HCS SS SB 401 -- HEALTH INSURANCE

SPONSOR: Rupp (Molendorp)

COMMITTEE ACTION: Voted "Do Pass" by the Committee on Insurance Policy by a vote of 9 to 0.

This substitute changes the laws regarding health insurance. In its main provision, the substitute:

(1) Specifies that the powers of a health maintenance organization (HMO) include offering at least one health benefit plan that contains deductibles combined with a health savings or health reimbursement account meeting specified conditions, coinsurance, coinsurance differentials, or variable copayments;

(2) Requires that a statement or summary of evidence of coverage include any limitations on the services, kinds of services, benefits or kinds of benefits to be provided, including coinsurance or other cost sharing features as requested by the group contract holder or, in the case of non-group coverage, the individual certified holder;

(3) Allows a health carrier to offer a managed care plan that requires all health care services to be delivered by a participating provider in the health carrier's network, except for emergency services and certain chemical dependency treatments, and requires this provision to be disclosed in the policy form;

(4) Authorizes the Director of the Department of Insurance, Financial Institution and Professional Registration to make rules and regulations concerning the filing and submission of policies, including the disapproval of policies. If a policy form is disapproved, all specific reasons for noncompliance must be stated in writing within 45 days of the date of filing, and the director must approve or disapprove a submitted policy within 45 days of the date of filing or the policy will be considered approved. However if the director deems any provision of the policy is contrary to state law, the director must notify the carrier of the provision and request the carrier file an amendment to modify it. The amended policy will have force and effect as if the amendment was in the original filing or policy. When an amendment is necessary, at the request of the director, then the health carrier issuing the policy will be considered to have committed a level one violation under Section 374.049, RSMo;

(5) Specifies that beginning August 28, 2013, the board of directors, the executive director, and any employees of the Missouri Health Insurance Pool will have the authority to provide

assistance or resources to the federal government for the specific purpose of transitioning individuals enrolled in the pool to coverage outside of the pool on or before January 1, 2014. This authority does not extend to authorizing the pool to implement, establish, create, administer, or otherwise operate a state-based exchange. By September 1, 2013, the board must submit the amendments to the plan of operation as are necessary or suitable to ensure a reasonable transition period to allow for the termination of issuance of policies by the pool. The amendments must include all current requirements under Section 376.962.2, including the selection of an administering insurer or third-party administrator, and must address the transition of individuals covered under the pool to alternative health insurance coverage as it is available after January 1, 2014. The plan of operation must also address procedures for finalizing the financial matters of the pool, including assessments, claims expenses, and other specified matters. The department director must review the plan of operation and must establish rules to effectuate the transitional plan of operation. The rules must be effective no later than October 1, 2013;

(6) Specifies that prior to January 1, 2014, the board of directors and administering insurers may issue policies of insurance from the Missouri Health Insurance Pool; however, they are prohibited from issuing new insurance policies on or after January 1, 2014. All coverage under the pool must expire on January 1, 2014;

(7) Requires, by September 1, 2013, the board to invite all insurers and third-party administrators, including the current administering insurer, to submit bids to serve as the administering insurer or third-party administrator for the pool. The selection of the administering insurer or third-party administrator must be made prior to January 1, 2014. Beginning January 1, 2014, the administering insurer or third-party administrator must:

(a) Submit to the board and the department director a detailed plan outlining the winding down of operations of the pool. The plan must be submitted no later than January 31, 2014, and must be updated quarterly thereafter;

(b) Perform all administrative claim-payment functions relating to the pool;

(c) Perform all necessary functions to assure timely payment of benefits to covered persons under the pool including making information on submitting a claim for benefits to the pool available, distributing forms on which submissions must be made, and evaluating the eligibility of each claim for payment by the

pool;

(d) Submit regular reports to the board regarding the operation of the pool. The frequency, content, and form of the report must be determined by the board;

(e) Determine, following the close of each calendar year, the expense of administration and the paid and incurred losses for the year and report the information to the board and department on a form prescribed by the department director; and

(f) Be paid as provided in the plan of operation for its expenses incurred in the performance of its services;

(8) Requires Missouri Health Insurance Pool assessments to continue until the executive director of the pool notifies the board and the department director that all claims have been paid. Any assessment funds remaining at the time that all claims have been paid must be deposited in the General Revenue Fund; and

(9) Allows a health carrier to electronically contact enrollees and providers acting on behalf of enrollees in the case of a determination or adverse determination to certify an admission, procedure, service, extended stay, or additional services.

HEALTH INSURANCE MARKETPLACE INNOVATION ACT OF 2013

(1) Prohibits an individual from performing or advertising a service as a navigator unless the individual is licensed by the Department of Insurance, Financial Institutions and Professional Registration. A "navigator" is a person who provides information or services in connection with the eligibility, enrollment, or program specifications of a health benefit exchange operating in Missouri;

(2) Allows a navigator to provide fair and impartial information and services regarding the eligibility, enrollment, and program specifications of a health insurance exchange, facilitate the selection of a qualified health plan, initiate the enrollment process, provide referrals for consumer assistance, and use culturally appropriate language to communicate information to the consumer;

(3) Prohibits a navigator from selling or negotiating health insurance; engaging in an activity that requires an insurance producer license; providing advice regarding the benefits, terms, and features of a plan; recommending a particular health plan; or providing information or services not included in the health insurance exchange;

(4) Exempts an insurance producer, licensed attorney, and a health care provider from the navigator licensing requirements;

(5) Requires the department director, when reviewing a navigator license application for approval to confirm that the individual is at least 18 years of age, resides or maintains his or her principal place of business in the state, has not committed a disqualifying act, has passed the written examination prescribed by the director, and when applicable, has the written consent of the director under 18 U.S.C. 1033; has identified his or her affiliated entity, and has paid the fees prescribed by the director;

(6) Requires an entity that acts as a navigator to apply for a navigator entity license and requires the entity to provide a list of individual navigators employed by the entity to the department director;

(7) Requires a navigator to obtain a surety bond or demonstrate a level of financial responsibility capable of protecting a person against a wrongful act or negligence;

(8) Specifies that a navigator license will be valid for two years and is renewal upon payment of a renewal fee and fulfillment of the continuing education requirements;

(9) Specifies that the department director may place on probation, suspend, revoke, or refuse to issue or renew a navigator license and may levy a fine of up to $1,000 for a violation under Sections 375.141 and 375.936 regarding insurance producers. The applicant may appeal the nonrenewal or denial of a license. Other violations are also specified in the substitute; and

(10) Specifies that the activities and duties of a navigator must be deemed to constitute transacting the business of insurance.

The substitute contains an emergency clause for the provisions regarding navigators and are severable.

PROPONENTS: Supporters say that the bill will allow states to regulate navigators who will receive federal funds to assist individuals regarding the new federally run health exchanges. Because navigators receive sensitive information such as financial, tax, and health records, it is necessary to regulate them.

Testifying for the bill were Senator Rupp; and Missouri Association of Insurance Agents and Missouri Insurance Coalition.

OPPONENTS: Opponents say that the bill modifies certain sections

regarding the usual enforcement practices for insurance. Sections 376.405 and 376.777 modify penalty provisions so that it may not be possible to use enhanced monetary penalties against health insurance carriers who knowingly violate state law. The bill could interfere with nonprofit organizations that provide navigator services and subject them to unnecessary and burdensome regulation.

Testifying in opposition to the bill were Department of Insurance, Financial Institutions, and Professional Registration; and American Cancer Society.