SECOND REGULAR SESSION

HOUSE BILL NO. 1739

92ND GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES PAGE (Sponsor), ZWEIFEL, HARRIS (110), WILDBERGER, JOLLY, YOUNG, SUTHERLAND, WALTON, SAGER, YAEGER, CARNAHAN, WALKER, SKAGGS, MEADOWS, WILLOUGHBY, HUBBARD, MEINERS, LeVOTA AND GEORGE (Co-sponsors).

Read 1st time April 15, 2004, and copies ordered printed.

STEPHEN S. DAVIS, Chief Clerk

4903L.01I

AN ACT

To repeal sections 379.930, 379.938, 379.940, 379.942, 379.943, and 379.952, RSMo, and to enact in lieu thereof five new sections relating to the small employer health insurance availability act, with an effective date for a certain section.

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

Section A. Sections 379.930, 379.938, 379.940, 379.942, 379.943, and 379.952, RSMo, are repealed and five new sections enacted in lieu thereof, to be known as sections 379.930, 379.938, 379.940, 379.943, and 379.952, to read as follows:

379.930. 1. Sections 379.930 to 379.952 shall be known and may be cited as the "Small Employer Health Insurance Availability Act".

2. For the purposes of sections 379.930 to 379.952**, the following terms mean**:

(1) "Actuarial certification" **[**means**],** a written statement by a member of the American Academy of Actuaries or other individual acceptable to the director that a small employer carrier is in compliance with the provisions of section 379.936, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans;

(2) "Affiliate" or "affiliated" **[**means**],** any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person;

(3) **[**"Agent" means "insurance agent" as that term is defined in section 375.012, RSMo;

(4)**]** "Base premium rate" **[**means**]**, for each class of business as to a rating period, the

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.

lowest premium rate charged or that could have been charged under the rating system for that class of business, by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage;

[(5) "Basic health benefit plan" means a lower cost health benefit plan developed pursuant to section 379.944;

(6)**] (4)** "Board" **[**means**],** the board of directors of the program established pursuant to sections 379.942 and 379.943;

[(7) "Broker" means "broker" as that term is defined in section 375.012, RSMo;**]**

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

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

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

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

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

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

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

[(8)**] (6)** "Carrier" **[**means**] or "health insurance issuer",** any entity that provides health insurance or health benefits in this state. For the purposes of sections 379.930 to 379.952, carrier includes an insurance company, health services corporation, fraternal benefit society, health maintenance organization, multiple employer welfare arrangement specifically authorized to operate in the state of Missouri, or any other entity providing a plan of health insurance or health benefits subject to state insurance regulation;

[(9)**] (7)** "Case characteristics" **[**means**],** demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, provided that claim experience, health status and duration of coverage since issue shall not be case characteristics for the purposes of sections 379.930 to 379.952;

(8) "Church plan", the meaning given such term in Section 3(33) of the Employee Retirement Income Security Act of 1974;

[(10)**] (9)** "Class of business" **[**means**],** all or a separate grouping of small employers

established pursuant to section 379.934;

[(11)**]** **(10)** "Committee" **[**means**],** the health benefit plan committee created pursuant to section 379.944;

[(12)**]** **(11)** "Control" shall be defined in manner consistent with chapter 382, RSMo;

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

(a) Coverage of the individual pursuant to any of the following:

a. A group health plan;

b. Health insurance coverage;

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

d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 28 of the Social Security Act;

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

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

g. A state health benefits risk pool;

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

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

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

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

(13) "Dependent" **[**means**],** a spouse or an unmarried child under the age of nineteen years; an unmarried child who is a full-time student under the age of twenty-three years and who is financially dependent upon the parent; or an unmarried child of any age who is medically certified as disabled and dependent upon the parent;

(14) "Director" **[**means**],** the director of the department of insurance of this state;

(15) "Eligible employee" **[**means**],** an employee who works on a full-time basis and has a normal work week of thirty or more hours. The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a part-time, temporary or substitute basis. For purposes of sections 379.930 to 379.952, a person, his spouse and his minor children shall constitute only one eligible employee when they are employed by the same small employer;

(16) "Established geographic service area" **[**means**],** a geographical area, as approved by the director and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage;

(17) **"Excepted benfits":**

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

(b) Coverage only for disability income insurance;

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

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

(e) Workers' compensation or similar insurance;

(f) Automobile medical payment insurance;

(g) Credit-only insurance;

(h) Coverage for onsite medical clinics;

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

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

a. Limited scope dental or vision benefits;

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

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

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

a. Coverage only for a specified disease or illness;

b. Hospital indemnity or other fixed indemnity insurance;

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

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

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

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

(18) "Governmental plan", the meaning given such term under Section 3(32) of the Employee Retirement Income Security Act of 1974 or any federal government plan;

(19) "Group health plan", an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 and Public Law 104-191 to the extent that the plan provides medical care, as defined in this section, and including any item or service paid for as medical care to an employee or the employee's dependent, as

defined under the terms of the plan, directly or through insurance, reimbursement, or otherwise, but not excluding excepted benefits;

(20) "Health benefit plan" **[**means any hospital or medical policy or certificate, health services corporation contract, or health maintenance organization subscriber contract. Health benefit plan does not include a policy of individual accident and sickness insurance or hospital supplemental policies having a fixed daily benefit, or accident-only, specified disease-only, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance, or coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, or automobile medical payment insurance**] or "health insurance coverage", benefits consisting of medical care, including items and services paid for as medical care, that are provided directly, through insurance, reimbursement, or otherwise, under a policy, certificate, membership contract, or health services agreement offered by a health insurance issuer, but not including excepted benefits;**

(21) "Health status-related factor", any of the following:

(a) Health status;

(b) Medical condition, including both physical and mental illness;

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information;

(g) Evidence of insurability, including a condition arising out of an act of domestic violence;

(h) Disability;

[(18)**] (22)** "Index rate" **[**means**]**, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic mean of the applicable base premium rate and the corresponding highest premium rate;

[(19)**] (23)** "Late enrollee" **[**means**],** an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period for which such individual is entitled to enroll under the terms of the health benefit plan, provided that such initial enrollment period is a period of at least thirty days. However, an eligible employee or dependent shall not be considered a late enrollee if:

(a) The individual meets each of the following:

a. The individual was covered under **[**qualifying previous**] creditable** coverage at the time of the initial enrollment;

b. The individual lost coverage under **[**qualifying previous**] creditable** coverage as a result of **cessation of employer contribution,** termination of employment or eligibility,

reduction in the number of hours of employment, the involuntary termination of the **[**qualifying previous**]** **creditable** coverage, death of a spouse **[**or divorce**], dissolution or legal separation**;

c. The individual requests enrollment within thirty days after termination of the **[**qualifying previous**]** **creditable** coverage;

(b) The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

(c) A court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within thirty days after issuance of the court order;

(24) "Medical care", an amount paid for:

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

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

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

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

[(20)**]** **(26)** "New business premium rate" **[**means**]**, for each class of business as to a rating period, the lowest premium rate charged or offered, or which could have been charged or offered, by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage;

[(21)**]** **(27)** "Plan of operation" **[**means**],** the plan of operation of the program established pursuant to sections 379.942 and 379.943;

(28) "Plan sponsor", the meaning given such term in section 3(16)(B) of the Employee Retirement Income Security Act of 1974;

[(22)**]** **(29)** "Premium" **[**means**],** all moneys paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan;

[(23)**]** **(30)** "Producer"**, the meaning given such term in section 375.012, RSMo, and** includes an insurance agent or broker;

[(24)**]** **(31)** "Program" **[**means**],** the Missouri small employer health reinsurance program created pursuant to sections 379.942 and 379.943;

[(25) "Qualifying previous coverage" and "qualifying existing coverage" mean benefits or coverage provided under:

(a) Medicare or Medicaid;

(b) An employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan; or

(c) An individual health insurance policy (including coverage issued by a health maintenance organization, health services corporation or a fraternal benefit society) that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided that such policy has been in effect for a period of at least one year;

(26)**] (32)** "Rating period" **[**means**],** the calendar period for which premium rates established by a small employer carrier are assumed to be in effect;

[(27)**] (33)** "Restricted network provision" **[**means**],** any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to section 354.400, RSMo, et seq. to provide health care services to covered individuals;

[(28)**] (34)** "Small employer" **[**means**], in connection with a group health plan with respect to a calendar year and a plan year,** any person, firm, corporation, partnership **[**or**],** association**, or political subdivision** that is actively engaged in business that**[**, on at least fifty percent of its working days during the preceding calendar quarter, employed not less than three nor**] employed an average of at least two but not** more than **[**twenty-five**] fifty** eligible employees**[**, the majority of whom were employed within this state. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer**] on business days during the preceding calendar year and that employs at least two employees on the first day of the plan year. All persons treated as a single employer under Section 414(b), (c), (m), or (o) of the Internal Revenue Code of 1986, as amended, shall be treated as one employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining continued eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, the provisions of sections 379.930 to 379.952 that apply to a small employer shall continue to apply at least until the plan anniversary following the date the small employer no longer meets the requirements of this definition. In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that is reasonably expected that the employer will employ on business days in the current calendar year. Any reference in sections 379.930 to 379.952 to an employer shall include a reference to any**

predecessor of such employer;

[(29)**] (35)** "Small employer carrier" **[**means**],** a carrier that offers health benefit plans covering eligible employees of one or more small employers in this state**[**;

(30) "Standard health benefit plan" means a health benefit plan developed pursuant to section 379.944**]**.

3. Other terms used in sections 379.930 to 379.952 not set forth in subsection 2 of this section shall have the same meaning as such terms are defined in section 376.450, RSMo.

379.938. 1. A health benefit plan subject to sections 379.930 to 379.952 shall be renewable with respect to all eligible employees and dependents, at the option of the small employer, except in any of the following cases:

(1) **[**Nonpayment of the required premiums**] The plan sponsor fails to pay a premium or contribution in accordance with the terms of a health benefit plan or the health carrier has not received a timely premium payment**;

(2) **[**Fraud or misrepresentation of the small employer or, with respect to coverage of individual insureds, the insureds or their representatives**] The plan sponsor performs an act or practice that constitutes fraud, or makes an intentional misrepresentation of material fact under the terms of the coverage**;

(3) Noncompliance with the carrier's minimum participation requirements;

(4) Noncompliance with the carrier's employer contribution requirements;

(5) **[**Repeated misuse of a provider network provision; or

(6) The small employer carrier elects to nonrenew all of its health benefit plans delivered or issued for delivery to small employers in this state. In such a case the carrier shall:

(a) Provide advance notice of its decision under this subdivision to the insurance supervisory official in each state in which it is licensed; and

(b) Provide notice of the decision not to renew coverage to all affected small employers and to the insurance supervisory official in each state in which an affected covered individual is known to reside at least one hundred eighty days prior to the nonrenewal of any health benefit plan by the carrier. Notice to the insurance supervisory official under this paragraph shall be provided at least three working days prior to the notice to the affected small employers;

(7)**] In the case of a small employer carrier that offers coverage through a network plan, there is no longer any enrollee under the health benefit plan who lives, resides or works in the service area of the health insurance issuer and the small employer carrier would deny enrollment with respect to such plan under subsection 4 of this section;**

(6) The small employer carrier elects to discontinue offering a particular type of health benefit plan in the state's small employer market. A type of health benefit plan may

be discontinued by a small employer carrier in such market only if such carrier:

(a) Issues a notice to each plan sponsor provided coverage of such type in the small group market (and participants and beneficiaries covered under such coverage) of the discontinuation at least ninety days prior to the date of discontinuation of the coverage;

(b) Offers to each plan sponsor provided coverage of such type the option to purchase all other health benefit plans currently being offered by the small employer carrier in the state's small employer market; and

(c) Acts uniformly without regard to the claims experience of those plan sponsors or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage;

(7) A small employer carrier elects to discontinue offering all health insurance coverage in the small group market in this state. A small employer carrier may not discontinue offering all health insurance coverage in the small employer market unless:

(a) The carrier provides notice of discontinuation to the director and to each plan sponsor (and participants and beneficiaries covered under such coverage) at least one hundred eighty days prior to the date of the discontinuation of coverage; and

(b) All health insurance issued or delivered for issuance in Missouri in the small employer market is discontinued and coverage under such health insurance is not renewed;

(8) In the case of health insurance coverage that is made available in the small group market only through one or more bona fide associations, the membership of an employer in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this subdivision uniformly without regard to any health status-related factor relating to any covered individual;

(9) The director finds that the continuation of the coverage would:

(a) Not be in the best interests of the policyholders or certificate holders; or

(b) Impair the carrier's ability to meet its contractual obligations.

In such instance the director shall assist affected small employers in finding replacement coverage.

2. A small employer carrier that elects not to renew a health benefit plan under subdivision **[**(6)**]** **(7)** of subsection 1 of this section shall be prohibited from writing new business in the small employer market in this state for a period of five years from the date of notice to the director.

3. In the case of a small employer carrier doing business in one established geographic service area of the state, the provisions of this section shall apply only to the carrier's operations in such service area.

4. At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a product offered to a group health plan in the small group market if, for coverage that is available in such market other than only through one or more bona fide associations, such modification is consistent with state law and effective on a uniform basis among group health plans with that product. For purposes of this subsection, renewal shall be deemed to occur not more often than annually on the anniversary of the effective date of the group health plan's health insurance coverage unless a longer term is specified in the policy or contract.

5. In the case of health insurance coverage that is made available by a small employer carrier only through one or more bona fide associations, references to "plan sponsor" in this section is deemed, with respect to coverage provided to a small employer 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 business in this state with small employers, actively offer to small employers **[**at least two health benefit plans. One plan offered by each small employer carrier shall be a basic health benefit plan and one plan shall be a standard health benefit plan**]** **all health benefit plans it actively markets to small employers in this state**.

(2) (a) A small employer carrier shall issue a **[**basic health benefit plan or a standard**]** health benefit plan to any eligible small employer that applies for **[**either**]** such plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with sections 379.930 to 379.952.

(b) In the case of a small employer carrier that establishes more than one class of business pursuant to section 379.934, the small employer carrier shall maintain and issue to eligible small employers **[**at least one basic health benefit plan and at least one standard**]** **all** health benefit **[**plan**]** **plans** in each class of business so established. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business, provided that:

a. The criteria are not intended to discourage or prevent acceptance of small employers applying for a **[**basic or standard**]** health benefit plan;

b. The criteria are not related to the health status or claim experience of the small employer;

c. The criteria are applied consistently to all small employers applying for coverage in the class of business; and

d. The small employer carrier provides for the acceptance of all eligible small employers into one or more classes of business. The provisions of this paragraph shall not apply to a class of business into which the small employer carrier is no longer enrolling new small employers.

[(3) A small employer is eligible under subdivision (2) of this subsection if it employed at least three or more eligible employees within this state on at least fifty percent of its working days during the preceding calendar quarter.

(4) The provisions of this subsection shall be effective one hundred eighty days after the director's approval of the basic health benefit plan and the standard health benefit plan developed pursuant to section 379.944, provided that if the small employer health reinsurance program created pursuant to sections 379.942 and 379.943 is not yet in operation on such date, the provisions of this subsection shall be effective on the date that such program begins operation.**]**

2. Health benefit plans covering small employers shall comply with the following provisions:

(1) A health benefit plan shall **[**not deny, exclude or limit benefits for a covered individual for losses incurred more than twelve months following the effective date of the individual's coverage due to a preexisting condition. A health benefit plan shall not define a preexisting condition more restrictively than:

(a) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six months immediately preceding the effective date of coverage;

(b) a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six months immediately preceding the effective date of coverage; or

(c) a pregnancy existing on the effective date of coverage.

(2) A health benefit plan shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to such services, provided that the qualifying previous coverage was continuous to a date not less than thirty days prior to the effective date of the new coverage. This subdivision does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

(3) A health benefit plan may exclude coverage for late enrollees for the greater of eighteen months or provide for an eighteen-month preexisting condition exclusion, provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed eighteen months from the date the individual enrolls for coverage under the health benefit plan**] comply with the provisions of sections 376.450 and 376.451, RSMo**.

[(4)**] (2)** (a) Except as provided in paragraph (d) of this subdivision, requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer

contributions, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier.

(b) A small employer carrier **[**may vary application of minimum participation requirements only by the size of the small employer group**]** **shall not require a minimum participation level greater than:**

a. One hundred percent of eligible employees working for groups of three or less employees; and

b. Seventy-five percent of eligible employees working for groups with more than three employees.

(c) **[**a. Except as provided in paragraph (b) of this subdivision,**]** In applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether the applicable percentage of participation is met.

[b. With respect to a small employer with ten or fewer eligible employees, a small employer carrier may consider employees or dependents who have coverage under another health benefit plan sponsored by such small employer in applying minimum participation requirements.**]**

(d) A small employer carrier shall not increase any requirement for minimum employee participation or **modify** any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

[(5)**]** **(3)** (a) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents **who apply for enrollment during the period in which the employee first becomes eligible to enroll under the terms of the plan**. A small employer carrier shall not offer coverage to only certain individuals **or dependents** in a small employer group or to only part of the group**[**, except in the case of late enrollees as provided in subdivision (3) of this subsection**]**.

(b) A small employer carrier shall not modify a **[**basic or standard**]** health benefit plan with respect to a small employer or any eligible employee or dependent through riders, endorsements or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

3. (1) **Subject to subdivision (3) of this subsection,** a small employer carrier shall not be required to offer coverage or accept applications pursuant to subsection 1 of this section in the case of the following:

(a) To a small employer, where the small employer is not physically located in the carrier's established geographic service area;

(b) To an employee, when the employee does not work or reside within the carrier's established geographic service area; or

(c) Within an area where the small employer carrier reasonably anticipates, and demonstrates to the satisfaction of the director, that it will not have the capacity within its established geographic service area to deliver service adequately to the members of such groups because of its obligations to existing group policyholders and enrollees.

(2) A small employer carrier that cannot offer coverage pursuant to paragraph (c) of subdivision (1) of this subsection may not offer coverage in the applicable area to new cases of employer groups with more than **[**twenty-five**]** **fifty** eligible employees or to any small employer groups until the later of one hundred eighty days following each such refusal or the date on which the carrier notifies the director that it has regained capacity to deliver services to small employer groups.

(3) A small employer carrier shall apply the provisions of this subsection uniformly to all small employers without regard to the claims experience of a small employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents.

4. A small employer carrier shall not be required to provide coverage to small employers pursuant to subsection 1 of this section for any period of time for which the director determines that requiring the acceptance of small employers in accordance with the provisions of subsection 1 of this section would place the small employer carrier in a financially impaired condition**, and the small employer is applying this subsection uniformly to all small employers in the small group market in this state consistent with applicable state law and without regard to the claims experience of a small employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents**.

[5. Sections 379.930 to 379.938 and sections 379.942 to 379.950 shall become effective 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, the board shall submit to the director a plan of operation and thereafter any amendments thereto necessary or suitable, to assure the fair, reasonable and equitable administration of the program. The director may, after notice and hearing, approve the plan of operation if the director determines it to be suitable to assure the fair, reasonable and equitable administration of the program, and provides for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of sections 379.942 and 379.943. The plan of operation shall become effective upon approval in writing by the director.

2. If the board fails to submit a suitable plan of operation within one hundred eighty days after its appointment, the director shall, after notice and hearing, promulgate and adopt a

temporary plan of operation. The director shall amend or rescind any plan so adopted under this subsection at the time a plan of operation is submitted by the board and approved by the director.

3. The plan of operation shall:

(1) Establish procedures for handling and accounting of program assets and moneys and for an annual fiscal report to the director;

(2) Establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;

(3) Establish procedures for reinsuring risks in accordance with the provisions of sections 379.942 and 379.943;

(4) Establish procedures for collecting assessments from reinsuring carriers to fund claims and administrative expenses incurred or estimated to be incurred by the program; and

(5) Provide for any additional matters necessary for the implementation and administration of the program.

4. The program shall have the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals. In addition thereto, the program shall have the specific authority to:

(1) Enter into contracts as necessary or proper to carry out the provisions and purposes of sections 379.930 to 379.952, including the authority, with the approval of the director, to enter into contracts with similar programs in other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(2) Sue or be sued, including taking any legal actions necessary or proper to recover any assessments and penalties for, on behalf of, or against the program or any reinsuring carriers;

(3) Take any legal action necessary to avoid the payment of improper claims against the program;

(4) Define the health benefit plans for which reinsurance will be provided, and to issue reinsurance policies, in accordance with the requirements of sections 379.930 to 379.952;

(5) Establish rules, conditions and procedures for reinsuring risks under the program;

(6) Establish actuarial functions as appropriate for the operation of the program;

(7) Assess carriers in accordance with the provisions of subsection 8 of this section, and to make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the calendar year;

(8) Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the program, policy and other contract design, and any other function within the authority of the program; and

(9) Borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default shall be legal investments for carriers and may be carried as admitted assets.

5. A small employer carrier participating in the program may reinsure an entire small employer group with the program as provided for in this subsection:

(1) With respect to a basic health benefit plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a basic or standard health benefit plan.

(2) A small employer carrier may reinsure an entire small employer group within sixty days of the commencement of the group's coverage under a health benefit plan or within thirty days after an annual renewal of a small employer group.

(3) (a) The program shall not reimburse a small employer carrier with respect to the claims of an employee or dependent who is part of a reinsured small employer group until the carrier has incurred an initial level of claims for such employee or dependent of five thousand dollars in a calendar year for benefits covered by the program. In addition, the small employer carrier shall be responsible for ten percent of the remaining incurred claims during a calendar year and the program shall reinsure the remainder. A small employer carrier's liability under this paragraph shall not exceed a maximum limit of twenty-five thousand dollars in any one calendar year with respect to any individual who is part of a reinsured small employer group.

(b) The board annually shall adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the "Consumer Price Index for All Urban Consumers" of the federal Department of Labor, Bureau of Labor Statistics, unless the board proposes and the director approves a lower adjustment factor.

(4) A small employer carrier may terminate reinsurance for a small employer on any plan anniversary.

6. (1) The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to sections 379.942 and 379.943. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall also include a system for classification of small employer carriers that reflects the degree to which the small employer carrier uses the cost containment features adopted by the health benefit plan committee under section 379.944. The methodology shall provide for the development of base reinsurance

premium rates, which shall be multiplied by the factors set forth in subdivision (2) of this act to determine the premium rates for the program. The base reinsurance premium rates, shall be established by the board, subject to the approval of the director, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard health benefit plan.

(2) Only an entire small employer group may be reinsured, and the rate for such reinsurance shall be one and one-half times the base reinsurance insurance premium rate for the group established pursuant to this subsection.

(3) The board periodically shall review the methodology established under subdivisions (1) and (2) of this section, including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology which shall be subject to the approval of the director.

7. If a health benefit plan for a small employer is reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued shall meet the requirements relating to premium rates set forth in section 379.936.

8. (1) Prior to March first of each year, the board shall determine and report to the director the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(2) Any net loss for the year shall be recouped by assessments of reinsuring carriers.

(a) The board shall establish, as part of the plan of operation, a formula by which to make assessments against reinsuring carriers and small employer carriers. The assessment formula shall be based on:

a. The share of each reinsuring carrier which reinsures any small employer group with the program, of the program net loss described in this subsection shall be their proportionate share, determined by premiums earned in the preceding calendar year from health benefit plans which have been ceded to the program, times one-half of the total program net loss;

b. Each reinsuring carrier's share of the program net loss described in this subsection shall be its proportionate share, determined by premiums earned in the preceding calendar year from all health benefit plans delivered or issued for delivery to small employers in this state by all reinsuring carriers, times one-half of the total program net loss. An assessment levied or paid by a reinsuring carrier pursuant to subparagraph a of this paragraph shall not be credited or offset against any assessment levied pursuant to this subparagraph.

(b) The formula established pursuant to paragraph (a) of this subdivision shall not result in any reinsuring carrier having an assessment share that is less than fifty percent nor more than one hundred fifty percent of an amount which is based on the proportion of the small employer

carrier's total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by small employer carriers to total premiums earned in the preceding calendar year from health benefit plans delivered or issued for delivery to small employers in this state by all small employer carriers.

(c) The director by rule and after a hearing thereon, may change the assessment formula established pursuant to paragraph (a) of this subdivision from time to time as appropriate. The director may provide for the shares of the assessment base attributable to premiums from all health benefit plans and to premiums from health benefit plans ceded to the program to vary during a transition period.

(d) Subject to the approval of the director, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved health maintenance organizations which are federally qualified under 42 U.S.C.

section 300, et seq., to the extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers.

(e) Premiums and benefits payable by a reinsuring carrier that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments.

(3) (a) Prior to March first of each year, the board shall determine and file with the director an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.

(b) If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount specified in paragraph (c) of this subdivision, the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the director within ninety days following the end of the calendar year in which the losses were incurred. The evaluation shall include: an estimate of future assessments, the administrative costs of the program, the appropriateness of the premiums charged and the level of insurer retention under the program and the costs of coverage for small employers. If the board fails to file a report with the director within ninety days following the end of the applicable calendar year, the director may evaluate the operations of the program and implement such amendments to the plan of operation the director deems necessary to reduce future losses and assessments.

(c) For any calendar year, the amount specified in this paragraph is five percent of total premiums earned in the previous year from health benefit plans delivered or issued for delivery to small employers in this state by reinsuring carriers.

(d) a. If assessments in each of two consecutive calendar years exceed the amount specified in paragraph (c) of subdivision (3) of this subsection, the program shall be eligible to

receive additional financing as provided in subparagraph b of this paragraph.

b. The additional financing provided for in subparagraph a of this paragraph shall be obtained from additional assessments apportioned among all carriers which are not small employer carriers; the amount of the assessment for each carrier determined by the carrier's proportionate share of premiums earned in the preceding calendar year from all health benefit plans delivered, issued for delivery or continued in this state to individuals and groups, other than small employer groups subject to sections 379.930 to 379.952, by all carriers, times the total amount of additional financing to be obtained.

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

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

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

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

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

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

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

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

10. The board, as part of the plan of operation, shall develop standards setting forth the manner and levels of compensation to be paid to producers for the sale of basic and standard health benefit plans. In establishing such standards, the board shall take into the consideration: the need to assure the broad availability of coverages; the objectives of the program; the time and effort expended in placing the coverage; the need to provide ongoing service to the small employer; the levels of compensation currently used in the industry; and the overall costs of coverage to small employers selecting these plans.

11. The program shall be exempt from any and all taxes.

12. The director shall make an initial assessment of one thousand dollars on each insurance company authorized to transact accident or health insurance, each health services corporation, and each health maintenance organization. Initial assessments shall be made during January, 1993, and shall be paid before April 1, 1993. Initial assessments shall be deposited into the department of insurance dedicated fund. Within ten days after the effective date of the program's plan of operation, the total amount of the initial assessments shall be transferred at the request of the director to the Missouri small employer health reinsurance program. The program may use such initial assessment in the same manner and for the same purposes as other assessments pursuant to sections 379.942 and 379.943.

13. The program shall not accept any new risks or renew any existing risk on or after October 1, 2004.

14. Any program assets or moneys that exceed six hundred thousand dollars on August 28, 2004, shall be delivered on October 1, 2004, to the Missouri health insurance pool as established in sections 376.960 to 376.989, and shall be accepted by the Missouri health insurance pool and used for the administration and operation of the Missouri health insurance pool.

15. Any program assets or moneys that remain on October 1, 2005, shall be delivered on October 31, 2005, to the Missouri health insurance pool as established in sections 376.960 to 376.989, and shall be accepted by the Missouri health insurance pool and used for the administration and operation of the Missouri health insurance pool.

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 coverage, including the basic and standard health benefit plans, to eligible small employers in

the state. If a small employer carrier denies coverage to a small employer on the basis of the health status or claims experience of the small employer or its employees or dependents, the small employer carrier shall offer the small employer the opportunity to purchase a basic health benefit plan or a standard health benefit plan**] all health benefit plans sold by the carrier in the small group market to eligible employers in the state**.

2. (1) Except as provided in subdivision (2) of this subsection, no small employer carrier or **[**agent or broker**] producer** shall, directly or indirectly, engage in the following activities:

(a) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of **[**the**] any** health **[**status**] status-related factor**, claims experience, industry, occupation or geographic location of the small employer;

(b) Encouraging or directing small employers to seek coverage from another carrier because of **[**the**] any** health **[**status**] status-related factor**, claims experience, industry, occupation or geographic location of the small employer.

(2) The provisions of subdivision (1) of this subsection shall not apply with respect to information provided by a small employer carrier or **[**agent or broker**] producer** to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

3. (1) Except as provided in subdivision (2) of this subsection, no small employer carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with **[**an agent or broker**] a producer** that provides for or results in the compensation paid to an agent or broker for the sale of a health benefit plan to be varied because of **[**the**] any** health **[**status**] status-related factor**, claims experience, industry, occupation or geographic location of the small employer.

(2) Subdivision (1) of this subsection shall not apply with respect to a compensation arrangement that provides compensation to **[**an agent or broker**] a producer** on the basis of percentage of premium, provided that the percentage shall not vary because of **[**the**] any** health **[**status**] status-related factor**, claims experience, industry, occupation or geographic area of the small employer.

4. **[**A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to an agent or broker, if any, for the sale of a basic or standard health benefit plan.

5.**]** No small employer carrier shall terminate, fail to renew or limit its contract or agreement of representation with **[**an agent or broker**] a producer** for any reason related to **[**the**] any initial or renewal** health **[**status**] status-related factor**, claims experience, occupation, or geographic location of the small employers placed by the agent or broker with the small employer carrier.

[6.**]** **5.** No small employer carrier or producer shall induce or otherwise encourage a small employer to separate or otherwise exclude an employee **or dependent** from health coverage or benefits provided in connection with the employee's employment.

[7.**]** **6.** Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial with specificity.

[8.**]** **7.** The director may promulgate rules setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

[9.**]** **8.** (1) A violation of this section by a small employer carrier or a producer shall be an unfair trade practice under sections 375.930 to 375.949, RSMo.

(2) If a small employer carrier enters into a contract, agreement or other arrangement with a third-party administrator to provide administrative marketing or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this section as if it were a small employer carrier.

9. For purposes of health benefit plans sold to employers of exactly two eligible employees and health benefit plans sold to employers with more than twenty-five eligible employees but not more than fifty eligible employees, sections 379.934 and 379.936 shall become effective July 1, 2005.

[379.942. 1. There is hereby created a nonprofit entity to be known as the "Missouri Small Employer Health Reinsurance Program". All small employer carriers shall participate in the program as reinsuring carriers for a minimum of three years beginning July 1, 1993. After the expiration of such three years, a small employer carrier may apply to the director to opt out of the program. The director shall decide whether to grant such an application to opt out, and shall consider in making such determination only: the carrier's financial condition and the financial condition of its guaranteeing or reinsuring corporation, if any; its history of assuming and managing risk; its ability to assume and manage the risk of enrolling small employers without the protection of the program; and its commitment to market fairly to all small employers in its service area. If the director grants such application, the small employer carrier shall participate in the program neither as a ceding nor reinsuring carrier.

2. (1) The program shall operate subject to the supervision and control of the board. Subject to the provisions of subdivision (2) of this subsection, the board shall consist of nine members appointed by the director plus the director or his designated representative, who shall serve as an ex officio member of the board.

(2) (a) In selecting the members of the board, the director

shall include representatives of small employers, small employer employees or their representatives and small employer carriers and such other individuals determined to be qualified by the director. At least five of the members of the board shall be representatives of reinsuring carriers and at least one of the members of the board shall be a representative of a health maintenance organization which is a small employer carrier. All members shall be selected from individuals nominated by small employer carriers in this state pursuant to procedures and guidelines developed by the director, except that the director shall select two small employers' employees, including at least one representative of a labor organization.

(b) In the event that the program becomes eligible for additional financing pursuant to subdivision (3) of subsection 8 of section 379.943, the board shall be expanded to include two additional members who shall be appointed by the director. In selecting the additional members of the board, the director shall choose individuals who represent reinsuring carriers. The expansion of the board under this paragraph shall continue for the period that the program continues to be eligible for additional financing under subdivision (3) of subsection 8 of section 379.943.

(3) The initial board members shall be appointed as follows: one-third of the members to serve a term of two years; one-third of the members to serve a term of four years; and one-third of the members to serve a term of six years. Subsequent board members shall serve for a term of three years. A board member's term shall continue until his successor is appointed.

(4) A vacancy in the board shall be filled by the director. A board member may be removed by the director for cause.

3. Within sixty days of July 1, 1993, each small employer carrier shall make a filing with the director containing the carrier's net health insurance premium derived from health benefit plans delivered or issued for delivery to small employers in this state in the previous calendar year.**]**

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