

FIRST REGULAR SESSION

[PERFECTED]

HOUSE COMMITTEE SUBSTITUTE FOR

HOUSE BILL NO. 818

94TH GENERAL ASSEMBLY

Reported from the Special Committee on Health Insurance March 15, 2007 with recommendation that House Committee Substitute for House Bill No. 818 Do Pass. Referred to the Committee on Rules pursuant to Rule 25(21)(f).

Reported from the Committee on Rules March 28, 2007 with recommendation that House Committee Substitute for House Bill No. 818 Do Pass.

Taken up for Perfection April 10, 2007. House Committee Substitute for House Bill No. 818 ordered Perfected and printed, as amended.

D. ADAM CRUMBLISS, Chief Clerk

1261L.05P

AN ACT

To repeal sections 376.960, 376.961, 376.964, 376.966, 376.986, 376.989, 379.930, 379.938, 379.940, 379.942, 379.943, 379.944, and 379.952, RSMo, and to enact in lieu thereof seventeen new sections relating to portability and accessibility of health insurance.

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

Section A. Sections 376.960, 376.961, 376.964, 376.966, 376.986, 376.989, 379.930,
2 379.938, 379.940, 379.942, 379.943, 379.944, and 379.952, RSMo, are repealed and seventeen
3 new sections enacted in lieu thereof, to be known as sections 376.392, 376.435, 376.450,
4 376.451, 376.452, 376.453, 376.454, 376.960, 376.961, 376.964, 376.966, 376.986, 376.989,
5 379.930, 379.938, 379.940, and 379.952, to read as follows:

376.392. For any health carrier or health benefit plan, as defined in section
2 **376.1350, that provides prescription drug coverage or contracts with a third-party for**
3 **prescription drug services, the health carrier or health benefit plan shall notify enrollees**
4 **in writing, or electronically with the permission of the enrollee, at least thirty days prior**
5 **to any deletions, other than generic substitutions, in the health carrier's or health benefit**
6 **plan's prescription drug formulary that affect such enrollees.**

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

376.435. 1. Beginning January 1, 2008, a health carrier providing a group health benefit plan or plans as such terms are defined in section 376.1350, to an employer who meets the requirements specified in subsection 2 of this section shall, upon request by the employer or the employer's producer of record, provide a report of the total dollar amount and total number of claims paid under the plan or plans for each of the prior three years or for each year coverage was in place if less than three years at the time of the request. In the case of an employer with multiple plans, the total dollar amounts shall be aggregated into one report. The report shall be provided within thirty days of the request. The information provided to the employer or the employer's producer of record shall be furnished in a manner that does not individually identify any employee or other person covered by the health benefit plan and shall comply with all applicable federal and state privacy laws regarding the disclosure of health records.

2. For purposes of subsection 1 of this section, an employer is one who:

(1) Employs at least fifty-one employees either at the time of the request or at the start of the reporting period; and

(2) Has been insured continuously with the health carrier or a carrier affiliated with the health carrier for at least the preceding twenty-two months.

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

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

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

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

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

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

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

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

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

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

29 (4) "COBRA continuation provision":

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

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

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

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

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

37 a. A group health plan;

38 b. Health insurance coverage;

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

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

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

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

44 g. A state health benefits risk pool;

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

46 i. A public health plan as defined in federal regulations authorized by Section
47 2701(c)(1)(I) of the Public Health Services Act, as amended by Public Law 104-191;

48 j. A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C.
49 2504(3));

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

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

- 54 (7) "Director", the director of the Missouri department of insurance, financial
55 institutions and professional registration;
- 56 (8) "Enrollment date", with respect to an individual covered under a group health
57 plan or health insurance coverage, the date of enrollment of the individual in the plan or
58 coverage or, if earlier, the first day of the waiting period for such enrollment;
- 59 (9) "Excepted benefits":
- 60 (a) Coverage only for accident (including accidental death and dismemberment)
61 insurance;
- 62 (b) Coverage only for disability income insurance;
- 63 (c) Coverage issued as a supplement to liability insurance;
- 64 (d) Liability insurance, including general liability insurance and automobile
65 liability insurance;
- 66 (e) Workers' compensation or similar insurance;
- 67 (f) Automobile medical payment insurance;
- 68 (g) Credit-only insurance;
- 69 (h) Coverage for onsite medical clinics;
- 70 (i) Other similar insurance coverage, as approved by the director, under which
71 benefits for medical care are secondary or incidental to other insurance benefits;
- 72 (j) If provided under a separate policy, certificate or contract of insurance, any of
73 the following:
- 74 a. Limited scope dental or vision benefits;
- 75 b. Benefits for long-term care, nursing home care, home health care, community-
76 based care, or any combination thereof;
- 77 c. Other similar limited benefits as specified by the director;
- 78 (k) If provided under a separate policy, certificate or contract of insurance, any of
79 the following:
- 80 a. Coverage only for a specified disease or illness;
- 81 b. Hospital indemnity or other fixed indemnity insurance;
- 82 (l) If offered as a separate policy, certificate, or contract of insurance, any of the
83 following:
- 84 a. Medicare supplemental coverage (as defined under Section 1882(g)(1) of the
85 Social Security Act);
- 86 b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10,
87 United States Code;
- 88 c. Similar supplemental coverage provided to coverage under a group health plan;

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

91 (11) "Group health plan", an employee welfare benefit plan as defined in Section
92 3(1) of the Employee Retirement Income Security Act of 1974 and Public Law 104-191 to
93 the extent that the plan provides medical care, as defined in this section, and including any
94 item or service paid for as medical care to an employee or the employee's dependent, as
95 defined under the terms of the plan, directly or through insurance, reimbursement or
96 otherwise, but not including excepted benefits;

97 (12) "Health insurance coverage", or "health benefit plan" as defined in section
98 376.1350 and benefits consisting of medical care, including items and services paid for as
99 medical care, that are provided directly, through insurance, reimbursement, or otherwise
100 under a policy, certificate, membership contract, or health services agreement offered by
101 a health insurance issuer, but not including excepted benefits;

102 (13) "Health insurance issuer", "issuer", or "insurer", an insurance company,
103 health services corporation, fraternal benefit society, health maintenance organization,
104 multiple employer welfare arrangement specifically authorized to operate in the state of
105 Missouri, or any other entity providing a plan of health insurance or health benefits
106 subject to state insurance regulation;

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

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

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

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

120 (18) "Late enrollee", a participant who enrolls in a group health plan other than
121 during the first period in which the individual is eligible to enroll under the plan, or a
122 special enrollment period under subsection 6 of section 376.450;

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

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

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

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

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

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

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

138 (23) "Preexisting condition exclusion", with respect to coverage, a limitation or
139 exclusion of benefits relating to a condition based on the fact that the condition was present
140 before the date of enrollment for such coverage, whether or not any medical advice,
141 diagnosis, care, or treatment was recommended or received before such date. Genetic
142 information shall not be treated as a preexisting condition in the absence of a diagnosis of
143 the condition related to such information;

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

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

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

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

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

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

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

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

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

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

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

176 (4) (a) A health insurance issuer offering group health insurance coverage may
177 elect to apply the provisions of subdivision (3) of subsection 2 of this section based on
178 coverage within any category of benefits within each of several classes or categories of
179 benefits specified in regulations implementing Public Law 104-191, rather than as provided
180 under subdivision (3) of this subsection. Such election shall be made on a uniform basis
181 for all participants and beneficiaries. Under such election a health insurance issuer shall
182 count a period of creditable coverage with respect to any class or category of benefits if any
183 level of benefits is covered within the class or category.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

246 **(3) The coverage becomes effective:**

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

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

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

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

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

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

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

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

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

2 **376.451. 1. A health insurance issuer offering group health insurance coverage**
3 **shall comply with the following standards prohibiting discrimination as to eligibility based**
4 **upon health status:**

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

8 **(a) Health status;**

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

10 **(c) Claims experience;**

11 **(d) Receipt of health care;**

12 **(e) Medical history;**

13 **(f) Genetic information;**

14 **(g) Evidence of insurability, including conditions arising out of acts of domestic**
15 **violence; or**

16 **(h) Disability;**

17 **(2) This subsection does not require a health insurance issuer offering group health**
18 **insurance coverage to provide particular benefits other than those provided under the**
19 **terms of the group health insurance coverage, or prevent the issuer from establishing**
20 **limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage**
21 **for similarly situated individuals enrolled in the group health insurance coverage;**

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

25 **2. A health insurance issuer offering group health insurance coverage shall comply**
26 **with the following standards prohibiting discrimination as to premium contributions based**
27 **upon health status:**

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

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

35 **(a) Restrict the amount that any employer may be charged for coverage under a**
36 **group health plan, other than as provided in sections 379.930 to 379.952, RSMo, for health**
37 **insurance coverage provided in the small group market; or**

38 **(b) Prevent a health insurance issuer offering group health insurance coverage**
39 **from establishing premium discounts or rebates or modifying otherwise applicable**

40 copayments or deductibles in return for adherence to programs of health promotion and
41 disease prevention.

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

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

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

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

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

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

16 (5) The health insurance issuer is ceasing to offer coverage in the large group
17 market in accordance with subsection 3 of this section;

18 (6) In the case of a health insurance issuer that offers health insurance coverage in
19 the large group market through a network plan, there is no longer any enrollee under the
20 group health plan who lives, resides, or works in the service area of the health insurance
21 issuer or in the area for which the issuer is authorized to do business;

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

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

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

32 (2) The issuer offers to each plan sponsor being provided coverage of this type in
33 the large group market the option to purchase any other health insurance coverage

34 currently being offered by the health insurance issuer to a group health plan in the large
35 group market; and

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

39 4. (1) A health insurance issuer shall not discontinue offering all health insurance
40 coverage in the large group market unless:

41 (a) The issuer provides notice of discontinuation to the director and to each plan
42 sponsor, participant and beneficiary covered at least one hundred eighty days prior to the
43 date of the discontinuation of coverage; and

44 (b) All health insurance issued or delivered for issuance in Missouri in the large
45 group market is discontinued and coverage under such health insurance is not renewed.

46 (2) In the case of a discontinuation under this subsection, the health insurance
47 issuer shall not provide for the issuance of any health insurance coverage in the large
48 group market for a period of five years beginning on the date of the discontinuation of the
49 last health insurance coverage not renewed.

50 5. At the time of coverage renewal, a health insurance issuer may modify the health
51 insurance coverage for a product offered to a group health plan in the large group market.
52 For purposes of this subsection, renewal shall be deemed to occur not more often than
53 annually on the anniversary of the effective date of the group health plan's health
54 insurance coverage unless a longer term is specified in the policy or contract.

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

376.453. 1. A health carrier that provides health insurance coverage for which any
2 portion of the premium is payable by an employer or for which the employer has agreed
3 to deduct the premium from the employees' paycheck shall not provide such coverage
4 unless the employer has established a premium only cafeteria plan as permitted under
5 federal law, 26 U.S.C. Section 125.

6 2. Nothing in this act shall prohibit or otherwise restrict an employer's ability to
7 either provide a group health benefit plan or create a premium only cafeteria plan with
8 defined contributions and in which the employee purchases the policy.

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

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

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

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

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

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

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

24 **3. In any case in which an issuer decides to discontinue offering a particular type**
25 **of health insurance coverage offered in the individual market, coverage of such type may**
26 **be discontinued by the issuer only if:**

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

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

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

37 **4. (1) In any case in which a health insurance issuer elects to discontinue offering**
38 **all health insurance coverage in the individual market in the state, health insurance**
39 **coverage may be discontinued by the issuer only if:**

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

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

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

50 5. At the time of coverage renewal, a health insurance issuer may modify the health
51 insurance coverage for a policy form offered to individuals in the individual market so long
52 as such modification is consistent with applicable law and effective on a uniform basis
53 among all individuals with that policy form. For purposes of this subsection, renewal shall
54 be deemed to occur not more often than annually on the anniversary of the effective date
55 of the individual's health insurance coverage or as specified in the policy or contract.

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

60 7. An insurer shall provide a certification of creditable coverage as required by
61 Public Law 104-191 and regulations pursuant thereto.

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

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

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

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

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

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

9 a. A group health plan;

10 b. Health insurance coverage;

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

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

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

- 15 **f. A medical care program of the Indian Health Service or of a tribal organization;**
16 **g. A state health benefits risk pool;**
17 **h. A health plan offered under Chapter 89 of Title 5, United States Code;**
18 **i. A public health plan as defined in federal regulations; or**
19 **j. A health benefit plan under Section 5(e) of the Peace Corps Act, 22 U.S.C.**
20 **2504(e);**
- 21 **(b) Creditable coverage does not include coverage consisting solely of excepted**
22 **benefits;**
- 23 **(5) "Director", the director of the Missouri department of insurance, financial**
24 **institutions and professional registration;**
- 25 **[4)] (6) "Department", the Missouri department of insurance, financial institutions and**
26 **professional registration;**
- 27 **(7) "Dependent", a resident spouse or resident unmarried child under the age of**
28 **nineteen years, a child who is a student under the age of twenty-three years and who is**
29 **financially dependent upon the parent, or a child of any age who is disabled and dependent**
30 **upon the parent;**
- 31 **(8) "Excepted benefits":**
- 32 **(a) Coverage only for accident, including accidental death and dismemberment,**
33 **insurance;**
- 34 **(b) Coverage only for disability income insurance;**
- 35 **(c) Coverage issued as a supplement to liability insurance;**
- 36 **(d) Liability insurance, including general liability insurance and automobile**
37 **liability insurance;**
- 38 **(e) Workers' compensation or similar insurance;**
- 39 **(f) Automobile medical payment insurance;**
- 40 **(g) Credit-only insurance;**
- 41 **(h) Coverage for onsite medical clinics;**
- 42 **(i) Other similar insurance coverage, as approved by the director, under which**
43 **benefits for medical care are secondary or incidental to other insurance benefits;**
- 44 **(j) If provided under a separate policy, certificate or contract of insurance, any of**
45 **the following:**
- 46 **a. Limited scope dental or vision benefits;**
47 **b. Benefits for long-term care, nursing home care, home health care, community-**
48 **based care, or any combination thereof;**
49 **c. Other similar, limited benefits as specified by the director;**

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

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

53 b. Hospital indemnity or other fixed indemnity insurance;

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

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

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

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

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

62 (a) For whom, as of the date on which the individual seeks coverage through the
63 pool, the aggregate of the periods of creditable coverage as defined in this section, is
64 eighteen or more months and whose most recent prior creditable coverage was under a
65 group health plan, governmental plan, church plan, or health insurance coverage offered
66 in connection with any such plan;

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

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

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

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

77 (11) "Group health plan", an employee welfare benefit plan as defined in Section
78 3(1) of the Employee Retirement Income Security Act of 1974 and Public Law 104-191 to
79 the extent that the plan provides medical care and including items and services paid for as
80 medical care to employees or their dependents as defined under the terms of the plan
81 directly or through insurance, reimbursement or otherwise, but not including excepted
82 benefits;

83 [(5)] (12) "Health insurance", any hospital and medical expense incurred policy,
84 nonprofit health care service for benefits other than through an insurer, nonprofit health care
85 service plan contract, health maintenance organization subscriber contract, preferred provider

86 arrangement or contract, or any other similar contract or agreement for the provisions of health
87 care benefits. The term "health insurance" does not include [short-term,] accident, fixed
88 indemnity, limited benefit or credit insurance, coverage issued as a supplement to liability
89 insurance, insurance arising out of a workers' compensation or similar law, automobile
90 medical-payment insurance, or insurance under which benefits are payable with or without
91 regard to fault and which is statutorily required to be contained in any liability insurance policy
92 or equivalent self-insurance;

93 [(6)] (13) "Health maintenance organization", any person which undertakes to provide
94 or arrange for basic and supplemental health care services to enrollees on a prepaid basis, or
95 which meets the requirements of section 1301 of the United States Public Health Service Act;

96 [(7)] (14) "Hospital", a place devoted primarily to the maintenance and operation of
97 facilities for the diagnosis, treatment or care for not less than twenty-four hours in any week of
98 three or more nonrelated individuals suffering from illness, disease, injury, deformity or other
99 abnormal physical condition; or a place devoted primarily to provide medical or nursing care for
100 three or more nonrelated individuals for not less than twenty-four hours in any week. The term
101 "hospital" does not include convalescent, nursing, shelter or boarding homes, as defined in
102 chapter 198, RSMo;

103 [(8)] (15) "Insurance arrangement", any plan, program, contract or other arrangement
104 under which one or more employers, unions or other organizations provide to their employees
105 or members, either directly or indirectly through a trust or third party administration, health care
106 services or benefits other than through an insurer;

107 [(9)] (16) "Insured", any individual resident of this state who is eligible to receive
108 benefits from any insurer or insurance arrangement, as defined in this section;

109 [(10)] (17) "Insurer", any insurance company authorized to transact health insurance
110 business in this state, any nonprofit health care service plan act, or any health maintenance
111 organization;

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

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

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

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

119 [(11)] (19) "Medicare", coverage under both part A and part B of Title XVIII of the
120 Social Security Act, 42 U.S.C. 1395 et seq., as amended;

121 [(12)] (20) "Member", all insurers and insurance arrangements participating in the pool;

122 [(13)] (21) "Physician", physicians and surgeons licensed under chapter 334, RSMo, or
123 by state board of healing arts in the state of Missouri;

124 [(14)] (22) "Plan of operation", the plan of operation of the pool, including articles,
125 bylaws and operating rules, adopted by the board pursuant to the provisions of sections 376.961,
126 376.962 and 376.964;

127 [(15)] (23) "Pool", the state health insurance pool created in sections 376.961, 376.962
128 and 376.964;

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

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

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

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

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

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

- 5 (1) Enter into contracts as are necessary or proper to carry out the provisions and
6 purposes of sections 376.960 to 376.989, including the authority, with the approval of the
7 director [of insurance], to enter into contracts with similar pools of other states for the joint
8 performance of common administrative functions, or with persons or other organizations for the
9 performance of administrative functions;
- 10 (2) Sue or be sued, including taking any legal actions necessary or proper for recovery
11 of any assessments for, on behalf of, or against pool members;
- 12 (3) Take such legal actions as necessary to avoid the payment of improper claims against
13 the pool or the coverage provided by or through the pool;
- 14 (4) Establish appropriate rates, rate schedules, rate adjustments, expense allowances,
15 agents' referral fees, claim reserve formulas and any other actuarial function appropriate to the
16 operation of the pool. Rates shall not be unreasonable in relation to the coverage provided, the
17 risk experience and expenses of providing the coverage. Rates and rate schedules may be
18 adjusted for appropriate risk factors such as age and area variation in claim costs and shall take
19 into consideration appropriate risk factors in accordance with established actuarial and
20 underwriting practices;
- 21 (5) Assess members of the pool in accordance with the provisions of this section, and
22 to make advance interim assessments as may be reasonable and necessary for the organizational
23 and interim operating expenses. Any such interim assessments are to be credited as offsets
24 against any regular assessments due following the close of the fiscal year;
- 25 (6) Issue policies of insurance in accordance with the requirements of sections 376.960
26 to 376.989;
- 27 (7) Appoint, from among members, appropriate legal, actuarial and other committees as
28 necessary to provide technical assistance in the operation of the pool, policy or other contract
29 design, and any other function within the authority of the pool;
- 30 (8) Establish rules, conditions and procedures for reinsuring risks of pool members
31 desiring to issue pool plan coverages in their own name. Such reinsurance facility shall not
32 subject the pool to any of the capital or surplus requirements, if any, otherwise applicable to
33 reinsurers;
- 34 (9) Negotiate rates of reimbursement with health care providers on behalf of the
35 association and its members;
- 36 **(10) Administer separate accounts to separate federally defined eligible individuals**
37 **and trade act eligible individuals who qualify for plan coverage from the other eligible**
38 **individuals entitled to pool coverage and apportion the costs of administration among such**
39 **separate accounts.**

376.966. 1. No employee shall involuntarily lose his **or her** group coverage by decision of his **or her** employer on the grounds that such employee may subsequently enroll in the pool. The department [of insurance] shall have authority to promulgate rules and regulations to enforce this subsection.

2. [Any individual who is a resident of this state shall be eligible for pool coverage, except the following] **The following individual persons shall be eligible for coverage under the pool if they are and continue to be residents of this state:**

(1) **An individual person who provides evidence of the following:**

(a) **A notice of rejection or refusal to issue substantially similar health insurance for health reasons by at least two insurers; or**

(b) **A refusal by an insurer to issue health insurance except at a rate exceeding the plan rate for substantially similar health insurance;**

(2) **A federally defined eligible individual who has not experienced a significant break in coverage;**

(3) **A trade act eligible individual;**

(4) **Each resident dependent of a person who is eligible for plan coverage;**

(5) **Any person, regardless of age, that can be claimed as a dependent of a trade act eligible individual on such trade act eligible individual's tax filing;**

(6) **Any person whose health insurance coverage is involuntarily terminated for any reason other than nonpayment of premium or fraud, and who is not otherwise ineligible under subdivision (4) of subsection 3 of this section. If application for pool coverage is made not later than sixty-three days after the involuntary termination, the effective date of the coverage shall be the date of termination of the previous coverage;**

(7) **Any person whose premiums for health insurance coverage have increased to one hundred fifty percent or more of rates established by the board as applicable for individual standard risks;**

(8) **Any person currently insured who would have qualified as a federally defined eligible individual or a trade act eligible individual between the effective date of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the effective date of this act.**

3. **The following individual persons shall not be eligible for coverage under the pool:**

(1) **Persons who have, on the date of issue of coverage by the pool, or obtain coverage under health insurance or an insurance arrangement substantially similar to or more comprehensive than a plan policy, or would be eligible to have coverage if the person elected to obtain it, except that:**

37 (a) This exclusion shall not apply to a person who has such coverage but whose
38 premiums have increased to [three] **one** hundred **fifty** percent or more of rates established by the
39 board as applicable for individual standard risks;

40 (b) **A person may maintain other coverage for the period of time the person is**
41 **satisfying any preexisting condition waiting period under a pool policy; and**

42 (c) **A person may maintain plan coverage for the period of time the person is**
43 **satisfying a preexisting condition waiting period under another health insurance policy**
44 **intended to replace the pool policy;**

45 (2) Any person who is at the time of pool application receiving health care benefits under
46 section 208.151, RSMo;

47 (3) Any person having terminated coverage in the pool unless twelve months have
48 elapsed since such termination, **unless such person is a federally defined eligible individual;**

49 (4) Any person on whose behalf the pool has paid out one million dollars in benefits;

50 (5) Inmates **or residents** of public institutions, **unless such person is a federally**
51 **defined eligible individual**, and persons eligible for public programs;

52 (6) Any person whose medical condition which precludes other insurance coverage is
53 directly due to alcohol or drug abuse or self-inflicted injury, **unless such person is a federally**
54 **defined eligible individual or a trade act eligible individual;**

55 (7) [Any person who is eligible for continuation or conversion of insurance coverage
56 under 29 U.S.C. 1161 to 29 U.S.C. 1168, 42 U.S.C. 300bb-1 to 42 U.S.C. 300bb-8, sections
57 376.395 to 376.404, or section 376.428, except that this exclusion shall not apply to a person
58 who has such coverage but whose premiums have increased to three hundred percent or more
59 of rates established by the board as applicable for individual standard risks; or

60 (8)] Any person who is eligible for Medicare coverage.

61 [3.] **4.** Any person who ceases to meet the eligibility requirements of this section may
62 be terminated at the end of [his] **such person's** policy period.

63 [4. Any person whose health insurance coverage is involuntarily terminated for any
64 reason other than nonpayment of premium or any person whose premiums have increased to
65 three hundred percent or more of rates established by the board as applicable for individual
66 standard risks, may apply for coverage under the plan. If such coverage is applied for within
67 sixty days after the involuntary termination and the application is approved and if premiums are
68 paid for the entire coverage period, the effective date of the coverage shall be the date of
69 termination of the previous coverage.]

70 **5. (1) If an insurer issues one or more of the following or takes any other action**
71 **based wholly or partially on medical underwriting considerations which is likely to render**
72 **any person eligible for pool coverage, the insurer shall notify all persons affected of the**

73 **existence of the pool, as well as the eligibility requirements and methods of applying for**
74 **pool coverage:**

75 **(a) A notice of rejection or cancellation of coverage;**

76 **(b) A notice of reduction or limitation of coverage, including restrictive riders, if**
77 **the effect of the reduction or limitation is to substantially reduce coverage compared to the**
78 **coverage available to a person considered a standard risk for the type of coverage provided**
79 **by the plan.**

376.986. 1. The pool shall offer major medical expense coverage to every person
2 eligible for coverage under section 376.966. The coverage to be issued by the pool and its
3 schedule of benefits, exclusions and other limitations, shall be established by the board with the
4 advice and recommendations of the pool members, and such plan of pool coverage shall be
5 submitted to the director for approval. The pool shall also offer coverage for drugs and supplies
6 requiring a medical prescription and coverage for patient education services, to be provided at
7 the direction of a physician, encompassing the provision of information, therapy, programs, or
8 other services on an inpatient or outpatient basis, designed to restrict, control, or otherwise cause
9 remission of the covered condition, illness or defect.

10 2. In establishing the pool coverage the board shall take into consideration the levels of
11 health insurance provided in this state and medical economic factors as may be deemed
12 appropriate, and shall promulgate benefit levels, deductibles, coinsurance factors, exclusions and
13 limitations determined to be generally reflective of and commensurate with health insurance
14 provided through a representative number of insurers in this state.

15 3. [Premiums charged for pool coverage may not be unreasonable in relation to the
16 benefits provided, the risk experience and the reasonable expenses of providing the coverage.]
17 **The pool shall establish premium rates for pool coverage as provided in subsection 4 of this**
18 **section.** Separate schedules of premium rates based on age, sex and geographical location may
19 apply for individual risks. **Premium rates and schedules shall be submitted to the director**
20 **for approval prior to use.**

21 4. The pool, **with the assistance of the director**, shall determine the standard risk rate
22 by [calculating the average individual standard rate charged by the five insurers with the largest
23 number of individual contracts in force. In the event five insurers do not offer comparable
24 coverage,] **considering the premium rates charged by other insurers offering health**
25 **insurance coverage to individuals.** The standard risk rate shall be established using reasonable
26 actuarial techniques and shall reflect anticipated experience and expenses for such coverage.
27 Initial rates for pool coverage shall not be less than one hundred [fifty] **twenty-five** percent of
28 rates established as applicable for individual standard risks. **Subject to the limits provided in**
29 **this subsection**, subsequent rates shall be established to provide fully for the expected costs of

30 claims including recovery of prior losses, expenses of operation, investment income of claim
31 reserves, and any other cost factors subject to the limitations described herein. In no event shall
32 pool rates exceed [two hundred percent of rates applicable to individual standard risks.

33

34 All rates and rate schedules shall be submitted to the director for approval] **the following:**

35 **(1) For federally defined eligible individuals, rates shall be equal to the percent of**
36 **rates applicable to individual standard risks actuarially determined to be sufficient to**
37 **recover the sum of the cost of benefits paid under the pool for federally defined eligible**
38 **individuals plus the proportion of the pool's administrative expense applicable to federally**
39 **defined eligible individuals enrolled for pool coverage, provided that such rates shall not**
40 **exceed one hundred thirty-five percent of rates applicable to individual standard risks; and**

41 **(2) For all other individuals covered under the pool, one hundred thirty-five**
42 **percent of rates applicable to individual standard risks.**

43 5. Pool coverage established pursuant to this section shall provide an appropriate high
44 and low deductible to be selected by the pool applicant. The deductibles and coinsurance factors
45 may be adjusted annually in accordance with the medical component of the consumer price
46 index.

47 6. Pool coverage shall exclude charges or expenses incurred during the first twelve
48 months following the effective date of coverage as to any condition [which, during the six-month
49 period immediately preceding the effective date of coverage, had manifested itself in such a
50 manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment or] for
51 which medical advice, care or treatment was recommended or received as to such condition
52 **during the six-month period immediately preceding the effective date of coverage.** Such
53 preexisting condition exclusions shall be waived to the extent to which similar exclusions, if any,
54 have been satisfied under any prior health insurance coverage which was involuntarily
55 terminated, if [that] application for pool coverage is made not later than [sixty] **sixty-three** days
56 following such involuntary termination and, in such case, coverage in the pool shall be effective
57 from the date on which such prior coverage was terminated.

58 7. **No preexisting condition exclusion shall be applied to the following:**

59 **(1) A federally defined eligible individual who has not experienced a significant gap**
60 **in coverage; or**

61 **(2) A trade act eligible individual who maintained creditable health insurance**
62 **coverage for an aggregate period of three months prior to loss of employment and who has**
63 **not experienced a significant gap in coverage since that time.**

64 8. Benefits otherwise payable under pool coverage shall be reduced by all amounts paid
65 or payable through any other health insurance, or insurance arrangement, and by all hospital and

66 medical expense benefits paid or payable under any workers' compensation coverage, automobile
 67 medical payment or liability insurance whether provided on the basis of fault or nonfault, and
 68 by any hospital or medical benefits paid or payable under or provided pursuant to any state or
 69 federal law or program except Medicaid. The insurer or the pool shall have a cause of action
 70 against an eligible person for the recovery of the amount of benefits paid which are not for
 71 covered expenses. Benefits due from the pool may be reduced or refused as a setoff against any
 72 amount recoverable under this subsection.

73 [8.] 9. Medical expenses shall include expenses for comparable benefits for those who
 74 rely solely on spiritual means through prayer for healing.

376.989. Neither the participation in the pool as members, the establishment of rates,
 2 forms or procedures, nor any other joint or collective action required or permitted by the
 3 provisions of sections 376.960 to 376.989 shall be the basis of any legal action, criminal or civil
 4 liability or penalty against the pool, **the pool administrator, the board or any of its members,**
 5 **or pool employees, contractors, or consultants,** or any of its members.

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

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

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

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

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

13 (4) "Base premium rate" [means], for each class of business as to a rating period, the
 14 lowest premium rate charged or that could have been charged under the rating system for that
 15 class of business, by the small employer carrier to small employers with similar case
 16 characteristics for health benefit plans with the same or similar coverage;

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

19 [(6)] (4) "Board" means the board of directors of the program established pursuant to
 20 sections 379.942 and 379.943;

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

22 [(8)] (5) **"Bona fide association", an association which:**

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

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

- 95 **(f) Automobile medical payment insurance;**
96 **(g) Credit-only insurance;**
97 **(h) Coverage for onsite medical clinics;**
98 **(i) Other similar insurance coverage, as approved by the director, under which**
99 **benefits for medical care are secondary or incidental to other insurance benefits;**
100 **(j) If provided under a separate policy, certificate or contract of insurance, any of**
101 **the following:**
102 **a. Limited scope dental or vision benefits;**
103 **b. Benefits for long-term care, nursing home care, home health care, community-**
104 **based care, or any combination thereof;**
105 **c. Other similar, limited benefits as specified by the director.**
106 **(k) If provided under a separate policy, certificate or contract of insurance, any of**
107 **the following:**
108 **a. Coverage only for a specified disease or illness;**
109 **b. Hospital indemnity or other fixed indemnity insurance.**
110 **(l) If offered as a separate policy, certificate or contract of insurance, any of the**
111 **following:**
112 **a. Medicare supplemental coverage (as defined under Section 1882(g)(1) of the**
113 **Social Security Act);**
114 **b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10,**
115 **United States Code;**
116 **c. Similar supplemental coverage provided to coverage under a group health plan;**
117 **(18) "Governmental plan", the meaning given such term under Section 3(32) of the**
118 **Employee Retirement Income Security Act of 1974 or any federal government plan;**
119 **(19) "Group health plan", an employee welfare benefit plan as defined in Section**
120 **3(1) of the Employee Retirement Income Security Act of 1974 and Public Law 104-191 to**
121 **the extent that the plan provides medical care, as defined in this section, and including any**
122 **item or service paid for as medical care to an employee or the employee's dependent, as**
123 **defined under the terms of the plan, directly or through insurance, reimbursement or**
124 **otherwise, but not including excepted benefits;**
125 **(20) "Health benefit plan" [means any hospital or medical policy or certificate, health**
126 **services corporation contract, or health maintenance organization subscriber contract. Health**
127 **benefit plan does not include a policy of individual accident and sickness insurance or hospital**
128 **supplemental policies having a fixed daily benefit, or accident-only, specified disease-only,**
129 **credit, dental, vision, Medicare supplement, long-term care, or disability income insurance, or**
130 **coverage issued as a supplement to liability insurance, worker's compensation or similar**

131 insurance, or automobile medical payment insurance] or **"health insurance coverage"**, benefits
132 **consisting of medical care, including items and services paid for as medical care, that are**
133 **provided directly, through insurance, reimbursement, or otherwise, under a policy,**
134 **certificate, membership contract, or health services agreement offered by a health**
135 **insurance issuer, but not including excepted benefits or a policy that is individually**
136 **underwritten;**

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

138 (a) **Health status;**

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

140 (c) **Claims experience;**

141 (d) **Receipt of health care;**

142 (e) **Medical history;**

143 (f) **Genetic information;**

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

146 (h) **Disability;**

147 [(18)] (22) **"Index rate"** [means], for each class of business as to a rating period for small
148 employers with similar case characteristics, the arithmetic mean of the applicable base premium
149 rate and the corresponding highest premium rate;

150 [(19)] (23) **"Late enrollee"** [means] , an eligible employee or dependent who requests
151 enrollment in a health benefit plan of a small employer following the initial enrollment period
152 for which such individual is entitled to enroll under the terms of the health benefit plan, provided
153 that such initial enrollment period is a period of at least thirty days. However, an eligible
154 employee or dependent shall not be considered a late enrollee if:

155 (a) The individual meets each of the following:

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

158 b. The individual lost coverage under [qualifying previous] **creditable** coverage as a
159 result of **cessation of employer contribution**, termination of employment or eligibility,
160 **reduction in the number of hours of employment**, the involuntary termination of the
161 [qualifying previous] **creditable** coverage, death of a spouse [or divorce] , **dissolution or legal**
162 **separation;**

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

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

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

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

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

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

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

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

181 [(20)] **(26) "New business premium rate" [means], for each class of business as to a**
182 **rating period, the lowest premium rate charged or offered, or which could have been charged or**
183 **offered, by the small employer carrier to small employers with similar case characteristics for**
184 **newly issued health benefit plans with the same or similar coverage;**

185 [(21)] **(27) "Plan of operation" [means], the plan of operation of the program established**
186 **pursuant to sections 379.942 and 379.943;**

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

189 [(22)] **(29) "Premium" [means], all moneys paid by a small employer and eligible**
190 **employees as a condition of receiving coverage from a small employer carrier, including any fees**
191 **or other contributions associated with the health benefit plan;**

192 [(23)] **(30) "Producer", the meaning given such term in section 375.012, RSMo, and**
193 **includes an insurance agent or broker;**

194 [(24)] **(31) "Program" [means], the Missouri small employer health reinsurance program**
195 **created pursuant to sections 379.942 and 379.943;**

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

198 (a) Medicare or Medicaid;

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

201 (c) An individual health insurance policy (including coverage issued by a health
202 maintenance organization, health services corporation or a fraternal benefit society) that provides

203 benefits similar to or exceeding the benefits provided under the basic health benefit plan,
204 provided that such policy has been in effect for a period of at least one year;

205 (26)] (32) "Rating period" [means] , the calendar period for which premium rates
206 established by a small employer carrier are assumed to be in effect;

207 [(27)] (33) "Restricted network provision" [means] , any provision of a health benefit
208 plan that conditions the payment of benefits, in whole or in part, on the use of health care
209 providers that have entered into a contractual arrangement with the carrier pursuant to section
210 354.400, RSMo, et seq. to provide health care services to covered individuals;

211 [(28)] (34) "Small employer" [means] , **in connection with a group health plan with**
212 **respect to a calendar year and a plan year**, any person, firm, corporation, partnership [or] ,
213 association, **or political subdivision** that is actively engaged in business that[, on at least fifty
214 percent of its working days during the preceding calendar quarter, employed not less than three
215 nor] **employed an average of at least two but no** more than [twenty-five] **fifty** eligible
216 employees[, the majority of whom were employed within this state. In determining the number
217 of eligible employees, companies that are affiliated companies, or that are eligible to file a
218 combined tax return for purposes of state taxation, shall be considered one employer] **on**
219 **business days during the preceding calendar year and that employs at least two employees**
220 **on the first day of the plan year. All persons treated as a single employer under subsection**
221 **(b), (c), (m) or (o) of Section 414 of the Internal Revenue Code of 1986 shall be treated as**
222 **one employer. Subsequent to the issuance of a health plan to a small employer and for the**
223 **purpose of determining continued eligibility, the size of a small employer shall be**
224 **determined annually. Except as otherwise specifically provided, the provisions of sections**
225 **379.930 to 379.952 that apply to a small employer shall continue to apply at least until the**
226 **plan anniversary following the date the small employer no longer meets the requirements**
227 **of this definition. In the case of an employer which was not in existence throughout the**
228 **preceding calendar year, the determination of whether the employer is a small or large**
229 **employer shall be based on the average number of employees that it is reasonably expected**
230 **that the employer will employ on business days in the current calendar year. Any**
231 **reference in sections 379.930 to 379.952 to an employer shall include a reference to any**
232 **predecessor of such employer;**

233 [(29)] (35) "Small employer carrier" [means] , a carrier that offers health benefit plans
234 covering eligible employees of one or more small employers in this state[;

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

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

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

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

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

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

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

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

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

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

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

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

27 (6) **The small employer carrier elects to discontinue offering a particular type of**
28 **health benefit plan in the state's small group market. A type of health benefit plan may be**
29 **discontinued by a small employer carrier in such market only if such carrier:**

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

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

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

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

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

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

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

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

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

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

55

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

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

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

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

71 **effective date of the group health plan's health insurance coverage unless a longer term is**
72 **specified in the policy or contract.**

73 **5. In the case of health insurance coverage that is made available by a small**
74 **employer carrier only through one or more bona fide associations, references to "plan**
75 **sponsor" in this section is deemed, with respect to coverage provided to a small employer**
76 **member of the association, to include a reference to such employer.**

379.940. 1. (1) Every small employer carrier shall, as a condition of transacting
2 business in this state with small employers, actively offer to small employers [at least two health
3 benefit plans. One plan offered by each small employer carrier shall be a basic health benefit
4 plan and one plan shall be a standard health benefit plan] **all health benefit plans it actively**
5 **markets to small employers in this state.**

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

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

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

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

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

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

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

28 (4) The provisions of this subsection shall be effective one hundred eighty days after the
29 director's approval of the basic health benefit plan and the standard health benefit plan developed
30 pursuant to section 379.944, provided that if the small employer health reinsurance program

31 created pursuant to sections 379.942 and 379.943 is not yet in operation on such date, the
32 provisions of this subsection shall be effective on the date that such program begins operation.]

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

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

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

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

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

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

53 (3) A health benefit plan may exclude coverage for late enrollees for the greater of
54 eighteen months or provide for an eighteen-month preexisting condition exclusion, provided that
55 if both a period of exclusion from coverage and a preexisting condition exclusion are applicable
56 to a late enrollee, the combined period shall not exceed eighteen months from the date the
57 individual enrolls for coverage under the health benefit plan.

58 (4)] **comply with the provisions of sections 376.450 and 376.451, RSMo.**

59 (2) (a) Except as provided in paragraph (d) of this subdivision, requirements used by a
60 small employer carrier in determining whether to provide coverage to a small employer,
61 including requirements for minimum participation of eligible employees and minimum employer
62 contributions, shall be applied uniformly among all small employers with the same number of
63 eligible employees applying for coverage or receiving coverage from the small employer carrier.

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

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

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

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

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

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

82 [(5)] **(3) (a)** If a small employer carrier offers coverage to a small employer, the small
83 employer carrier shall offer coverage to all of the eligible employees of a small employer and
84 their dependents **who apply for enrollment during the period in which the employee first**
85 **becomes eligible to enroll under the terms of the plan.** A small employer carrier shall not
86 offer coverage to only certain individuals **or dependents** in a small employer group or to only
87 part of the group[, except in the case of late enrollees as provided in subdivision (3) of this
88 subsection].

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

93 **(c) An eligible employee may choose to retain their individual health benefit plan**
94 **at the time of open enrollment in a small employer health benefit plan. If the eligible**
95 **employee retains their individual health benefit plan, a small employer shall provide a**
96 **defined contribution through the establishment of a cafeteria 125 plan under section**
97 **379.953. Small employers shall establish an equal amount of defined contribution for all**
98 **plans.**

99 3. (1) **Subject to subdivision (3) of this subsection,** a small employer carrier shall not
100 be required to offer coverage or accept applications pursuant to subsection 1 of this section in
101 the case of the following:

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

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

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

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

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

120 4. A small employer carrier shall not be required to provide coverage to small employers
121 pursuant to subsection 1 of this section for any period of time for which the director determines
122 that requiring the acceptance of small employers in accordance with the provisions of subsection
123 1 of this section would place the small employer carrier in a financially impaired condition[.

124 5. Sections 379.930 to 379.938 and sections 379.942 to 379.950 shall become effective
125 July 1, 1993, this section and section 379.952 shall become effective July 1, 1994] , **and the**
126 **small employer is applying this subsection uniformly to all small employers in the small**
127 **group market in this state consistent with applicable state law and without regard to the**
128 **claims experience of a small employer and its employees and their dependents or any**
129 **health status-related factor relating to such employees and their dependents.**

379.952. 1. Each small employer carrier shall actively market [health benefit plan
2 coverage, including the basic and standard health benefit plans, to eligible small employers in
3 the state. If a small employer carrier denies coverage to a small employer on the basis of the
4 health status or claims experience of the small employer or its employees or dependents, the
5 small employer carrier shall offer the small employer the opportunity to purchase a basic health
6 benefit plan or a standard health benefit plan] **all health benefit plans sold by the carrier in**
7 **the small group market to eligible employers in the state.**

8 2. (1) Except as provided in subdivision (2) of this subsection, no small employer carrier
9 or agent or broker shall, directly or indirectly, engage in the following activities:

10 (a) Encouraging or directing small employers to refrain from filing an application for
11 coverage with the small employer carrier because of the health status, claims experience,
12 industry, occupation or geographic location of the small employer;

13 (b) Encouraging or directing small employers to seek coverage from another carrier
14 because of the health status, claims experience, industry, occupation or geographic location of
15 the small employer.

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

20 3. (1) Except as provided in subdivision (2) of this subsection, no small employer carrier
21 shall, directly or indirectly, enter into any contract, agreement or arrangement with an agent or
22 broker that provides for or results in the compensation paid to an agent or broker for the sale of
23 a health benefit plan to be varied because of the health status, claims experience, industry,
24 occupation or geographic location of the small employer.

25 (2) Subdivision (1) of this subsection shall not apply with respect to a compensation
26 arrangement that provides compensation to an agent or broker on the basis of percentage of
27 premium, provided that the percentage shall not vary because of the health status, claims
28 experience, industry, occupation or geographic area of the small employer.

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

32 5. No small employer carrier shall terminate, fail to renew or limit its contract or
33 agreement of representation with an agent or broker for any reason related to the health status,
34 claims experience, occupation, or geographic location of the small employers placed by the agent
35 or broker with the small employer carrier.

36 6. No small employer carrier or producer shall induce or otherwise encourage a small
37 employer to separate or otherwise exclude an employee from health coverage or benefits
38 provided in connection with the employee's employment; except that, a carrier may offer a policy
39 to a small employer that charges a reduced premium rate or deductible for employees who do not
40 smoke or use tobacco products, and such carrier shall not be considered in violation of sections
41 379.930 to 379.952 or any unfair trade practice, as defined in section 379.936, even if only some
42 small employers elect to purchase such a policy and other small employers do not.

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

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

47 9. (1) A violation of this section by a small employer carrier or a producer shall be an
48 unfair trade practice under sections 375.930 to 375.949, RSMo.

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

2 [379.942. 1. There is hereby created a nonprofit entity to be known as
3 the "Missouri Small Employer Health Reinsurance Program". All small
4 employer carriers shall participate in the program as reinsuring carriers for a
5 minimum of three years beginning July 1, 1993. After the expiration of such
6 three years, a small employer carrier may apply to the director to opt out of the
7 program. The director shall decide whether to grant such an application to opt
8 out, and shall consider in making such determination only: the carrier's financial
9 condition and the financial condition of its guaranteeing or reinsuring
10 corporation, if any; its history of assuming and managing risk; its ability to
11 assume and manage the risk of enrolling small employers without the protection
12 of the program; and its commitment to market fairly to all small employers in its
13 service area. If the director grants such application, the small employer carrier
14 shall participate in the program neither as a ceding nor reinsuring carrier.

15 2. (1) The program shall operate subject to the supervision and control
16 of the board. Subject to the provisions of subdivision (2) of this subsection, the
17 board shall consist of nine members appointed by the director plus the director
18 or his designated representative, who shall serve as an ex officio member of the
19 board.

20 (2) (a) In selecting the members of the board, the director shall include
21 representatives of small employers, small employer employees or their
22 representatives and small employer carriers and such other individuals
23 determined to be qualified by the director. At least five of the members of the
24 board shall be representatives of reinsuring carriers and at least one of the
25 members of the board shall be a representative of a health maintenance
26 organization which is a small employer carrier. All members shall be selected
27 from individuals nominated by small employer carriers in this state pursuant to
28 procedures and guidelines developed by the director, except that the director shall
29 select two small employers' employees, including at least one representative of
30 a labor organization.

31 (b) In the event that the program becomes eligible for additional
financing pursuant to subdivision (3) of subsection 8 of section 379.943, the

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

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

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

45 3. Within sixty days of July 1, 1993, each small employer carrier shall
46 make a filing with the director containing the carrier's net health insurance
47 premium derived from health benefit plans delivered or issued for delivery to
48 small employers in this state in the previous calendar year.]
49

2 [379.943. 1. Within one hundred eighty days after the appointment of the
3 initial board, the board shall submit to the director a plan of operation and
4 thereafter any amendments thereto necessary or suitable, to assure the fair,
5 reasonable and equitable administration of the program. The director may, after
6 notice and hearing, approve the plan of operation if the director determines it to
7 be suitable to assure the fair, reasonable and equitable administration of the
8 program, and provides for the sharing of program gains or losses on an equitable
9 and proportionate basis in accordance with the provisions of section 379.942 and
10 this section. The plan of operation shall become effective upon approval in
11 writing by the director.

12 2. If the board fails to submit a suitable plan of operation within one
13 hundred eighty days after its appointment, the director shall, after notice and
14 hearing, promulgate and adopt a temporary plan of operation. The director shall
15 amend or rescind any plan so adopted under this subsection at the time a plan of
16 operation is submitted by the board and approved by the director.

17 3. The plan of operation shall:

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

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

22 (3) Establish procedures for reinsuring risks in accordance with the
23 provisions of section 379.942 and this section;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

91 6. (1) The board, as part of the plan of operation, shall establish a
92 methodology for determining premium rates to be charged by the program for
93 reinsuring small employers and individuals pursuant to section 379.942 and this
94 section. The methodology shall include a system for classification of small
95 employers that reflects the types of case characteristics commonly used by small
96 employer carriers in the state. The methodology shall also include a system for
97 classification of small employer carriers that reflects the degree to which the
98 small employer carrier uses the cost containment features adopted by the health
99 benefit plan committee under section 379.944. The methodology shall provide
100 for the development of base reinsurance premium rates, which shall be multiplied
101 by the factors set forth in subdivision (2) of this act to determine the premium
102 rates for the program. The base reinsurance premium rates shall be established
103 by the board, subject to the approval of the director, and shall be set at levels
104 which reasonably approximate gross premiums charged to small employers by
105 small employer carriers for health benefit plans with benefits similar to the
106 standard health benefit plan.

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

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

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

119 8. (1) Prior to March first of each year, the board shall determine and
120 report to the director the program net loss for the previous calendar year,
121 including administrative expenses and incurred losses for the year, taking into
122 account investment income and other appropriate gains and losses.

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

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

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

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

140 (b) The formula established pursuant to paragraph (a) of this subdivision
141 shall not result in any reinsuring carrier having an assessment share that is less
142 than fifty percent nor more than one hundred fifty percent of an amount which is
143 based on the proportion of the small employer carrier's total premiums earned in
144 the preceding calendar year from health benefit plans delivered or issued for
145 delivery to small employers in this state by small employer carriers to total
146 premiums earned in the preceding calendar year from health benefit plans
147 delivered or issued for delivery to small employers in this state by all small
148 employer carriers.

149 (c) The director by rule and after a hearing thereon may change the
150 assessment formula established pursuant to paragraph (a) of this subdivision from
151 time to time as appropriate. The director may provide for the shares of the
152 assessment base attributable to premiums from all health benefit plans and to

153 premiums from health benefit plans ceded to the program to vary during a
154 transition period.

155 (d) Subject to the approval of the director, the board shall make an
156 adjustment to the assessment formula for reinsuring carriers that are approved
157 health maintenance organizations which are federally qualified under 42 U.S.C.
158 Section 300, et seq., to the extent, if any, that restrictions are placed on them that
159 are not imposed on other small employer carriers.

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

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

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

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

183 (d) a. If assessments in each of two consecutive calendar years exceed
184 the amount specified in paragraph (c) of this subdivision, the program shall be
185 eligible to receive additional financing as provided in subparagraph b of this
186 paragraph.

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

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

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

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

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

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

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

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

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

234 10. The board, as part of the plan of operation, shall develop standards
235 setting forth the manner and levels of compensation to be paid to producers for
236 the sale of basic and standard health benefit plans. In establishing such standards,
237 the board shall take into the consideration: the need to assure the broad

238 availability of coverages; the objectives of the program; the time and effort
239 expended in placing the coverage; the need to provide ongoing service to the
240 small employer; the levels of compensation currently used in the industry; and the
241 overall costs of coverage to small employers selecting these plans.

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

243 12. The director shall make an initial assessment of one thousand dollars
244 on each insurance company authorized to transact accident or health insurance,
245 each health services corporation, and each health maintenance organization.
246 Initial assessments shall be made during January, 1993, and shall be paid before
247 April 1, 1993. Initial assessments shall be deposited into the department of
248 insurance dedicated fund. Within ten days after the effective date of the
249 program's plan of operation, the total amount of the initial assessments shall be
250 transferred at the request of the director to the Missouri small employer health
251 reinsurance program. The program may use such initial assessment in the same
252 manner and for the same purposes as other assessments pursuant to section
253 379.942 and this section.

254 13. The program, as defined in section 379.930, shall not accept any new
255 risks or renew any existing risk on or after October 1, 2005.

256 14. Any program assets or moneys that exceed six hundred thousand
257 dollars on August 28, 2005, shall be delivered on October 1, 2005, to the
258 Missouri health insurance pool as established in sections 376.960 to 376.989,
259 RSMo, and shall be accepted by the Missouri health insurance pool and used for
260 the administration and operation of the Missouri health insurance pool.

261 15. Any program assets or moneys that remain on October 1, 2006, shall
262 be delivered on October 31, 2006, to the Missouri health insurance pool as
263 established in sections 376.960 to 376.989, RSMo, and shall be accepted by the
264 Missouri health insurance pool and used for the administration and operation of
265 the Missouri health insurance pool.

266 16. The provisions of this section shall expire on December 31, 2006.]

267

2 [379.944. 1. The director shall appoint a seven-member "Health Benefit
3 Plan Committee". The committee shall be composed of one representative from
4 each of the following categories: an insurance company which is a small
5 employer carrier, a health services corporation which is a small employer carrier,
6 a health maintenance organization which is a small employer carrier, a health
7 care provider, and a small employer. The director shall select two representatives
8 of employees of small employers, including at least one representative of a labor
9 organization.

10 2. The committee shall recommend the form and level of coverages to be
11 made available by small employer carriers pursuant to sections 379.942 and
12 379.943.

13 3. The committee shall recommend benefit levels, cost sharing levels,
exclusions and limitations for the basic health benefit plan and the standard

14 health benefit plan. The committee shall also design a basic health benefit plan
15 and a standard health benefit plan which contain benefit and cost sharing levels
16 that are consistent with the basic method of operation and the benefit plans of
17 health maintenance organizations, including any restrictions imposed by federal
18 law.

19 (1) The plans recommended by the committee shall include cost
20 containment features such as:

21 (a) Utilization review of health care services, including review of medical
22 necessity of hospital and physician services;

23 (b) Case management;

24 (c) Selective contracting with hospitals, physicians and other health care
25 providers;

26 (d) Reasonable benefit differentials applicable to providers that
27 participate or do not participate in arrangements using restricted network
28 provisions; and

29 (e) Other managed care provisions.

30 (2) The committee shall submit the health benefit plans described in this
31 subsection to the director for approval within one hundred eighty days after the
32 appointment of the committee.]

✓