HCS HB 818 -- MISSOURI HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (Ervin)

COMMITTEE OF ORIGIN: Special Committee on Health Insurance

This substitute establishes the Missouri Health Insurance Portability and Accountability Act and changes the laws regarding the Missouri Health Insurance Pool, small employer insurance availability, prescription drug formularies, and health carrier claims information.

MISSOURI HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The substitute:

(1) Establishes the Missouri Health Insurance Portability and Accountability Act with provisions that will apply to small, large, and individual group health insurance markets which:

(a) Bring the Missouri Health Insurance Pool into compliance with the federal Health Insurance Portability and Accountability Act (HIPPA);

(b) Define the terms needed to carry out the provisions of the substitute;

(c) Allow an entity providing a group health plan to exclude or limit plan benefits, for no more than 18 months, if a medical condition received medical consideration within six months of enrolling into the plan;

(d) Allow an entity providing a group health plan to reduce pre-existing condition exclusions by the amount of creditable coverage a participant has accrued, subject to specified restrictions;

(e) Prohibit an entity providing group health insurance coverage from applying pre-existing conditions when creditable coverage applies;

(f) Require carriers to provide a certification of creditable coverage;

(g) Require a health insurance issuer to provide special enrollment periods when a health insurance issuer allows an employee or a dependent who is eligible but not enrolled for coverage, subject to specified restrictions; and

(h) Allow a health management organization to provide an affiliation period for coverage if no pre-existing condition

exclusions are imposed, the period is applied uniformly and does not exceed three months, or the period starts on the enrollment date and runs concurrently with waiting periods;

(2) Requires an entity offering group health insurance coverage to follow standards prohibiting discrimination of eligible individuals based on physical or mental health, claims experience, medical history, genetics, insurability, or disability and premiums based on health status; however, there will be no restrictions on the amount of employer contributions or from offering discounts or rebates for adherence to health programs;

(3) Requires the health insurance issuer to renew or continue coverage if opted by a health plan sponsor or individual, subject to specified restrictions;

(4) Prohibits an issuer from discontinuing a type of coverage or all health insurance coverage offered in the market subject to some specified exceptions, but allows modifications to the coverage;

(5) Prohibits a renewal from being denied to the employer unless it is denied to all employers in the association;

(6) Requires a premium-only cafeteria plan to be provided by a carrier when employers contribute to a health plan for an employee. Currently, there are premium only, child care, and reimbursed medical expenses sections of a cafeteria plan;

(7) Allows an employer to pursue a define-contribution model without a group plan;

(8) Allows an issuer to discontinue or not renew a type of coverage or all health insurance coverage offered in the market, subject to specified exceptions;

(9) Requires a health insurance issuer electing to discontinue offering all coverage in a defined market to provide notice and discontinue or not renew all health insurance coverage in the market. The issuer cannot re-enter the market for five years;

(10) Allows a health insurance issuer offering coverage in the individual market to modify coverage at the time of renewal only if the change is applied uniformly among all individual policies;

(11) Prohibits an association from denying coverage renewal to an individual unless the association doesn't renew all coverage;

(12) Requires an insurer to provide a certification of coverage

to the insured;

(13) Requires small employer health plans to comply with the requirements used by small employer carriers when determining whether to provide coverage to an employer. A carrier is prohibited from requiring minimum participation by greater than 100% of groups of three or less eligible employees or greater than 75% of groups of three or more employees;

(14) Allows a small employer carrier to not offer coverage to an employer or employee if the employer or employee is not physically located in the carrier's established geographic service area or there is no capability to deliver services adequately; and

(15) Requires each small employer carrier to actively market all plans sold in the small group market to eligible small employers.

MISSOURI HEALTH INSURANCE POOL

The substitute:

(1) Provides additional reasons for removing board members from the Missouri Health Insurance Pool Board;

(2) Establishes criteria for determining the eligibility of an individual for the high-risk pool and for determining when notifications need to be provided to pool members regarding underwriting, eligibility, premiums, and changes in coverage;

(3) Requires rates charged to pool members to be between 125% and 135% of the standard rate charge;

(4) Requires pool coverage to exclude expenses for pre-existing conditions;

(5) Excludes individuals without significant gaps in coverage from pre-existing condition exclusions; and

(6) Exempts the pool board administrator or employees from legal action pertaining to participation in the required duties of the pool.

PRESCRIPTION DRUG FORMULARIES

Any health carrier or health benefit plan that provides prescription drug coverage is required to notify enrollees in writing of all additions or deletions in its prescription drug formularies at least 30 days prior to the immediately preceding plan year and for each calendar quarter.

HEALTH CARRIER CLAIMS INFORMATION

Health carriers are required to provide a report of the total number and dollar amount of claims paid in the previous three years within 30 days of an employer's request. When an employer has multiple plans, the total dollar amounts must be combined into one report. The information will be furnished in a manner that does not individually identify any employee or other person covered by the health benefit plan and will comply with all applicable federal and state privacy laws regarding the disclosure of health records.

FISCAL NOTE: Estimated Cost on General Revenue Fund of Unknown less than $18,099,228 in FY 2008, Unknown less than $27,132,342 in FY 2009, and Unknown less than $31,615,917 in FY 2010. Estimated Cost on Other State Funds of Unknown less than $10,833 in FY 2008, Unknown less than $13,000 in FY 2009, and Unknown less than $13,000 in FY 2010.