FIRST REGULAR SESSION

HOUSE BILL NO. 449

100TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE HILL.

0257H.04I DANA RADEMAN MILLER, Chief Clerk

AN ACT

To repeal sections 135.800, 376.450, 376.960, 376.961, 376.962, 376.964, 376.965, 376.966, 376.970, and 376.987, RSMo, and to enact in lieu thereof nineteen new sections relating to the Missouri reinsurance plan.

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

Section A. Sections 135.800, 376.450, 376.960, 376.961, 376.962, 376.964, 376.965, 376.966, 376.970, and 376.987, RSMo, are repealed and nineteen new sections enacted in lieu thereof, to be known as sections 135.800, 374.900, 374.905, 374.910, 374.915, 374.920, 374.925, 374.930, 374.935, 374.960, 376.450, 376.960, 376.961, 376.962, 376.964, 376.965, 376.966, 376.970, and 376.987, to read as follows:

135.800. 1. The provisions of sections 135.800 to 135.830 shall be known and may be cited as the "Tax Credit Accountability Act of 2004".

2. As used in sections 135.800 to 135.830, the following terms mean:

(1) "Administering agency", the state agency or department charged with administering a particular tax credit program, as set forth by the program's enacting statute; where no department or agency is set forth, the department of revenue;

(2) "Agricultural tax credits", the agricultural product utilization contributor tax credit created pursuant to section 348.430, the new generation cooperative incentive tax credit created pursuant to section 348.432, the family farm breeding livestock loan tax credit created under section 348.505, the qualified beef tax credit created under section 135.679, and the wine and grape production tax credit created pursuant to section 135.700;

(3) "All tax credit programs", or "any tax credit program", the tax credit programs included in the definitions of agricultural tax credits, business recruitment tax credits, community

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.

development tax credits, domestic and social tax credits, entrepreneurial tax credits, environmental tax credits, financial and insurance tax credits, housing tax credits, redevelopment tax credits, and training and educational tax credits;

(4) "Business recruitment tax credits", the business facility tax credit created pursuant to sections 135.110 to 135.150 and section 135.258, the enterprise zone tax benefits created pursuant to sections 135.200 to 135.270, the business use incentives for large-scale development programs created pursuant to sections 100.700 to 100.850, the development tax credits created pursuant to sections 32.100 to 32.125, the rebuilding communities tax credit created pursuant to section 135.535, the film production tax credit created pursuant to section 135.750, the enhanced enterprise zone created pursuant to sections 135.950 to 135.970, and the Missouri quality jobs program created pursuant to sections 620.1875 to 620.1900;

(5) "Community development tax credits", the neighborhood assistance tax credit created pursuant to sections 32.100 to 32.125, the family development account tax credit created pursuant to sections 208.750 to 208.775, the dry fire hydrant tax credit created pursuant to section 320.093, and the transportation development tax credit created pursuant to section 135.545;

(6) "Domestic and social tax credits", the youth opportunities tax credit created pursuant to section 135.460 and sections 620.1100 to 620.1103, the shelter for victims of domestic violence created pursuant to section 135.550, the senior citizen or disabled person property tax credit created pursuant to sections 135.010 to 135.035, the special needs adoption tax credit created pursuant to sections 135.325 to 135.339, the champion for children tax credit created pursuant to section 135.341, the maternity home tax credit created pursuant to section 135.600, the surviving spouse tax credit created pursuant to section 135.090, the residential treatment agency tax credit created pursuant to section 135.1150, the pregnancy resource center tax credit created pursuant to section 135.630, the food pantry tax credit created pursuant to section 135.647, the health care access fund tax credit created pursuant to section 135.575, the residential dwelling access tax credit created pursuant to section 135.562, the developmental disability care provider tax credit created under section 135.1180, the shared care tax credit created pursuant to section 192.2015, and the diaper bank tax credit created pursuant to section 135.621;

(7) "Entrepreneurial tax credits", the capital tax credit created pursuant to sections 135.400 to 135.429, the certified capital company tax credit created pursuant to sections 135.500 to 135.529, the seed capital tax credit created pursuant to sections 348.300 to 348.318, the new enterprise creation tax credit created pursuant to sections 620.635 to 620.653, the research tax credit created pursuant to section 620.1039, the small business incubator tax credit created

pursuant to section 620.495, the guarantee fee tax credit created pursuant to section 135.766, and the new generation cooperative tax credit created pursuant to sections 32.105 to 32.125;

(8) "Environmental tax credits", the charcoal producer tax credit created pursuant to section 135.313, the wood energy tax credit created pursuant to sections 135.300 to 135.311, and the alternative fuel stations tax credit created pursuant to section 135.710;

(9) "Financial and insurance tax credits", the bank franchise tax credit created pursuant to section 148.030, the bank tax credit for S corporations created pursuant to section 143.471, the exam fee tax credit created pursuant to section 148.400, the **[**~~health insurance~~**]** **reinsurance** pool tax credit created pursuant to section 376.975, the life and health insurance guaranty tax credit created pursuant to section 376.745, the property and casualty guaranty tax credit created pursuant to section 375.774, and the self-employed health insurance tax credit created pursuant to section 143.119;

(10) "Housing tax credits", the neighborhood preservation tax credit created pursuant to sections 135.475 to 135.487, the low-income housing tax credit created pursuant to sections 135.350 to 135.363, and the affordable housing tax credit created pursuant to sections 32.105 to 32.125;

(11) "Recipient", the individual or entity who is the original applicant for and who receives proceeds from a tax credit program directly from the administering agency, the person or entity responsible for the reporting requirements established in section 135.805;

(12) "Redevelopment tax credits", the historic preservation tax credit created pursuant to sections 253.545 to 253.559, the brownfield redevelopment program tax credit created pursuant to sections 447.700 to 447.718, the community development corporations tax credit created pursuant to sections 135.400 to 135.430, the infrastructure tax credit created pursuant to subsection 6 of section 100.286, the bond guarantee tax credit created pursuant to section 100.297, the disabled access tax credit created pursuant to section 135.490, the new markets tax credit created pursuant to section 135.680, and the distressed areas land assemblage tax credit created pursuant to section 99.1205;

(13) "Training and educational tax credits", the Missouri works new jobs tax credit and Missouri works retained jobs credit created pursuant to sections 620.800 to 620.809.

374.900. 1. Sections 374.900 to 374.960 shall be known as the "Missouri Reinsurance Plan".

2. For the purposes of sections 374.900 to 374.960, the following terms shall mean:

(1) "Affordable Care Act", the federal Patient Protection and Affordable Health Care Act, as defined in section 376.1186;

(2) "Attachment point", an amount as provided in subdivision (2) of subsection 2 of section 374.910;

(3) "Benefit year", the calendar year for which an eligible health carrier provides coverage through an individual health insurance coverage;

(4) "Board", the board of directors of the reinsurance pool established under sections 376.960 to 376.989;

(5) "Coinsurance rate", the rate as provided in subdivision (3) of subsection 2 of section 374.910;

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

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

(8) "Eligible health carrier", any of the following entities that offer individual health insurance coverage, incur claims costs for individual health insurance coverage, and incur claims costs for an individual enrollee's covered benefits in the applicable benefit year:

(a) An insurance company licensed under section 375.014 to offer, sell, or issue a policy of accident and sickness insurance as defined in section 376.773;

(b) A nonprofit health service plan corporation operating under section 354.090; or

(c) A health maintenance organization as defined in section 354.400;

(9) "Individual health insurance coverage", as defined in section 376.450;

(10) "Individual market", as defined in section 376.450;

(11) "Missouri reinsurance plan" or "plan", the state-based reinsurance program authorized under section 374.910 and sections 376.960 to 376.989;

(12) "Payment parameters", the attachment point, reinsurance cap, and coinsurance rate for the plan;

(13) "Reinsurance cap", the threshold amount as provided in subdivision (4) of subsection 2 of section 374.910;

(14) "Reinsurance payments", an amount paid by the department to an eligible health carrier under the plan.

374.905. The director shall require eligible health carriers to calculate the premium amount the eligible health carrier would have charged for the benefit year if the Missouri reinsurance plan had not been established. The eligible health carrier shall submit this information as part of its rate filing. The director shall consider this information as part of the rate review.

374.910. 1. The department shall be Missouri's reinsurance entity to monitor the board. The department shall:

(1) Have the authority to apply for any available federal funding for the plan. The department shall notify the chairs and ranking minority members of the legislative committees with jurisdiction over health and senior services and insurance within ten days of receiving any federal funds;

(2) Collect or access data from an eligible health carrier that is necessary to determine reinsurance payments, according to the date requirements under subdivision (3) of subsection 5 of this section;

(3) For each applicable benefit year, notify eligible health carriers of reinsurance payments to be made for the applicable benefit year no later than June thirtieth of the year following the applicable benefit year;

(4) On a quarterly basis during the applicable benefit year, provide each eligible health carrier with the calculation of total reinsurance payment requests; and

(5) By August fifteenth of the year following the applicable benefit year, disburse all applicable reinsurance payments to an eligible health carrier.

2. The board shall design and adjust the payment parameters to ensure the payment parameters:

(1) Will stabilize or reduce premium rates in the individual market;

(2) Will increase participation in the individual market;

(3) Will improve access to health care providers and services for those in the individual market;

(4) Mitigate the impact high-risk individuals have on premium rates in the individual market;

(5) Take into account any federal funding available for the plan; and

(6) Take into account the total amount available to fund the plan.

3. (1) The board shall determine the payment parameters for the next benefit year by January fifteenth of the year before the applicable benefit year.

(2) If the amount in the Missouri reinsurance fund established under section 374.920 is not anticipated to be adequate to fully fund the approved payment parameters as of July first of the year before the applicable benefit year, the director shall assess to each insurer, under the provisions of sections 376.960 to 376.989, any additional funds due that exceed available reinsurance funds. The director shall permit an eligible health carrier to revise an applicable rate filing based on the final payment parameters for the next benefit year.

4. Each reinsurance payment shall be calculated with respect to an eligible health carrier's incurred claims costs for an individual enrollee's covered benefits in the applicable benefit year. If the claims costs do not exceed the attachment point, the

reinsurance payment is zero dollars. If the claims costs exceed the attachment point, the reinsurance payment shall be calculated as the product of the coinsurance rate and the lesser of the claims costs minus the attachment point or the reinsurance cap minus the attachment point. The board shall ensure that reinsurance payments made to eligible health carriers do not exceed the total amount paid by the eligible health carrier for an eligible claim.

5. (1) An eligible health carrier may request reinsurance payments from the department when the eligible health carrier meets the requirements of this subsection and subsection 4 of this section.

(2) An eligible health carrier shall make requests for reinsurance payments in accordance with any requirements established by the department.

(3) An eligible health carrier shall provide the department with access to the data within the dedicated data environment established by the eligible health carrier under the federal risk adjustment program under U.S.C. Title 42, Section 18063. Eligible health carriers shall submit an attestation to the department asserting compliance with the dedicated data environments, data requirements, establishment and usage of masked enrollee identification numbers, and data submission deadlines.

(4) An eligible health carrier shall provide the access described in subdivision (3) for the applicable benefit year by April thirtieth of each year following the applicable benefit year.

(5) An eligible health carrier shall maintain documents and records, whether paper, electronic, or in other media, sufficient to substantiate the requests for reinsurance payments made under this section for a period of at least six years. An eligible health carrier shall also make those documents and records available upon request from the director for the purposes of verification, investigation, audit, or other review of reinsurance payment requests.

(6) The department shall have an eligible health carrier audited to assess the health carrier's compliance with the requirements of this section when there is evidence of noncompliance. The eligible health carrier shall ensure that its contractors, subcontractors, or agents cooperate with any audit under this section. If an audit results in a proposed finding of material weakness or significant deficiency with respect to compliance with any requirement of this section, the eligible health carrier may provide a response to the proposed finding within thirty days. Within thirty days of the issuance of a final audit report that includes a finding of material weakness or significant deficiency, the eligible health carrier shall:

(a) Provide a written corrective action plan to the department for approval;

(b) Implement the approved plan; and

(c) Provide the department with written documentation that the eligible health carrier has taken corrective action.

374.915. 1. The department shall keep an accounting for each benefit year that illustrates:

(1) Funds appropriated for reinsurance payments and administrative and operational expenses related to the administration of the plan;

(2) Requests for reinsurance payments received from eligible health carriers;

(3) Reinsurance payments made to eligible health carriers; and

(4) Administrative and operational expenses incurred for the plan.

2. The director shall make available to the public a report summarizing the plan operations for each benefit year by posting the summary on the department's web page and making the summary otherwise available by November first of the year following the applicable benefit year or sixty calendar days following the final disbursement of reinsurance payments for the applicable benefit year, whichever is later.

3. (1) The department shall engage and cooperate with an independent certified public accountant or certified public accountant firm licensed or permitted to perform an audit for each benefit year of the plan. The audit shall, at a minimum:

(a) Assess compliance with the requirements of sections 374.905 to 374.920; and

(b) Identify any material weaknesses or significant deficiencies and address manners in which to correct any such weaknesses or deficiencies.

(2) The department, after receiving the completed audit, shall:

(a) Provide the director with the results of the audit;

(b) Identify to the director any material weaknesses or significant deficiencies identified in the audit and address, in writing, how the department intends to correct any such weakness or deficiency, in compliance with subsection 4 of this section; and

(c) Make public the results of the audit, to the extent that the audit contains government data that is public, including any material weaknesses or significant deficiencies and how the department intends to correct any such weakness or deficiency, by posting the audit results on the department web page and making the audit results otherwise available.

4. (1) If an audit results in a finding of material weakness or significant deficiency with respect to compliance by the department with any requirement under sections 374.905 to 374.920, the department shall:

(a) Create a written corrective action plan to be approved by the director within sixty days of the completed audit;

(b) Implement the corrective action plan; and

(c) Record written documentation of the corrective actions taken.

(2) By December first of each year, the department shall submit a report to the standing committees of the legislature having jurisdiction over health and senior services and insurance regarding any finding of material weakness or significant deficiency found in an audit.

374.920. 1. There is hereby created in the state treasury the "Missouri Reinsurance Fund", which shall consist of moneys collected under sections 374.900 to 374.960. The state treasurer shall be custodian of the fund. In accordance with sections 30.170 and 30.180, the state treasurer may approve disbursements. The fund shall be a dedicated fund and, upon appropriation, moneys in the fund shall be used solely for the administration of sections 374.900 to 374.960 and 376.960 to 376.989.

2. Notwithstanding the provisions of section 33.080 to the contrary, any moneys remaining in the fund at the end of the biennium shall not revert to the credit of the general revenue fund.

3. The state treasurer shall invest moneys in the fund in the same manner as other funds are invested. Any interest and moneys earned on such investments shall be credited to the fund.

374.925. 1. The director shall apply to the Secretary of Health and Human Services under 42 U.S.C. Section 18052 for a state innovation waiver to implement the Missouri reinsurance plan for benefit years beginning January 1, 2020, and future years, to maximize federal funding for the plan. The waiver application shall clearly state the implementation of sections 376.960 to 376.989 is contingent on approval of the waiver request.

2. In developing the waiver application, the director shall consult with the director of the department of health and senior services.

3. The director shall submit the waiver application to the Secretary of Health and Human Services on or before June 15, 2020.

374.930. A state department that incurs administrative costs to implement any provision of this act that does not receive an appropriation for administrative costs of this act shall implement the act within the limits of existing appropriations.

374.935. If the state innovation waiver request in section 374.925 is not approved, the department shall not administer the plan nor provide reinsurance payments to the eligible health carriers.

374.960. The department may promulgate rules for the implementation of sections 374.900 to 374.960 and 376.960 to 376.989. 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 section 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. This section 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, 2019, shall be invalid and void.

376.450. 1. Sections 376.450 to 376.454 shall be known and may be cited as the "Missouri Health Insurance Portability and Accountability Act". Notwithstanding any other provision of law to the contrary, health insurance coverage offered in connection with the small group market, the large group market and the individual market shall comply with the provisions of sections 376.450 to 376.453 and, in the case of the small group market, the provisions of sections 379.930 to 379.952. As used in sections 376.450 to 376.453, the following terms mean:

(1) "Affiliation period", a period which, under the terms of the coverage offered by a health maintenance organization, must expire before the coverage becomes effective. The organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period;

(2) "Beneficiary", the same meaning given such term under Section 3(8) of the Employee Retirement Income Security Act of 1974 and Public Law 104-191;

(3) "Bona fide association", an association which:

(a) Has been actively in existence for at least five years;

(b) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(c) Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

(d) Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member); and

(e) Does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

(f) Meets all other requirements for an association set forth in subdivision (5) of subsection 1 of section 376.421 that are not inconsistent with this subdivision;

(4) "COBRA continuation provision":

(a) Section 4980B of the Internal Revenue Code (26 U.S.C. 4980B), as amended, other than subsection (f)(1) of such section as it relates to pediatric vaccines;

(b) Title I, Subtitle B, Part 6, excluding Section 609, of the Employee Retirement Income Security Act of 1974; or

(c) Title XXII of the Public Health Service Act, 42 U.S.C. 300dd, et seq.;

(5) "Creditable coverage", with respect to an individual:

(a) Coverage of the individual under any of the following:

a. A group health plan;

b. Health insurance coverage;

c. Part A or Part B of Title XVIII of the Social Security Act;

d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928 of such act;

e. Chapter 55 of Title 10, United States Code;

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

g. A state health benefits risk pool;

h. A health plan offered under Title 5, Chapter 89, of the United States Code;

i. A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the Public Health Services Act, as amended by Public Law 104-191;

j. A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(3));

(b) Creditable coverage does not include coverage consisting solely of excepted benefits;

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

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

(8) "Enrollment date", with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment;

(9) "Excepted benefits":

(a) Coverage only for accident (including accidental death and dismemberment) insurance;

(b) Coverage only for disability income insurance;

(c) Coverage issued as a supplement to liability insurance;

(d) Liability insurance, including general liability insurance and automobile liability insurance;

(e) Workers' compensation or similar insurance;

(f) Automobile medical payment insurance;

(g) Credit-only insurance;

(h) Coverage for on-site medical clinics;

(i) Other similar insurance coverage, as approved by the director, under which benefits for medical care are secondary or incidental to other insurance benefits;

(j) If provided under a separate policy, certificate or contract of insurance, any of the following:

a. Limited scope dental or vision benefits;

b. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;

c. Other similar limited benefits as specified by the director;

(k) If provided under a separate policy, certificate or contract of insurance, any of the following:

a. Coverage only for a specified disease or illness;

b. Hospital indemnity or other fixed indemnity insurance;

(l) If offered as a separate policy, certificate, or contract of insurance, any of the following:

a. Medicare supplemental coverage (as defined under Section 1882(g)(1) of the Social Security Act);

b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code;

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

(10) "Group health insurance coverage", health insurance coverage offered in connection with a group health plan;

(11) "Group health plan", an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 and Public Law 104-191 to the extent that the plan provides medical care, as defined in this section, and including any item or service paid for as medical care to an employee or the employee's dependent, as defined under the terms of the plan, directly or through insurance, reimbursement or otherwise, but not including excepted benefits;

(12) "Health insurance coverage", or "health benefit plan" as defined in section 376.1350 and benefits consisting of medical care, including items and services paid for as medical care, that are provided directly, through insurance, reimbursement, or otherwise under a policy, certificate, membership contract, or health services agreement offered by a health insurance issuer, but not including excepted benefits;

(13) "Health insurance issuer", "issuer", or "insurer", an insurance company, health services corporation, fraternal benefit society, health maintenance organization, multiple employer welfare arrangement specifically authorized to operate in the state of Missouri, or any

other entity providing a plan of health insurance or health benefits subject to state insurance regulation;

(14) "Individual health insurance coverage", health insurance coverage offered to individuals in the individual market, not including excepted benefits **[**~~or short-term limited duration insurance~~**]**;

(15) "Individual market", the market for health insurance coverage offered to individuals other than in connection with a group health plan;

(16) "Large employer", in connection with a group health plan, with respect to a calendar year and a plan year, an employer who employed an average of at least fifty-one employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year;

(17) "Large group market", the health insurance market under which individuals obtain health insurance coverage directly or through any arrangement on behalf of themselves and their dependents through a group health plan maintained by a large employer;

(18) "Late enrollee", a participant who enrolls in a group health plan other than during the first period in which the individual is eligible to enroll under the plan, or a special enrollment period under subsection 6 of this section;

(19) "Medical care", amounts paid for:

(a) The diagnosis, cure, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body;

(b) Transportation primarily for and essential to medical care referred to in paragraph (a) of this subdivision; or

(c) Insurance covering medical care referred to in paragraphs (a) and (b) of this subdivision;

(20) "Network plan", health insurance coverage offered by a health insurance issuer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the issuer;

(21) "Participant", the same meaning given such term under Section 3(7) of the Employer Retirement Income Security Act of 1974 and Public Law 104-191;

(22) "Plan sponsor", the same meaning given such term under Section 3(16)(B) of the Employee Retirement Income Security Act of 1974;

(23) "Preexisting condition exclusion", with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date. Genetic information shall not

be treated as a preexisting condition in the absence of a diagnosis of the condition related to such information;

(24) "Public Law 104-191", the federal Health Insurance Portability and Accountability Act of 1996;

(25) "Small group market", the health insurance market under which individuals obtain health insurance coverage directly or through an arrangement, on behalf of themselves and their dependents, through a group health plan maintained by a small employer as defined in section 379.930;

(26) "Waiting period", with respect to a group health plan and an individual who is a potential participant or beneficiary in a group health plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the group health plan.

2. A health insurance issuer offering group health insurance coverage may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if:

(1) Such exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date;

(2) Such exclusion extends for a period of not more than twelve months, or eighteen months in the case of a late enrollee, after the enrollment date; and

(3) The period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage, if any, applicable to the participant as of the enrollment date.

3. For the purposes of applying subdivision (3) of subsection 2 of this section:

(1) A period of creditable coverage shall not be counted, with respect to enrollment of an individual under group health insurance coverage, if, after such period and before the enrollment date, there was a sixty-three day period during all of which the individual was not covered under any creditable coverage;

(2) Any period of time that an individual is in a waiting period for coverage under group health insurance coverage, or is in an affiliation period, shall not be taken into account in determining whether a sixty-three day break under subdivision (1) of this subsection has occurred;

(3) Except as provided in subdivision (4) of this subsection, a health insurance issuer offering group health insurance coverage shall count a period of creditable coverage without regard to the specific benefits included in the coverage;

(4) (a) A health insurance issuer offering group health insurance coverage may elect to apply the provisions of subdivision (3) of subsection 2 of this section based on coverage within

any category of benefits within each of several classes or categories of benefits specified in regulations implementing Public Law 104-191, rather than as provided under subdivision (3) of this subsection. Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a health insurance issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.

(b) In the case of an election with respect to health insurance coverage offered by a health insurance issuer in the small or large group market under this subdivision, the health insurance issuer shall prominently state in any disclosure statements concerning the coverage, and prominently state to each employer at the time of the offer or sale of the coverage, that the issuer has made such election, and include in such statements a description of the effect of this election;

(5) Periods of creditable coverage with respect to an individual may be established through presentation of certifications and other means as specified in Public Law 104-191 and regulations pursuant thereto.

4. A health insurance issuer offering group health insurance coverage shall not apply any preexisting condition exclusion in the following circumstances:

(1) Subject to subdivision (4) of this subsection, a health insurance issuer offering group health insurance coverage shall not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the thirty-one-day period beginning with the date of birth, is covered under creditable coverage;

(2) Subject to subdivision (4) of this subsection, a health insurance issuer offering group health insurance coverage shall not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption;

(3) A health insurance issuer offering group health insurance coverage shall not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition;

(4) Subdivisions (1) and (2) of this subsection shall no longer apply to an individual after the end of the first sixty-three-day period during all of which the individual was not covered under any creditable coverage.

5. A health insurance issuer offering group health insurance coverage shall provide a certification of creditable coverage as required by Public Law 104-191 and regulations pursuant thereto.

6. A health insurance issuer offering group health insurance coverage shall provide for special enrollment periods in the following circumstances:

(1) A health insurance issuer offering group health insurance in connection with a group health plan shall permit an employee or a dependent of an employee who is eligible but not enrolled for coverage under the terms of the plan to enroll for coverage if:

(a) The employee or dependent was covered under a group health plan or had health insurance coverage at the time that coverage was previously offered to the employee or dependent;

(b) The employee stated in writing at the time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or health insurance issuer required the statement at the time and provided the employee with notice of the requirement and the consequences of the requirement at the time;

(c) The employee's or dependent's coverage described in paragraph (a) of this subdivision was:

a. Under a COBRA continuation provision and was exhausted; or

b. Not under a COBRA continuation provision and was terminated as a result of loss of eligibility for the coverage or because employer contributions toward the cost of coverage were terminated; and

(d) Under the terms of the group health plan, the employee requests the enrollment not later than thirty days after the date of exhaustion of coverage described in subparagraph a. of paragraph (c) of this subdivision or termination of coverage or employer contributions described in subparagraph b. of paragraph (c) of this subdivision;

(2) (a) A group health plan shall provide for a dependent special enrollment period described in paragraph (b) of this subdivision during which an employee who is eligible but not enrolled and a dependent may be enrolled under the group health plan and, in the case of the birth or adoption of a child, the spouse of the employee may be enrolled as a dependent if the spouse is otherwise eligible for coverage.

(b) A dependent special enrollment period under this subdivision is a period of not less than thirty days that begins on the date of the marriage or adoption or placement for adoption, or the period provided for enrollment in section 376.406 in the case of a birth;

(3) The coverage becomes effective:

(a) In the case of marriage, not later than the first day of the first month beginning after the date on which the completed request for enrollment is received;

(b) In the case of a dependent's birth, as of the date of birth; or

(c) In the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

7. In the case of group health insurance coverage offered by a health maintenance organization, the plan may provide for an affiliation period with respect to coverage through the organization only if:

(1) No preexisting condition exclusion is imposed with respect to coverage through the organization;

(2) The period is applied uniformly without regard to any health status-related factors;

(3) Such period does not exceed two months, or three months in the case of a late enrollee;

(4) Such period begins on the enrollment date; and

(5) Such period runs concurrently with any waiting period.

376.960. As used in sections 376.960 to 376.989, the following terms mean:

(1) "Benefit plan", the coverages to be offered by the pool to eligible persons pursuant to the provisions of section 376.986;

(2) "Board", the board of directors of the pool;

(3) "Church plan", a plan as defined in Section 3(33) of the Employee Retirement Income Security Act of 1974, as amended;

(4) "Creditable coverage", with respect to an individual:

(a) Coverage of the individual provided under any of the following:

a. A group health plan;

b. Health insurance coverage;

c. Part A or Part B of Title XVIII of the Social Security Act;

d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928;

e. Chapter 55 of Title 10, United States Code;

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

g. A state health benefits risk pool;

h. A health plan offered under Chapter 89 of Title 5, United States Code;

i. A public health plan as defined in federal regulations; or

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

(b) Creditable coverage does not include coverage consisting solely of excepted benefits;

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

(6) "Dependent", a resident spouse or resident unmarried child under the age of nineteen years, a child who is a student under the age of twenty-five years and who is financially dependent upon the parent, or a child of any age who is disabled and dependent upon the parent;

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

(8) "Excepted benefits":

(a) Coverage only for accident, including accidental death and dismemberment, insurance;

(b) Coverage only for disability income insurance;

(c) Coverage issued as a supplement to liability insurance;

(d) Liability insurance, including general liability insurance and automobile liability insurance;

(e) Workers' compensation or similar insurance;

(f) Automobile medical payment insurance;

(g) Credit-only insurance;

(h) Coverage for on-site medical clinics;

(i) Other similar insurance coverage, as approved by the director, under which benefits for medical care are secondary or incidental to other insurance benefits;

(j) If provided under a separate policy, certificate or contract of insurance, any of the following:

a. Limited scope dental or vision benefits;

b. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;

c. Other similar, limited benefits as specified by the director;

(k) If provided under a separate policy, certificate or contract of insurance, any of the following:

a. Coverage only for a specified disease or illness;

b. Hospital indemnity or other fixed indemnity insurance;

(l) If offered as a separate policy, certificate or contract of insurance, any of the following:

a. Medicare supplemental coverage (as defined under Section 1882(g)(1) of the Social Security Act);

b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code;

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

(9) "Federally defined eligible individual", an individual:

(a) For whom, as of the date on which the individual seeks coverage through the pool, the aggregate of the periods of creditable coverage as defined in this section is eighteen or more months and whose most recent prior creditable coverage was under a group health plan,

governmental plan, church plan, or health insurance coverage offered in connection with any such plan;

(b) Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act, or state plan under Title XIX of such act or any successor program, and who does not have other health insurance coverage;

(c) With respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated because of nonpayment of premiums or fraud;

(d) Who, if offered the option of continuation coverage under COBRA continuation provision or under a similar state program, both elected and exhausted the continuation coverage;

(10) "Governmental plan", a plan as defined in Section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan;

(11) "Group health plan", an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 and Public Law 104-191 to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement or otherwise, but not including excepted benefits;

(12) "Health insurance", any hospital and medical expense incurred policy, nonprofit health care service for benefits other than through an insurer, nonprofit health care service plan contract, health maintenance organization subscriber contract, preferred provider arrangement or contract, or any other similar contract or agreement for the provisions of health care benefits. The term "health insurance" does not include accident, fixed indemnity, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;

(13) "Health maintenance organization", any person which undertakes to provide or arrange for basic and supplemental health care services to enrollees on a prepaid basis, or which meets the requirements of section 1301 of the United States Public Health Service Act;

(14) "Hospital", a place devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment or care for not less than twenty-four hours in any week of three or more nonrelated individuals suffering from illness, disease, injury, deformity or other abnormal physical condition; or a place devoted primarily to provide medical or nursing care for three or more nonrelated individuals for not less than twenty-four hours in any week. The term "hospital" does not include convalescent, nursing, shelter or boarding homes, as defined in chapter 198;

(15) "Insurance arrangement", any plan, program, contract or other arrangement under which one or more employers, unions or other organizations provide to their employees or

members, either directly or indirectly through a trust or third party administration, health care services or benefits other than through an insurer;

(16) "Insured", any individual resident of this state who is eligible to receive benefits from any insurer or insurance arrangement, as defined in this section;

(17) "Insurer", any insurance company authorized to transact health insurance business in this state, any nonprofit health care service plan act, or any health maintenance organization;

(18) "Medical care", amounts paid for:

(a) The diagnosis, care, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(b) Transportation primarily for and essential to medical care referred to in paragraph (a) of this subdivision; and

(c) Insurance covering medical care referred to in paragraphs (a) and (b) of this subdivision;

(19) "Medicare", coverage under both part A and part B of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq., as amended;

(20) "Member", all insurers and insurance arrangements participating in the pool;

(21) "Physician", physicians and surgeons licensed under chapter 334 or by state board of healing arts in the state of Missouri;

(22) "Plan of operation", the plan of operation of the pool, including articles, bylaws and operating rules, adopted by the board pursuant to the provisions of sections 376.961, 376.962 and 376.964;

(23) "Pool", the state **[**~~health insurance~~**]** **reinsurance** pool created in sections 376.961, 376.962 and 376.964;

(24) "Resident", an individual who has been legally domiciled in this state for a period of at least thirty days, except that for a federally defined eligible individual, there shall not be a thirty-day requirement;

(25) "Significant break in coverage", a period of sixty-three consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage;

(26) "Trade act eligible individual", an individual who is eligible for the federal health coverage tax credit under the Trade Act of 2002, Public Law 107-210.

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

2. Beginning January 1, **[**~~2007~~**]** **2020**, the board of directors shall consist of the director of the department of insurance, financial institutions and professional registration or the director's designee, and eight members appointed by the director. Of the initial eight members appointed, three shall serve a three-year term, three shall serve a two-year term, and two shall serve a one-year term. All subsequent appointments to the board shall be for three-year terms. Members of the board shall have a background and experience in health insurance plans or health maintenance organization plans, in health care finance, or as a health care provider or a member of the general public; except that, the director shall not be required to appoint members from each of the categories listed. The director may reappoint members of the board. The director shall fill vacancies on the board in the same manner as appointments are made at the expiration of a member's term and may remove any member of the board for neglect of duty, misfeasance, malfeasance, or nonfeasance in office.

3. Beginning August 28, **[**~~2007~~**]** **2020**, the board of directors shall consist of fourteen members. The board shall consist of the director and the eight members described in subsection 2 of this section and shall consist of the following additional five members:

(1) One member from a hospital located in Missouri, appointed by the governor, with the advice and consent of the senate;

(2) Two members of the senate, with one member from the majority party appointed by the president pro tem of the senate and one member of the minority party appointed by the president pro tem of the senate with the concurrence of the minority floor leader of the senate; and

(3) Two members of the house of representatives, with one member from the majority party appointed by the speaker of the house of representatives and one member of the minority party appointed by the speaker of the house of representatives with the concurrence of the minority floor leader of the house of representatives.

4. The members appointed under subsection 3 of this section shall serve in an ex officio capacity. The terms of the members of the board of directors appointed under subsection 3 of this section shall expire on December 31, **[**~~2009~~**]** **2022**. On such date, the membership of the board shall revert back to nine members as provided for in subsection 2 of this section.

5. Beginning on August 28, **[**~~2013~~**]** **2020**, the board of directors, on behalf of the pool, the executive director, and any other employees of the pool, shall have the authority to provide assistance or resources to any department, agency, public official, employee, or agent of the federal government for the specific purpose of transitioning individuals enrolled in the pool to coverage outside of the pool **[**~~beginning on or before January 1, 2014~~**]**. Such authority does not extend to authorizing the pool to implement, establish, create, administer, or otherwise operate a state-based exchange.

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 or third-party administrator in accordance with section 376.968;

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

(4) Establish procedures for the collection of assessments**, required in addition to any funds received under the provisions of sections 374.900 to 374.960,** 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.

[~~3. On or before September 1, 2013, the board shall 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.~~

~~4. The amendments to the plan of operation submitted by the board shall include all of the requirements outlined in subsection 2 of this section and shall 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 shall also address procedures for finalizing the financial matters of the pool, including assessments, claims expenses, and other matters identified in subsection 2 of this section.~~

~~5. The director shall review the plan of operation submitted under subsection 3 of this section and shall promulgate rules to effectuate the transitional plan of operation. Such rules shall be effective no later than October 1, 2013. 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 section 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. This section 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, 2013, shall be invalid and void.~~]

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

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

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

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

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

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

(6) **[**~~Prior to January 1, 2014,~~**]** Issue policies of insurance in accordance with the requirements of sections 376.960 to 376.989**[**~~. In no event shall new policies of insurance be issued on or after January 1, 2014~~**]**;

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

(8) Establish rules, conditions and procedures for reinsuring risks of pool members desiring to issue pool plan coverages in their own name. Such reinsurance facility shall not subject the pool to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers;

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

(10) Administer separate accounts to separate federally defined eligible individuals and trade act eligible individuals who qualify for plan coverage from the other eligible individuals entitled to pool coverage and apportion the costs of administration among such separate accounts.

376.965. No member of the board of directors of the Missouri **[**~~health insurance~~**]** **reinsurance** pool shall be civilly liable, either jointly or separately, as a result of any act, omission or decision in performance of his duties as specifically required by sections 376.960 to 376.989. Such immunity shall not attach for any intentional or reckless act affecting the property or rights of any person.

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. **[**~~Prior to January 1, 2014,~~**]** 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;

(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;

(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 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.

[~~6. Coverage under the pool shall expire on January 1, 2014.~~**]**

376.970. 1. The administering insurer shall serve for a period of three years subject to removal for cause. At least one year prior to the expiration of each three-year period of service by an administering insurer, the board shall invite all insurers, including the current administering insurer, to submit bids to serve as the administering insurer for the succeeding three-year period. Selection of the administering insurer for the succeeding period shall be made at least six months prior to the end of the current three-year period.

2. The administering insurer shall:

(1) Perform all eligibility and administrative claim-payment functions relating to the pool;

(2) Establish a premium billing procedure for collection of premium from insured persons. Billings shall be made on a period basis as determined by the board;

(3) Perform all necessary functions to assure timely payment of benefits to covered persons under the pool including:

(a) Making available information relating to the proper manner of submitting a claim for benefits to the pool and distributing forms upon which submission shall be made;

(b) Evaluating the eligibility of each claim for payment by the pool;

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

(5) Following the close of each calendar year, determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the board and the department on a form prescribed by the director;

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

[~~3. On or before September 1, 2013, the board shall 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. Selection of the administering insurer or third-party administrator shall be made prior to January 1, 2014.~~

~~4. Beginning January 1, 2014, the administering insurer or third-party administrator shall:~~

~~(1) Submit to the board and director a detailed plan outlining the winding down of operations of the pool. The plan shall be submitted no later than January 31, 2014, and shall be updated quarterly thereafter;~~

~~(2) Perform all administrative claim-payment functions relating to the pool;~~

~~(3) Perform all necessary functions to assure timely payment of benefits to covered persons under the pool including:~~

~~(a) Making available information relating to the proper manner of submitting a claim for benefits to the pool and distributing forms upon which submission shall be made;~~

~~(b) Evaluating the eligibility of each claim for payment by the pool;~~

~~(4) Submit regular reports to the board regarding the operation of the pool. The frequency, content and form of the report shall be determined by the board;~~

~~(5) Following the close of each calendar year, determine the expense of administration, and the paid and incurred losses for the year, and report such information to the board and department on a form prescribed by the director;~~

~~(6) Be paid as provided in the plan of operation for its expenses incurred in the performance of its services.~~]

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. 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 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, 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 and, if applicable, section 536.028. This section 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, **[**~~2007~~**]** **2020**, shall be invalid and void.

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