HOUSE _____ AMENDMENT NO.___

Offered By

AMEND House Committee Substitute for Senate Committee Substitute for Senate Bill No. 17, in the title, Lines 2 - 3 by deleting the words “cord blood banking” and insert in lieu thereof the words “healthy living”; and

Further amend said Bill, Section 191.758, Page 2, Line 7, by inserting after all of said section and line the following:

“376.1150. 1. Sections 376.1150 to 376.1185 shall be known and may be cited as the "Show-Me Health Insurance Exchange Act".

2. The purpose of sections 376.1150 to 376.1185 is to provide for the establishment of a health benefit exchange to facilitate the purchase and sale of qualified health plans and qualified dental plans in the individual market in this state and to provide for the establishment of a small business health options program (SHOP exchange) to assist qualified small employers in this state in facilitating the enrollment of their employees in qualified health plans and qualified dental plans offered in the small group market. The intent of the exchange is to reduce the number of uninsured, provide a transparent marketplace, increase competition in the health insurance market, increase portability of health insurance coverage, reduce health care costs, provide consumer education, and assist individuals with access to programs, premium assistance tax credits, and cost-sharing reductions. The exchange shall conduct extensive consumer outreach to increase the awareness and effectiveness of the exchange.

3. As used in sections 376.1150 to 376.1185, the following terms shall mean:

(1) "Beneficiaries of an eligible entity", individuals who are determined to be eligible for programs administered under Title XIX or Title XXI of the Social Security Act.

(2) "Board of trustees" or "board", the Show-Me health insurance exchange board of trustees;

(3) "Catastrophic plan", a health plan meeting the requirements of Section 1302(e) of the federal act;

(4) "Department", the department of insurance, financial institutions and professional registration;

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

(6) "Educated health care consumer", an individual who is knowledgeable about the health care system, and has background or experience in making informed decisions regarding health, medical, and scientific matters;

(7) "Eligible entity", a person or agency meeting the requirements of Section 1311(f)(3)(B) of the federal act;

(8) "Exchange", the Show-Me health insurance exchange established under section 376.1153;

(9) "Federal act", the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments thereto, or regulations or guidance issued under such federal acts;

(10) "Health insurance coverage" or "health benefit plan", shall have the same meaning as such terms are defined in section 376.450. For purpose of sections 376.1150 through 376.1185, the terms "health plan" and "health insurance" shall also have the same meaning as the terms "health insurance coverage" or "health benefit plan" as such terms are defined in section 376.450;

(11) "Health insurance issuer" or "insurer" or "issuer", the same meaning as such terms are defined in section 376.450;

(12) "Navigator", an entity chosen by the exchange that meets the requirements of the federal act and the exchange. A navigator may carry out activities authorized by the federal act and the exchange except a navigator or any person acting on behalf of a navigator may not perform any function or engage in any conduct requiring licensure as an insurance producer without being properly licensed as an insurance producer;

(13) "Qualified dental plan", a limited scope dental plan that has been certified in accordance with subsection 4 of section 376.1165;

(14) "Qualified employer", a small employer that elects to make its full-time employees eligible for one or more qualified health plans and qualified dental plans offered through the SHOP exchange, and at the option of the employer, some or all of its part-time employees, provided that:

(a) The employer has its principal place of business in this state and elects to provide coverage through the SHOP exchange to all of its eligible employees, wherever employed; or

(b) The employer's full-time employees meet the requirements of section 379.930;

(15) "Qualified health plan", a health plan that meets the criteria for certification described in Sections 1301 and 1311 of the federal act and section 376.1165. Health plans considered qualified health plans may include health benefit plans as defined in section 376.450;

(16) "Qualified individual", an individual, including a minor, who:

(a) Is seeking to enroll in a qualified health plan or a qualified dental plan offered to individuals through the exchange;

(b) Resides in this state;

(c) At the time of enrollment is not incarcerated, other than incarceration pending the disposition of charges; and

(d) Is and is reasonably expected to be for the entire period for which enrollment is sought a citizen or national of the United States or an alien lawfully present in the United States;

(17) "Secretary", the secretary of the federal Department of Health and Human Services;

(18) "SHOP exchange", the small group market health options program within the unified exchange established under section 376.1153;

(19) "Small employer", an employer that employed an average of not more than fifty employees during the preceding calendar year. For purposes of this subdivision:

(a) All persons treated as a single employer under Section 414(b), (c), (m), or (o) of the Internal Revenue Code of 1986, as amended, shall be treated as a single employer;

(b) An employer and any predecessor employer shall be treated as a single employer;

(c) All employees shall be counted, including part-time employees and employees who are not eligible for coverage through the employer;

(d) If an employer was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees the employer is reasonably expected to employ on business days in the current calendar year;

(e) An employer that makes enrollment in qualified health plans or qualified dental plans available to its employees through the SHOP exchange and would cease to be a small employer by reason of an increase in the number of its employees, shall continue to be treated as a small employer for purposes of sections 376.1150 to 376.1185 as long as it continuously makes enrollment through the SHOP exchange available to its employees;

(20) "Unified exchange", for administrative purposes only, an organized and transparent marketplace for individuals and small employers to purchase health insurance coverage through qualified health plans and qualified dental plans and obtain health insurance information; except that, a unified exchange shall not combine actuarial and underwriting functions for the individual and small group market, and shall keep intact a separate and distinct risk pool for the individual market and the SHOP exchange market.

376.1153. 1. There is hereby created the "Show-Me Health Insurance Exchange" as a quasi-public governmental agency under the direction of a board of trustees. The purpose of the board of trustees shall be to conduct the business necessary to implement the exchange and to carry out the functions of the exchange in a fair and impartial manner in order to execute a more competitive insurance marketplace. Notwithstanding any provision of law to the contrary, such exchange may transact business, contract, sue and be sued, invest funds and hold cash, securities, and other property, and shall be vested with such other powers as may be necessary or proper to enable it, its officers, employees, and agents to carry out fully and effectively the purposes of sections 376.1150 to 376.1185.

2. The board shall be comprised of the following seventeen members:

(1) The directors of the following departments as ex officio members:

(a) Social services;

(b) Insurance, financial institutions and professional registration, who shall serve as vice-chair;

(c) Mental health;

(d) Health and senior services;

(2) Two members of the house of representatives, one from the majority party and one from the minority party, to be appointed by the speaker of the house;

(3) Two members of the senate, one from the majority party and one from the minority party, to be appointed by the president pro tem of the senate;

(4) The following nine members to be appointed by the governor with the advice and consent of the senate:

(a) A representative for licensed health insurance producers;

(b) A representative for licensed health insurance issuers that is ranked as one of the top ten health insurance issuers by total market share in the state in the department's annual market share ranking

and participates in the unified exchange;

(c) A representative of a licensed health insurance issuer that is ranked between eleven and twenty health insurance issuers by total market share in the state in the department's annual market share ranking and participates in the unified exchange;

(d) A public health consumer advocate for individuals who purchase coverage through the exchange;

(e) A large employer representative;

(f) A small employer representative;

(g) An individual with expertise in administering and negotiating health plan contracts on behalf of employees; and

(h) Two at-large members.

3. One member of the board shall serve as chair, to be elected annually by a majority of the members of the board.

4. The general assembly and department director members of the board shall serve on the board so long as they hold their respective title and position. With the exception of the initial terms, all members of the board appointed by the governor shall serve a three-year term; except that, the initial terms of the appointed board members shall be as follows:

(1) The at-large member shall serve a one-year term;

(2) The small employer and large employer representatives shall serve two-year terms;

(3) The representatives for licensed health insurance producers, licensed health insurance issuers, public health consumer advocate, and the individual with expertise in administering and negotiating health plan contracts on behalf of employees shall serve three-year terms.

5. Vacancies for an unexpired term for a member of the general assembly shall be filled by the speaker of the house of representatives and president pro tem of the senate. Vacancies for an unexpired term of members appointed by the governor shall be filled by the governor.

6. All members shall be eligible for reappointment.

7. A financial interest in the exchange shall not prohibit an individual from being appointed by the governor or the general assembly to serve on the board; except that, all appointed board members shall annually disclose to the board any and all personal and professional financial interests related to the operation of the exchange, which shall be made available upon public request. The annual disclosure shall be supplemented as necessary during the year if any board member's personal or professional financial interest related to the operation of the exchange changes in any way. A board member shall recuse himself or herself from any deliberations or voting actions of the board when a conflict of interest has been disclosed.

8. Any board member or employee of the exchange accepting any gratuity or compensation for the purpose of influencing his or her action with respect to the investment of the funds of the exchange or who fails to disclose conflicts of interest and recuse himself or herself from board deliberations and voting actions related to such conflict of interest shall thereby forfeit his or her membership or employment and shall be subject to the penalties prescribed by law.

9. (1) The board shall appoint an executive director for the exchange, who shall have charge of

the offices, records, and employees of the exchange, subject to the board's approval. The executive director and the board shall employ additional essential officers of the quasi-public governmental agency necessary to the operation of the exchange.

(2) The executive director shall employ such other employees as authorized by the board to conduct the business of the exchange.

(3) Employees and officers of the exchange shall receive salaries and necessary expenses set by the board. The board shall take into account salaries paid by health insurance issuers, health plans, and health care providers in establishing appropriate pay schedules for its employees.

10. The board shall arrange for annual audits of the records and accounts of the plan by a certified public accountant or firm of certified public accountants. The state auditor shall examine such audits at least once every three years and report to the board and the governor.

11. The state auditor shall have the authority to independently audit the accounts and records of the "Show-Me Health Insurance Exchange" and its board of trustees.

12. The board shall keep a record of its proceedings, which shall be open to public inspection. The board shall prepare annually and make available a report showing the financial condition of the exchange which shall contain, but not be limited to, a financial balance sheet, a statement of income and disbursements, a detailed statement of investments acquired and disposed of during the year, together with a detailed statement of the annual rates on investment return from all assets and from each type of investment, a listing of all advisors and consultants retained by the board, and such other data as the board shall deem necessary or desirable for a proper understanding of the condition of the plan. The board and exchange shall be subject to the provisions of chapter 610.

13. Members of the board of trustees shall serve without compensation for their services as members of the board, but shall be paid for any necessary expenses incurred in attending meetings of the board or committees thereof or in the performance of other duties authorized by the board.

14. The board shall meet within the state of Missouri not less than once per calendar quarter, at a time set at a previously scheduled meeting or at the request of the chair or any four members of the board acting jointly. Board members may use teleconferencing and other electronic means to attend board meetings. Notice of the meeting shall be made public on the exchange website or such other readily available public access media. The board may meet at any time by unanimous consent.

15. Subject to the limitations of law, the board shall formulate and adopt rules for the governing of its own proceedings.

376.1155. The exchange shall:

(1) Facilitate the purchase and sale of qualified health plans and qualified dental plans;

(2) Provide for the establishment of a unified exchange to assist both individuals who purchase coverage in the individual market and qualified small employers in this state in facilitating the enrollment of their employees in qualified health plans and qualified dental plans in the SHOP exchange;

(3) Meet the requirements of sections 376.1150 to 376.1185 and any rules promulgated thereunder;

(4) Implement procedures for the certification, recertification, and decertification of health plans as qualified health plans and qualified dental plans, consistent with Sections 1301 and 1311 of the federal

act and guidelines developed by the Secretary;

(5) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

(6) Provide for enrollment periods under Section 1311(c)(6) of the federal act;

(7) Maintain an internet website through which enrollees and prospective enrollees of qualified health plans and qualified dental plans may obtain standardized comparative information on such plans;

(8) Assign a rating to each qualified health plan and qualified dental plan offered through the exchange in accordance with the criteria developed by the Secretary under Section 1311(c)(3) of the federal act, and determine each qualified health plan's or dental plan's level of coverage in accordance with regulations issued by the Secretary under Section 1302(d) of the federal act;

(9) Use a standardized format for presenting health benefit plan options in the exchange, including the use of the uniform outline of coverage established under Section 2715 of the federal Public Health Services Act;

(10) In accordance with Section 1413 of the federal act, inform individuals of eligibility requirements for the Medicaid program under Title XIX of the Social Security Act, the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act, or any applicable state or local public program and if through screening of the application by the exchanges, the exchange determines that any individual is eligible for any such program, enroll the individual in such program. Nothing in this subdivision shall be construed to require an individual to participate in the exchange;

(11) Establish and make available by electronic means:

(a) A calculator to determine the actual cost of coverage after application of any premium tax credit under Section 36B of the Internal Revenue Code of 1986, as amended, and any cost-sharing reduction under Section 1402 of the federal act; and

(b) A consumer tool to calculate out-of-pocket costs for each health plan offered through the exchange if the data required to support the tool is provided by the health insurance issuer that offers a health plan through the exchange;

(12) Develop a standardized application for qualified individuals and small employers to use to apply for health benefit plans through the exchange. Each health insurance issuer that offers a qualified health plan through the exchange shall use the standard application and shall not use any other application for health benefit plans;

(13) Subject to Section 1411 of the federal act, grant a certification attesting that, for purposes of the individual responsibility penalty under Section 5000A of the Internal Revenue Code of 1986, as amended, an individual is exempt from the individual responsibility requirement or from the penalty imposed by Section 5000A of the Internal Revenue Code of 1986, as amended, because:

(a) There is no affordable qualified health plan available through the exchange or the individual's employer covering the individual; or

(b) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

(14) Transfer information under Section 1311(d)(4)(I) to the federal Secretary of the Treasury regarding:

(a) Individuals exempted from the individual responsibility requirement;

(b) Employed individuals eligible for the premium tax credit under Section 36B of the Internal Revenue Code of 1986, as amended; and

(c) Individuals with changes to their employer-sponsored coverage;

(15) Provide to each employer the name of each employee of the employer described in paragraph (b) of subdivision (14) of this section who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

(16) Perform duties required of the exchange by the Secretary or the Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost-sharing, or individual responsibility requirement exemptions;

(17) Establish a navigator program as a function of the exchange operations for the purpose of awarding grants to selected entities to perform and carry out functions of a navigator, as described in Section 1311(i) of the federal act. Grants awarded by the exchange shall be made from the operational funds of the exchange. Federal funds received by the state to establish the exchange shall not be used for grants;

(18) Establish a fair and impartial health insurance producer referral network for the purpose of assisting individual and qualified small employers in obtaining health insurance coverage through the unified exchange. The producers in the producer referral network shall be compensated in a manner appropriate to the health insurance producer industry;

(19) Stakeholder groups may be formed to provide consultation or guidance to the exchange, or its board, with regard to the duties and activities required under sections 376.1150 to 376.1185. Members of the stakeholder group may include but not be limited to:

(a) Educated health care consumers who are enrollees in qualified health plans and qualified dental plans;

(b) Individuals and entities with experience in facilitating enrollment in qualified health plans and qualified dental plans;

(c) Representatives of small employers and self-employed individuals;

(d) Advocates for enrolling hard-to-reach populations;

(e) Appropriate eligible entities as identified in section 376.1160;

(f) Health insurance issuers;

(g) Health care providers, including but not limited to physicians, hospitals, pharmacists, and pharmaceutical manufacturers; and

(h) Others interested in access to affordable quality health care services;

(20) Meet the following financial integrity requirements:

(a) Keep an accurate accounting of all activities, receipts, and expenditures, and annually submit to the Secretary, the governor, and the general assembly a report concerning such accountings;

(b) Fully cooperate with any investigation conducted by the Secretary in accordance with the Secretary's authority under the federal act, and allow the Secretary, in coordination with the Inspector General of the U.S. Department of Health and Human Services, to:

a. Investigate the affairs of the exchange;

b. Examine the properties and records of the exchange; and

c. Require periodic reports in relation to the activities undertaken by the exchange; and

(c) In carrying out its activities under sections 376.1150 to 376.1185, not use any funds intended for the administrative and operational expenses of the exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative and regulatory modifications;

(21) Develop guidelines for qualified health plans and qualified dental plans to mitigate the occurrence of adverse selection within the exchange as allowable under the federal act; and

(22) Review the rate of premium growth within the exchange and outside the exchange, and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers.

376.1160. 1. The exchange may enter contract or enter into a memorandum of understanding with an eligible entity or health plan for state employees as defined in chapter 103 for any or all of its administrative functions described in sections 376.1150 to 376.1185.

2. Beneficiaries of an eligible entity may select any health plan offered by a health insurance issuer contracted with MO HealthNet. The director of the MO HealthNet division shall provide to the exchange no less than annually a list of contracted health insurance issuers. Health plans offered through the exchange to beneficiaries of an eligible entity shall be maintained in a risk pool that is separate and distinct from qualified health plans and qualified dental plans offered within the exchange to individuals who are not beneficiaries of an eligible entity. Nothing in this section shall require a health insurance issuer to offer a health plan to beneficiaries of an eligible entity.

3. A state employee as defined in section 103.003 may select any qualified health plan or qualified dental plan through the exchange.

4. The exchange may contract with the department for the certification, recertification, and decertification of health plans and dental plans as qualified health plans and qualified dental plans.

5. An eligible entity that contracts with the exchange for purposes of this section shall not be eligible to offer a qualified health plan or qualified dental plan through the exchange.

6. The exchange may enter into information-sharing agreements with federal and state agencies and other state exchanges to carry out its responsibilities under sections 376.1150 to 376.1185, provided such agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all state and federal laws and regulations.

376.1165. 1. The exchange shall certify a health plan as a qualified health plan or qualified dental plan if that plan has met the requirements in subdivision (4) of section 376.1155.

2. The exchange shall not exclude a health plan:

(1) On the basis that the plan is a fee-for-service plan;

(2) Through the imposition of premium price controls by the exchange;

(3) On the basis that the health plan provides treatments necessary to prevent patients' deaths in circumstances the exchange determines are inappropriate or too costly; or

(4) On the basis that the health plan is offered by a health insurance issuer not contracted with the MO HealthNet program.

3. The exchange shall require each health insurance issuer seeking certification of a plan as a

qualified health plan or qualified dental plan to meet the following requirements:

(1) Submitting justification for premium increases under Section 1311(e)(2) of the federal act;

(2) Providing public disclosure of information under Section 1311(e)(3)(A) of the federal act;

(3) Providing consumer education about the exchange under Section 1311(e)(3)(C) of the federal act;

(4) Providing notification of health plan changes;

(5) Promptly notifying affected individuals of price and benefit changes, or other changes in circumstance that could materially impact enrollment or coverage; and

(6) Providing timely updates regarding the plan's provider network, including the addition of new providers or the withdrawal of an existing provider through the publicly accessible internet website selected by the exchange as the most appropriate way to disseminate the information.

4. (1) The provisions of sections 376.1150 to 376.1185 that are applicable to qualified health plans shall also apply to the extent relevant to qualified dental plans, except as modified in accordance with the provisions of subdivisions (2) to (4) of this subsection or by regulations adopted by the exchange.

(2) The issuer shall be licensed to offer dental coverage, but need not be licensed to offer other health benefits.

(3) The exchange shall allow a health insurance issuer to offer a plan that provides limited scope dental benefits meeting the requirements of Section 9832(c)(2)(A) of the Internal Revenue Code of 1986, as amended, through the exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of Section 1302(b)(1)(J) of the federal act. The plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health plans without dental coverage and shall include, at a minimum, the essential pediatric dental benefits prescribed by the Secretary under Section 1302(b)(1)(J) of the federal act, and such other dental benefits as the exchange or the Secretary may specify by regulation.

(4) Health insurance issuers may jointly offer a comprehensive plan through the exchange in which the dental benefits are provided by a health insurance issuer through a qualified dental plan and the other benefits are provided by a health insurance issuer through a qualified health plan, provided the plans are priced separately and are also made available for purchase separately at the same price. Nothing in this section shall be construed as prohibiting a health insurance issuer from offering a discounted rate on a qualified dental plan when purchased jointly with a qualified health plan.

5. (1) The exchange shall not exempt any health insurance issuer seeking certification of a qualified health plan or qualified dental plan, regardless of the type or size of the health insurance issuer, from state licensure or solvency requirements and shall apply the criteria of this section in a manner that assures competition between or among health insurance issuers participating in the exchange.

(2) The director shall determine whether a health plan seeking certification or recertification as a qualified health plan or qualified dental plan meets all the requirements related to licensure and solvency.

6. The exchange shall establish an appeals process for health insurance issuers to appeal a decertification decision or the denial of certification as a qualified health plan or qualified dental plan.

376.1170. 1. Beginning January 1, 2014, the exchange shall be operational to make available for purchase qualified health plans and qualified dental plans to qualified individuals and qualified

employers. The exchange shall not make available any health benefit plan that is not a qualified health plan or qualified dental plan; except for any health plan described in subsection 2 of section 376.1160. Prior to January 1, 2014, the exchange may disclose qualified health plan and qualified dental plan coverage and price information available for consumers.

2. Neither the exchange nor a health insurance issuer offering health plans through the exchange may charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable under the standards of Section 36B(c)(2)(C) of the Internal Revenue Code of 1986, as amended.

3. Qualified employers in the small group market may make their employees eligible for one or more qualified health plans offered through the exchange and specify a level of coverage so that any of its employees may enroll in any qualified health plan or qualified dental plan offered through the SHOP exchange at the specified level of coverage.

4. The exchange shall permit a consumer to establish a personal health record.

376.1175. 1. Federal funding for direct costs related to the development and operation of the exchange through 2014, the first year of operation, shall be provided under federal law. By January 1, 2015, the exchange shall be financially self-sustained through fees and assessments under subsection 3 of this section and under Section 1311(d)(5)(A) of the federal act.

2. The board shall annually submit a copy of the operating budget for the exchange to the speaker of the house of representatives and president pro tem of the senate for any year in which the exchange is allocated federal funds.

3. The exchange shall charge assessments or user fees to health insurance issuers, whether or not they are participating
in the exchange, for each policyholder of an individual health insurance policy issued in this state, for each employee covered under a small group policy issued in this state, and may otherwise generate funding necessary to support its operations provided under sections 376.1150 to 376.1185. Any assessments or fees charged to health insurance issuers shall be limited to the minimum amount necessary to pay for the administrative and capital costs and expenses that have been approved in the annual budget process, with consideration of other available funding sources. Services performed by the exchange on behalf of other state programs or federal programs shall not be funded with assessments or user fees collected from health insurance issuers.

4. Any unexpended funding of the exchange shall be used for further exchange operations or returned to health insurance issuers and health plans as a credit for future imposed assessments or fees.

5. The exchange shall publish the average costs of licensing, regulatory fees, taxes, issuer assessments, and any other payments required by the exchange, and the administrative costs of the exchange, on an internet website to educate consumers on such costs as authorized under Section 1311(d)(7) of the federal act.

6. Taxes, fees, or assessments used to finance the exchange shall be considered a state tax or assessment as outlined in Section 2718 of the Public Health Services Act and its implementing regulations, and shall be excluded from health plan administrative costs for the purpose of calculating

medical loss ratios or rebates, to the full extent allowed by federal regulation.

7. The board shall have exclusive jurisdiction and control over the funds and property of the exchange. Income of the exchange shall not be considered revenue of the state of Missouri. The assets of the exchange shall be exempt from state and all political subdivision taxes.

8. All moneys received by or belonging to the exchange shall be paid to the executive director and promptly deposited by the executive director to the credit of the exchange in one or more banks, trust companies, or other financial institutions as selected by the board. No such moneys shall be deposited or be retained by any bank, trust company, or other financial institution which does not have on deposit with and for the board at the time the kind and value of collateral required by sections 30.240 and 30.270 for depositories of the state treasurer. Such moneys shall be funds of the exchange and shall not be commingled with any funds in the state treasury. The executive director shall be responsible for all funds, securities, and property belonging to the exchange and shall be provided with such corporate surety bond for the faithful handling of such funds, securities, and property as the board shall require.

376.1180. 1. Nothing in sections 376.1150 to 376.1185 shall prohibit qualified individuals or qualified employers from purchasing any health plans and dental plans outside the exchange.

2. The provisions of sections 376.1150 to 376.1185 shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policy of six months' or less duration, or any other supplemental policy.

376.1185. 1. (1) The board may promulgate rules for the proceedings, implementation, and operations of sections 376.1150 to 376.1185.

(2) Rules promulgated under this subdivision shall not conflict with or prevent the application of rules promulgated by the Secretary under the federal act.

(3) Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in sections 376.1150 to 376.1185 shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. Sections 376.1150 to 376.1185 and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 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, 2011, shall be invalid and void.

2. (1) Nothing in sections 376.1150 to 376.1185 and no action taken by the exchange under sections 376.1150 to 376.1185 shall be construed to preempt or supersede the authority of the director to regulate the business of insurance within this state.

(2) Except as expressly provided to the contrary in sections 376.1150 to 376.1185, all health insurance issuers offering qualified health plans in this state shall comply fully with all applicable health insurance laws of this state and regulations adopted and orders issued by the director.

(3) The director may promulgate rules regarding the activities of navigators, consistent with the federal act and any regulations issued by the secretary. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this subdivision shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable,

section 536.028. The provisions of this subdivision and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 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, 2011, shall be invalid and void.

3. Sections 376.1150 to 376.1185 shall become null and void and be unenforceable in this state as of the date the federal act in its entirety or Section 1311 of the federal act is declared to be unconstitutional or otherwise invalid by the United States Supreme Court or is repealed by the United States Congress.

[374.284. The department of insurance, financial institutions and professional registration shall create an advisory committee to be known as the "Health Insurance Advisory Committee". This committee shall be a voluntary committee comprised of representatives of the insurance industry, provider groups and the public. The committee shall consist of at least, but not limited to, one member representing each of the following areas: small group insurance, managed care, doctors of medicine, doctors of osteopathy, pharmacists, dentists and public members representing self-employed workers and the elderly. This committee shall meet to discuss and advise the department on issues relating to health care insurance.**]**"; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.