SECOND REGULAR SESSION

SENATE COMMITTEE SUBSTITUTE FOR

HOUSE COMMITTEE SUBSTITUTE FOR

HOUSE BILL NO. 1278

92ND GENERAL ASSEMBLY

Reported from the Committee on Small Business, Insurance and Industrial Relations, April 29, 2004, with recommendation that the Senate Committee Substitute do pass.

TERRY L. SPIELER, Secretary.

3304S.08C

AN ACT

To repeal sections 376.421, 376.424, 376.426, 376.816, 379.930, 379.938, 379.940, 379.942, 379.943, and 379.952, RSMo, and to enact in lieu thereof seventeen new sections relating to health insurance, with an effective date.

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

Section A. Sections 376.421, 376.424, 376.426, 376.816, 379.930, 379.938, 379.940, 379.942, 379.943, and 379.952, RSMo, are repealed and seventeen new sections enacted in lieu thereof, to be known as sections 376.381, 376.421, 376.424, 376.426, 376.450, 376.451, 376.452, 376.771, 376.794, 376.816, 376.841, 376.963, 379.930, 379.938, 379.940, 379.943, and 379.952, to read as follows:

376.381. 1. Any health maintenance organization, as defined in section 354.400, RSMo, may offer as an option, one or more health benefit plans which contain deductibles, coinsurance, coinsurance differentials, or variable copayments, as agreed to by the group or individual policy holder. Health benefit plans which contain deductibles may be combined with health savings accounts (HSAs), as described in the Medicare Reform Act, P.L. No. 108-173, Title XII, Section 1201. Nothing in this section shall relieve or be construed as exempting a health maintenance organization from providing or covering the various mandated health insurance benefits required by chapter 376. Coverage and benefits provided by policies issued pursuant to this section for the various mandated health insurance benefits required by

EXPLANATION–Matter enclosed in bold-faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

chapter 376 shall be subject to the dollar limits and copayments as prescribed in this chapter.

2. Any health maintenance organization that issues optional health benefit plans described in subsection 1 of this section shall, quarterly pay, beginning with the year 2005, a tax upon the direct premiums received by the health maintenance organization from such health benefit plans, at the rate of two percent per annum in the same manner as taxes are assessed on life and health insurance companies pursuant to section 148.370, RSMo. Upon receiving the premium taxes from the director of revenue, the state treasurer shall place such moneys to the credit of the Missouri health insurance pool fund established in section 376.963 and shall be used for the purposes of administering and operating the Missouri health insurance pool established in sections 376.960 to 376.989.

376.421. 1. Except as provided in subsection 2 of this section, no policy of group health insurance shall be delivered in this state unless it conforms to one of the following descriptions:

(1) A policy issued to an employer, or to the trustees of a fund established by an employer, which employer or trustees shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

(a) The employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any class or classes thereof. The policy may provide that the term "employees" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships, if the business of the employer and of such affiliated corporations, proprietorships or partnerships is under common control. The policy may provide that the term "employees" shall include the individual proprietor or partners if the employer is an individual proprietorship or partnership. The policy may provide that the term "employees" shall include retired employees, former employees and directors of a corporate employer. A policy issued to insure the employees of a public body may provide that the term "employees" shall include elected or appointed officials;

(b) The premium for the policy shall be paid either from the employer's funds or from funds contributed by the insured employees, or from both. Except as provided in paragraph (c) of this subdivision, a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible

employees, except those who reject such coverage in writing; and

(c) An insurer may exclude or limit the coverage on any person **[**as to whom evidence of individual insurability is not satisfactory to the insurer in a policy insuring fewer than ten employees and in a policy insuring ten or more employees if:

a. Application is not made within thirty-one days after the date of eligibility for insurance; or

b. The person voluntarily terminated the insurance while continuing to be eligible for insurance under the policy; or

c. After the expiration of an open enrollment period during which the person could have enrolled for the insurance or could have elected another level of benefits under the policy**] only to the extent authorized by sections 376.450 to 376.452**;

(2) A policy issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by two or more creditors, which creditor, holding company, affiliate, trustee, trustees or agent shall be deemed the policyholder, to insure debtors of the creditor or creditors with respect to their indebtedness subject to the following requirements:

(a) The debtors eligible for insurance under the policy shall be all of the debtors of the creditor or creditors, or all of any class or classes thereof. The policy may provide that the term "debtors" shall include:

a. Borrowers of money or purchasers or lessees of goods, services, or property for which payment is arranged through a credit transaction;

b. The debtors of one or more subsidiary corporations; and

c. The debtors of one or more affiliated corporations, proprietorships or partnerships if the business of the policyholder and of such affiliated corporations, proprietorships or partnerships is under common control;

(b) The premium for the policy shall be paid either from the creditor's funds or from charges collected from the insured debtors, or from both. Except as provided in paragraph (c) of this subdivision, a policy on which no part of the premium is to be derived from funds contributed by insured debtors specifically for their insurance must insure all eligible debtors;

(c) An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer in a policy insuring fewer than ten debtors and in a policy insuring ten or more debtors if:

a. Application is not made within thirty-one days after the date of eligibility for insurance; or

b. The person voluntarily terminated the insurance while continuing to be

eligible for insurance under the policy; or

c. After the expiration of an open enrollment period during which the person could have enrolled for the insurance or could have elected another level of benefits under the policy;

(d) The total amount of insurance payable with respect to an indebtedness shall not exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor. The insurer may exclude any payments which are delinquent on the date the debtor becomes disabled as defined in the policy;

(e) The insurance may be payable to the creditor or to any successor to the right, title, and interest of the creditor. Such payment or payments shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of each such payment and any excess of insurance shall be payable to the insured or the estate of the insured;

(f) Notwithstanding the preceding provisions of this subdivision, insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment, and insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan;

(3) A policy issued to a labor union or similar employee organization, which shall be deemed to be the policyholder, to insure members of such union or organization for the benefit of persons other than the union or organization or any of its officials, representatives, or agents, subject to the following requirements:

(a) The members eligible for insurance under the policy shall be all of the members of the union or organization, or all of any class or classes thereof;

(b) The premium for the policy shall be paid either from funds of the union or organization or from funds contributed by the insured members specifically for their insurance, or from both. Except as provided in paragraph (c) of this subdivision, a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject such coverage in writing;

(c) An insurer may exclude or limit the coverage on any person **[**as to whom evidence of individual insurability is not satisfactory to the insurer in a policy insuring fewer than ten members and in a policy insuring ten or more members if:

a. Application is not made within thirty-one days after the date of eligibility for insurance; or

b. The person voluntarily terminated the insurance while continuing to be eligible for insurance under the policy; or

c. After the expiration of an open enrollment period during which the person could have enrolled for the insurance or could have elected another level of benefits under the policy**] only to the extent authorized by sections 376.450 to 376.452**;

(4) A policy issued to a trust, or to the trustee of a fund, established or adopted by two or more employers, or by one or more labor unions or similar employee organizations, or by one or more employers and one or more labor unions or similar employee organizations, which trust or trustee shall be deemed the policyholder, to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations, subject to the following requirements:

(a) The persons eligible for insurance shall be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes thereof. The policy may provide that the term "employees" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of such affiliated corporations, proprietorships or partnerships is under common control. The policy may provide that the term "employees" shall include the individual proprietor or partners if the employer is an individual proprietorship or partnership. The policy may provide that the term "employees" shall include retired employees, former employees and directors of a corporate employer. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship;

(b) The premium for the policy shall be paid from funds contributed by the employer or employers of the insured persons or by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and the employer or union or similar employee organization. Except as provided in paragraph (c) of this subdivision, a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance, must insure all eligible persons except those who reject such coverage in writing;

(c) An insurer may exclude or limit the coverage on any person **[**as to whom evidence of individual insurability is not satisfactory to the insurer**] only to the extent authorized by sections 376.450 to 376.452**;

(5) A policy issued to an association or to a trust or to the trustees of a fund established, created and maintained for the benefit of members of one or more

associations. The association or associations shall have at the outset a minimum of one hundred persons; shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least two years; shall have a constitution and bylaws which provide that the association or associations shall hold regular meetings not less than annually to further the purposes of the members; shall, except for credit unions, collect dues or solicit contributions from members; and shall provide the members with voting privileges and representation on the governing board and committees. The policy shall be subject to the following requirements:

(a) The policy may insure members of such association or associations, employees thereof, or employees of members, or one or more of the preceding, or all of any class or classes thereof for the benefit of persons other than the employee's employer;

(b) The premium for the policy shall be paid from funds contributed by the association or associations or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations, or employer members;

(c) Except as provided in paragraph (d) of this subdivision, a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for their insurance must insure all eligible persons, except those who reject such coverage in writing;

(d) An insurer may exclude or limit the coverage on any person **[**as to whom evidence of individual insurability is not satisfactory to the insurer**] only to the extent authorized by sections 376.450 to 376.452**;

(6) A policy issued to a credit union or to a trustee or trustees or agent designated by two or more credit unions, which credit union, trustee, trustees or agent shall be deemed the policyholder, to insure members of such credit union or credit unions for the benefit of persons other than the credit union or credit unions, trustee or trustees, or agent or any of their officials, subject to the following requirements:

(a) The members eligible for insurance shall be all of the members of the credit union or credit unions, or all of any class or classes thereof;

(b) The premium for the policy shall be paid by the policyholder from the credit union's funds and, except as provided in paragraph (c) of this subdivision, must insure all eligible members;

(c) An insurer may exclude or limit the coverage on any member **[**as to whom evidence of individual insurability is not satisfactory to the insurer**] only to the extent authorized by sections 376.450 to 376.452**;

(7) A policy issued to cover persons in a group where that group is specifically described by a law of this state as one which may be covered for group life insurance. The provisions of such law relating to eligibility and evidence of insurability shall apply.

2. Group health insurance offered to a resident of this state under a group health insurance policy issued to a group other than one described in subsection 1 of this section shall be subject to the following requirements:

(1) No such group health insurance policy shall be delivered in this state unless the director finds that:

(a) The issuance of such group policy is not contrary to the best interest of the public;

(b) The issuance of the group policy would result in economies of acquisition or administration; and

(c) The benefits are reasonable in relation to the premiums charged;

(2) No such group health insurance coverage may be offered in this state by an insurer under a policy issued in another state unless this state or another state having requirements substantially similar to those contained in subdivision (1) of this subsection has made a determination that such requirements have been met;

(3) The premium for the policy shall be paid either from the policyholder's funds, or from funds contributed by the covered persons, or from both;

(4) An insurer may exclude or limit the coverage on any person **[**as to whom evidence of individual insurability is not satisfactory to the insurer**] only to the extent authorized by sections 376.450 to 376.452**.

376.424. Except for a policy issued under subdivision (2) of subsection 1 of section 376.421, a group health insurance policy may be extended to insure the employees and members with respect to their family members or dependents, or any class or classes thereof, subject to the following:

(1) The premium for the insurance shall be paid either from funds contributed by the employer, union, association or other person to whom the policy has been issued or from funds contributed by the covered persons, or from both. Except as provided in subdivision (2) of this section, a policy on which no part of the premium for the family members' or dependents' coverage is to be derived from funds contributed by the covered persons must insure all eligible employees or members with respect to their family members or dependents, or any class or classes thereof;

(2) An insurer may exclude or limit the coverage on any family member or dependent **[**as to whom evidence of individual insurability is not satisfactory to the

insurer**]**, subject to sections 376.406 and 376.776 **[**in a policy insuring fewer than ten employees or members and in a policy insuring ten or more employees or members if:

a. Application is not made within thirty-one days after the date of eligibility for insurance; or

b. The employee or member voluntarily terminated the insurance of the family member or dependent while such family member or dependent continues to be eligible for insurance under the policy; or

c. After the expiration of an open enrollment period during which the family member or dependent could have been enrolled for the insurance or could have been enrolled for another level of benefits under the policy**], only to the extent authorized by sections 376.450 to 376.452**.

376.426. No policy of group health insurance shall be delivered in this state unless it contains in substance the following provisions, or provisions which in the opinion of the director of insurance are more favorable to the persons insured or at least as favorable to the persons insured and more favorable to the policyholder; except that: Provisions in subdivisions (5), (7), (12), (15), and (16) of this section shall not apply to policies insuring debtors; standard provisions required for individual health insurance policies shall not apply to group health insurance policies; and if any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the director, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy:

(1) A provision that the policyholder is entitled to a grace period of thirty-one days for the payment of any premium due except the first, during which grace period the policy shall continue in force, unless the policyholder shall have given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such grace period;

(2) A provision that the validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue, and that no statement made by any person covered under the policy relating to insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime nor unless it is contained

in a written instrument signed by the person making such statement; except that, no such provision shall preclude the assertion at any time of defenses based upon the person's ineligibility for coverage under the policy or upon other provisions in the policy;

(3) A provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or, in the event of the death or incapacity of the insured person, to the individual's beneficiary or personal representative;

(4) A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the individual's coverage;

(5) A provision specifying the additional exclusions or limitations, if any, applicable under the policy with respect to a disease or physical condition of a person, not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss, which existed prior to the effective date of the person's coverage under the policy. Any such exclusion or limitation **[**may only apply to a disease or physical condition for which medical advice or treatment was received by the person during the twelve months prior to the effective date of the person's coverage. In no event shall such exclusion or limitation apply to loss incurred or disability commencing after the earlier of:

(a) The end of a continuous period of twelve months commencing on or after the effective date of the person's coverage during all of which the person has received no medical advice or treatment in connection with such disease or physical condition; or

(b) The end of the two-year period commencing on the effective date of the person's coverage**] shall comply with the requirements of subsection 5 of section 376.450**;

(6) If the premiums or benefits vary by age, there shall be a provision specifying an equitable adjustment of premiums or of benefits, or both, to be made in the event the age of the covered person has been misstated, such provision to contain a clear statement of the method of adjustment to be used;

(7) A provision that the insurer shall issue to the policyholder, for delivery to each person insured, a certificate setting forth a statement as to the insurance protection to which that person is entitled, to whom the insurance benefits are payable, and a

statement as to any family member's or dependent's coverage;

(8) A provision that written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible;

(9) A provision that the insurer shall furnish to the person making claim, or to the policyholder for delivery to such person, such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of fifteen days after the insurer receives notice of any claim under the policy, the person making such claim shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made;

(10) A provision that in the case of claim for loss of time for disability, written proof of such loss must be furnished to the insurer within ninety days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of such disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of claim for any other loss, written proof of such loss must be furnished to the insurer within ninety days after the date of such loss. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required;

(11) A provision that all benefits payable under the policy other than benefits for loss of time shall be payable not more than thirty days after receipt of proof and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time shall be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period shall be paid as soon as possible after receipt of such proof;

(12) A provision that benefits for accidental loss of life of a person insured shall be payable to the beneficiary designated by the person insured or, if the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms. In either case, payment of these benefits is subject to the provisions of the policy in the event no such designated or specified beneficiary is living

at the death of the person insured. All other benefits of the policy shall be payable to the person insured. The policy may also provide that if any benefit is payable to the estate of a person, or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay such benefit, up to an amount not exceeding two thousand dollars, to any relative by blood or connection by marriage of such person who is deemed by the insurer to be equitably entitled thereto;

(13) A provision that the insurer shall have the right and opportunity, at the insurer's own expense, to examine the person of the individual for whom claim is made when and so often as it may reasonably require during the pendency of the claim under the policy and also the right and opportunity, at the insurer's own expense, to make an autopsy in case of death where it is not prohibited by law;

(14) A provision that no action at law or in equity shall be brought to recover on the policy prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy and that no such action shall be brought at all unless brought within three years from the expiration of the time within which proof of loss is required by the policy;

(15) A provision specifying the conditions under which the policy may be terminated. Such provision shall state that except for nonpayment of the required premium or the failure to meet continued underwriting standards, the insurer may not terminate the policy prior to the first anniversary date of the effective date of the policy as specified therein, and a notice of any intention to terminate the policy by the insurer must be given to the policyholder at least thirty-one days prior to the effective date of the termination. Any termination by the insurer shall be without prejudice to any expenses originating prior to the effective date of termination. An expense will be considered incurred on the date the medical care or supply is received;

(16) A provision stating that if a policy provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in the policy, such policy, so long as it remains in force, shall be deemed to provide that attainment of such limiting age does not operate to terminate the hospital and medical coverage of such child while the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the policyholder for support and maintenance. Proof of such incapacity and dependency must be furnished to the insurer by the policyholder at least thirty-one days before the child's attainment of the limiting age. The insurer may require at reasonable intervals during the two years following the child's attainment of the limiting age subsequent proof of the child's incapacity and dependency. After such two-year

period, the insurer may require subsequent proof not more than once each year. This subdivision shall apply only to policies delivered or issued for delivery in this state on or after one hundred twenty days after September 28, 1985;

(17) In the case of a policy insuring debtors, a provision that the insurer shall furnish to the policyholder for delivery to each debtor insured under the policy a certificate of insurance describing the coverage and specifying that the benefits payable shall first be applied to reduce or extinguish the indebtedness.

376.450. 1. As used in sections 376.450 to 376.452, the following terms mean:

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

(2) "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.

(3) "COBRA continuation provision":

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

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

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

(4) "Creditable coverage", coverage of the individual under any of the

following:

(a) A group health plan;

(b) Health insurance coverage;

(c) Part A or Part B of Title XVIII of the Social Security Act ("Medicare");

(d) Title XIX of the Social Security Act ("Medicaid"), other than coverage consisting solely of benefits under section 1928 of such act (the program for distribution of pediatric vaccines);

(e) Chapter 55 of Title 10, United States Code (medical and dental care for members and certain former members of the uniformed services);

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

(g) A state health benefits risk pool;

(h) A health plan offered under Title 5, Chapter 89, of the United States Code (the Federal Employees Health Benefits Program);

(i) A public health plan (established or maintained by the state or a political subdivision thereof providing health insurance coverage);

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

Creditable coverage does not include coverage consisting solely of excepted benefits.

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

(6) "Excepted benefits":

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

(b) Coverage only for disability income insurance;

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

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

(e) Workers' compensation or similar insurance;

(f) Automobile medical payment insurance;

(g) Credit-only insurance;

(h) Coverage for 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 pursuant to Chapter 55 of Title 10, United States Code (CHAMPUS supplemental programs);

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

(7) "Group health insurance coverage", health insurance coverage offered in connection with a group health plan or health insurance coverage offered to an eligible group as described in section 376.421;

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

(9) "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;

(10) "Health insurance issuer", 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;

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

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

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

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

(15) "Late enrollee", a participant who enrolls in a group health plan other than during the first period in which the individual is eligible to enroll under the plan, or a special enrollment period pursuant to subsection 3 of section 376.450;

(16) "Medical care":

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

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

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

(17) "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;

(18) "Participant", a person enrolled for coverage under a group health plan;

(19) "Plan sponsor", the entity described in Section 3 of the Employee Retirement Income Security Act of 1974;

(20) "Preexisting condition exclusion", with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact

that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to such information;

(21) "Small group market", the health insurance market under which individuals obtain health insurance coverage directly or through an arrangement, on behalf of themselves and their dependents, through a group health plan maintained by a small employer as defined in subdivision (37) of section 379.930, RSMo;

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

2. (1) No period of creditable coverage that occurs before a sixty-three day break in coverage during which the individual was not covered under any creditable coverage need be considered for purposes of paragraph (c) of subdivision (1) of subsection 5 of section 376.450.

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

(3) Except as provided in subdivision (4) of this subsection, for the purposes of applying paragraph (c) of subdivision (1) of subsection 5 of section 376.450, a health insurance issuer offering group health insurance coverage shall count a period of creditable coverage without regard to the specific benefits included in the coverage.

(4) (a) A health insurance issuer offering group health insurance coverage may elect to apply the provisions of paragraph (c) of subdivision (1) of subsection 5 of section 376.450, based on coverage within any category of benefits within each of several classes or categories of benefits specified in regulations implementing Public Law 104-191, rather than as provided pursuant to subdivision (3) of this subsection. Such election shall be made on a uniform basis for all participants. Under such election a health insurance issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.

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

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

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

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

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

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

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

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

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

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

of a child, the spouse of the employee may be enrolled as a dependent if the spouse is otherwise eligible for coverage.

(b) A dependent special enrollment period pursuant to this subdivision is a period of not less than thirty days that begins on the date of the marriage, birth, or adoption or placement for adoption.

(3) The coverage becomes effective:

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

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

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

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

5. (1) A health insurance issuer offering group health insurance coverage may with respect to a participant impose a preexisting condition exclusion if:

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

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

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

(2) A health insurance issuer offering group health insurance coverage may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage.

(3) Subject to subdivision (5) of this subsection, a health insurance issuer offering group health insurance coverage may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-day period beginning on the date of the adoption or

placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption.

(4) A health insurance issuer offering group health insurance coverage may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(5) Subdivisions (2) and (3) of this subsection shall no longer apply to an individual after the end of the first sixty-three-day period during all of which the individual was not covered under any creditable coverage.

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

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

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

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

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

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

376.451. 1. (1) A health insurance issuer offering group health insurance coverage may not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of the group health plan based on any of the following health status-related factors of the individual or a dependent of the individual:

(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 conditions arising out of acts of domestic violence; or

(h) Disability.

(2) This subsection does not require a health insurance issuer offering group health insurance coverage to provide particular benefits other than those provided under the terms of the group health insurance coverage, or

prevent the issuer from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the group health insurance coverage.

(3) For purposes of subdivision (1) of this subsection, rules for eligibility to enroll include rules defining any applicable waiting or affiliation period for such enrollment, and rules relating to late and special enrollments.

2. (1) A health insurance issuer offering health insurance coverage in connection with a group health plan may not require any individual, as a condition of enrollment or continued enrollment under the plan, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the group health plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

(2) Nothing in subdivision (1) of this subsection shall be construed to:

(a) Restrict the amount that any employer may be charged for coverage under a group health plan; or

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

376.452. 1. Except as provided in this section, if a health insurance issuer offers health insurance coverage in the large group market in connection with a group health plan, the health insurance issuer shall renew or continue the coverage in force at the option of the plan sponsor.

2. A health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a group health plan in the large group market if:

(1) The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or if the health insurance issuer has not received timely premium payments;

(2) The plan sponsor has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact in connection with the coverage;

(3) The plan sponsor has failed to comply with the health insurance issuer's minimum participation requirements;

(4) The plan sponsor has failed to comply with the health insurance issuer's employer contribution requirements;

(5) The health insurance issuer is ceasing to offer coverage in that group market in accordance with this section;

(6) In the case of a health insurance issuer that offers health insurance coverage in the group market through a network plan, there is no longer any enrollee under the group health plan who lives, resides, or works in the service area of the health insurance issuer;

(7) In the case of health insurance coverage that is made available in the small group market or large group market only through one or more bona fide associations, the membership of an employer in the bona fide association ceases, but only if coverage is terminated pursuant to this subdivision uniformly without regard to any health status-related factor of any covered individual.

3. A health insurance issuer may not discontinue offering a particular type of group health insurance coverage offered in the large group market unless:

(1) The issuer provides notice to each plan sponsor and participant provided coverage of this type in that group market of the discontinuation at least ninety days prior to the date of the discontinuation of the coverage;

(2) The issuer offers to each plan sponsor provided coverage of this type in the market the option to purchase any other health insurance coverage currently being offered by the health insurance issuer to a group health plan in the market; and

(3) The issuer acts uniformly without regard to the claims experience of those plan sponsors or any health status-related factor of any participant covered or new participant who may become eligible for such coverage.

4. (1) A health insurance issuer may not discontinue offering all health insurance coverage in the large group market unless:

(a) The issuer provides notice of discontinuation to the director and to each plan sponsor and participant covered 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 large group market is discontinued and coverage under such health insurance is not renewed.

(2) In the case of a discontinuation pursuant to this subsection, the health insurance issuer may not provide for the issuance of any health insurance coverage in the large group market for a period of five years beginning on the date of the discontinuation of the last health insurance

coverage not renewed.

5. 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 large group market.

6. In the case of health insurance coverage that is made available by a health insurance issuer only through one or more bona fide associations, references to "plan sponsor" in this section is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

376.771. 1. Except as provided in this section, a health insurance issuer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual.

2. A health insurance issuer may nonrenew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following:

(1) The individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments;

(2) The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(3) The issuer is ceasing to offer coverage in the individual market in accordance with subsection 4 of this section;

(4) In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area (or in an area for which the issuer is authorized to do business) but only if such coverage is terminated pursuant to this subdivision uniformly without regard to any health status-related factor of covered individuals;

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

3. In any case in which an issuer decides to discontinue offering a particular type of health insurance coverage offered in the individual market,

coverage of such type may be discontinued by the issuer only if:

(1) The issuer provides notice to each covered individual provided coverage of this type in such market of such discontinuation at least ninety days prior to the date of the discontinuation of such coverage;

(2) The issuer offers to each individual in the individual market provided coverage of this type, the option to purchase any other individual health insurance coverage currently being offered by the issuer for individuals in such market; and

(3) In exercising the option to discontinue coverage of this type and in offering the option of coverage pursuant to subdivision (2) of this subsection, the issuer acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage.

4. (1) In any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the individual market in the state, health insurance coverage may be discontinued by the issuer only if:

(a) The issuer provides notice to the director of the department of insurance and to each individual of such discontinuation at least one hundred eighty days prior to the date of the expiration of such coverage; and

(b) All health insurance issued or delivered for issuance in the state in such market are discontinued and coverage under such health insurance coverage in such market is not renewed.

(2) In the case of a discontinuation pursuant to subdivision (1) of this subsection, the issuer shall not provide for the issuance of any health insurance coverage in the market and for a five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

5. At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a policy form offered to individuals in the individual market so long as such modification is consistent with applicable law and effective on a uniform basis among all individuals with that policy form.

6. In applying this section in the case of health insurance coverage that is made available by a health insurance issuer in the individual market to individuals only through one or more associations, a reference to an individual is deemed to include a reference to such an association of which

the individual is a member.

376.794. An insurer shall provide a certification of creditable coverage as required by Public Law 104-191 and regulations promulgated thereunder.

376.816. 1. No individual or group insurance policy providing coverage on an expense-incurred basis, no individual or group service or indemnity contract issued by a not-for-profit health services corporation, no health maintenance organization nor any self-insured group health benefit plan of any type or description shall be offered, issued or renewed in this state on or after July 10, 1991, unless the policy, plan or contract covers adopted children of the insured, subscriber or enrollee on the same basis as other dependents.

2. The coverage required by subsection 1 of this section is effective:

(1) From the date of birth if a petition for adoption is filed within thirty days of the birth of such child; or

(2) From the date of placement for the purpose of adoption if a petition for adoption is filed within thirty days of placement of such child. Such coverage shall continue unless the placement is disrupted prior to legal adoption and the child is removed from placement. Coverage shall include the necessary care and treatment of medical conditions existing prior to the date of placement.

3. As used in this section, "placement" means **[**in the physical custody of the adoptive parent**]** **the assumption and retention by the insured, subscriber or enrollee of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation**.

376.841. Sections 376.825 to 376.840 shall expire on January 1, 2010.

376.963. 1. There is hereby created in the state treasury the "Missouri Health Insurance Pool Fund", which shall consist of all moneys duly authorized and appropriated by the general assembly, all moneys received from federal funds, gifts, bequests, donations, any other moneys so designated and all moneys collected pursuant to section 376.381. The fund shall be administered by the department of insurance in conjunction with the board of directors of the Missouri health insurance pool. Upon appropriation, moneys in the fund shall be used solely for the administration of sections 376.960 to 376.989.

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

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

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

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

[(8)**] (7)** "Carrier" **[**means**],** 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)**] (8)** "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;

[(10)**]** **(9)** "Class of business" **[**means**],** all or a separate grouping of small employers established pursuant to section 379.934;

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

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

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

(13) **"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 pursuant to Section 1928 of such act;

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

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

g. A state health benefits risk pool;

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

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

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

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

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

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

[(15)**]** **(16)** "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)**]** **(17)** "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;

(18) "Excepted benefits":

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

(b) Coverage only for disability income insurance;

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

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

(e) Workers' compensation or similar insurance;

(f) Automobile medical payment insurance;

(g) Credit-only insurance;

(h) Coverage for 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 pursuant to Chapter 55 of Title 10, United States Code (CHAMPUS supplemental programs);

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

[(17)**] (19) "Government plan", the meaning given such term pursuant to Section 3(32) of the Employee Retirement Income Security Act of 1974 or any federal government plan;**

(20) "Group health plan", an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care, 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. For purposes of sections 379.930 to 379.952:

(a) Any plan, fund or program which would not be, but for this subdivision, an employee welfare benefit plan except pursuant to the provisions of this subdivision, and which is established or maintained by a partnership to the extent that such plan, fund or program provides medical care, including any item or service paid for as medical care to a present or former partner in such partnership, or to the partner's dependents, as defined under the terms of the plan, fund or program, directly or through insurance, reimbursement or otherwise, shall be treated, subject to paragraph (b) of this subdivision, as an employee welfare benefit plan which is a group health plan;

(b) In the case of a group health plan, the term "employer" also includes a partnership in relation to any partner; and

(c) In the case of a group health plan, the term "participant" also includes:

a. In connection with a group health plan maintained by a partnership, an individual who is a partner in relation to a partnership; or

b. In connection with a group health plan maintained by a self-

employed individual under which one or more employees are participants, the self-employed individual, if such individual is or may become eligible to receive a benefit under the plan or such individual's beneficiary may be eligible to receive any such benefit;

(d) Group health plan does not include excepted benefits;

(21) "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;

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

(a) Health status;

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

(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)**]** **(23)** "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)**]** **(24)** "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; and**

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;

[(20)**] (25) "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;

(26) "Network plan", a health benefit plan that requires an enrollee to use or creates incentives, including financial incentives, for an enrollee to use, health care providers managed, owned, under contract with or employed by the health carrier;

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

[(22)**] (29) "Plan sponsor", the meaning given such term pursuant to Section 3(16)(B) of the Employee Retirement Income Security Act of 1974;**

(30) "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)**] (31)** "Producer" includes an insurance agent or broker;

[(24)**] (32) "Professional association", an association which meets all of the following:**

(a) Serves a single profession, if such profession requires a significant amount of education, training or experience, or a license or certificate from a state authority to practice such profession;

(b) Has been actively in existence for five years;

(c) Has a constitution or bylaws, or any other analogous governing document;

(d) Has been formed and maintained in good faith for a purpose other than obtaining insurance;

(e) Is not owned or controlled by a carrier or affiliated with a carrier;

(f) Does not condition membership in the association on health status or claims experience;

(g) Has at least one thousand members if it is a national association; five hundred members if it is a state association; or two hundred members if it is a local association;

(h) Any member or dependent of a member is eligible for coverage regardless of health status or claims experience;

(i) Does not offer a health benefit plan to an individual through the association other than in connection with a member of the association;

(j) Is governed by a board of directors and sponsors annual meetings of its members; and

(k) Producers may only market an association membership, accept an application for membership, or sign up a member in the professional association if such individual is actively engaged in, or directly related to, the profession represented by the professional association;

(33) "Professional association plan", a health benefit plan offered through a professional association that covers members of a professional association and their dependents in this state regardless of the situs of delivery of the policy or contract and meets the following:

(a) Conforms with the provisions of section 379.936 concerning the premium rates as they apply to an individual carrier and individual health benefit plan;

(b) Provides renewability of coverage for the members and dependents of members of a professional association which meets the requirements set forth in subsection 2 of section 379.938 as applied to an individual health benefit plan;

(c) Provides availability of coverage for the members and dependents of members of the professional association in conformance with the

provisions of subdivisions (1), (2) and (3) of subsection 2 of section 379.940 as applied to an individual health benefit plan and individual carrier;

(d) Is offered by a carrier that offers health benefit plan coverage to any professional association seeking health benefit plan coverage from such carrier; and

(e) Conforms with the preexisting condition provisions of subsection 2 of section 379.940 as applied to an individual health benefit plan;

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

[(27)**]** **(36)** "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.**]** **sections 354.400 to 354.550, RSMo,** to provide health care services to covered individuals;

[(28)**]** **(37)** "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 no** 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 pursuant to subsection (b), (c), (m) or (o) of Section 414 of the Internal Revenue Code of 1986 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 it is reasonably expected that the employer will employ on business days in the current calendar year. Any reference in this act to an employer shall include a reference to any predecessor of such employer;

[(29)**] (38)** "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**]**.

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**] 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;**

(6) The small employer carrier discontinues offering a particular type of group 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 and participant provided coverage of such type 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 any of the 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 participant covered or new participant who may become eligible for such coverage;

(7) 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 participant covered 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;

[(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)**]** **(8)** 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**]** **pursuant to** 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. A small employer carrier offering coverage through a network plan shall not be required to offer coverage or accept applications pursuant to subsection 1 or 2 of this section:

(1) To an eligible person who no longer resides, lives or works in the service area or in an area for which the carrier is authorized to do business, but only if coverage is terminated pursuant to this subdivision uniformly without regard to any health status-related factor of any covered individual; or

(2) To a small employer that no longer has an enrollee in such plan who lives, resides or works in the service area of the carrier or the area for which the carrier is authorized to do business.

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)**]** **provided, however, that** a pregnancy existing on the effective date of

coverage **shall not be considered a preexisting condition**.

(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**] creditable** coverage **[**that provided benefits with respect to such services, provided that the qualifying previous**]:**

(a) The creditable coverage was continuous to a date not less than **[**thirty**] sixty-three** days prior to the **[**effective**]** date of **application for** the new coverage. **[**This subdivision does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan**]; and**

(b) The aggregate period of such individual's creditable coverage is not less than twelve months.

(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**[.];**

(4) A small employer carrier is prohibited from imposing any preexisting condition exclusion in the following cases:

(a) A small employer carrier shall not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition;

(b) Subject to paragraph (e) of this subdivision, a small employer carrier shall not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage;

(c) Subject to paragraph (e) of this subdivision, a small employer carrier shall not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-day period beginning on the date of adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of adoption or placement for adoption;

(d) A small employer carrier shall not impose any preexisting condition exclusion in the case of a condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time while the covered person held creditable coverage, and the medical advice, diagnosis,

care or treatment was a covered benefit under the plan, provided that the creditable coverage was continuous to a date not more than sixty-three days prior to the enrollment date of the new coverage;

(e) Paragraphs (b) and (c) of this subdivision shall no longer apply to an individual after the end of the first sixty-three-day period during all of which the individual was not covered under any creditable coverage;

[(4)**] (5)** (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.

(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**]** **creditable** 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 any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

[(5)**] (6)** (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. A small employer carrier shall not offer coverage to only certain individuals 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) **In accordance with the federal Health Insurance Portability and Accountability Act of 1996,** 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) 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 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.

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.

[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.**]**

2. (1) Except as provided in subdivision (2) of this subsection, no small employer carrier or agent or broker 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 health status, 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 health status, 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 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 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 health status, 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 on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, 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 for any reason related to the health status, claims experience, occupation, or geographic location of the small employers placed by the agent or broker with the small employer carrier.

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

7. 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. 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. (1) A violation of this section by a small employer carrier or a producer shall be an unfair trade practice **[**under**]** **pursuant to** 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.

10. 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 379.930 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.

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