SECOND REGULAR SESSION

HOUSE BILL NO. 2413

94TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES ERVIN (Sponsor), RICHARD, BIVINS, SCHARNHORST, FLOOK, STEVENSON, BAKER (123), JETTON, NIEVES, FAITH, NANCE, MUNZLINGER, MAY, SANDER, STREAM, POLLOCK, DETHROW, DUSENBERG, PRATT, PEARCE, DAY, FRANZ, SUTHERLAND, DIXON, ROBB, SCHOELLER, WILSON (130), COX, YATES, TILLEY, SMITH (150), MOORE, SCHNEIDER, DENISON, WELLS, BRANDOM, THOMSON, GRISAMORE, WETER, DEEKEN, PORTWOOD, JONES (89), FUNDERBURK, KINGERY, LIPKE, HOBBS, HUNTER, EMERY AND CUNNINGHAM (145) (Co-sponsors).

Read 1st time March 12, 2008 and copies ordered printed.

D. ADAM CRUMBLISS, Chief Clerk

4585L.01I

AN ACT

To repeal sections 148.380, 376.962, 376.966, 376.973, 376.975, 376.980, 376.984, 376.986, 376.987, and 376.990, RSMo, and to enact in lieu thereof seventeen new sections relating to the insure Missouri program, with an emergency clause and an effective date for certain sections.

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

Section A. Sections 148.380, 376.962, 376.966, 376.973, 376.975, 376.980, 376.984, 376.986, 376.987, and 376.990, RSMo, are repealed and seventeen new sections enacted in lieu thereof, to be known as sections 148.380, 376.962, 376.966, 376.981, 376.983, 376.985, 376.986, 376.987, 376.991, 1, 2, 3, 4, 5, 6, 7, and 8, to read as follows:

148.380. 1. Every such company, on or before the first day of March in each year, shall make a return verified by the affidavit of its president and secretary, or other chief officers, to the director of the department of insurance, stating the amount of all direct premiums received by it from policyholders in this state, whether in cash or in notes, during the year ending on the thirty-first day of December, next preceding. Upon receipt of such returns the director of the department of insurance shall verify the same and certify the amount of the tax due from the various companies on the basis and at the rate provided in section 148.370, taking into

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.

consideration deductions and credits allowed by law, and shall certify the same to the director of revenue together with the amount of the quarterly installments to be made as provided in subsection 2 of this section, on or before the thirtieth day of April of each year.

2. Beginning January 1, 1983, the amount of the tax due for that calendar year and each succeeding calendar year thereafter shall be paid in four approximately equal estimated quarterly installments, and a fifth reconciling installment. The first four installments shall be based upon the tax for the immediately preceding taxable year ending on the thirty-first day of December, next preceding. The quarterly installments shall be made on the first day of March, the first day of June, the first day of September and the first day of December. Immediately after receiving certification from the director of the department of insurance of the amount of tax due from the various companies, the director of revenue shall notify and assess each company the amount of taxes on its premiums for the calendar year ending on the thirty-first day of December, next preceding. The director of revenue shall also notify and assess each company the amount of the estimated quarterly installments to be made for the calendar year. If the amount of the actual tax due for any year exceeds the total of the installments made for such year, the balance of the tax due shall be paid on the first day of June of the year following, together with the regular quarterly payment due at that time. If the total amount of the tax actually due is less than the total amount of the installments actually paid, the amount by which the amount paid exceeds the amount due shall be credited against the tax for the following year and deducted from the quarterly installment otherwise due on the first day of June. If the March first quarterly installment made by a company is less than the amount assessed by the director of revenue, the difference will be due on June first, but no interest will accrue to the state on the difference unless the amount paid by the company is less than eighty percent of one-fourth of the total amount of tax assessed by the director of revenue for the immediately preceding taxable year.

3. If the estimated quarterly tax installments are not so paid, the director of revenue shall notify the director of the department of insurance who shall thereupon suspend such delinquent company from the further transaction of business in this state until such taxes shall be paid, and such companies shall be subject to the provisions of sections 148.410 to 148.461.

4. Upon receipt of the money the state treasurer shall receipt one-half thereof into the general revenue fund of the state, and one-half thereof to the credit of the county foreign insurance fund for the purposes set forth in section 148.360. **Beginning in fiscal year 2009 and every fiscal year thereafter, moneys collected under this section shall be distributed in accordance with section 376.991, RSMo.**

376.962. 1. The board of directors on behalf of the pool shall submit to the director a plan of operation for the pool and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the pool. 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. The 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. If the pool fails to submit a suitable plan of operation within one hundred eighty days after the appointment of the board of directors, 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.

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

2. The following individual persons shall be eligible for coverage under the pool if they are and continue to be residents of this state:

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

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

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

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

(3) A trade act eligible individual;

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

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

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

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

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

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

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

(a) This exclusion shall not apply to a person who has such coverage but whose premiums have increased to one hundred fifty percent to two hundred percent of rates established by the board as applicable for individual standard risks. After December 31, 2009, this exclusion shall not apply to a person who has such coverage but whose premiums have increased to three hundred percent or more of rates established by the board as applicable for individual standard risks;

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

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

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

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

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

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

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

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

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

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

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

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

376.981. The pool shall offer individual stop-loss coverage for any insurer licensed providing individual health insurance policies in this state. Such stop-loss coverage shall be provided by an insurer licensed by the state to write accident and health insurance on a direct basis. The stop-loss coverage shall cover claim liability for an insured person in the individual market who becomes uninsurable and any uninsurable dependent of an insured person, if coverage for an uninsurable dependent is requested. The stop-loss insurer shall bear the risk of coverage for such uninsurable persons.

376.983. 1. The pool shall establish a two-year pilot program that offers small group stop-loss coverage for health insurers providing health insurance coverage in the small group market in a county with a charter form of government and with more than six hundred thousand but fewer than seven hundred thousand inhabitants and in a county of the first classification with more than two hundred forty thousand three hundred but fewer than two hundred forty thousand four hundred inhabitants. The board shall promulgate rules for implementation of the pilot program established under this section.

2. To be eligible to purchase small group stop-loss coverage under the pool:

(1) The insurer shall not be permitted to purchase small group stop-loss coverage from the pool in the aggregate, but shall be required to purchase a separate stop-loss policy for each small group policy for which stop-loss coverage is being sought through the pool;

(2) The insurer shall provide the pool with sufficient information, to be determined by the board, establishing a need for the purchase of such stop-loss coverage for a small employer policy of the insurer;

(3) The risk or risks sought to be covered under such stop-loss coverage would result in the standard risk rate for an individual to exceed one hundred twenty-five percent of the standard risk rate for such individual under the policy;

(4) The stop-loss coverage shall include all individuals under the group policy that exceed the standard risk rates under subdivision (3) of this subsection; and

(5) The insurer shall establish to the satisfaction of the pool, as determined by the board, that purchase of stop-loss coverage of a small group policy will stabilize the standard risk rate for the small group policy.

3. By January 1, 2011, the board shall submit a report to the general assembly regarding the pilot project established under this section and any recommendations for expanding the program statewide.

4. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2008, shall be invalid and void.

376.985. 1. Beginning July 1, 2008, the pool shall offer at least one plan for uninsurable individuals eligible under the insure Missouri program established under sections 1 to 8 of this act that meets the criteria of the federal Centers for Medicare and Medicaid for such program.

2. The board may establish a premium subsidy program for low-income persons who are eligible for participation in the high-risk pool in accordance with the premiums established under section 376.986. The program may include incentives designed to encourage and promote healthy lifestyle choices which are appropriate and attainable for such participants, taking into consideration any limitations on lifestyle choices which exist based on the medical conditions and needs of the population served under the high-risk pool.

376.986. 1. The pool shall offer major medical expense coverage to every person eligible for coverage under section 376.966 **and may offer other health plans that the board determines to be in the best interest of the individuals covered under the pool**. The coverage to be issued by the pool and its schedule of benefits, exclusions and other limitations, shall be established by the board with the advice and recommendations of the pool members, and such plan of pool coverage shall be submitted to the director for approval. The pool shall also offer coverage for drugs and supplies requiring a medical prescription and coverage for patient education services, to be provided at the direction of a physician, encompassing the provision of information, therapy, programs, or other services on an inpatient or outpatient basis, designed to restrict, control, or otherwise cause remission of the covered condition, illness or defect.

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

3. The pool shall establish premium rates for pool coverage as provided in **[**subsection 4**] subsections 4 and 5** of this section. Separate schedules of premium rates based on age, sex and geographical location may apply for individual risks. Premium rates and schedules shall be submitted to the director for approval prior to use.

4. The pool, with the assistance of the director, shall determine the standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. **[**Initial rates for pool coverage shall not be less than one hundred twenty-five percent of rates established as applicable for individual standard risks.**]** Subject to the limits provided in this subsection, **[**subsequent**]** rates shall be established **in accordance with the premium rate schedule in subsection 5 of this section** to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein. In no event shall pool rates exceed the following:

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

(2) For all other individuals covered under the pool, one hundred fifty percent of rates applicable to individual standard risks.

5. **Premium rates for pool coverage shall be established in accordance with the following schedule:**

(1) For individuals with incomes of less than three hundred percent of the federal poverty level, a premium rate equal to the standard risk rates;

(2) For individuals with incomes of three hundred percent of the federal poverty level or more, a sliding scale premium rate based on income which is between one hundred and one hundred twenty-five percent of the standard risk rates established by rule.

6. For uninsurable individuals eligible for the insure Missouri program established under sections 1 to 8 of this act, the pool shall offer the coverage required under subsection 1 of section 376.985 to such individuals at the standard risk rates of the pool subject to the following:

(1) The department of social services shall pay all or a portion of the premium for such coverage for an individual to the extent authorized under the insure Missouri program;

(2) If the premium exceeds the amount paid by the department under this subsection, the individual covered shall be responsible for payment of any premium for such coverage not paid by the department; and

(3) For insure Missouri program participants who are eligible for federal participation moneys, the coverage for such individuals may, in accordance with the requirements of the federal waiver for such program, exceed the standard risk rates of the pool.

Any insurance agent broker licensed in this state who sells a health insurance policy offered under the pool to an individual eligible for coverage under this subsection shall receive an agent's or broker's commission from the pool for the sale of such policy in an amount equal to one percent of the premium for such policy.

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

[6.**] 8.** Pool coverage shall exclude charges or expenses incurred during the first **[**twelve**] six** months following the effective date of coverage as to any condition for which medical advice, care or treatment was recommended or received as to such condition during the six-month period immediately preceding the effective date of coverage. Such preexisting condition exclusions

shall be waived to the extent to which similar exclusions, if any, have been satisfied under any prior health insurance coverage which was involuntarily terminated, if application for pool coverage is made not later than sixty-three days following such involuntary termination and, in such case, coverage in the pool shall be effective from the date on which such prior coverage was terminated.

[7.**] 9.** No preexisting condition exclusion shall be applied to the following:

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

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

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

[9.**] 11.** Medical expenses shall include expenses for comparable benefits for those who rely solely on spiritual means through prayer for healing.

376.987. 1. The board shall offer to all eligible persons for pool coverage under section 376.966 the option of receiving health insurance coverage through a high-deductible health plan and the establishment of a health savings account**, or other similar account**. In order for a qualified individual to obtain a high-deductible health plan through the pool, such individual shall present evidence, in a manner prescribed by regulation, to the board that he or she has established a health savings account in compliance with 26 U.S.C. Section 223, and any amendments and regulations promulgated thereto.

2. As used in this section, the term "health savings account" shall have the same meaning ascribed to it as in 26 U.S.C. Section 223(d), as amended. The term "high-deductible health plan" shall mean a policy or contract of health insurance or health care plan that meets the criteria established in 26 U.S.C. Section 223(c)(2), as amended, and any regulations promulgated thereunder.

3. **The utilization of high deductible plans and the establishment of health savings accounts or other similar accounts shall be reviewed and reassessed annually by the appropriate legislative committees of the general assembly.**

4. The board is authorized to promulgate rules and regulations for the administration and implementation of this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2007, shall be invalid and void.

376.991. Notwithstanding any other provision of law to the contrary, beginning January 1, 2009, any premium tax imposed and collected in connection with the conduct of business in this state by a health insurer or any insurer offering health-related insurance products shall be distributed to the health insurance pool established under sections 376.960 to 376.991, as follows:

(1) For fiscal years 2009 and 2010, fifty percent of all such premium taxes collected;

(2) For fiscal year 2011 and every fiscal year thereafter, one hundred percent of all such premium taxes collected.

Section 1. 1. As used in sections 1 to 8 of this act, the following terms shall mean:

(1) "Department", the department of social services;

(2) "Health insurance pool" or "pool", the health insurance pool established under sections 376.960 to 376.991, RSMo;

(3) "Insure Missouri program" or "program", the insure Missouri initiative established in sections 1 to 8 of this act;

(4) "Prevention and wellness services", medically appropriate and age appropriate care that is provided to an individual to prevent and diagnose disease, and promote good health and a healthy lifestyle.

2. There is hereby established within the department of social services the "Insure Missouri Program" to provide health care coverage through the private insurance market to low-income working adults residing in this state. The department shall apply to the United States Department of Health and Human Services for approval of a Section 1115 demonstration waiver and/or a Medicaid state plan amendment to develop and implement the program. Such submitted waiver or amendment shall include but not be limited to:

(1) A provision that allows for transitional participation in the program as set forth in subsection 3 of section 6 of this act; and

(2) For uninsurable individuals receiving coverage through the state's health insurance pool, a provision that allows for:

(a) Federal participation moneys to be used to provide such uninsurable individuals with pool coverage under the program; and

(b) Premium rates for coverage for such individuals that exceed the standard risk rates of the health insurance pool based on the aggregate losses for all such individuals eligible for federal participation moneys.

3. Prior to the submission of an application for a federal waiver or amendment under subsection 2 of this section, the department shall submit the proposed application for such waiver or amendment to the joint committee on MO HealthNet for the committee's review and recommendations.

4. The program is not an entitlement program for participants with incomes over eighty-five percent of the federal poverty level. The maximum enrollment of individuals who may participate in the program is dependent on funding appropriated for the program by the general assembly. Eligibility for the program may be phased in incrementally on the basis of actions taken by the general assembly in the appropriations process.

5. The department shall establish standards for consumer protection, including the following:

(1) Quality of care standards;

(2) A uniform process for participant grievances and appeals;

(3) Standardized reporting concerning provider performance, consumer experience, and cost.

6. The insure Missouri program shall pay one hundred percent of the premium costs for all participants in the program, except for participants eligible for transitional participation under subsection 3 of section 6 of this act.

Section 2. 1. An individual shall be eligible for participation in the program if the individual meets the following requirements:

(1) The individual is at least nineteen years of age and less than sixty-five years of age;

(2) The individual is a United States citizen and has been a resident of Missouri for at least twelve months;

(3) The individual has an annual household income of not more than two hundred twenty-five percent of the federal income poverty level;

(4) The individual is not eligible for health insurance coverage through the individual's employer;

(5) The individual has not had health insurance coverage for at least six months;

(6) The individual has household earned income that exceeds the maximum income for eligibility for Temporary Assistance for Needy Families (TANF) benefits.

2. The following individuals shall not be eligible for the program:

(1) An individual who participates in the federal Medicare program, 42 U.S.C. 1395, et seq.;

(2) A pregnant woman for purposes of pregnancy-related services.

3. The eligibility requirements specified in subsection 1 of this section are subject to approval for federal financial participation by the United States Department of Health and Human Services.

4. The department shall provide for enrollment with the program through the department's Internet web site and family support division offices.

Section 3. 1. The program shall include the following medically necessary services in a manner and to the extent determined by the department:

(1) Inpatient hospital services;

(2) Outpatient hospital and ambulatory surgical center services;

(3) Emergency room services;

(4) Physician and advanced practice nurse services;

(5) Federally qualified health center and rural health clinic services;

(6) Laboratory, radiology, and other diagnostic services;

(7) Prescription drug coverage;

(8) Mental health and substance abuse treatment. The program shall not permit treatment limitations or financial requirements on the coverage of mental health care services or substance abuse services if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions;

(9) Home health services;

(10) Durable medical equipment;

(11) Family planning services:

(a) Including contraceptives and sexually transmitted disease testing, as described in federal Medicaid law, 42 U.S.C. 1396, et seq.; and

(b) Not including abortion or abortifacients, except as required in federal Medicaid law, 42 U.S.C. 1396, et seq.;

(12) Personal care services;

(13) Emergency ground and air transportation services;

(14) Hospice services;

(15) Prevention and wellness services. The program shall, at no cost to the individual, provide payment for at least three hundred dollars of qualifying prevention and wellness services per year for an individual who participates in the program. Any additional prevention and wellness services covered under the program and received by the individual during the year are subject to the deductible and payment requirements of the program; and

(16) Case management, care coordination, and disease management.

2. The program may include incentives designed to encourage and promote healthy lifestyle choices which are medically appropriate, age appropriate, and attainable for individual participants, taking into consideration any limitations on lifestyle choices which may exist based on medical conditions and the needs of the population serviced under the program.

Section 4. 1. Every individual who participates in the program shall have an individual insure Missouri account to which payments may be made for the individual's participation in the program by any of the following:

(1) The individual;

(2) An employer;

(3) The state;

(4) Any philanthropic or charitable contributor.

2. The minimum funding amount for an individual insure Missouri account is the amount required under section 6 of this act.

3. An individual insure Missouri account shall be used to pay the individual's deductible for health care services under the program.

4. An individual may make payments to his or her individual insure Missouri account as follows:

(1) An employer withholding or causing to be withheld from an employee's wages or salary, after taxes are deducted from the wages or salary, the individual's contribution under this section and distributed equally throughout the calendar year;

(2) Submission of the individual's contribution under sections 1 to 8 of this act to the department to deposit in the participant's individual insure Missouri account in a manner prescribed by the department;

(3) Another method determined by the department.

5. An employer may make, from moneys not payable by the employer to the employee, not more than fifty percent of an individual's required payment to his or her individual insure Missouri account.

6. Any employer making any contributions for a participant in the insure Missouri program may make such contribution to the employee's individual insure Missouri account or may make such contribution towards the payment of any premiums for coverage of the employee under the program.

Section 5. 1. An individual's participation in the program shall not begin until an initial payment is made for the individual's participation in the program. A required payment to the program for the individual's participation shall not exceed one-twelfth of the annual payment required under subsection 2 of this section.

2. To participate in the program, an individual shall:

(1) Apply for the program in a manner prescribed by the department. The department may develop and allow a joint application for a household;

(2) If the individual is approved by the department to participate in the program, contribute to an individual insure Missouri account the lesser of the following:

(a) One thousand dollars per year or an amount not to exceed the deductible for the participant's coverage under the program, whichever is greater, less any amounts paid by the individual under:

a. The MO HealthNet program;

b. The children's health insurance program; and

c. The Medicare program, 42 U.S.C. 1395, et seq.,

as determined by the department; or

(b) Not more than the following applicable percentage of the individual's annual household income per year, less any amounts paid by the individual under the MO HealthNet program, the children's health insurance program, and the Medicare program, 42 U.S.C. 1395, et seq., as determined by the department:

a. One percent of the individual's annual household income per year for incomes up to one hundred percent of the federal poverty level;

b. Two percent of the individual's annual household income per year if the individual has an annual household income of more than one hundred percent and not more than one hundred twenty-five percent of the federal poverty level;

c. Three percent of the individual's annual household income per year if the individual has an annual household income of more than one hundred twenty-five percent and not more than one hundred fifty percent of the federal poverty level;

d. Four percent of the individual's annual household income per year if the individual has an annual household income of more than one hundred fifty percent and not more than two hundred percent of the federal poverty level; or

e. Five percent of the individual's annual household income per year if the individual has an annual household income of more than two hundred and not more than two hundred twenty-five percent of the federal poverty level.

3. The state shall contribute the difference to the individual's account if the individual's payment required under subdivision (2) of subsection 2 of this section is less than one thousand dollars.

4. If an individual's required payment to the program is not made within sixty days after the required payment date, the individual may be terminated from participation in the program. The individual shall receive written notice before the individual is terminated from the program.

5. If an individual is terminated from the program for fraud or under subsection 4 of this section, the individual shall not reapply for participation in the program within six months of termination.

Section 6. 1. An individual who is approved to participate in the program is eligible for a twelve-month program period. An individual who participates in the program without a break in service shall not be refused renewal of participation in the program:

(1) For the sole reason that the program has reached the program's maximum enrollment; or

(2) If the individual is eligible for transitional participation under subsection 3 of this section.

2. If the individual chooses to renew participation in the program, the individual shall complete a renewal application and any necessary documentation, and submit to the insure Missouri program the documentation and application on a form prescribed by the department.

3. If an individual is eligible and participates in the program without a break in service and such individual's income subsequently exceeds two hundred twenty-five percent of the federal poverty level at the time of such individual's renewal, the individual may choose and shall be eligible for transitional participation in the program. Any individual participating in the program as a transitional participant shall be eligible to receive coverage at the same premium rates established for the program and shall be responsible for payment of the total premium costs for such coverage. Any moneys in such participant's insure Missouri account shall:

(1) If the participant receives coverage through a deductible plan, be rolled over into a health savings account; or

(2) If the participant receives coverage through a nondeductible plan, be paid directly to such participant.

4. Any moneys remaining in an individual insure Missouri account of a participant who renews participation in the program at the end of the individual's twelve-month program period shall be used to reduce the individual's payments for the subsequent program period.

5. If an individual is no longer eligible for the program, does not renew participation in the program at the end of the program period, is terminated from the program for nonpayment of a required payment, or is a transitional participant under subdivision (2) of subsection 3 of this section, the department shall, as determined by rule and not more than ninety days after the last date of participation in the program, refund to the individual the amount of any individual payments remaining in the individual insure Missouri account less any healthy lifestyle incentive moneys remaining in the account.

Section 7. 1. For individuals approved for participation in the program, health care coverage shall be obtained as follows:

(1) An individual approved for participation in the program shall seek health care coverage through a qualified plan available in the private individual health insurance market from insurance agents and brokers; or

(2) If an individual approved for participation in the program is uninsurable in the private individual health insurance market, the individual shall receive health care coverage through a qualified plan available in the health insurance in accordance with the provisions of sections 376.960 to 376.991, RSMo, established for such coverage.

2. The deductible for any qualified plan under the program shall not exceed two thousand five hundred dollars.

3. Any insurance agent or broker licensed in this state who sells an individual health insurance policy in the private individual market or in the health insurance pool to an individual approved for participation in the insure Missouri program shall receive an agent's or broker's commission for the sale of such policy in an amount equal to one percent of the premium for such policy.

4. The department of social services, in consultation and coordination with the department of insurance, financial institutions and professional registration and the board of directors for the health insurance pool, shall ensure that individuals approved for participation in the program are able to seek and obtain health insurance coverage under the program through insurance agents and brokers licensed in this state.

5. The department of social services, the department of insurance, financial institutions and professional registration, and the board of directors for the health insurance pool may promulgate rules and/or joint rules to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo,

that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after the effective date of this section shall be invalid and void.

Section 8. The department of social services shall promulgate rules and regulations for the implementation of sections 1 to 8 of this act. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. Sections 1 to 8 of this act and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after the effective date of sections 1 to 8 of this act shall be invalid and void.

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

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

3. Each insurance arrangement's assessment shall be determined by multiplying the total cost of pool operation calculated under subsection 1 of this

section by a fraction, the numerator of which equals one hundred ten percent of the benefits paid by that insurance arrangement on behalf of insureds in this state during the preceding calendar year and the denominator of which equals the total of all premiums, subscriber contract charges and one hundred ten percent of all benefits paid by insurance arrangements made on behalf of insureds in this state during the preceding calendar year. Insurance arrangements shall report to the board claims payments made in this state on an annual basis on a form prescribed by the director.

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

[376.975. Each member's proportion of participation in the pool shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the member with it. Any deficit incurred by the pool shall be recouped by assessments apportioned as provided in subsections 1, 2, and 3 of section 376.973 by the board among members. The amount of assessments incurred by each member of the pool shall be allowed as an offset against certain taxes, and shall be subject to certain limitations, as follows: Each pool member subject to chapter 148, RSMo, may deduct from premium taxes payable for any calendar year to the state any and all assessments paid for the same year pursuant to sections 376.960 to 376.989. All assessments, for a fiscal year, shall not exceed the net premium tax due and payable by such member in the previous year. If the assessment exceeds any premium tax due or payable in such year, the excess shall be a credit or offset carried forward against any premium tax due or payable in succeeding years until the excess is exhausted.**]**

[376.980. Each pool member exempt from chapter 148, RSMo, shall be allowed to offset against any sales or use tax on purchases due, paid, or payable in the calendar year in which such assessments are made. Further, such assessment, for any fiscal year, shall not exceed one percent of nongroup premium income, exclusive of Medicare supplement programs, received in the previous year. If the assessment exceeds the part of any sales tax or use tax due or payable in such year, the excess shall be a credit or offset carried forward against the part of any sales tax or use tax due or payable in succeeding years until the excess is exhausted. The director of revenue, in consultation with the board, shall promulgate and enforce reasonable rules and regulations and prescribe forms for the administration and enforcement of this law.**]**

[376.984. The board may abate or defer, in whole or in part, the assessment of a member if, in the opinion of the board, payment of the

assessment would endanger the ability of the member to fulfill its contractual obligations. In the event an assessment against a member is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessment set forth in subsections 1, 2, and 3 of section 376.973. The member receiving such abatement or deferment shall remain liable to the pool for the deficiency for four years.**]**

[376.990. The board of directors of the state health insurance pool is hereby directed to conduct a study regarding the financing of the state health insurance pool. Such study shall include, but not be limited to, research and findings of how other states finance their state high-risk pools. The study shall consider alternative assessment approaches to the current assessment method employed in section 376.975. In addition to studying alternative financing mechanisms employed by other state high-risk pools, the board shall explore the ramifications of eliminating or reducing a carrier's ability to offset their assessments against their premium tax liability. The polestar of the study shall be establishing a stable funding source for the Missouri state health insurance pool while providing adequate health insurance coverage to Missouri's uninsurable population. The board of directors of the state health insurance pool shall submit a report of its findings and recommendations to each member of the general assembly no later than January 1, 2008.**]**

Section B. Because immediate action is necessary to ensure adequate health care coverage for low-income individuals, section A of this act is deemed necessary for the immediate preservation of the public health, welfare, peace, and safety, and is hereby declared to be an emergency act within the meaning of the constitution, and section A of this act shall be in full force and effect on July 1, 2008, or upon its passage and approval, whichever later occurs.

Section C. Sections 376.966, 376.981, 376.983, and subsections 1 to 5 and 7 to 11 of section 376.986 of section A of this act shall become effective January 1, 2009.

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