By: Representatives Lamar, White

To: Ways and Means

HOUSE BILL NO. 1647
(As Sent to Governor)

AN ACT TO AUTHORIZE THE COMMISSIONER OF INSURANCE TO ESTABLISH ANY PROGRAM OR PROMULGATE ANY RULE, POLICY, GUIDELINE OR PLAN OR TO CHANGE ANY PROGRAM, RULE, POLICY OR GUIDELINE TO IMPLEMENT, ESTABLISH, CREATE, ADMINISTER OR OTHERWISE OPERATE AN EXCHANGE, TO APPLY FOR, ACCEPT OR EXPEND FEDERAL MONIES RELATED TO THE CREATION, IMPLEMENTATION OR OPERATION OF AN EXCHANGE, TO ESTABLISH ANY ADVISORY BOARD OR COMMITTEE AS NECESSARY FOR PROVIDING RECOMMENDATIONS ON THE CREATION, IMPLEMENTATION OR OPERATION OF AN EXCHANGE, TO USE THE SERVICES AND FUNDS OF THE COMPREHENSIVE HEALTH INSURANCE RISK POOL ASSOCIATION AND THE COMPREHENSIVE HEALTH INSURANCE RISK POOL BOARD TO FULFILL THE PURPOSES OF THIS SECTION, AND TO ENGAGE ACTUARIAL AND OTHER ASSISTANCE AS NECESSARY TO CARRY OUT THE DUTIES OF THE DEPARTMENT; TO CREATE THE MISSISSIPPI HEALTH INSURANCE STATE EXCHANGE TRUST FUND, AND TO AUTHORIZE THE COMMISSIONER OF INSURANCE TO EXPEND MONIES FROM THIS FUND FOR THE PAYMENT OF EXPENSES INCURRED IN THE CREATION, IMPLEMENTATION OR OPERATION OF AN EXCHANGE; TO PROVIDE THAT THE AMOUNT TO BE CONTRIBUTED ANNUALLY TO THE FUND SHALL BE FIXED EACH YEAR BY THE COMMISSIONER AS A PERCENTAGE OF FEES ASSESSED ON THE GROSS PREMIUMS CHARGED ON ALL POLICIES SOLD ON THE EXCHANGE, WHICH PERCENTAGE SHALL NOT BE MORE THAN 3.5%, UNLESS OTHERWISE APPROVED BY THE LEGISLATURE; TO PROVIDE THAT USER FEES SHALL BE COLLECTED DIRECTLY BY THE EXCHANGE ON ALL POLICIES SOLD AND REMITTED TO THE HEALTH INSURANCE STATE EXCHANGE FUND ON A MONTHLY BASIS; TO PROVIDE THAT THE COMPREHENSIVE HEALTH INSURANCE RISK POOL ASSOCIATION SHALL HAVE THE AUTHORITY TO DEVELOP AND FUND AN ONLINE PORTAL THAT SHALL BE AVAILABLE TO ALL MISSISSIPPIANS TO ASSIST CONSUMERS IN SELECTION OF A HEALTH PLAN; TO AMEND SECTIONS 83-9-203 AND 83-9-205, MISSISSIPPI CODE OF 1972, TO CONFORM TO THE PROVISIONS OF THIS ACT; AND FOR RELATED PURPOSES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

SECTION 1. For the purposes of this act, the following words and phrases shall have the meanings as defined in this section unless the context clearly indicates otherwise:

(a) "Exchange" means a state, federal, or partnership exchange or marketplace operating in Mississippi pursuant to Section 1311 of 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 regulations and guidance issued under those acts.

(b) "Comprehensive Health Insurance Risk Pool Association" means the mechanism as established in Sections 83-9-201 through 83-9-223.

(c) "Comprehensive Health Insurance Risk Pool Board" shall have the same meaning as provided in Section 83-9-205(b).

SECTION 2. The Commissioner of Insurance shall have the authority to:

(a) Establish any program, promulgate any rule, policy, guideline, or plan; or change any program, rule, policy or guideline to implement, establish, create, administer, or otherwise operate an exchange;

(b) Apply for, accept or expend federal monies related to the creation, implementation or operation of an exchange;

(c) Establish any advisory board or committee the Commissioner deems necessary for providing recommendations on the creation, implementation or operation of an exchange;

(d) Use the services and funds of the Comprehensive Health Insurance Risk Pool Association and the Comprehensive Health Insurance Risk Pool Board to fulfill the purposes of this section; and

(e) Engage such actuarial and other assistance as shall be necessary to carry out the duties of the department under this act. The engagement of such services shall not be subject to the procurement provisions of Section 31-7-13.

The Commissioner of Insurance may, immediately after the effective date of this act, begin action to carry out the authority provided in this section.

SECTION 3. There is created in the State Treasury a special fund to be designated as the "Mississippi Health Insurance State Exchange Trust Fund." The Commissioner of Insurance is authorized to expend monies from this fund for the payment of the expenses incurred in the creation, implementation or operation of an exchange. The amount to be contributed annually to the special fund shall be fixed each year by the commissioner as a percentage of fees assessed on the gross premiums charged on all policies sold on the exchange. This percentage shall not be more than three and a half percent (3.5%), unless otherwise approved by the Legislature. The user fees shall be collected directly by the exchange on all policies sold and remitted to the special fund on a monthly basis. Unexpended amounts remaining in the fund at the end of a fiscal year shall not lapse into the State General Fund,

and any interest earned on amounts in the special fund shall be deposited to the credit of the special fund.

SECTION 4. The Comprehensive Health Insurance Risk Pool Association shall have the authority to develop and fund an online portal that shall be available to all Mississippians to assist consumers in selection of a health plan. This program shall have the capacity to aggregate information regarding providers, drug coverage and pricing that would allow consumers to make informed decisions in selecting a health plan.

SECTION 5. Section 83-9-203, Mississippi Code of 1972, is amended as follows:

83-9-203. It is the purpose of the Legislature to establish a mechanism to allow the availability of a health insurance program and to allow the availability of health and accident insurance coverage to those citizens of this state who (a) because of health conditions cannot secure such coverage, or (b) desire to obtain or continue health insurance coverage under any state or federal program designed to enable persons to obtain or maintain health insurance coverage. It is further the purpose of the Legislature to establish a mechanism to assist the Commissioner of Insurance with the creation, implementation or operation of an exchange.

SECTION 6. Section 83-9-205, Mississippi Code of 1972, is amended as follows:

83-9-205. As used in Sections 83-9-201 through 83-9-222, the following words shall have the meaning ascribed herein unless the context clearly requires otherwise:

(a) "Association" means the Comprehensive Health Insurance Risk Pool Association.

(b) "Board" means the board of directors of the association.

(c) "Church plan" has the meaning given such term under Section 3(33) of the Employee Retirement Income Security Act of 1974.

(d) "Commissioner" means the Commissioner of Insurance of this state.

(e) "Creditable coverage" has the meaning set forth in the federal Health Insurance Portability and Accountability Act of 1996 (26 USCS Section 9801(c)(1)). A period of creditable coverage shall not be counted, with respect to the enrollment of an individual who seeks coverage under the plan, if, after such period and before the enrollment date, the individual experiences a significant break in coverage.

(f) "Dependent" means a resident spouse or resident unmarried child under the age of nineteen (19) years, a child who is a student under the age of twenty-three (23) years and who is financially dependent upon the parent or a child of any age who is disabled and dependent upon the parent.

(g) "Excess or stoploss coverage" means an arrangement whereby an insurer insures against the risk that any one (1) claim will exceed a specific dollar amount or that the entire loss of a self-insurance plan will exceed a specific amount.

(h) "Federally defined eligible individual" means an individual:

(i) For whom, as of the date on which the individual seeks coverage under the plan, the aggregate of the periods of creditable coverage is eighteen (18) or more months;

(ii) Whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan or health insurance coverage offered in connection with such a plan;

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

(iv) With respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;

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

(vi) Who has exhausted continuation coverage under this provision or program, if the individual elected the continuation coverage described in subparagraph (v).

(i) "Governmental plan" has the meaning given such term under Section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan.

(j) "Group health plan" means an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement or otherwise.

(k) "Health insurance coverage" means any hospital and medical expense incurred policy, nonprofit health care services plan contract, health maintenance organization subscriber contract or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise.

(i) "Health insurance coverage" shall not include one or more, or any combination of, the following:

1. Coverage only for accident, or disability income insurance, or any combination thereof;

2. Coverage issued as a supplement to liability insurance;

3. Liability insurance, including general liability insurance and automobile liability insurance;

4. Workers' compensation or similar insurance;

5. Automobile medical payment insurance;

6. Credit-only insurance;

7. Coverage for on-site medical clinics; and

8. Other similar insurance coverage, specified in federal regulations issued pursuant to Public Law 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.

(ii) "Health insurance coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the coverage:

1. Limited scope dental or vision benefits;

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

3. Other similar, limited benefits specified in federal regulations issued pursuant to Public Law 104-191.

(iii) "Health insurance coverage" shall not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any

exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

1. Coverage only for a specified disease or illness; or

2. Hospital indemnity or other fixed indemnity insurance.

(iv) "Health insurance coverage" shall not include the following if offered as a separate policy, certificate or contract of insurance:

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

2. Coverage supplemental to the coverage provided under Chapter 55, Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or

3. Similar supplemental coverage provided to coverage under a group health plan.

(l) "Health maintenance organization" means any organization authorized under the Health Maintenance Organization, Preferred Provider Organization and Other Prepaid Health Benefit Plans Protection Act, Section 83-41-301 et seq., to operate a health maintenance organization in this state.

(m) "Insurer" means any entity that is authorized in this state to write health insurance coverage or that provides health insurance coverage in this state or any third-party administrator. For the purposes of Sections 83-9-201 through 83-9-222, insurer includes an insurance company, nonprofit health care services plan, fraternal benefit society, health maintenance organization, to the extent consistent with federal law any self-insurance arrangement covered by the Employee Retirement Income Security Act of 1974, as amended, that provides health care benefits in this state, any other entity providing a plan of health insurance coverage or health benefits subject to state insurance regulation and any reinsurer reinsuring health insurance coverage in this state.

(n) "Medicare" means coverage under both Parts A or B of Title XVIII of the Social Security Act, 42 USC, Section 1395 et seq., as amended.

(o) "Plan" means the health insurance plan adopted by the board under Sections 83-9-201 through 83-9-222.

(p) "Resident" means an individual who is legally located in the United States and has been legally domiciled in this state for a period to be established by the board and subject to the approval of the commissioner but in no event shall such residency requirement be greater than one (1) year, except that for a federally defined eligible individual, there shall not be a prior residency requirement.

(q) "Agent" means a person who is licensed to sell health insurance in this state or a third-party administrator.

(r) "Covered person" means any individual resident of this state (excluding dependents) who is eligible to receive benefits from any insurer.

(s) "Third-party administrator" means any entity who is paying or processing health insurance claims for any Mississippi resident.

(t) "Reinsurer" means any insurer from whom any person providing health insurance coverage for any Mississippi resident procures insurance for itself in the insurer, with respect to all or part of the health insurance coverage risk of the person.

(u) "Significant break in coverage" means a period of sixty-three (63) 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.

(v) "Exchange" means a state, federal, or partnership exchange or marketplace operating in Mississippi pursuant to Section 1311 of 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 regulations and guidance issued under those acts.

SECTION 7. This act shall take effect and be in force from and after its passage.