SECOND REGULAR SESSION

HOUSE BILL NO. 1469

92ND GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES JOLLY (Sponsor), JOHNSON (90), VOGT, SKAGGS, SPRENG, LIESE, WARD AND BROOKS (Co-sponsors).

Read 1st time February 11, 2004, and copies ordered printed.

STEPHEN S. DAVIS, Chief Clerk

4581L.01I

AN ACT

To repeal sections 376.960, 376.961, 376.966, 376.975, 376.980, 376.986, 379.930, 379.938, 379.940, 379.942, 379.943, and 379.952, RSMo, and to enact in lieu thereof sixteen new sections relating to health insurance, with an effective date for the repeal of a certain section.

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

Section A. Sections 376.960, 376.961, 376.966, 376.975, 376.980, 376.986, 379.930,
2 379.938, 379.940, 379.942, 379.943, and 379.952, RSMo, are repealed and sixteen new sections
3 enacted in lieu thereof, to be known as sections 376.400, 376.450, 376.451, 376.452, 376.453,
4 376.960, 376.961, 376.966, 376.975, 376.980, 376.986, 379.930, 379.938, 379.940, 379.943, and
5 379.952, to read as follows:

376.400. Premium rates for conversion coverage provided under sections 376.395
2 **to 376.404 shall not exceed the premium rates charged by the Missouri health insurance**
3 **pool for similar coverage provided under sections 376.960 to 376.989. All conversion**
4 **coverage shall be guaranteed renewable.**

376.450. 1. Sections 376.450 to 376.453 shall be known and may be cited as the
2 **"Missouri Health Insurance Portability and Accountability Act".**
3 **2. Notwithstanding any other provision of law to the contrary, health insurance**
4 **coverage offered in connection with the small group market, the large group market and**
5 **the individual market shall comply with the provisions of sections 376.450 to 376.453 and,**
6 **in the case of the small group market, the provisions of sections 379.930 to 379.952.**
7 **3. As used in sections 376.450 to 376.452, the following terms mean:**

EXPLANATION — Matter enclosed in bold faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law. Matter in boldface type in the above law is proposed language.

8 **(1) "Affiliation period", a period which, under the terms of the coverage offered**
9 **by a health maintenance organization, must expire before the coverage becomes effective.**
10 **The organization is not required to provide health care services or benefits during such**
11 **period and no premium shall be charged to the participant or beneficiary for any coverage**
12 **during the period;**
13 **(2) "Beneficiary", the same meaning given such term under Section 3(8) of the**
14 **Employee Retirement Income Security Act of 1974 and Public Law 104-191;**
15 **(3) "Bona fide association", an association which:**
16 **(a) Has been actively in existence for at least five years;**
17 **(b) Has been formed and maintained in good faith for purposes other than**
18 **obtaining insurance;**
19 **(c) Does not condition membership in the association on any health status-related**
20 **factor relating to an individual (including an employee of an employer or a dependent of**
21 **an employee);**
22 **(d) Makes health insurance coverage offered through the association available to**
23 **all members regardless of any health status-related factor relating to such members (or**
24 **individuals eligible for coverage through a member);**
25 **(e) Does not make health insurance coverage offered through the association**
26 **available other than in connection with a member of the association; and**
27 **(f) Meets all other requirements for an association set forth in subdivision (5) of**
28 **subsection 1 of section 376.421 that are not inconsistent with this subdivision;**
29 **(4) "COBRA continuation provision":**
30 **(a) Section 4980B of the Internal Revenue Code (26 U.S.C. Section 4980B), other**
31 **than Subsection (f)(1) of that section as it relates to pediatric vaccines;**
32 **(b) Title I, Subtitle B, Part 6, excluding Section 609, of the Employee Retirement**
33 **Income Security Act of 1974; or**
34 **(c) Title XXII of the Public Health Service Act, 42 U.S.C. Section 300dd, et seq.**
35 **(5) "Creditable coverage", with respect to an individual:**
36 **(a) Coverage of the individual under any of the following:**
37 **a. A group health plan;**
38 **b. Health insurance coverage;**
39 **c. Part A or Part B of Title XVIII of the Social Security Act;**
40 **d. Title XIX of the Social Security Act, other than coverage consisting solely of**
41 **benefits under section 1928 of such act;**
42 **e. Chapter 55 of Title 10, United States Code;**
43 **f. A medical care program of the Indian Health Service or of a tribal organization;**

44 **g. A state health benefits risk pool;**
45 **h. A health plan offered under Title 5, Chapter 89, of the United States Code;**
46 **i. A public health plan as defined in federal regulations authorized by Section**
47 **2701(c)(1)(l) of the Public Health Services Act, as amended by Public Law 104-191;**
48 **j. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. Section**
49 **2504(3)).**
50 **(b) Creditable coverage does not include coverage consisting solely of excepted**
51 **benefits;**
52 **(6) "Enrollment date", with respect to an individual covered under a group health**
53 **plan, the date of enrollment of the individual in the plan or, if earlier, the first day of the**
54 **waiting period for enrollment;**
55 **(7) "Excepted benefits":**
56 **(a) Coverage only for accident (including accidental death and dismemberment)**
57 **insurance;**
58 **(b) Coverage only for disability income insurance;**
59 **(c) Coverage issued as a supplement to liability insurance;**
60 **(d) Liability insurance, including general liability insurance and automobile**
61 **liability insurance;**
62 **(e) Workers' compensation or similar insurance;**
63 **(f) Automobile medical payment insurance;**
64 **(g) Credit-only insurance;**
65 **(h) Coverage for onsite medical clinics;**
66 **(i) Other similar insurance coverage, as approved by the director, under which**
67 **benefits for medical care are secondary or incidental to other insurance benefits;**
68 **(j) If provided under a separate policy, certificate or contract of insurance, any of**
69 **the following:**
70 **a. Limited scope dental or vision benefits;**
71 **b. Benefits for long-term care, nursing home care, home health care, community-**
72 **based care, or any combination thereof;**
73 **c. Other similar, limited benefits as specified by the director;**
74 **(k) If provided under a separate policy, certificate or contract of insurance, any of**
75 **the following:**
76 **a. Coverage only for a specified disease or illness;**
77 **b. Hospital indemnity or other fixed indemnity insurance;**
78 **(l) If offered as a separate policy, certificate or contract of insurance, any of the**
79 **following:**

80 **a. Medicare supplemental coverage (as defined under section 1882(g)(1) of the**
81 **Social Security Act);**
82 **b. Coverage supplemental to the coverage provided pursuant to Chapter 55 of Title**
83 **10, United States Code;**
84 **c. Similar supplemental coverage provided to coverage under a group health plan;**
85 **(8) "Group health insurance coverage", health insurance coverage offered in**
86 **connection with a group health plan;**
87 **(9) "Group health plan", an employee welfare benefit plan as defined in Section**
88 **3(1) of the Employee Retirement Income Security Act of 1974 and Public Law 104-191 to**
89 **the extent that the plan provides medical care, as defined in this section, and including any**
90 **item or services paid for as medical care to employees or the employee's dependents, as**
91 **defined under the terms of the plan, directly or through insurance, reimbursement, or**
92 **otherwise, but not including excepted benefits;**
93 **(10) "Health insurance coverage", benefits consisting of medical care, including**
94 **items and services paid for as medical care, that are provided directly, through insurance,**
95 **reimbursement, or otherwise, under a policy, certificate, membership contract, or health**
96 **services agreement offered by a health insurance issuer, but not including excepted**
97 **benefits;**
98 **(11) "Health insurance issuer", an insurance company, health services corporation,**
99 **fraternal benefit society, health maintenance organization, multiple employer welfare**
100 **arrangement specifically authorized to operate in the state of Missouri, or any other entity**
101 **providing a plan of health insurance or health benefits subject to state insurance**
102 **regulation;**
103 **(12) "Individual health insurance coverage", health insurance coverage offered to**
104 **individuals in the individual market, not including excepted benefits or short-term limited**
105 **duration insurance;**
106 **(13) "Individual market", the market for health insurance coverage offered to**
107 **individuals other than in connection with a group health plan;**
108 **(14) "Large employer", in connection with a group health plan, with respect to a**
109 **calendar year and a plan year, an employer who employed an average of at least fifty-one**
110 **employees on business days during the preceding calendar year and who employs at least**
111 **two employees on the first day of the plan year;**
112 **(15) "Large group market", the health insurance market under which individuals**
113 **obtain health insurance coverage directly or through any arrangement on behalf of**
114 **themselves and their dependents through a group health plan maintained by a large**
115 **employer;**

116 **(16) "Late enrollee", a participant who enrolls in a group health plan other than**
117 **during the first period in which the individual is eligible to enroll under the plan, or a**
118 **special enrollment period pursuant to subsection 7 of this section;**
119 **(17) "Medical care", amounts paid for:**
120 **(a) The diagnosis, cure, mitigation, treatment, or prevention of disease or amounts**
121 **paid for the purpose of affecting any structure or function of the body;**
122 **(b) Transportation primarily for and essential to medical care referred to in**
123 **paragraph (a) of this subdivision; or**
124 **(c) Insurance covering medical care referred to in paragraphs (a) and (b) of this**
125 **subdivision;**
126 **(18) "Network plan", health insurance coverage offered by a health insurance**
127 **issuer under which the financing and delivery of medical care, including items and services**
128 **paid for as medical care, are provided, in whole or in part, through a defined set of**
129 **providers under contract with the issuer;**
130 **(19) "Participant", the same meaning given such term under Section 3(7) of the**
131 **Employer Retirement Income Security Act of 1974 and Public Law 104-191;**
132 **(20) "Plan sponsor", the same meaning given such term in Section 3(16)(B) of the**
133 **Employee Retirement Income Security Act of 1974;**
134 **(21) "Preexisting condition exclusion", with respect to coverage, a limitation or**
135 **exclusion of benefits relating to a condition based on the fact that the condition was present**
136 **before the date of enrollment for such coverage, whether or not any medical advice,**
137 **diagnosis, care, or treatment was recommended or received before such date. Genetic**
138 **information shall not be treated as a preexisting condition in the absence of a diagnosis of**
139 **the condition related to such information;**
140 **(22) "Public Law 104-191", the federal Health Insurance Portability and**
141 **Accountability Act of 1996;**
142 **(23) "Small group market", the health insurance market under which individuals**
143 **obtain health insurance coverage directly or through an arrangement, on behalf of**
144 **themselves and their dependents, through a group health plan maintained by a small**
145 **employer as defined in subdivision (34) of section 379.930, RSMo;**
146 **(24) "Waiting period", with respect to a group health plan and an individual who**
147 **is a potential participant in a group health plan, the period that must pass with respect to**
148 **the individual before the individual is eligible to be covered for benefits under the terms**
149 **of the group health plan.**
150 **4. A health insurance issuer offering group health insurance coverage may, with**
151 **respect to a participant or beneficiary, impose a preexisting condition exclusion only if:**

152 **(1) Such exclusion relates to a condition, whether physical or mental, regardless of**
153 **the cause of the condition, for which medical advice, diagnosis, care, or treatment was**
154 **recommended or received within the six-month period ending on the enrollment date;**
155 **(2) Such exclusion extends for a period of not more than twelve months, or eighteen**
156 **months in the case of a late enrollee, after the enrollment date; and**
157 **(3) The period of any such preexisting condition exclusion is reduced by the**
158 **aggregate of the periods of creditable coverage, if any, applicable to the participant as of**
159 **the enrollment date.**
160 **5. For purposes of subdivision (3) of subsection 4 of this section:**
161 **(1) A period of creditable coverage shall not be counted, with respect to enrollment**
162 **of an individual under group health insurance coverage, if, after such period and before**
163 **the enrollment date, there was a sixty-three day period during all of which the individual**
164 **was not covered under any creditable coverage;**
165 **(2) Any period of time that an individual is in a waiting period for coverage under**
166 **group health insurance coverage, or is in an affiliation period, shall not be taken into**
167 **account in determining whether a sixty-three day break under subdivision (1) of this**
168 **subsection has occurred;**
169 **(3) Except as provided in subdivision (4) of this subsection, a health insurance**
170 **issuer offering group health insurance coverage shall count a period of creditable coverage**
171 **without regard to the specific benefits included in the coverage;**
172 **(4) (a) A health insurance issuer offering group health insurance coverage may**
173 **elect to apply the provisions of subdivision (3) of subsection 4 of this section based on**
174 **coverage within any category of benefits within each of several classes or categories of**
175 **benefits specified in regulations implementing Public Law 104-191, rather than as provided**
176 **pursuant to subdivision (3) of this subsection. Such election shall be made on a uniform**
177 **basis for all participants and beneficiaries. Under such election a health insurance issuer**
178 **shall count a period of creditable coverage with respect to any class or category of benefits**
179 **if any level of benefits is covered within the class or category;**
180 **(b) In the case of an election with respect to health insurance coverage offered by**
181 **a health insurance issuer in the small or large group market pursuant to this subdivision,**
182 **the health insurance issuer shall prominently state in any disclosure statements concerning**
183 **the coverage, and prominently state to each employer at the time of the offer or sale of the**
184 **coverage, that the issuer has made such election, and include in such statements a**
185 **description of the effect of this election;**
186 **(5) Periods of creditable coverage with respect to an individual may be established**
187 **through presentation of certifications and other means as specified in Public Law 104-191**

188 **and regulations pertinent thereto.**
189 **6. A health insurance issuer offering group health insurance coverage shall not**
190 **apply any preexisting condition exclusion in the following circumstances:**
191 **(1) Subject to subdivision (4) of this subsection, a health insurance issuer offering**
192 **group health insurance coverage shall not impose any preexisting condition exclusion in**
193 **the case of an individual who, as of the last day of the thirty-one day period beginning with**
194 **the date of birth, is covered under creditable coverage;**
195 **(2) Subject to subdivision (4) of this subsection, a health insurance issuer offering**
196 **group health insurance coverage shall not impose any preexisting condition exclusion in**
197 **the case of a child who is adopted or placed for adoption before attaining eighteen years**
198 **of age and who, as of the last day of the thirty-day period beginning on the date of the**
199 **adoption or placement for adoption, is covered under creditable coverage. This provision**
200 **shall not apply to coverage before the date of such adoption or placement for adoption;**
201 **(3) A health insurance issuer offering group health insurance coverage shall not**
202 **impose any preexisting condition exclusion relating to pregnancy as a preexisting**
203 **condition;**
204 **(4) Subdivisions (1) and (2) of this subsection shall not apply to an individual after**
205 **the end of the first sixty-three day period during all of which the individual was not**
206 **covered under any creditable coverage.**
207 **7. A health insurance issuer offering group health insurance coverage shall provide**
208 **a certification of creditable coverage as required by Public Law 104-191 and regulations**
209 **pursuant thereto.**
210 **8. A health insurance issuer offering group health insurance coverage shall provide**
211 **for special enrollment periods in the following circumstances:**
212 **(1) A health insurance issuer offering group health insurance in connection with**
213 **a group health plan shall permit an employee or a dependent of an employee who is eligible**
214 **but not enrolled for coverage under the terms of the plan to enroll for coverage if:**
215 **(a) The employee or dependent was covered under a group health plan or had**
216 **health insurance coverage at the time that coverage was previously offered to the employee**
217 **or dependent;**
218 **(b) The employee stated in writing at the time that coverage under a group health**
219 **plan or health insurance coverage was the reason for declining enrollment, but only if the**
220 **plan sponsor or health insurance issuer required the statement at the time and provided**
221 **the employee with notice of the requirement and the consequences of the requirement at**
222 **the time;**
223 **(c) The employee's or dependent's coverage described in paragraph (a) of this**

224 **subdivision was:**
225 **a. Under a COBRA continuation provision and was exhausted; or**
226 **b. Not under a COBRA continuation provision and was terminated as a result of**
227 **loss of eligibility for the coverage or because employer contributions toward the cost of**
228 **coverage were terminated; and**
229 **(d) Under the terms of the group health plan, the employee requests the enrollment**
230 **not later than thirty days after the date of exhaustion of coverage described in**
231 **subparagraph a. of paragraph (c) of this subdivision or termination of coverage or**
232 **employer contributions described in subparagraph b. of paragraph (c) of this subdivision;**
233 **(2) (a) A group health plan shall provide for a dependent special enrollment period**
234 **described in paragraph (b) of this subdivision during which an employee who is eligible**
235 **but not enrolled and a dependent may be enrolled under the group health plan and, in the**
236 **case of the birth or adoption of a child, the spouse of the employee may be enrolled as a**
237 **dependent if the spouse is otherwise eligible for coverage;**
238 **(b) A dependent special enrollment period pursuant to this subdivision is a period**
239 **of not less than thirty days that begins on the date of the marriage, birth, or adoption or**
240 **placement for adoption, or the period provided for enrollment under section 376.406 in the**
241 **case of a birth;**
242 **(3) The coverage becomes effective:**
243 **(a) In the case of marriage, not later than the first day of the first month beginning**
244 **after the date on which the completed request for enrollment is received;**
245 **(b) In the case of a dependent's birth, as of the date of birth; or**
246 **(c) In the case of a dependent's adoption or placement for adoption, the date of the**
247 **adoption or placement for adoption.**
248 **9. In the case of group health insurance coverage offered by a health maintenance**
249 **organization, the plan may provide for an affiliation period with respect to coverage**
250 **through the organization only if:**
251 **(1) No preexisting condition exclusion is imposed with respect to coverage through**
252 **the organization;**
253 **(2) The period is applied uniformly without regard to any health status-related**
254 **factors;**
255 **(3) Such period does not exceed two months, or three months in the case of a late**
256 **enrollee;**
257 **(4) Such period begins on the enrollment date; and**
258 **(5) Such period runs concurrently with any waiting period.**
376.451. 1. A health insurance issuer offering group health insurance coverage

2 **shall comply with the following standards prohibiting discrimination as to eligibility based**
3 **upon health status:**
4 **(1) A health insurance issuer offering group health insurance coverage shall not**
5 **establish rules for eligibility, including continued eligibility, of any individual to enroll**
6 **under the terms of the group health plan based on any of the following health status-**
7 **related factors of the individual or a dependent of the individual:**
8 **(a) Health status;**
9 **(b) Medical condition, including both physical and mental illness;**
10 **(c) Claims experience;**
11 **(d) Receipt of health care;**
12 **(e) Medical history;**
13 **(f) Genetic information;**
14 **(g) Evidence of insurability, including conditions arising out of acts of domestic**
15 **violence; or**
16 **(h) Disability;**
17 **(2) This subsection does not require a health insurance issuer offering group health**
18 **insurance coverage to provide particular benefits other than those provided under the**
19 **terms of the group health insurance coverage, or prevent the issuer from establishing**
20 **limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage**
21 **for similarly situated individuals enrolled in the group health insurance coverage;**
22 **(3) For purposes of subdivision (1) of this subsection, rules for eligibility to enroll**
23 **include rules defining any applicable waiting or affiliation period for such enrollment, and**
24 **rules relating to late and special enrollments.**
25 **2. A health insurance issuer offering group health insurance coverage shall comply**
26 **with the following standards prohibiting discrimination as to premium contributions based**
27 **upon health status:**
28 **(1) A health insurance issuer offering health insurance coverage in connection with**
29 **a group health plan shall not require any individual, as a condition of enrollment or**
30 **continued enrollment under the plan, to pay a premium or contribution that is greater than**
31 **the premium or contribution for a similarly situated individual enrolled in the group**
32 **health plan on the basis of any health status-related factor in relation to the individual or**
33 **to an individual enrolled under the plan as a dependent of the individual;**
34 **(2) Nothing in subdivision (1) of this subsection shall be construed to:**
35 **(a) Restrict the amount that any employer may be charged for coverage under a**
36 **group health plan, other than as provided in sections 379.930 to 379.952 for health**
37 **insurance coverage provided in the small group market; or**

38 **(b) Prevent a health insurance issuer offering group health insurance coverage,**
39 **from establishing premium discounts or rebates or modifying otherwise applicable**
40 **copayments or deductibles in return for adherence to programs of health promotion and**
41 **disease prevention.**

376.452. 1. Except as provided in this section, if a health insurance issuer offers
2 **health insurance coverage in the large group market in connection with a group health**
3 **plan, the health insurance issuer shall renew or continue the coverage in force at the option**
4 **of the plan sponsor.**
5 **2. A health insurance issuer may nonrenew or discontinue health insurance**
6 **coverage offered in connection with a group health plan in the large group market if:**
7 **(1) The plan sponsor has failed to pay premiums or contributions in accordance**
8 **with the terms of the health insurance coverage or if the health insurance issuer has not**
9 **received timely premium payments;**
10 **(2) The plan sponsor has performed an act or practice that constitutes fraud or has**
11 **made an intentional misrepresentation of material fact in connection with the coverage;**
12 **(3) The plan sponsor has failed to comply with the health insurance issuer's**
13 **minimum participation requirements;**
14 **(4) The plan sponsor has failed to comply with the health insurance issuer's**
15 **employer contribution requirements;**
16 **(5) The health insurance issuer is ceasing to offer coverage in that group market**
17 **in accordance with this section;**
18 **(6) In the case of a health insurance issuer that offers health insurance coverage in**
19 **the group market through a network plan, there is no longer any enrollee under the group**
20 **health plan who lives, resides, or works in the service area of the health insurance issuer**
21 **(or in the area for which the issuer is authorized to do business);**
22 **(7) In the case of health insurance coverage that is made available in the large**
23 **group market only through one or more bona fide associations, the membership of an**
24 **employer in the bona fide association ceases, but only if coverage is terminated pursuant**
25 **to this subdivision uniformly without regard to any health status-related factor of any**
26 **covered individual.**
27 **3. A health insurance issuer shall not discontinue offering a particular type of**
28 **group health insurance coverage offered in the large group market unless:**
29 **(1) The issuer provides notice to each plan sponsor, participant, and benficiary**
30 **provided coverage of this type in the large group market of the discontinuation at least**
31 **ninety days prior to the date of the discontinuation of the coverage;**
32 **(2) The issuer offers to each plan sponsor provided coverage of this type in the large**

33 **group market the option to purchase any other health insurance coverage currently being**
34 **offered by the health insurance issuer to a group health plan in the market; and**
35 **(3) The issuer acts uniformly without regard to the claims experience of those plan**
36 **sponsors or any health status-related factor of any participant or beneficiary covered or**
37 **new participant or beneficiary who may become eligible for such coverage.**
38 **4. (1) A health insurance issuer shall not discontinue offering all health insurance**
39 **coverage in the large group market unless:**
40 **(a) The issuer provides notice of discontinuation to the director of the department**
41 **of insurance and to each plan sponsor, participant, and beneficiary covered at least one**
42 **hundred eighty days prior to the date of the discontinuation of coverage; and**
43 **(b) All health insurance issued or delivered for issuance in Missouri in the large**
44 **group market is discontinued and coverage under such health insurance is not renewed.**
45 **(2) In the case of a discontinuation pursuant to this subsection, the health insurance**
46 **issuer shall not provide for the issuance of any health insurance coverage in the large**
47 **group market for a period of five years beginning on the date of the discontinuation of the**
48 **last health insurance coverage not renewed.**
49 **5. At the time of coverage renewal, a health insurance issuer may modify the health**
50 **insurance coverage for a product offered to a group health plan in the large group market.**
51 **For purposes of this subsection, renewal shall be deemed to occur not more than annually**
52 **on the anniversary of the effective date of the group health plan's health insurance**
53 **coverage unless a longer term is specified in the policy or contract.**
54 **6. In the case of health insurance coverage that is made available by a health**
55 **insurance issuer only through one or more bona fide associations, a reference to "plan**
56 **sponsor" in this section is deemed, with respect to coverage provided to an employer**
57 **member of the association, to include a reference to such employer.**
376.453. 1. Except as provided in this section, a health insurance issuer that
2 **provides individual health insurance coverage to an individual shall renew or continue in**
3 **force such coverage at the option of the individual.**
4 **2. A health insurance issuer may nonrenew or discontinue health insurance**
5 **coverage of an individual market based only on one or more of the following:**
6 **(1) The individual has failed to pay premiums or contributions in accordance with**
7 **the terms of the health insurance coverage or the issuer has not received timely premium**
8 **payments;**
9 **(2) The individual has performed an act or practice that constitutes fraud or made**
10 **an intentional misrepresentation of material fact under the terms of the coverage;**
11 **(3) The issuer is ceasing to offer coverage in the individual market in accordance**

12 **with subsection 4 of this section;**
13 **(4) In the case of a health insurance issuer that offers health insurance coverage in**
14 **the market through a network plan, the individual no longer resides, lives, or works in the**
15 **service area (or in an area for which the issuer is authorized to do business) but only if**
16 **such coverage is terminated under this subdivision uniformly without regard to any health**
17 **status-related factor of covered individuals;**
18 **(5) In the case of health insurance coverage that is made available in the individual**
19 **market only through one or more bona fide associations, the membership of the individual**
20 **in the association (on the basis of which the coverage is provided) ceases, but only if such**
21 **coverage is terminated under this subdivision uniformly without regard to any health**
22 **status-related factor of covered individuals.**
23 **3. In any case in which an issuer decides to discontinue offering a particular type**
24 **of health insurance coverage offered in the individual market, coverage of such type may**
25 **be discontinued by the issuer only if:**
26 **(1) The issuer provides notice to each covered individual provided coverage of this**
27 **type in such market of such discontinuation at least ninety days prior to the date of the**
28 **discontinuation of such coverage;**
29 **(2) The issuer offers to each individual in the individual market provided coverage**
30 **of this type, the option to purchase any other individual health insurance coverage**
31 **currently being offered by the issuer for individuals in such market; and**
32 **(3) In exercising the option to discontinue coverage of this type and in offering the**
33 **option of coverage under subdivision (2) of this subsection, the issuer acts uniformly**
34 **without regard to any health status-related factor of enrolled individuals or individuals**
35 **who may become eligible for such coverage.**
36 **4. (1) In any case in which a health insurance issuer elects to discontinue offering**
37 **all health insurance coverage in the individual market in the state, health insurance**
38 **coverage may be discontinued by the issuer only if:**
39 **(a) The issuer provides notice to the director of the department of insurance and**
40 **to each individual of such discontinuation at least one hundred eighty days to the date of**
41 **the expiration of such coverage; and**
42 **(b) All health insurance issued or delivered for issuance in the state in such market**
43 **is discontinued and coverage under such health insurance coverage in such market is not**
44 **renewed.**
45 **(2) In the case of discontinuation under subdivision (1) of this subsection, the issuer**
46 **shall not provide for the issuance of any health insurance coverage in the individual**
47 **market for a five-year period beginning on the date of discontinuation of the last health**

48 **insurance coverage not so renewed.**
49 **5. At the time of coverage renewal, a health insurance issuer may modify the health**
50 **insurance coverage for a policy form offered to individuals in the individual market so long**
51 **as such modification is consistent with applicable law and effective on a uniform basis**
52 **among all individuals with that policy form. For purposes of this subsection, renewal shall**
53 **be deemed to occur not more often than annually on the anniversary of the effective date**
54 **of the individual's health insurance coverage unless a longer term is specified in the policy**
55 **or contract.**
56 **6. In applying this section in the case of health insurance coverage that is made**
57 **available by a health insurance issuer in the individual market to individuals only through**
58 **one or more associations, a reference to an individual is deemed to include a reference to**
59 **such an association of which the individual is a member.**
60 **7. An insurer shall provide a certification of creditable coverage as required by**
61 **Public Law 104-191 and regulations pursuant thereto.**

376.960. As used in sections 376.960 to 376.989, the following terms mean:
2 (1) "Benefit plan", the coverages to be offered by the pool to eligible persons pursuant
3 to the provisions of section 376.986;
4 (2) "Board", the board of directors of the pool;
5 (3) **"Church plan", a plan as defined in Section 3(33) of the Employee Retirement**
6 **Income Security Act of 1974;**
7 **(4) "Creditable coverage", with respect to an individual:**
8 **(a) Coverage of the individual provided under any of the following:**
9 **a. A group health plan;**
10 **b. Health insurance coverage;**
11 **c. Part A or Part B of Title XVIII of the Social Security Act;**
12 **d. Title XIX of the Social Security Act, other than coverage consisting solely of**
13 **benefits under section 1928 of such act;**
14 **e. Chapter 55 of Title 10, United States Code;**
15 **f. A medical care program of the Indian Health Service or of a tribal organization;**
16 **g. A state health benefits risk pool;**
17 **h. A health plan offered under Title 5, Chapter 89, of the United States Code;**
18 **i. A public health plan as defined in federal regulations; or**
19 **j. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. Section**
20 **2504(3));**
21 **(b) Creditable coverage does not include coverage consisting solely of excepted**
22 **benefits;**

23 **(5)** "Director", the director of the Missouri department of insurance;
24 **[**(4)**] (6)** "Department", the Missouri department of insurance;
25 **(7) "Dependent", a resident spouse or resident unmarried child under the age of**
26 **nineteen years, a child who is a student under the age of twenty-three years and who is**
27 **financially dependent upon the parent, or a child of any age who is disabled and dependent**
28 **upon the parent;**
29 **(7) "Federally defined eligible individual", an individual:**
30 **(a) For whom, as of the date on which the individual seeks coverage through the**
31 **pool, the aggregate of the periods of creditable coverage as defined in subdivision (4) of this**
32 **section, is eighteen or more months and whose most recent prior creditable coverage was**
33 **under a group health plan, governmental plan, church plan, or health insurance coverage**
34 **offered in connection with any such plan;**
35 **(b) Who is not eligible for coverage under a group health plan, Part A or Part B of**
36 **Title XVIII of the Social Security Act, or state plan under Title XIX of such act or any**
37 **successor program, and who does not have other health insurance coverage;**
38 **(c) With respect to whom the most recent coverage within the period of aggregate**
39 **creditable coverage was not terminated because of nonpayment of premiums or fraud;**
40 **(e) Who, if offered the option of continuation coverage under COBRA continuation**
41 **provision or under a similar state program, both elected and exhausted the continuation**
42 **coverage;**
43 **(9) "Government plan", a plan as defined in Section 3(32) of the Employee**
44 **Retirement Income Security Act of 1974 and any federal governmental plan;**
45 **(10) "Group health plan", an employee welfare benefit plan as defined in Section**
46 **3(1) of the Employee Retirement Income Security Act of 1974 and Public Law 104-191 to**
47 **the extent that the plan provides medical care and including items and services paid for as**
48 **medical care to employees or their dependents, as defined under the terms of the plan,**
49 **directly or through insurance, reimbursement, or otherwise, but not including excepted**
50 **benefits;**
51 **[**(5)**] (11)** "Health insurance", any hospital and medical expense incurred policy,
52 nonprofit health care service for benefits other than through an insurer, nonprofit health care
53 service plan contract, health maintenance organization subscriber contract, preferred provider
54 arrangement or contract, or any other similar contract or agreement for the provisions of health
55 care benefits. The term "health insurance" does not include short-term, accident, fixed
56 indemnity, limited benefit or credit insurance, coverage issued as a supplement to liability
57 insurance, insurance arising out of a workers' compensation or similar law, automobile
58 medical-payment insurance, or insurance under which benefits are payable with or without

59 regard to fault and which is statutorily required to be contained in any liability insurance policy
60 or equivalent self-insurance;
61 **[**(6)**] (12)** "Health maintenance organization", any person which undertakes to provide
62 or arrange for basic and supplemental health care services to enrollees on a prepaid basis, or
63 which meets the requirements of section 1301 of the United States Public Health Service Act;
64 **[**(7)**] (13)** "Hospital", a place devoted primarily to the maintenance and operation of
65 facilities for the diagnosis, treatment or care for not less than twenty-four hours in any week of
66 three or more nonrelated individuals suffering from illness, disease, injury, deformity or other
67 abnormal physical condition; or a place devoted primarily to provide medical or nursing care for
68 three or more nonrelated individuals for not less than twenty-four hours in any week. The term
69 "hospital" does not include convalescent, nursing, shelter or boarding homes, as defined in
70 chapter 198, RSMo;
71 **[**(8)**] (14)** "Insurance arrangement", any plan, program, contract or other arrangement
72 under which one or more employers, unions or other organizations provide to their employees
73 or members, either directly or indirectly through a trust or third party administration, health care
74 services or benefits other than through an insurer;
75 **[**(9)**] (15)** "Insured", any individual resident of this state who is eligible to receive
76 benefits from any insurer or insurance arrangement, as defined in this section;
77 **[**(10)**] (16)** "Insurer", any insurance company authorized to transact health insurance
78 business in this state, any nonprofit health care service plan act, or any health maintenance
79 organization;
80 **(17) "Medical care", amounts paid for:**
81 **(a) The diagnosis, cure, mitigation, treatment, or prevention of disease or amounts**
82 **paid for the purpose of affecting any structure or function of the body;**
83 **(b) Transportation primarily for and essential to medical care referred to in**
84 **paragraph (a) of this subdivision; or**
85 **(c) Insurance covering medical care referred to in paragraphs (a) and (b) of this**
86 **subdivision;**
87 **[**(11)**] (18)** "Medicare", coverage under both Part A and Part B of Title XVIII of the
88 Social Security Act, 42 U.S.C. 1395 et seq., as amended;
89 **[**(12)**] (19)** "Member", all insurers and insurance arrangements participating in the pool;
90 **[**(13)**] (20)** "Physician", physicians and surgeons licensed under chapter 334, RSMo, or
91 by state board of healing arts in the state of Missouri;
92 **[**(14)**] (21)** "Plan of operation", the plan of operation of the pool, including articles,
93 bylaws and operating rules, adopted by the board pursuant to the provisions of sections 376.961,
94 376.962 and 376.964;

95 [(15)] **(22)** "Pool", the state health insurance pool created in sections 376.961, 376.962
96 and 376.964**;**
97 **(23) "Resident", an individual who has been legally domiciled in this state for a**
98 **period of at least thirty days, except that for a federally defined eligible individual, there**
99 **shall not be a thirty-day requirement;**
100 **(24) "Significant break in coverage", a period of sixty-three consecutive days**
101 **during all of which the individual does not have any creditable coverage, except that**
102 **neither a waiting period nor an affiliation period is taken into account in determining a**
103 **significant break in coverage;**
104 **(25) "Trade act eligible individual", an individual who is eligible for the federal**
105 **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
2 Health Insurance Pool". All insurers issuing health insurance in this state and insurance
3 arrangements providing health plan benefits in this state on and after January 1, 1991, shall be
4 members of the pool.
5 2. [The director shall give notice to all insurers and insurance arrangements of the time
6 and place for the initial organizational meetings. The board of directors shall be selected by the
7 pool participants, and shall consist of seven members: one member each from the three largest
8 domestic insurance companies participating in the pool, based on premium income in Missouri;
9 one member each from the two largest domestic health services corporations participating in the
10 pool, based on premium income in Missouri; one member from an independent domestic health
11 maintenance organization participating in the pool; and one member from the general public who
12 is not an insurer, or any officer, director, or employee of an insurer. Two members of the board
13 of directors shall be of minority groups and at least one such member shall be an
14 African-American. The board shall appoint one or more insurers to serve as administrator. Both
15 the selection of the board of directors and the administering insurer shall be subject to approval
16 by the director.
17 3. If, within sixty days of the organizational meeting, the board of directors is not
18 selected or the administering insurer is not appointed, the director shall appoint the initial board
19 and appoint an administering insurer.] **The pool shall operate subject to the supervision and**
20 **control of the board. The board of directors shall consist of the director or the director's**
21 **designated representative, who shall serve as an ex officio member of the board and shall**
22 **be its chairperson, and eight other board members appointed by the governor. At least two**
23 **board members shall be individuals, or the parent, spouse, or child of individuals,**
24 **reasonably expected to qualify for coverage by the pool. At least two board members shall**
25 **be representatives of insurers. A majority of the board shall be composed of individuals**

26 **who are not representatives of insurers or health care providers.**
27 **3. The initial board members shall be appointed as follows: one-third of the**
28 **members to serve a term of two years; one-third of the members to serve a term of four**
29 **years; and one-third of the members to serve a term of six years. Subsequent board**
30 **members shall serve for a term of three years. A board member's term shall continue until**
31 **his or her successor is appointed.**
32 **4. Vacancies on the board shall be filled by the governor. Board members may be**
33 **removed by the governor for cause.**
34 **5. Board members shall not be compensated in their capacity as board members**
35 **but shall be reimbursed for reasonable expenses incurred in the necessary performance of**
36 **their duties.**

376.966. 1. No employee shall involuntarily lose his **or her** group coverage by decision
2 of his **or her** employer on the grounds that such employee may subsequently enroll in the pool.
3 The department of insurance shall have authority to promulgate rules and regulations to enforce
4 this subsection.
5 2. **The following individual persons shall be eligible for coverage under the pool if**
6 **they are and continue to be residents of this state:**
7 **(1) An individual person who provides evidence of the following:**
8 **(a) A notice of rejection or refusal to issue substantially similar health insurance**
9 **for health reasons by one insurer; or**
10 **(b) A refusal by an insurer to issue health insurance except at a rate exceeding the**
11 **plan rate for substantially similar health insurance;**
12 **(2) A federally defined eligible individual who has not experienced a significant**
13 **break in coverage;**
14 **(3) A Trade Act eligible individual;**
15 **(4) Persons who can demonstrate the existence or history of any medical or health**
16 **conditions on a list promulgated by the board. For this purpose, the board shall**
17 **promulgate a list of medical or health conditions for which a person shall be eligible for**
18 **plan coverage without applying for health insurance coverage under subsection 1 of this**
19 **section, and such persons shall not be required to provide the evidence specified in**
20 **subdivision (1) of this subsection. The list may be amended from time to time as may be**
21 **appropriate;**
22 **(5) Each resident dependent of a person who is eligible for plan coverage;**
23 **(6) Any person whose health insurance coverage is involuntarily terminated for any**
24 **reason other than nonpayment of premium or fraud, and who is not otherwise ineligible**
25 **under subdivision (4) of subsection 3 of this section. If application for pool coverage is**

26 **made not later than sixty-three days after the involuntary termination, the effective date**
27 **of the coverage shall be the date of termination of the previous coverage; or**
28 **(7) Any person whose premiums for health insurance coverage have increased to**
29 **two hundred percent or more of rates established by the board as applicable for individual**
30 **standard risks.**
31 **3.** **[**Any individual who is a resident of this state shall be eligible for pool coverage,
32 except the following**] The following individual persons shall not be eligible for coverage**
33 **under the pool**:
34 (1) Persons who have, on the date of issue of coverage by the pool, **or obtain** coverage
35 under health insurance or an insurance arrangement **substantially similar to more**
36 **comprehensive than a plan policy, or would be eligible to have coverage if the person**
37 **elected to obtain it,** except that**:**
38 **(a)** This exclusion shall not apply to a person who has such coverage but whose
39 premiums have increased to **[**three**] two** hundred percent or more of rates established by the
40 board as applicable for individual standard risks;
41 **(b) A person may maintain other coverage for the period of time the person is**
42 **satisfying any preexisting condition waiting period under a pool policy; and**
43 **(c) A person may maintain plan coverage for the period of time the person is**
44 **satisfying a preexisting condition waiting period under another health insurance policy**
45 **intended to replace the pool policy;**
46 (2) Any person who is at the time of pool application receiving **or eligible to receive**
47 health care benefits under section 208.151, RSMo;
48 (3) **[**Any person having terminated coverage in the pool unless twelve months have
49 elapsed since such termination;
50 (4) Any person on whose behalf the pool has paid out one million dollars in benefits;
51 (5)**]** Inmates **or residents** of public institutions**, unless such person is a federally**
52 **defined eligible individual,** and persons eligible for public programs;
53 **[**(6) Any person whose medical condition which precludes other insurance coverage is
54 directly due to alcohol or drug abuse or self-inflicted injury;
55 (7)**] (4)** Any person who is eligible for continuation or conversion of insurance coverage
56 under 29 U.S.C. 1161 to 29 U.S.C. 1168, 42 U.S.C. 300bb-1 to 42 U.S.C. 300bb-8, sections
57 376.395 to 376.404, or section 376.428, except that this exclusion shall not apply to a person
58 who has such coverage but whose premiums have increased to **[**three**] two** hundred percent or
59 more of rates established by the board as applicable for individual standard risks; or
60 **[**(8)**] (5)** Any person who is eligible for Medicare coverage.
61 **[**3.**] 4.** Any person who ceases to meet the eligibility requirements of this section may

62 be terminated at the end of [his] **such person's** policy period.
63 [4. Any person whose health insurance coverage is involuntarily terminated for any
64 reason other than nonpayment of premium or any person whose premiums have increased to
65 three hundred percent or more of rates established by the board as applicable for individual
66 standard risks, may apply for coverage under the plan. If such coverage is applied for within
67 sixty days after the involuntary termination and the application is approved and if premiums are
68 paid for the entire coverage period, the effective date of the coverage shall be the date of
69 termination of the previous coverage.]
70 **5. (1) If an insurer issues one or more of the following or takes any other action**
71 **based wholly or partially on medical underwriting considerations which is likely to render**
72 **any person eligible for pool coverage, the insurer shall notify all persons affected of the**
73 **existence of the pool, as well as the eligibility requirements and methods of applying for**
74 **pool coverage:**
75 **(a) A notice of rejection or cancellation of coverage;**
76 **(b) A notice of reduction or limitation of coverage, including restrictive riders, if**
77 **the effect of the reduction or limitation is to substantially reduce coverage compared to the**
78 **coverage available to a person considered a standard risk for the type of coverage provided**
79 **by the plan;**
80 **(c) A notice of increase in premium to an amount exceeding the premium then in**
81 **effect for pool coverage having the same or similar deductible for a person of the same age,**
82 **sex, and geographical location;**
83 **(d) A notice of premium for coverage not yet in effect which exceeds the premium**
84 **then in effect for pool coverage having the same or similar deductible for a person of the**
85 **same age, sex, and geographical location.**
86 **(2) Any notice issued under subdivision (1) of this subsection shall also state the**
87 **reasons for the rejection, termination, cancellation, or imposition of underwriting**
88 **restrictions.**
376.975. Each member's proportion of participation in the pool shall be determined
2 annually by the board based on annual statements and other reports deemed necessary by the
3 board and filed by the member with it. Any deficit incurred by the pool shall be recouped by
4 assessments apportioned as provided in subsections 1, 2, and 3 of section 376.973 by the board
5 among members. The amount of assessments incurred by each member of the pool shall be
6 allowed as [an offset against certain taxes, and shall be subject to certain limitations, as follows:]
7 **a deduction from the gross amount of premiums received prior to calculating the premium**
8 **tax payable under chapter 148, RSMo.** Each pool member subject to chapter 148, RSMo, may
9 deduct from [premium taxes payable] **the gross amount of premiums received** for any calendar

10 year [to the state] any and all assessments paid for the same year pursuant to sections 376.960
11 to 376.989. [All assessments, for a fiscal year, shall not exceed the net premium tax due and
12 payable by such member in the previous year.] If the assessment [exceeds any premium tax due
13 or payable] **by a pool member in any calendar year exceeds the gross amount of premium**
14 **received by that pool member** in such year, the excess shall be [a credit or offset] carried
15 forward [against any premium tax due or payable] **and applied as a deduction from the gross**
16 **amount of premiums received** in succeeding years until the excess is exhausted.

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

376.986. 1. The pool shall offer major medical expense coverage to every person
2 eligible for coverage under section 376.966. The coverage to be issued by the pool and its
3 schedule of benefits, exclusions and other limitations, shall be established by the board with the
4 advice and recommendations of the pool members, and such plan of pool coverage shall be
5 submitted to the director for approval. The pool shall also offer coverage for drugs and supplies
6 requiring a medical prescription and coverage for patient education services, to be provided at
7 the direction of a physician, encompassing the provision of information, therapy, programs, or
8 other services on an inpatient or outpatient basis, designed to restrict, control, or otherwise cause
9 remission of the covered condition, illness or defect.
10 2. In establishing the pool coverage the board shall take into consideration the levels of
11 health insurance provided in this state and medical economic factors as may be deemed
12 appropriate, and shall promulgate benefit levels, deductibles, coinsurance factors, exclusions and
13 limitations determined to be generally reflective of and commensurate with health insurance
14 provided through a representative number of [insurers] **large employers** in this state.
15 3. [Premiums charged for pool coverage may not be unreasonable in relation to the
16 benefits provided, the risk experience and the reasonable expenses of providing the coverage.]
17 **The pool shall establish premium rates for pool coverage as provided in subsection 4 of this**
18 **section.** Separate schedules of premium rates based on age, sex and geographical location may
19 apply for individual risks. **Premium rates and schedules shall be submitted to the director**

20 **for approval prior to use.**
21 4. The pool**, with the assistance of the director,** shall determine the standard risk rate
22 by [calculating the average individual standard rate charged by the five insurers with the largest
23 number of individual contracts in force. In the event five insurers do not offer comparable
24 coverage,] **considering the premium rates charged by other insurers offering health**
25 **insurance coverage to individuals.** The standard risk rate shall be established using reasonable
26 actuarial techniques and shall reflect anticipated experience and expenses for such coverage.
27 Initial rates for pool coverage shall not be less than one hundred [fifty] **twenty-five** percent of
28 rates established as applicable for individual standard risks. **Subject to the limits provided in**
29 **this subsection,** subsequent rates shall be established to provide fully for the expected costs of
30 claims including recovery of prior losses, expenses of operation, investment income of claim
31 reserves, and any other cost factors subject to the limitations described herein. In no event shall
32 pool rates exceed [two hundred percent of rates applicable to individual standard risks. All rates
33 and rate schedules shall be submitted to the director for approval] **the following:**
34 **(1) For federally defined eligible individuals, rates shall be equal to the percent of**
35 **rates applicable to individual standard risks actuarially determined to be sufficient to**
36 **recover the sum of the cost of benefits paid under the pool for federally defined eligible**
37 **individuals plus the proportion of the pool's administrative expense applicable to federally**
38 **defined eligible individuals enrolled for pool coverage, provided that such rates shall not**
39 **exceed one hundred twenty-five percent of rates applicable to individual standard risks;**
40 **and**
41 **(2) For all other individuals covered under the pool, one hundred twenty-five**
42 **percent of rates applicable to individual standard risks**.
43 5. Pool coverage established pursuant to this section shall provide an appropriate high
44 and low deductible to be selected by the pool applicant. The deductibles and coinsurance factors
45 may be adjusted annually in accordance with the medical component of the consumer price
46 index.
47 6. Pool coverage shall exclude charges or expenses incurred during the first twelve
48 months following the effective date of coverage as to any condition [which, during the six-month
49 period immediately preceding the effective date of coverage, had manifested itself in such a
50 manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment or] for
51 which medical advice, care or treatment was recommended or received as to such condition
52 **during the six-month period immediately preceding the effective date of coverage**. Such
53 preexisting condition exclusions shall be waived to the extent to which similar exclusions, if any,
54 have been satisfied under any prior health insurance coverage which was involuntarily
55 terminated, if [that] application for pool coverage is made not later than [six] **sixty-three** days

56 following such involuntary termination and, in such case, coverage in the pool shall be effective
57 from the date on which such prior coverage was terminated.
58 7. **No preexisting condition exclusion shall be applied to the following:**
59 **(1) A federally defined eligible individual who has not experienced a significant gap**
60 **in coverage; or**
61 **(2) A Trade Act eligible individual who maintained creditable health insurance**
62 **coverage for an aggregate period of three months prior to loss of employment and who has**
63 **not experienced a significant gap in coverage since that time.**
64 **8.** Benefits otherwise payable under pool coverage shall be reduced by all amounts paid
65 or payable through any other health insurance, or insurance arrangement, and by all hospital and
66 medical expense benefits paid or payable under any workers' compensation coverage, automobile
67 medical payment or liability insurance whether provided on the basis of fault or nonfault, and
68 by any hospital or medical benefits paid or payable under or provided pursuant to any state or
69 federal law or program except Medicaid. The insurer or the pool shall have a cause of action
70 against an eligible person for the recovery of the amount of benefits paid which are not for
71 covered expenses. Benefits due from the pool may be reduced or refused as a setoff against any
72 amount recoverable under this subsection.
73 **[**8.**]** **9.** Medical expenses shall include expenses for comparable benefits for those who
74 rely solely on spiritual means through prayer for healing.
379.930. 1. Sections 379.930 to 379.952 shall be known and may be cited as the "Small
2 Employer Health Insurance Availability Act".
3 2. For the purposes of sections 379.930 to 379.952**, the following terms shall mean**:
4 (1) "Actuarial certification" **[**means**],** a written statement by a member of the American
5 Academy of Actuaries or other individual acceptable to the director that a small employer carrier
6 is in compliance with the provisions of section 379.936, based upon the person's examination,
7 including a review of the appropriate records and of the actuarial assumptions and methods used
8 by the small employer carrier in establishing premium rates for applicable health benefit plans;
9 (2) "Affiliate" or "affiliated" **[**means**],** any entity or person who directly or indirectly
10 through one or more intermediaries, controls or is controlled by, or is under common control
11 with, a specified entity or person;
12 (3) **[**"Agent" means "insurance agent" as that term is defined in section 375.012, RSMo;
13 (4)**]** "Base premium rate" **[**means**]**, for each class of business as to a rating period, the
14 lowest premium rate charged or that could have been charged under the rating system for that
15 class of business, by the small employer carrier to small employers with similar case
16 characteristics for health benefit plans with the same or similar coverage;
17 **[**(5) "Basic health benefit plan" means a lower cost health benefit plan developed

18 pursuant to section 379.944;
19 (6)] **(4)** "Board" [means]**,** the board of directors of the program established pursuant to
20 sections 379.942 and 379.943;
21 [(7) "Broker" means "broker" as that term is defined in section 375.012, RSMo;
22 (8)] **(5) "Bona fide association", an association which:**
23 **(a) Has been actively in existence for at least five years;**
24 **(b) Has been formed and maintained in good faith for purposes other than**
25 **obtaining insurance;**
26 **(c) Does not condition membership in the association on any health status-related**
27 **factor relating to an individual (including an employee of an employer or a dependent of**
28 **an employee);**
29 **(d) Makes health insurance coverage offered through the association available to**
30 **all members regardless of any health status-related factor relating to such members (or**
31 **individuals eligible for coverage through a member);**
32 **(e) Does not make health insurance coverage offered through the association**
33 **available other than in connection with a member of the association; and**
34 **(f) Meets all other requirements for an association set forth in subdivision (5) of**
35 **subsection 1 of section 376.421 that are not inconsistent with this subdivision;**
36 (6) "Carrier" [means] **or "health insurance issuer",** any entity that provides health
37 insurance or health benefits in this state. For the purposes of sections 379.930 to 379.952, carrier
38 includes an insurance company, health services corporation, fraternal benefit society, health
39 maintenance organization, multiple employer welfare arrangement specifically authorized to
40 operate in the state of Missouri, or any other entity providing a plan of health insurance or health
41 benefits subject to state insurance regulation;
42 [(9)] **(7)** "Case characteristics" [means]**,** demographic or other objective characteristics
43 of a small employer that are considered by the small employer carrier in the determination of
44 premium rates for the small employer, provided that claim experience, health status and duration
45 of coverage since issue shall not be case characteristics for the purposes of sections 379.930 to
46 379.952;
47 [(10)] **(8)** "Class of business" [means]**,** all or a separate grouping of small employers
48 established pursuant to section 379.934;
49 **(9) "Church plan", the meaning given such term in Section 3(33) of the Employee**
50 **Retirement Income Security Act of 1974;**
51 [(11)] **(10)** "Committee" [means]**,** the health benefit plan committee created pursuant to
52 section 379.944;
53 [(12)] **(11)** "Control" shall be defined in manner consistent with chapter 382, RSMo;

54 **(12) "Creditable coverage", with respect to an individual:**
55 **(a) Coverage of the individual pursuant to any of the following:**
56 **a. A group health plan;**
57 **b. Health insurance coverage;**
58 **c. Part A or Part B of Title XVIII of the Social Security Act;**
59 **d. Title XIX of the Social Security Act, other than coverage consisting solely of**
60 **benefits pursuant to Section 1928 of such act;**
61 **e. Chapter 55 of Title 10, United States Code;**
62 **f. A medical care program of the Indian Health Service or of a tribal organization;**
63 **g. A state health benefits risk pool;**
64 **h. A health plan offered pursuant to Chapter 89 of Title 5, United States Code;**
65 **i. A public health plan, as defined in federal regulations authorized by Section**
66 **2701(c)(1)(I) of the Public Health Services Act, as amended by P.L. 104-191; and**
67 **j. A health benefit plan pursuant to Section 5(e) of the Peace Corps Act (22 U.S.C.**
68 **2504(e));**
69 **(b) Creditable coverage shall not include coverage consisting solely of excepted**
70 **benefits;**
71 (13) "Dependent" **[**means**],** a spouse or an unmarried child under the age of nineteen
72 years; an unmarried child who is a full-time student under the age of twenty-three years and who
73 is financially dependent upon the parent; or an unmarried child of any age who is medically
74 certified as disabled and dependent upon the parent;
75 (14) "Director" **[**means**],** the director of the department of insurance of this state;
76 (15) "Eligible employee" **[**means**],** an employee who works on a full-time basis and has
77 a normal work week of thirty or more hours. The term includes a sole proprietor, a partner of
78 a partnership, and an independent contractor, if the sole proprietor, partner or independent
79 contractor is included as an employee under a health benefit plan of a small employer, but does
80 not include an employee who works on a part-time, temporary or substitute basis. For purposes
81 of sections 379.930 to 379.952, a person, his spouse and his minor children shall constitute only
82 one eligible employee when they are employed by the same small employer;
83 (16) "Established geographic service area" **[**means**],** a geographical area, as approved by
84 the director and based on the carrier's certificate of authority to transact insurance in this state,
85 within which the carrier is authorized to provide coverage;
86 **(17) "Excepted benefits":**
87 **(a) Coverage only for accident (including accidental death and dismemberment)**
88 **insurance;**
89 **(b) Coverage only for disability income insurance;**

90 **(c) Coverage issued as a supplement to liability insurance;**
91 **(d) Liability insurance, including general liability insurance and automobile**
92 **liability insurance;**
93 **(e) Workers' compensation or similar insurance;**
94 **(f) Automobile medical payment insurance;**
95 **(g) Credit-only insurance;**
96 **(h) Coverage for onsite medical clinics;**
97 **(i) Other similar insurance coverage, as approved by the director, under which**
98 **benefits for medical care are secondary or incidental to other insurance benefits;**
99 **(j) If provided under a separate policy, certificate or contract of insurance, any of**
100 **the following:**
101 **a. Limited scope dental or vision benefits;**
102 **b. Benefits for long-term care, nursing home care, home health care, community-**
103 **based care, or any combination thereof;**
104 **c. Other similar, limited benefits as specified by the director;**
105 **(k) If provided under a separate policy, certificate or contract of insurance, any of**
106 **the following:**
107 **a. Coverage only for a specified disease or illness;**
108 **b. Hospital indemnity or other fixed indemnity insurance;**
109 **(l) If offered as a separate policy, certificate or contract of insurance, any of the**
110 **following:**
111 **a. Medicare supplemental coverage (as defined under section 1882(g)(1) of the**
112 **Social Security Act);**
113 **b. Coverage supplemental to the coverage provided pursuant to Chapter 55 of Title**
114 **10, United States Code;**
115 **c. Similar supplemental coverage provided to coverage under a group health plan;**
116 **[**(17)**] (18) "Government plan", the meaning given such term pursuant to Section**
117 **3(32) of the Employee Retirement Income Security Act of 1974 or any federal government**
118 **plan;**
119 **(19) "Group health plan", an employee welfare benefit plan as defined in Section**
120 **3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan**
121 **provides medical care, as defined in this section, and including any item or service paid for**
122 **as medical care to an employee or the employee's dependent, as defined under the terms**
123 **of the plan, directly or through insurance, reimbursement or otherwise, but not including**
124 **excepted benefits;**
125 **(20)** "Health benefit plan" **[**means any hospital or medical policy or certificate, health

126 services corporation contract, or health maintenance organization subscriber contract. Health
127 benefit plan does not include a policy of individual accident and sickness insurance, or hospital
128 supplemental policies having a fixed daily benefit, or accident-only, specified disease-only,
129 credit, dental, vision, Medicare supplement, long-term care, or disability income insurance, or
130 coverage issued as a supplement to liability insurance, worker's compensation or similar
131 insurance, or automobile medical payment insurance] **or "health insurance coverage", benefits**
132 **consisting of medical care, including items and services paid for as medical care, that are**
133 **provided directly, through insurance, reimbursement, or otherwise, under a policy,**
134 **certificate, membership contract, or health services agreement offered by a health**
135 **insurance issuer, but not including excepted benefits**;
136 **(21) "Health status-related factor", any of the following:**
137 **(a) Health status;**
138 **(b) Medical condition, including both physical and mental illnesses;**
139 **(c) Claims experience;**
140 **(d) Receipt of health care;**
141 **(e) Medical history;**
142 **(f) Genetic information;**
143 **(g) Evidence of insurability, including a condition arising out of an act of domestic**
144 **violence;**
145 **(h) Disability;**
146 [(18)] **(22)** "Index rate" [means], for each class of business as to a rating period for small
147 employers with similar case characteristics, the arithmetic mean of the applicable base premium
148 rate and the corresponding highest premium rate;
149 [(19)] **(23)** "Late enrollee" [means]**,** an eligible employee or dependent who requests
150 enrollment in a health benefit plan of a small employer following the initial enrollment period
151 for which such individual is entitled to enroll under the terms of the health benefit plan, provided
152 that such initial enrollment period is a period of at least thirty days. However, an eligible
153 employee or dependent shall not be considered a late enrollee if:
154 (a) The individual meets each of the following:
155 a. The individual was covered under [qualifying previous] **creditable** coverage at the
156 time of the initial enrollment;
157 b. The individual lost coverage under [qualifying previous] **creditable** coverage as a
158 result of **cessation of employer contribution,** termination of employment or eligibility,
159 **reduction in the number of hours of employment,** the involuntary termination of the
160 [qualifying previous] **creditable** coverage, death of a spouse [or divorce;]**, dissolution or legal**
161 **separation; and**

162 c. The individual requests enrollment within thirty days after termination of the
163 [qualifying previous] **creditable** coverage;
164 (b) The individual is employed by an employer that offers multiple health benefit plans
165 and the individual elects a different plan during an open enrollment period; or
166 (c) A court has ordered coverage be provided for a spouse or minor or dependent child
167 under a covered employee's health benefit plan and request for enrollment is made within thirty
168 days after issuance of the court order;
169 [(20)] **(24) "Medical care", an amount paid for:**
170 **(a) The diagnosis, care, mitigation, treatment or prevention of disease, or for the**
171 **purpose of affecting any structure or function of the body;**
172 **(b) Transportation primarily for and essential to medical care referred to in**
173 **paragraph (a) of this subdivision; or**
174 **(c) Insurance covering medical care referred to in paragraphs (a) and (b) of this**
175 **subdivision;**
176 **(25) "Network plan", health insurance coverage offered by a health insurance**
177 **issuer under which the financing and delivery of medical care including items and services**
178 **paid for as medical care, are provided, in whole or in part, through a defined set of**
179 **providers under contract with the issuer;**
180 **(26)** "New business premium rate" [means], for each class of business as to a rating
181 period, the lowest premium rate charged or offered, or which could have been charged or offered,
182 by the small employer carrier to small employers with similar case characteristics for newly
183 issued health benefit plans with the same or similar coverage;
184 [(21)] **(27)** "Plan of operation" [means]**,** the plan of operation of the program established
185 pursuant to sections 379.942 and 379.943;
186 [(22)] **(28) "Plan sponsor", the meaning given such term pursuant to Section**
187 **3(16)(B) of the Employee Retirement Income Security Act of 1974;**
188 **(29)** "Premium" [means]**,** all moneys paid by a small employer and eligible employees
189 as a condition of receiving coverage from a small employer carrier, including any fees or other
190 contributions associated with the health benefit plan;
191 [(23)] **(30)** "Producer" includes an insurance agent or broker;
192 [(24)] **(31)** "Program" [means]**,** the Missouri small employer health reinsurance program
193 created pursuant to sections 379.942 and 379.943;
194 [(25) "Qualifying previous coverage" and "qualifying existing coverage" mean benefits
195 or coverage provided under:
196 (a) Medicare or Medicaid;
197 (b) An employer-based health insurance or health benefit arrangement that provides

198 benefits similar to or exceeding benefits provided under the basic health benefit plan; or
199 (c) An individual health insurance policy (including coverage issued by a health
200 maintenance organization, health services corporation or a fraternal benefit society) that provides
201 benefits similar to or exceeding the benefits provided under the basic health benefit plan,
202 provided that such policy has been in effect for a period of at least one year;
203 (26)**]** **(32)** "Rating period" **[**means**],** the calendar period for which premium rates
204 established by a small employer carrier are assumed to be in effect;
205 **[**(27)**]** **(33)** "Restricted network provision" **[**means**],** any provision of a health benefit
206 plan that conditions the payment of benefits, in whole or in part, on the use of health care
207 providers that have entered into a contractual arrangement with the carrier pursuant to section
208 354.400, RSMo, et seq. to provide health care services to covered individuals;
209 **[**(28)**]** **(34)** "Small employer" **[**means**], in connection with a group health plan with**
210 **respect to a calendar year and a plan year,** any person, firm, corporation, partnership **[**or**],**
211 association **or political subdivision** that is actively engaged in business that**[**, on at least fifty
212 percent of its working days during the preceding calendar quarter, employed not less than three
213 nor**]** **employed an average of at least two but no** more than **[**twenty-five**]** **fifty** eligible
214 employees**[**, the majority of whom were employed within this state. In determining the number
215 of eligible employees, companies that are affiliated companies, or that are eligible to file a
216 combined tax return for purposes of state taxation, shall be considered one employer;**]** **on**
217 **business days during the preceding calendar year and that employs at least two employees**
218 **on the first day of the plan year. All persons treated as a single employer pursuant to**
219 **subsection (b), (c), (m) or (o) of Section 414 of the Internal Revenue Code of 1986 shall be**
220 **treated as one employer. Subsequent to the issuance of a health plan to a small employer**
221 **and for the purpose of determining continued eligibility, the size of a small employer shall**
222 **be determined annually. Except as otherwise specifically provided, the provisions of**
223 **sections 379.930 to 379.952 that apply to a small employer shall continue to apply at least**
224 **until the plan anniversary following the date the small employer no longer meets the**
225 **requirements of this definition. In the case of an employer which was not in existence**
226 **throughout the preceding calendar year, the determination of whether the employer is a**
227 **small or large employer shall be based on the average number of employees that it is**
228 **reasonably expected that the employer will employ on business days in the current**
229 **calendar year. Any reference in this act to an employer shall include a reference to any**
230 **predecessor of such employer;**
231 **[**(29)**]** **(35)** "Small employer carrier" **[**means**],** a carrier that offers health benefit plans
232 covering eligible employees of one or more small employers in this state**[**;
233 (30) "Standard health benefit plan" means a health benefit plan developed pursuant to

234 section 379.944**]**.
235 **3. Other terms used in sections 379.930 to 379.952 not set forth in subsection 2 of**
236 **this section shall have the same meaning as defined in section 376.450**.

379.938. 1. A health benefit plan subject to sections 379.930 to 379.952 shall be
2 renewable with respect to all eligible employees and dependents, at the option of the small
3 employer, except in any of the following cases:
4 (1) **[**Nonpayment of the required premiums**] The plan sponsor fails to pay a premium**
5 **or contribution in accordance with the terms of a health benefit plan or the health carrier**
6 **has not received a timely premium payment**;
7 (2) **[**Fraud or misrepresentation of the small employer or, with respect to coverage of
8 individual insureds, the insureds or their representatives**] The plan sponsor performs an act**
9 **or practice that constitutes fraud, or makes an intentional misrepresentation of material**
10 **fact under the terms of the coverage**;
11 (3) Noncompliance with the carrier's minimum participation requirements;
12 (4) Noncompliance with the carrier's employer contribution requirements;
13 (5) **[**Repeated misuse of a provider network provision; or**] In the case of a small**
14 **employer carrier that offers coverage through a network plan, there is no longer any**
15 **enrollee under the health benefit plan who lives, resides or works in the service area of the**
16 **health insurance issuer and the small employer carrier would deny enrollment with respect**
17 **to such plan under subsection 4 of this section;**
18 **(6) The small employer carrier elects to discontinue offering a particular type of**
19 **health benefit plan in the state's small employer market. A type of health benefit plan may**
20 **be discontinued by a small employer carrier in such market only if such carrier:**
21 **(a) Issues a notice to each plan sponsor provided coverage of such type in the small**
22 **group market (and participants and beneficiaries covered under such coverage) of the**
23 **discontinuation at least ninety days prior to the date of discontinuation of the coverage;**
24 **(b) Offers to each plan sponsor provided coverage of such type the option to**
25 **purchase all other health benefit plans currently being offered by the small employer**
26 **carrier in the state's small employer market; and**
27 **(c) Acts uniformly without regard to the claims experience of those plan sponsors**
28 **or any health status-related factor relating to any participants or beneficiaries covered or**
29 **new participants or beneficiaries who may become eligible for such coverage;**
30 **(7) A small employer carrier elects to discontinue offering all health insurance**
31 **coverage in the small employer market in this state. A small employer carrier shall not**
32 **discontinue offering all health insurance coverage in the small employer market unless:**
33 **(a) The carrier provides notice of discontinuation to the director and to each plan**

34 **sponsor (and participants and beneficiaries covered under such coverage) at least one**
35 **hundred eighty days prior to the date of the discontinuation of coverage; and**
36 **(b) All health insurance issued or delivered for issuance in Missouri in the small**
37 **employer market is discontinued and coverage under such health insurance is not renewed;**
38 **[**(6) The small employer carrier elects to nonrenew all of its health benefit plans
39 delivered or issued for delivery to small employers in this state. In such a case the carrier shall:
40 (a) Provide advance notice of its decision under this subdivision to the insurance
41 supervisory official in each state in which it is licensed; and
42 (b) Provide notice of the decision not to renew coverage to all affected small employers
43 and to the insurance supervisory official in each state in which an affected covered individual
44 is known to reside at least one hundred eighty days prior to the nonrenewal of any health benefit
45 plan by the carrier. Notice to the insurance supervisory official under this paragraph shall be
46 provided at least three working days prior to the notice to the affected small employers;
47 (7)**] (8) In the case of health insurance coverage that is made available in the small**
48 **group market only through one or more bona fide associations, the membership of an**
49 **employer in the association (on the basis of which the coverage is provided) ceases but only**
50 **if such coverage is terminated under this subdivision uniformly without regard to any**
51 **health status-related factor relating to any covered individual;**
52 **(9)** The director finds that the continuation of the coverage would:
53 (a) Not be in the best interests of the policyholders or certificate holders; or
54 (b) Impair the carrier's ability to meet its contractual obligations.
55
56 In such instance the director shall assist affected small employers in finding replacement
57 coverage.
58 2. A small employer carrier that elects not to renew a health benefit plan under
59 subdivision **[**(6)**] (7)** of subsection 1 of this section shall be prohibited from writing new business
60 in the small employer market in this state for a period of five years from the date of notice to the
61 director.
62 3. In the case of a small employer carrier doing business in one established geographic
63 service area of the state, the provisions of this section shall apply only to the carrier's operations
64 in such service area.
65 **4. At the time of coverage renewal, a health insurance issuer may modify the health**
66 **insurance coverage for a product offered to a group health plan in the small group market**
67 **if, for coverage that is available in such market other than only through one or more bona**
68 **fide associations, such modification is consistent with state law and effective on a uniform**
69 **basis among group health plans with that product. For purposes of this subsection,**

70 **renewal shall be deemed to occur not more often than annually on the anniversary of the**
71 **effective date of the group health plan's health insurance coverage unless a longer term is**
72 **specified in the policy or contract.**
73 **5. In the case of health insurance coverage that is made available by a small**
74 **employer carrier only through one or more bona fide associations, references to "plan**
75 **sponsor" in this section is deemed, with respect to coverage provided to a small employer**
76 **member of the association, to include a reference to such employer.**

379.940. 1. (1) Every small employer carrier shall, as a condition of transacting
2 business in this state with small employers, actively offer to small employers **[**at least two health
3 benefit plans. One plan offered by each small employer carrier shall be a basic health benefit
4 plan and one plan shall be a standard health benefit plan**]** **all health benefit plans it actively**
5 **markets to small employers in this state**.
6 (2) (a) A small employer carrier shall issue a **[**basic health benefit plan or a standard**]**
7 health benefit plan to any eligible small employer that applies for **[**either**]** such plan and agrees
8 to make the required premium payments and to satisfy the other reasonable provisions of the
9 health benefit plan not inconsistent with sections 379.930 to 379.952.
10 (b) In the case of a small employer carrier that establishes more than one class of
11 business pursuant to section 379.934, the small employer carrier shall maintain and issue to
12 eligible small employers **[**at least one basic health benefit plan and at least one standard**]** **all**
13 health benefit **[**plan**]** **plans** in each class of business so established. A small employer carrier
14 may apply reasonable criteria in determining whether to accept a small employer into a class of
15 business, provided that:
16 a. The criteria are not intended to discourage or prevent acceptance of small employers
17 applying for a **[**basic or standard**]** health benefit plan;
18 b. The criteria are not related to the health status or claim experience of the small
19 employer;
20 c. The criteria are applied consistently to all small employers applying for coverage in
21 the class of business; and
22 d. The small employer carrier provides for the acceptance of all eligible small employers
23 into one or more classes of business. The provisions of this paragraph shall not apply to a class
24 of business into which the small employer carrier is no longer enrolling new small employers.
25 **[**(3) A small employer is eligible under subdivision (2) of this subsection if it employed
26 at least three or more eligible employees within this state on at least fifty percent of its working
27 days during the preceding calendar quarter.
28 (4) The provisions of this subsection shall be effective one hundred eighty days after the
29 director's approval of the basic health benefit plan and the standard health benefit plan developed

30 pursuant to section 379.944, provided that if the small employer health reinsurance program
31 created pursuant to sections 379.942 and 379.943 is not yet in operation on such date, the
32 provisions of this subsection shall be effective on the date that such program begins operation.]
33 2. Health benefit plans covering small employers shall comply with the following
34 provisions:
35 (1) A health benefit plan shall [not deny, exclude or limit benefits for a covered
36 individual for losses incurred more than twelve months following the effective date of the
37 individual's coverage due to a preexisting condition. A health benefit plan shall not define a
38 preexisting condition more restrictively than:
39 (a) a condition that would have caused an ordinarily prudent person to seek medical
40 advice, diagnosis, care or treatment during the six months immediately preceding the effective
41 date of coverage;
42 (b) a condition for which medical advice, diagnosis, care or treatment was recommended
43 or received during the six months immediately preceding the effective date of coverage; or
44 (c) a pregnancy existing on the effective date of coverage.
45 (2) A health benefit plan shall waive any time period applicable to a preexisting
46 condition exclusion or limitation period with respect to particular services for the period of time
47 an individual was previously covered by qualifying previous coverage that provided benefits with
48 respect to such services, provided that the qualifying previous coverage was continuous to a date
49 not less than thirty days prior to the effective date of the new coverage. This subdivision does
50 not preclude application of any waiting period applicable to all new enrollees under the health
51 benefit plan.
52 (3) A health benefit plan may exclude coverage for late enrollees for the greater of
53 eighteen months or provide for an eighteen-month preexisting condition exclusion, provided that
54 if both a period of exclusion from coverage and a preexisting condition exclusion are applicable
55 to a late enrollee, the combined period shall not exceed eighteen months from the date the
56 individual enrolls for coverage under the health benefit plan] **comply with the provisions of**
57 **sections 376.450 and 376.451**.
58 [(4)] **(2)** (a) Except as provided in paragraph (d) of this subdivision, requirements used
59 by a small employer carrier in determining whether to provide coverage to a small employer,
60 including requirements for minimum participation of eligible employees and minimum employer
61 contributions, shall be applied uniformly among all small employers with the same number of
62 eligible employees applying for coverage or receiving coverage from the small employer carrier.
63 (b) A small employer carrier [may vary application of minimum participation
64 requirements only by the size of the small employer group] **shall not require a minimum**
65 **participation level greater than:**

66 **a. One hundred percent of eligible employees working for groups of three or less**
67 **employees; and**
68 **b. Seventy-five percent of eligible employees working for groups with more than**
69 **three employees**.
70 (c) **[**a. Except as provided in paragraph (b) of this subdivision,**]** In applying minimum
71 participation requirements with respect to a small employer, a small employer carrier shall not
72 consider employees or dependents who have qualifying existing coverage in determining whether
73 the applicable percentage of participation is met.
74 **[**b. With respect to a small employer with ten or fewer eligible employees, a small
75 employer carrier may consider employees or dependents who have coverage under another health
76 benefit plan sponsored by such small employer in applying minimum participation
77 requirements.**]**
78 (d) A small employer carrier shall not increase any requirement for minimum employee
79 participation or **modify** any requirement for minimum employer contribution applicable to a
80 small employer at any time after the small employer has been accepted for coverage.
81 **[**(5)**] (3)** (a) If a small employer carrier offers coverage to a small employer, the small
82 employer carrier shall offer coverage to all of the eligible employees of a small employer and
83 their dependents **who apply for enrollment during the period in which the employee first**
84 **becomes eligible to enroll under the terms of the plan**. A small employer carrier shall not
85 offer coverage to only certain individuals **or dependents** in a small employer group or to only
86 part of the group**[**, except in the case of late enrollees as provided in subdivision (3) of this
87 subsection**]**.
88 (b) A small employer carrier shall not modify a **[**basic or standard**]** health benefit plan
89 with respect to a small employer or any eligible employee or dependent through riders,
90 endorsements or otherwise, to restrict or exclude coverage for certain diseases or medical
91 conditions otherwise covered by the health benefit plan.
92 3. (1) **Subject to subdivision (3) of this subsection,** a small employer carrier shall not
93 be required to offer coverage or accept applications pursuant to subsection 1 of this section in
94 the case of the following:
95 (a) To a small employer, where the small employer is not physically located in the
96 carrier's established geographic service area;
97 (b) To an employee, when the employee does not work or reside within the carrier's
98 established geographic service area; or
99 (c) Within an area where the small employer carrier reasonably anticipates, and
100 demonstrates to the satisfaction of the director, that it will not have the capacity within its
101 established geographic service area to deliver service adequately to the members of such groups

102 because of its obligations to existing group policyholders and enrollees.
103 (2) A small employer carrier that cannot offer coverage pursuant to paragraph (c) of
104 subdivision (1) of this subsection may not offer coverage in the applicable area to new cases of
105 employer groups with more than [twenty-five] **fifty** eligible employees or to any small employer
106 groups until the later of one hundred eighty days following each such refusal or the date on
107 which the carrier notifies the director that it has regained capacity to deliver services to small
108 employer groups.
109 **(3) A small employer carrier shall apply the provisions of this subsection uniformly**
110 **to all small employers without regard to the claims experience of a small employer and its**
111 **employees and their dependents or any health status-related factor relating to such**
112 **employees and their dependents.**
113 4. A small employer carrier shall not be required to provide coverage to small employers
114 pursuant to subsection 1 of this section for any period of time for which the director determines
115 that requiring the acceptance of small employers in accordance with the provisions of subsection
116 1 of this section would place the small employer carrier in a financially impaired condition**, and**
117 **the small employer is applying this subsection uniformly to all small employers in the small**
118 **group market in this state consistent with applicable state law and without regard to the**
119 **claims experience of a small employer and its employees and their dependents or any**
120 **health status-related factor relating to such employees and their dependents**.
121 [5. Sections 379.930 to 379.938 and sections 379.942 to 379.950 shall become effective
122 July 1, 1993, this section and section 379.952 shall become effective July 1, 1994.]
379.943. 1. Within one hundred eighty days after the appointment of the initial board,
2 the board shall submit to the director a plan of operation and thereafter any amendments thereto
3 necessary or suitable, to assure the fair, reasonable and equitable administration of the program.
4 The director may, after notice and hearing, approve the plan of operation if the director
5 determines it to be suitable to assure the fair, reasonable and equitable administration of the
6 program, and provides for the sharing of program gains or losses on an equitable and
7 proportionate basis in accordance with the provisions of sections 379.942 and 379.943. The plan
8 of operation shall become effective upon approval in writing by the director.
9 2. If the board fails to submit a suitable plan of operation within one hundred eighty days
10 after its appointment, the director shall, after notice and hearing, promulgate and adopt a
11 temporary plan of operation. The director shall amend or rescind any plan so adopted under this
12 subsection at the time a plan of operation is submitted by the board and approved by the director.
13 3. The plan of operation shall:
14 (1) Establish procedures for handling and accounting of program assets and moneys and
15 for an annual fiscal report to the director;

16 (2) Establish procedures for selecting an administering carrier and setting forth the
17 powers and duties of the administering carrier;
18 (3) Establish procedures for reinsuring risks in accordance with the provisions of
19 sections 379.942 and 379.943;
20 (4) Establish procedures for collecting assessments from reinsuring carriers to fund
21 claims and administrative expenses incurred or estimated to be incurred by the program; and
22 (5) Provide for any additional matters necessary for the implementation and
23 administration of the program.
24 4. The program shall have the general powers and authority granted under the laws of
25 this state to insurance companies and health maintenance organizations licensed to transact
26 business, except the power to issue health benefit plans directly to either groups or individuals.
27 In addition thereto, the program shall have the specific authority to:
28 (1) Enter into contracts as necessary or proper to carry out the provisions and purposes
29 of sections 379.930 to 379.952, including the authority, with the approval of the director, to enter
30 into contracts with similar programs in other states for the joint performance of common
31 functions or with persons or other organizations for the performance of administrative functions;
32 (2) Sue or be sued, including taking any legal actions necessary or proper to recover any
33 assessments and penalties for, on behalf of, or against the program or any reinsuring carriers;
34 (3) Take any legal action necessary to avoid the payment of improper claims against the
35 program;
36 (4) Define the health benefit plans for which reinsurance will be provided, and to issue
37 reinsurance policies, in accordance with the requirements of sections 379.930 to 379.952;
38 (5) Establish rules, conditions and procedures for reinsuring risks under the program;
39 (6) Establish actuarial functions as appropriate for the operation of the program;
40 (7) Assess carriers in accordance with the provisions of subsection 8 of this section, and
41 to make advance interim assessments as may be reasonable and necessary for organizational and
42 interim operating expenses. Any interim assessments shall be credited as offsets against any
43 regular assessments due following the close of the calendar year;
44 (8) Appoint appropriate legal, actuarial and other committees as necessary to provide
45 technical assistance in the operation of the program, policy and other contract design, and any
46 other function within the authority of the program; and
47 (9) Borrow money to effect the purposes of the program. Any notes or other evidence
48 of indebtedness of the program not in default shall be legal investments for carriers and may be
49 carried as admitted assets.
50 5. A small employer carrier participating in the program may reinsure an entire small
51 employer group with the program as provided for in this subsection:

52 (1) With respect to a basic health benefit plan or a standard health benefit plan, the
53 program shall reinsure the level of coverage provided and, with respect to other plans, the
54 program shall reinsure up to the level of coverage provided in a basic or standard health benefit
55 plan.
56 (2) A small employer carrier may reinsure an entire small employer group within sixty
57 days of the commencement of the group's coverage under a health benefit plan or within thirty
58 days after an annual renewal of a small employer group.
59 (3) (a) The program shall not reimburse a small employer carrier with respect to the
60 claims of an employee or dependent who is part of a reinsured small employer group until the
61 carrier has incurred an initial level of claims for such employee or dependent of five thousand
62 dollars in a calendar year for benefits covered by the program. In addition, the small employer
63 carrier shall be responsible for ten percent of the remaining incurred claims during a calendar
64 year and the program shall reinsure the remainder. A small employer carrier's liability under this
65 paragraph shall not exceed a maximum limit of twenty-five thousand dollars in any one calendar
66 year with respect to any individual who is part of a reinsured small employer group.
67 (b) The board annually shall adjust the initial level of claims and the maximum limit to
68 be retained by the carrier to reflect increases in costs and utilization within the standard market
69 for health benefit plans within the state. The adjustment shall not be less than the annual change
70 in the medical component of the "Consumer Price Index for All Urban Consumers" of the federal
71 Department of Labor, Bureau of Labor Statistics, unless the board proposes and the director
72 approves a lower adjustment factor.
73 (4) A small employer carrier may terminate reinsurance for a small employer on any plan
74 anniversary.
75 6. (1) The board, as part of the plan of operation, shall establish a methodology for
76 determining premium rates to be charged by the program for reinsuring small employers and
77 individuals pursuant to sections 379.942 and 379.943. The methodology shall include a system
78 for classification of small employers that reflects the types of case characteristics commonly used
79 by small employer carriers in the state. The methodology shall also include a system for
80 classification of small employer carriers that reflects the degree to which the small employer
81 carrier uses the cost containment features adopted by the health benefit plan committee under
82 section 379.944. The methodology shall provide for the development of base reinsurance
83 premium rates, which shall be multiplied by the factors set forth in subdivision (2) of this act to
84 determine the premium rates for the program. The base reinsurance premium rates, shall be
85 established by the board, subject to the approval of the director, and shall be set at levels which
86 reasonably approximate gross premiums charged to small employers by small employer carriers
87 for health benefit plans with benefits similar to the standard health benefit plan.

88 (2) Only an entire small employer group may be reinsured, and the rate for such
89 reinsurance shall be one and one-half times the base reinsurance insurance premium rate for the
90 group established pursuant to this subsection.
91 (3) The board periodically shall review the methodology established under subdivisions
92 (1) and (2) of this section, including the system of classification and any rating factors, to assure
93 that it reasonably reflects the claims experience of the program. The board may propose changes
94 to the methodology which shall be subject to the approval of the director.
95 7. If a health benefit plan for a small employer is reinsured with the program, the
96 premium charged to the small employer for any rating period for the coverage issued shall meet
97 the requirements relating to premium rates set forth in section 379.936.
98 8. (1) Prior to March first of each year, the board shall determine and report to the
99 director the program net loss for the previous calendar year, including administrative expenses
100 and incurred losses for the year, taking into account investment income and other appropriate
101 gains and losses.
102 (2) Any net loss for the year shall be recouped by assessments of reinsuring carriers.
103 (a) The board shall establish, as part of the plan of operation, a formula by which to
104 make assessments against reinsuring carriers and small employer carriers. The assessment
105 formula shall be based on:
106 a. The share of each reinsuring carrier which reinsures any small employer group with
107 the program, of the program net loss described in this subsection shall be their proportionate
108 share, determined by premiums earned in the preceding calendar year from health benefit plans
109 which have been ceded to the program, times one-half of the total program net loss;
110 b. Each reinsuring carrier's share of the program net loss described in this subsection
111 shall be its proportionate share, determined by premiums earned in the preceding calendar year
112 from all health benefit plans delivered or issued for delivery to small employers in this state by
113 all reinsuring carriers, times one-half of the total program net loss. An assessment levied or paid
114 by a reinsuring carrier pursuant to subparagraph a of this paragraph shall not be credited or offset
115 against any assessment levied pursuant to this subparagraph.
116 (b) The formula established pursuant to paragraph (a) of this subdivision shall not result
117 in any reinsuring carrier having an assessment share that is less than fifty percent nor more than
118 one hundred fifty percent of an amount which is based on the proportion of the small employer
119 carrier's total premiums earned in the preceding calendar year from health benefit plans delivered
120 or issued for delivery to small employers in this state by small employer carriers to total
121 premiums earned in the preceding calendar year from health benefit plans delivered or issued for
122 delivery to small employers in this state by all small employer carriers.
123 (c) The director by rule and after a hearing thereon, may change the assessment formula

124 established pursuant to paragraph (a) of this subdivision from time to time as appropriate. The
125 director may provide for the shares of the assessment base attributable to premiums from all
126 health benefit plans and to premiums from health benefit plans ceded to the program to vary
127 during a transition period.
128 (d) Subject to the approval of the director, the board shall make an adjustment to the
129 assessment formula for reinsuring carriers that are approved health maintenance organizations
130 which are federally qualified under 42 U.S.C.
131 section 300, et seq., to the extent, if any, that restrictions are placed on them that are not
132 imposed on other small employer carriers.
133 (e) Premiums and benefits payable by a reinsuring carrier that are less than an amount
134 determined by the board to justify the cost of collection shall not be considered for purposes of
135 determining assessments.
136 (3) (a) Prior to March first of each year, the board shall determine and file with the
137 director an estimate of the assessments needed to fund the losses incurred by the program in the
138 previous calendar year.
139 (b) If the board determines that the assessments needed to fund the losses incurred by
140 the program in the previous calendar year will exceed the amount specified in paragraph (c) of
141 this subdivision, the board shall evaluate the operation of the program and report its findings,
142 including any recommendations for changes to the plan of operation, to the director within ninety
143 days following the end of the calendar year in which the losses were incurred. The evaluation
144 shall include: an estimate of future assessments, the administrative costs of the program, the
145 appropriateness of the premiums charged and the level of insurer retention under the program
146 and the costs of coverage for small employers. If the board fails to file a report with the director
147 within ninety days following the end of the applicable calendar year, the director may evaluate
148 the operations of the program and implement such amendments to the plan of operation the
149 director deems necessary to reduce future losses and assessments.
150 (c) For any calendar year, the amount specified in this paragraph is five percent of total
151 premiums earned in the previous year from health benefit plans delivered or issued for delivery
152 to small employers in this state by reinsuring carriers.
153 (d) a. If assessments in each of two consecutive calendar years exceed the amount
154 specified in paragraph (c) of subdivision (3) of this subsection, the program shall be eligible to
155 receive additional financing as provided in subparagraph b of this paragraph.
156 b. The additional financing provided for in subparagraph a of this paragraph shall be
157 obtained from additional assessments apportioned among all carriers which are not small
158 employer carriers; the amount of the assessment for each carrier determined by the carrier's
159 proportionate share of premiums earned in the preceding calendar year from all health benefit

160 plans delivered, issued for delivery or continued in this state to individuals and groups, other than
161 small employer groups subject to sections 379.930 to 379.952, by all carriers, times the total
162 amount of additional financing to be obtained.

163 c. The additional assessment provided by subparagraph b of this paragraph shall not
164 exceed an amount equal to one percent of the gross premium derived by that carrier from all
165 health benefit plans delivered, issued for delivery or continued in this state to individuals and
166 groups, other than small employer groups subject to sections 379.930 to 379.952.

167 d. Any loss sustained by the program which is not reimbursed by additional financing
168 obtained pursuant to this paragraph shall be carried forward to the calendar year succeeding the
169 year in which the loss is sustained, and shall be recouped by an increase in premiums charged
170 by the board for reinsurance of small employer groups with the program.

171 e. Additional financing received by the program pursuant to this paragraph shall be
172 distributed to reinsuring carriers in proportion to the assessments paid by such carriers over the
173 previous two calendar years.

174 (4) If assessments exceed net losses of the program, the excess shall be held at interest
175 and used by the board to offset future losses or to reduce program premiums. As used in this
176 paragraph, "future losses" includes reserves for incurred but not reported claims.

177 (5) Each carrier's proportion of the assessment shall be determined annually by the board
178 based on annual statements and other reports deemed necessary by the board and filed by the
179 carriers with the board.

180 (6) The plan of operation shall provide for the imposition of an interest penalty for late
181 payment of assessments.

182 (7) A carrier may seek from the director a deferment from all or part of an assessment
183 imposed by the board. The director may defer all or part of the assessment of a carrier if the
184 director determines that the payment of the assessment would place the carrier in a financially
185 impaired condition. If all or part of an assessment against a carrier is deferred, the amount
186 deferred shall be assessed against the other participating carriers in a manner consistent with the
187 basis for assessment set forth in this subsection. The carrier receiving such deferment shall
188 remain liable to the program for the amount deferred and the interest penalty provided in
189 subdivision (6) of this subsection and shall be prohibited from reinsuring any groups in the
190 program until such time as it pays such assessments.

191 9. Neither the participation in the program as reinsuring carriers, the establishment of
192 rates, forms or procedures, nor any other joint or collective action required by sections 379.930
193 to 379.952 shall be the basis of any legal action, criminal or civil liability, or penalty against the
194 program or any of its reinsuring carriers either jointly or separately, other than any action by the
195 director to enforce the provisions of sections 379.930 to 379.952.

196 10. The board, as part of the plan of operation, shall develop standards setting forth the
197 manner and levels of compensation to be paid to producers for the sale of basic and standard
198 health benefit plans. In establishing such standards, the board shall take into the consideration:
199 the need to assure the broad availability of coverages; the objectives of the program; the time and
200 effort expended in placing the coverage; the need to provide ongoing service to the small
201 employer; the levels of compensation currently used in the industry; and the overall costs of
202 coverage to small employers selecting these plans.
203 11. The program shall be exempt from any and all taxes.
204 12. The director shall make an initial assessment of one thousand dollars on each
205 insurance company authorized to transact accident or health insurance, each health services
206 corporation, and each health maintenance organization. Initial assessments shall be made during
207 January, 1993, and shall be paid before April 1, 1993. Initial assessments shall be deposited into
208 the department of insurance dedicated fund. Within ten days after the effective date of the
209 program's plan of operation, the total amount of the initial assessments shall be transferred at the
210 request of the director to the Missouri small employer health reinsurance program. The program
211 may use such initial assessment in the same manner and for the same purposes as other
212 assessments pursuant to sections 379.942 and 379.943.
213 **13. The program shall not accept any new risks or renew any existing risk on or**
214 **after October 1, 2004.**
215 **14. Any program assets or moneys that exceed six hundred thousand dollars on**
216 **August 28, 2004, shall be delivered on October 1, 2004, to the Missouri health insurance**
217 **pool as established in sections 376.960 to 376.989, and shall be accepted by the Missouri**
218 **health insurance pool and used for the administration and operation of the Missouri health**
219 **insurance pool.**
220 **15. Any program assets or moneys that remain on October 1, 2005, shall be**
221 **delivered on October 31, 2005, to the Missouri health insurance pool as established in**
222 **sections 376.960 to 376.989, and shall be accepted by the Missouri health insurance pool**
223 **and used for the administration and operation of the Missouri health insurance pool.**
224 **16. The provisions of this section shall expire on December 31, 2005.**
379.952. 1. Each small employer carrier shall actively market [health benefit plan
2 coverage, including the basic and standard health benefit plans, to eligible small employers in
3 the state. If a small employer carrier denies coverage to a small employer on the basis of the
4 health status or claims experience of the small employer or its employees or dependents, the
5 small employer carrier shall offer the small employer the opportunity to purchase a basic health
6 benefit plan or a standard health benefit plan] **all health benefit plans sold by the carrier in**
7 **the small group market to eligible employers in the state**.

8 2. (1) Except as provided in subdivision (2) of this subsection, no small employer carrier
9 or [agent or broker] **producer** shall, directly or indirectly, engage in the following activities:
10 (a) Encouraging or directing small employers to refrain from filing an application for
11 coverage with the small employer carrier because of [the health status] **any health status-related**
12 **factor**, claims experience, industry, occupation or geographic location of the small employer;
13 (b) Encouraging or directing small employers to seek coverage from another carrier
14 because of [the health status] **any health status-related factor**, claims experience, industry,
15 occupation or geographic location of the small employer.
16 (2) The provisions of subdivision (1) of this subsection shall not apply with respect to
17 information provided by a small employer carrier or [agent or broker] **producer** to a small
18 employer regarding the established geographic service area or a restricted network provision of
19 a small employer carrier.
20 3. (1) Except as provided in subdivision (2) of this subsection, no small employer carrier
21 shall, directly or indirectly, enter into any contract, agreement or arrangement with [an agent or
22 broker] **a producer** that provides for or results in the compensation paid to [an agent or broker]
23 **a producer** for the sale of a health benefit plan to be varied because of [the health status] **any**
24 **health status-related factor**, claims experience, industry, occupation or geographic location of
25 the small employer.
26 (2) Subdivision (1) of this subsection shall not apply with respect to a compensation
27 arrangement that provides compensation to [an agent or broker] **a producer** on the basis of
28 percentage of premium, provided that the percentage shall not vary because of [the health status]
29 **any health status-related factor**, claims experience, industry, occupation or geographic area
30 of the small employer.
31 4. [A small employer carrier shall provide reasonable compensation, as provided under
32 the plan of operation of the program, to an agent or broker, if any, for the sale of a basic or
33 standard health benefit plan.
34 5.] No small employer carrier shall terminate, fail to renew or limit its contract or
35 agreement of representation with [an agent or broker] **a producer** for any reason related to [the
36 health status] **any initial or renewal health status-related factor**, claims experience,
37 occupation, or geographic location of the small employers placed by the [agent or broker]
38 **producer** with the small employer carrier.
39 [6.] **5.** No small employer carrier or producer shall induce or otherwise encourage a small
40 employer to separate or otherwise exclude an employee **or dependent** from health coverage or
41 benefits provided in connection with the employee's employment.
42 [7.] **6.** Denial by a small employer carrier of an application for coverage from a small
43 employer shall be in writing and shall state the reason or reasons for the denial with specificity.

44 **[**8.**] 7.** The director may promulgate rules setting forth additional standards to provide
45 for the fair marketing and broad availability of health benefit plans to small employers in this
46 state.
47 **[**9.**] 8.** (1) A violation of this section by a small employer carrier or a producer shall be
48 an unfair trade practice under sections 375.930 to 375.949, RSMo.
49 (2) If a small employer carrier enters into a contract, agreement or other arrangement
50 with a third-party administrator to provide administrative marketing or other services related to
51 the offering of health benefit plans to small employers in this state, the third-party administrator
52 shall be subject to this section as if it were a small employer carrier.
53 **9. For purposes of health benefit plans sold to employers of exactly two eligible**
54 **employees and health benefit plans sold to employers with more than twenty-five eligible**
55 **employees but not more than fifty eligible employees, sections 379.934 and 379.936 shall**
56 **become effective July 1, 2005.**

[379.942. 1. There is hereby created a nonprofit entity to be
2 known as the "Missouri Small Employer Health Reinsurance
3 Program". All small employer carriers shall participate in the
4 program as reinsuring carriers for a minimum of three years
5 beginning July 1, 1993. After the expiration of such three years, a
6 small employer carrier may apply to the director to opt out of the
7 program. The director shall decide whether to grant such an
8 application to opt out, and shall consider in making such
9 determination only: the carrier's financial condition and the financial
10 condition of its guaranteeing or reinsuring corporation, if any; its
11 history of assuming and managing risk; its ability to assume and
12 manage the risk of enrolling small employers without the protection
13 of the program; and its commitment to market fairly to all small
14 employers in its service area. If the director grants such application,
15 the small employer carrier shall participate in the program neither as
16 a ceding nor reinsuring carrier.
17 2. (1) The program shall operate subject to the supervision
18 and control of the board. Subject to the provisions of subdivision (2)
19 of this subsection, the board shall consist of nine members appointed
20 by the director plus the director or his designated representative, who
21 shall serve as an ex officio member of the board. (2) (a) In
22 selecting the members of the board, the director shall include
23 representatives of small employers, small employer employees or
24 their representatives and small employer carriers and such other
25 individuals determined to be qualified by the director. At least five
26 of the members of the board shall be representatives of reinsuring
27 carriers and at least one of the members of the board shall be a
28 representative of a health maintenance organization which is a small

29 employer carrier. All members shall be selected from individuals
30 nominated by small employer carriers in this state pursuant to
31 procedures and guidelines developed by the director, except that the
32 director shall select two small employers' employees, including at
33 least one representative of a labor organization.
34 (b) In the event that the program becomes eligible for
35 additional financing pursuant to subdivision (3) of subsection 8 of
36 section 379.943, the board shall be expanded to include two
37 additional members who shall be appointed by the director. In
38 selecting the additional members of the board, the director shall
39 choose individuals who represent reinsuring carriers. The expansion
40 of the board under this paragraph shall continue for the period that the
41 program continues to be eligible for additional financing under
42 subdivision (3) of subsection 8 of section 379.943.
43 (3) The initial board members shall be appointed as follows:
44 one-third of the members to serve a term of two years; one-third of
45 the members to serve a term of four years; and one-third of the
46 members to serve a term of six years. Subsequent board members
47 shall serve for a term of three years. A board member's term shall
48 continue until his successor is appointed.
49 (4) A vacancy in the board shall be filled by the director. A
50 board member may be removed by the director for cause.
51 3. Within sixty days of July 1, 1993, each small employer
52 carrier shall make a filing with the director containing the carrier's net
53 health insurance premium derived from health benefit plans delivered
54 or issued for delivery to small employers in this state in the previous
55 calendar year.**]**

Section B. The repeal of section 379.942 of Section A of this act shall become effective
2 December 31, 2005.