) A state health benefits risk pool;

(h) A health plan offered under Chapter 89 of Title 5, United States Code (5 U.S.C. Section 8901 et seq.);

(i) A public health plan, as defined in federal or state regulations;

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

(k) Any other qualifying coverage required by HIPAA, as it may be amended, or regulations under that Act. Creditable coverage does not include coverage consisting solely of coverage of excepted benefits;

(4) "Dependent":

(a) The spouse of the principal insured; or

(b) An individual who is related to the principal insured by birth, marriage, or adoption; and

(c) Who also meets the definition of a dependent as set forth in the United States Internal Revenue Code of 1986, as amended, (26 U.S.C. Section 152);

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

(6) "Eligible individual", an individual who is eligible to participate in the exchange by reason of meeting one or more of the following qualifications:

(a) The individual is a Missouri resident, meaning that the individual is and continues to be legally domiciled and physically residing on a permanent and full-time basis in a place of permanent habitation in Missouri that remains the person's principal residence and from which the person is absent only for temporary or transitory purpose. A person who is a full-time student attending an institution outside of Missouri may maintain his or her Missouri residency;

(b) The individual is not a Missouri resident but is employed at least twenty hours a week on a regular basis at a Missouri location by a bona fide employer, and the individual's employer does not offer a group health insurance plan or the individual is not eligible to participate in any group health insurance plan offered by the individual's employer;

(c) The individual, whether a resident or not, is enrolled in or eligible to enroll in a participating employer plan;

(d) The individual is self-employed in Missouri, and if a nonresident self-employed individual, the individual's principal place of business is in Missouri;

(e) The individual is a full-time student attending an institution of higher education located in Missouri;

(f) The individual, whether a resident or not, is a dependent of another individual who is an eligible individual;

(7) "Employer", any individual, partnership, association, corporation, business trust, or person or group of persons employing one or more persons, and filing payroll tax information on such person or persons;

(8) "Excepted benefits", benefits under one or more, or any combination thereof, of the following:

(a) Benefits not subject to requirements:

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. Medical expense and loss of income benefits;

f. Credit-only insurance;

g. Coverage for on-site medical clinics; or

h. Other similar insurance coverage specified by rule under which benefits for medical care are secondary or incidental to other insurance benefits;

(b) Benefits not subject to requirements if offered separately:

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; or

c. Such other similar limited benefits as specified by rule;

(c) Benefits not subject to requirements if offered as independent noncoordinated benefits:

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

b. Hospital indemnity or other fixed indemnity insurance; and

(d) Benefits not subject to requirements if offered as a separate insurance policy:

a. Medicare supplemental health insurance, as defined in Section 1882(g)(1) of the federal Social Security Act, 42 U.S.C. Section 1395ss(g)(1);

b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code, 10 U.S.C. Section 1071 et seq.; or

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

(9) "Exchange", the Missouri health insurance exchange established in sections 376.1800 to 376.1839;

(10) "Federal health coverage tax credit eligible individual", any individual who is eligible for benefits under Section 201 of the Trade Act of 2002, 26 U.S.C. Section 35(c), as amended;

(11) "HIPAA", the Health Insurance Portability and Accountability Act of 1996, P. L. 104-191;

(12) "Participating employer plan", a group health plan, as defined in federal law, Section 706 of ERISA (29 U.S.C. Section 1186), that is sponsored by an employer and for which the plan sponsor has entered into an agreement with the exchange, in accordance with the provisions of section 376.1833, for the exchange to offer and administer health insurance benefits for enrollees in the plan;

(13) "Participating individual", a person who has been determined by the exchange to be and continues to remain an eligible individual for purposes of obtaining coverage under participating insurance plans offered through the exchange;

(14) "Participating insurance plan", a health benefit plan offered through the exchange;

(15) "Plan year", the period of time during which the insured is covered under a health benefit plan, as stipulated in the contract governing the plan;

(16) "Producer", a person required to be licensed in Missouri to sell, solicit, or negotiate insurance;

(17) "Rate", the premiums or fees charged by a health benefit plan for coverage under the plan.

376.1806. The articles of incorporation and bylaws of the Missouri health insurance exchange shall provide that:

(1) The purposes of the exchange are to provide eligible individuals with greater access to and choice and portability of health insurance products;

(2) The board of directors of the exchange is composed of nine persons. The governor shall annually appoint one of its members, who shall be from the private sector, as chairperson. The board shall consist of the following members:

(a) The director of the department of insurance, financial institutions, and professional registration, or the director's designee;

(b) The director of the department of social services, or the director's designee;

(c) The administrator of the Missouri high risk pool;

(d) The executive director of the Missouri consolidated health care plan;

(e) A member of the senate, appointed by the president pro tempore of the senate;

(f) A member of the house of representatives, appointed by the speaker of the house of representatives;

(g) Three members appointed by the governor from the private sector who shall include, but not be limited to, purchasers of health insurance, insurance producers, self-employed individuals, and small business owners;

(h) Each of the directors of the exchange who is appointed by the governor shall serve for a term of four years and until a successor is duly appointed; except that, of the directors serving on the exchange as of August 28, 2007, three directors shall be designated by the governor to serve a term of four years, three directors shall be designated to serve a term of three years, three directors shall be designated to serve a term of two years, and two directors shall be designated to serve a term of one year. Each director shall continue to serve until a successor is appointed by the governor;

(3) Any changes in the articles of incorporation or bylaws shall be approved by the governor.

376.1809. The exchange, after being certified by the governor as provided by section 376.1803, may:

(1) Contract with vendors to perform one or more of the functions specified in section 376.1812;

(2) Contract with private or public social service agencies to administer application, eligibility verification, enrollment, and premium payments for specified groups or populations of eligible individuals or participating individuals;

(3) Contract with employers to act as the plan administrator for participating employer plans, subject to the provisions of section 376.1833, and to undertake the obligations required by federal law of a plan administrator;

(4) Set and collect fees from participating individuals, participating employer plans, and participating insurance plans, sufficient to fund the cost of administering the exchange;

(5) Establish and administer rules and procedures governing the operations of the exchange;

(6) Establish one or more service centers within Missouri to facilitate enrollment;

(7) Sue and be sued or otherwise take any necessary or proper legal action;

(8) Establish bank accounts and borrow money;

(9) The exchange may receive money from any source, borrow money, enter into contracts, and expend money for any activities appropriate to its purpose;

(10) The exchange may appoint staff and do all other things necessary or incidental to carrying out the functions listed in this section.

376.1812. The exchange shall:

(1) Publicize the existence of the exchange and disseminate information on eligibility requirements and enrollment procedures for the exchange;

(2) Establish and administer procedures for enrolling eligible individuals in the exchange, including:

(a) Creating a standard application form to collect information necessary to determine the eligibility and previous coverage history of an applicant; and

(b) Preparing and distributing certificate of eligibility forms and application forms to insurance producers and the general public;

(3) Establish and administer procedures for the election of coverage by participating individuals, in accordance with section 376.1818, during open season periods and outside of open season periods upon the occurrence of any qualifying event specified in subsection 4 of section 376.1818, including preparing and distributing to participating individuals:

(a) Descriptions of the coverage, benefits, limitations, co-payments, and premiums for all participating plans; and

(b) Forms and instructions for electing coverage and arranging payment for coverage;

(4) Collect and transmit to the applicable participating plans all premium payments or contributions made by or on behalf of participating individuals, including developing mechanisms to:

(a) Receive and process automatic payroll deductions for participating individuals enrolled in participating employer plans;

(b) Enable participating individuals to pay, in whole or part, for coverage through the exchange by electing to assign to the exchange any federal earned income tax credit payments due the participating individual; and

(c) Receive and process any federal or state tax credits or other premium support payments for health insurance, as may be established by law;

(5) Upon request, issue certificates of previous coverage in accordance with the provisions of HIPAA to all such individuals who cease to be covered by a participating insurance plan;

(6) Establish procedures to account for all funds received and disbursed by the exchange, including:

(a) Maintaining a separate segregated management account for the receipt and disbursement of moneys allocated to fund the administration of the exchange;

(b) Maintaining a separate segregated operations account for:

(i) The receipt of all premium payments or contributions made by or on behalf of participating individuals; and

(ii) The distribution of premium payments to participating plans, and of commissions or payments to licensed insurance producers and such other organizations as are permitted under section 376.1836 to receive payments for their services in enrolling eligible individuals or groups in the exchange;

(7) Submit to the director, following the end of each plan year, the report of an independent audit of the exchange's accounts for the plan year;

(8) The exchange shall submit an annual independent audit following the end of each plan year to the governor and to the general assembly. The report shall be due on the first day of November for each year and shall include detailed information on the structure, operation and financial status of the exchange. The exchange shall conduct an annual public hearing to receive comments from interested parties regarding the independent audit and notice of the hearing shall be given at least fourteen days prior to the hearing;

(9) The exchange is subject to an annual audit by the state auditor and that the corporation shall bear the full cost of the audit; and

(10) All eligible individuals shall be permitted to obtain health insurance benefits through the exchange, subject to the provisions of sections 376.1800 to 376.1839.

376.1815. In order to assist the exchange in achieving the objectives identified in section 376.1806, the department of social services and the department of insurance, financial institutions, and professional registration may contract with the exchange for activities consistent with the exchange's purpose, as specified in section 376.1806. When contracting with the exchange under the provisions of this section, the departments authorized under this section may directly enter into agreements with the exchange and shall not be bound by the provisions of chapter 34, RSMo.

376.1818. 1. Any eligible individual may apply to participate in the exchange. An employer, a labor union, an educational, professional, civic, trade, church or social organization that has eligible individuals as employees or members may apply on behalf of those eligible persons. Upon determination by the exchange that an individual is eligible in accordance with the provisions of this section to participate in the exchange, he or she may enroll, or, when applicable, be enrolled by the individual's parent or legal guardian, in a participating insurance plan offered through the exchange during the next open season period or, when applicable, at such other times as are specified in subsection 4 of this section.

2. From November first to November thirtieth of each year the exchange shall administer an open season during which any eligible individual may enroll in any health benefit plan offered through the exchange, subject to the provisions of section 376.1824, without a waiting period, and shall not be declined coverage.

3. The first ninety days after the exchange begins to accept applications shall be considered the initial open season.

4. An eligible individual may enroll in a health benefit plan offered through the exchange, subject to the provisions of section 376.1824, without a waiting period, and shall not be declined coverage at a time other than the annual open season for any of the following reasons, provided the individual does so within sixty-three days of the triggering event:

(1) The individual loses coverage in an existing health insurance plan due to the death of a spouse, parent, or legal guardian;

(2) The individual, or a covered dependent, loses coverage in an existing health insurance plan due to a change in the individual's employment status;

(3) The individual, or a covered dependent, loses coverage in an existing health insurance plan because of a divorce, separation, or other change in familial status;

(4) The individual loses coverage in an existing health insurance plan because he or she achieves an age at which coverage lapses under that plan;

(5) The individual or a covered dependent becomes newly eligible by becoming a resident of Missouri or because the individual's place of employment has been changed to Missouri;

(6) The individual becomes newly eligible by becoming the spouse or dependent by reason of birth, adoption, court order or a change in custody arrangement, of an eligible individual;

(7) The individual becomes subject to a court order requiring him or her to provide health insurance coverage to certain dependents or enters into a new arrangement for the custody of dependents that requires the providing of health insurance for those dependents;

(8) The individual loses coverage in a plan offered through the exchange by reason of the plan terminating participation in the exchange prior to the end of the plan year.

376.1821. 1. No health benefit plan may be offered through the exchange unless the director has first certified to the exchange that:

(1) The carrier seeking to offer the plan is licensed to issue health insurance in Missouri and is in good standing with the department of insurance, financial institutions, and professional registration;

(2) The plan meets the requirements of this section and the plan and the carrier are in compliance with all other applicable health insurance laws.

2. No plan shall be certified that excludes from coverage any individual otherwise determined by the exchange as meeting the eligibility requirements for participating individuals.

3. The certification of plans to be offered through the exchange shall not be subject to any law in this state requiring competitive bidding.

4. Each certification shall be valid for a uniform term of at least one year, but may be made automatically renewable from term to term in the absence of notice of either:

(1) Withdrawal by the director; or

(2) Discontinuation of participation in the exchange by the plan or carrier.

5. Certification of a plan may be withdrawn only after notice to the carrier and opportunity for hearing. The director may, however, decline to renew the certification of any carrier at the end of a certification term.

6. Each plan certified by the director as eligible to be offered through the exchange shall contain a detailed description of benefits offered, including maximums, limitations, exclusions, and other benefit limits.

7. Each plan certified by the director as eligible to be offered through the exchange shall provide, subject to the plan's deductibles and co-insurance or co-payment schedule, major medical coverage that includes the following:

(1) Hospital benefits;

(2) Surgical benefits;

(3) In-hospital medical benefits;

(4) Ambulatory patient benefits;

(5) Prescription drug benefits.

8. Carriers shall offer plans in the exchange at standard rates based upon age, geography, healthy lifestyle considerations, and family composition and that are determined to be actuarially sound in the judgment of the director.

9. The rates determined for the first plan year for which the plan is offered through the exchange may be adjusted by the carrier for subsequent plan years based on experience and any later modifications to plan benefits, provided that any adjustments in rates shall be made in advance of the plan year for which they will apply and on a basis which, in the judgment of the director, is consistent with the general practice of carriers that issue health benefit plans to large employers.

10. The exchange shall not decline or refuse to offer, or otherwise restrict the offering to any participating individual, any plan that has obtained, in a timely fashion in

advance of the annual open season, certification by the director in accordance with the provisions of this section.

11. The exchange shall not sponsor any insurance or benefit plan, or contract with any carrier to offer any insurance or benefit plan, as a participating plan that has not first been certified by the director in accordance with the provisions of this section.

12. The exchange shall not impose on any participating plan or on any carrier or plan seeking to participate in the exchange, any terms or conditions, including any requirements or agreements with respect to rates or benefits, beyond, or in addition to, those terms and conditions established and imposed by the director in certifying plans under the provisions of this section.

13. The director shall establish and administer regulations and procedures for certifying plans to participate in the exchange in accordance with the provisions of this section.

376.1824. 1. The following rules shall govern the imposition by carriers of any preexisting condition provisions and rating surcharges with respect to any participating individual covered by any participating insurance plan:

(1) Current participants. Except as otherwise specified in subdivisions (3) and (4) of this subsection, during any open season a participating individual who elects to choose a different participating insurance plan or plan option for the next plan year shall not be subject to any preexisting condition provisions and shall be charged the standard rate of the new participating insurance plan or plan option for persons of the participating individual's age and geographic area. The same shall apply to any election by a participating individual of coverage for any dependent who is also a participating individual;

(2) New participants with creditable coverage. A new participating individual with eighteen months or more of creditable coverage who enrolls in a participating insurance plan shall not be subject to any preexisting condition provisions and shall be charged the applicable age and geography adjusted standard rate for the participating insurance plan;

(3) New participants with partial creditable coverage. A new participating individual with creditable coverage of between two and seventeen months may enroll in a participating insurance plan, but the participating individual may be subject to one or more preexisting condition provisions for a period not to exceed twelve months, the number of such months to be reduced by the number of months of creditable coverage, or charged a premium not to exceed one hundred twenty-five percent of the otherwise applicable age and geography adjusted standard rate for the participating insurance plan,

or both. Any such rate surcharge shall not be applied during the third or subsequent years of the individual's enrollment in any participating insurance plan;

(4) New participants without creditable coverage. A new participating individual with two months or less of creditable coverage may enroll in a participating insurance plan, but the participating individual may be subject to one or more preexisting condition provisions for a period not to exceed twelve months, the number of such months to be reduced by the number of months of creditable coverage, or charged a premium not to exceed one hundred fifty percent of the otherwise applicable age and geography adjusted standard rate for the participating insurance plan, or both. Any such rate surcharge shall not be applied during the third or subsequent years of the individual's enrollment in any participating insurance plan;

(5) Newly eligible dependents. In cases where an individual is enrolled in a plan offered through the exchange as a newly eligible dependent of a participating individual, by reason of birth, adoption, court order or a change in custody arrangement, either during open season or outside of open season in accordance with subdivision (6) of subsection 4 of section 376.1818, a carrier shall not impose any preexisting condition provisions or any change in the rate charged to the participating individual, except for such difference, if any, in the participating insurance plan's standard rates that reflect the addition of a new dependent to the participating individual's coverage;

(6) Creditable coverage. Periods of creditable coverage with respect to an individual shall be established through presentation of certifications or in such other manner as may be specified in federal or state law;

(7) Waiver of preexisting condition exclusion. For new participating individuals without creditable coverage, or with only limited creditable coverage as defined in subdivisions (3) and (4) of this subsection, a carrier may elect to waive the imposition of preexisting condition provisions and instead extend the applicable rate surcharge for an additional year beyond the time provided for in those subsections;

(8) Federal health coverage tax credit eligible individuals. For purposes of this section, any federal health coverage tax credit eligible individual shall be deemed to have eighteen months of creditable coverage.

2. For purposes of this section, any individual who is a participating individual by reason of enrollment in a participating employer plan shall be deemed to have eighteen months of creditable coverage.

376.1827. 1. Any participating individual may continue to participate in any participating insurance plan as long as the individual remains an eligible individual, subject to the carrier's rules regarding cancellation for nonpayment of premiums or fraud,

and shall not be cancelled or nonrenewed because of any change in employer or employment status, marital status, health status, age, membership in any organization or other change that does not affect eligibility as defined in this chapter.

2. A participating individual who is not a resident of Missouri and who ceases to be an eligible individual due to a qualifying event shall be deemed to remain an eligible individual and shall be deemed to remain a participating individual for a period not to exceed thirty-six months from the date of the qualifying event, if:

(1) The qualifying event consists of a loss of eligible individual status due to:

(a) Voluntary or involuntary termination of employment for reasons other than gross misconduct; or

(b) Loss of qualified dependent status for any reason; and

(2) The participating individual elects to remain a participating individual and notifies the exchange of such election within sixty-three days of the qualifying event.

376.1830. 1. The director shall establish procedures for resolving disputes arising from the operation of the exchange in accordance with the provisions of sections 376.1800 to 376.1839, including disputes with respect to:

(1) The eligibility of an individual to participate in the exchange;

(2) The imposition of a coverage surcharge on a participating individual by a participating plan; and

(3) The imposition of a preexisting condition provision on a participating individual by a participating plan.

2. In cases where a carrier, in accordance with the provisions of this section, imposes a preexisting condition exclusion or a premium surcharge in connection with enrollment of a participating individual in a participating insurance plan offered by the carrier and the participating individual disputes the imposition of such an exclusion or surcharge, the participating individual may request that the director issue a determination as to the validity or extent of such exclusion or surcharge under sections 376.1800 to 376.1839. The director, or the director's designee, shall issue such a determination within thirty days of the request being filed with the department. If either the participating individual or the carrier disagrees with the outcome, he or she may submit a request for a hearing to the director in accordance with chapter 536, RSMo.

376.1833. 1. Any employer may apply to the exchange to be the sponsor of a participating employer plan.

2. Any employer seeking to be the sponsor of a participating employer plan shall, as a condition of participation in the exchange, enter into a binding agreement with the exchange which shall include the following conditions:

(1) The sponsoring employer designates the exchange director to be the plan's administrator for the employer's group health plan and the exchange director agrees to undertake the obligations required of a plan administrator under federal law;

(2) Only the coverage and benefits offered by participating insurance plans shall constitute the coverage and benefits of the participating employer plan;

(3) That any individuals eligible to participate in the exchange by reason of their eligibility for coverage under the employer's participating employer plan, regardless of whether any such individuals would otherwise qualify as eligible individuals if not enrolled in the participating employer plan, may elect coverage under any participating insurance plan, and that neither the employer nor the exchange shall limit such individuals' choice of coverage from among all the participating insurance plans;

(4) The employer reserves the right to offer benefits supplemental to the benefits offered through the exchange, but any supplemental benefits offered by the employer shall constitute a separate plan or plans under federal law, for which the exchange director shall not be the plan administrator and for which neither the exchange director nor the exchange shall be responsible in any manner;

(5) The employer agrees that, for the term of the agreement, the employer will not offer to individuals eligible to participate in the exchange by reason of their eligibility for coverage under the employer's participating employer plan any separate or competing group health plan offering the same or substantially similar benefits as those provided by participating insurance plans through the exchange, regardless of whether any such individuals would otherwise qualify as eligible individuals if not enrolled in the participating employer plan;

(6) The employer reserves the right to determine the criteria for eligibility, enrollment, and participation in the participating employer plan and the terms and amounts of the employer's contributions to that plan, so long as for the term of the agreement with the exchange, the employer agrees not to alter or amend any criteria or contribution amounts at any time other than during an annual period designated by the exchange for participating employer plans to make such changes in conjunction with the exchange's annual open season;

(7) The employer agrees to make available to the exchange any of the employer's documents, records, or information, including copies of the employer's federal and state tax and wage reports, that the director reasonably determines are necessary for the exchange to verify:

(a) That the employer is in compliance with the terms of its agreement with the exchange governing the employer's sponsorship of a participating employer plan;

(b) That the participating employer plan is in compliance with applicable laws relating to employee welfare benefit plans, particularly those relating to nondiscrimination in coverage; and

(c) The eligibility, under the terms of the employer's plan, of those individuals enrolled in the participating employer plan;

(8) The employer agrees to sponsor a cafeteria plan as permitted under federal law, 26 U.S.C. Section 125, for all employees eligible for coverage under the employer's participating employer plan.

3. The exchange may not enter into any agreement with any employer with respect to any employer participating plan if such agreement does not, at a minimum, incorporate the conditions specified in subsection 2 of this section.

4. The exchange may not enter into any agreement with any employer with respect to any participating employer plan for the exchange to provide the participating employer plan with any additional or different services or benefits not otherwise provided or offered to all other participating employer plans.

5. Beginning with the first plan year following the establishment of the exchange, the state of Missouri shall enter into an agreement with the exchange to be the sponsor of a participating employer plan on behalf of any person eligible for health insurance benefits paid in whole or in part by the state of Missouri by reason of current or past employment by the state, or by reason of being a dependent of such person, except for any persons who are eligible only for benefits consisting solely of coverage of excepted benefits.

376.1836. 1. In cases when a producer licensed in Missouri enrolls in the exchange an eligible individual or group, the plan chosen by each individual shall pay the producer a commission in an amount or amounts voluntarily agreed to by the insurance carriers and producers of premium.

2. In cases when a membership organization enrolls in the exchange its eligible members or the eligible members of its member entities, the plan chosen by each individual shall pay the organization a fee equal to the commission specified in subsection 1 of this section. Nothing in this section shall be deemed either to require a membership organization that enrolls persons in the exchange to be licensed by the state of Missouri as an insurance producer, or to permit such an organization to provide any other services requiring licensure as an insurance producer without first obtaining such license.

376.1839. 1. A carrier shall not issue or renew an individual health benefit plan, other than through the exchange established under section 376.1806, after the first day of the plan year following the first regular open season conducted by the exchange in accordance with section 376.1818.

2. A carrier shall not issue or renew a group health benefit plan to a small employer with fifty or fewer employees other than through the exchange established under section 376.1806, after the first day of the plan year following the first regular open season conducted by the exchange in accordance with section 376.1818.

3. Subsections 1 and 2 of this section shall not apply to any health benefit plan that consists solely of one or more excepted benefits.

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