FIRST REGULAR SESSION

[TRULY AGREED TO AND FINALLY PASSED]

SENATE SUBSTITUTE NO. 2 FOR

SENATE COMMITTEE SUBSTITUTE FOR

HOUSE COMMITTEE SUBSTITUTE FOR

HOUSE BILL NO. 818

94TH GENERAL ASSEMBLY

1261S.22T 2007

AN ACT

To repeal sections 103.085, 143.121, 143.782, 313.321, 376.426, 376.776, 376.960, 376.961, 376.964, 376.966, 376.986, 376.989, 379.930, 379.936, 379.938, 379.940, 379.942, 379.943, 379.944, and 379.952, RSMo, and to enact in lieu thereof forty-nine new sections relating to health insurance, with an effective date for certain sections.

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

Section A. Sections 103.085, 143.121, 143.782, 313.321, 376.426, 376.776, 376.960, 376.961, 376.964, 376.966, 376.986, 376.989, 379.930, 379.936, 379.938, 379.940, 379.942, 379.943, 379.944, and 379.952, RSMo, are repealed and forty-nine new sections enacted in lieu thereof, to be known as sections 103.080, 103.085, 143.118, 143.119, 143.121, 143.782, 143.790, 191.912, 313.321, 354.536, 376.392, 376.426, 376.450, 376.451, 376.452, 376.453, 376.454, 376.776, 376.960, 376.961, 376.964, 376.966, 376.986, 376.987, 376.989, 376.990, 376.1500, 376.1502, 376.1504, 376.1506, 376.1508, 376.1510, 376.1512, 376.1514, 376.1516, 376.1518, 376.1520, 376.1522, 376.1524, 376.1528, 376.1530, 376.1532, 376.1750, 376.1753, 379.930, 379.936, 379.938, 379.940, and 379.952, to read as follows:

103.080. 1. As used in this section, the following terms shall mean:

(1) "Health savings account" or "account", shall have the same meaning ascribed to it as in 26 U.S.C. Section 223(d), as amended;

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.

(2) "High deductible health plan", a policy or contract of health insurance or health care plan that meets the criteria established in 26 U.S.C. Section 223(c)(2), as amended, and any regulations promulgated thereunder.

2. Beginning with the open enrollment period for the 2009 plan year, the board shall offer to all qualified state employees and retirees, in addition to the plans currently offered including but not limited to health maintenance organization plans, preferred provider organization plans, copay plans, and participating public entities the option of receiving health care coverage through a high deductible health plan and the establishment of a health savings account. In no instance shall a qualified employee or retiree be required to enroll in a high deductible health plan with a deductible greater than the minimum allowed by law, however, a qualified employee shall have the option to enroll in a high deductible health plan up to the maximum allowed by law. The health savings account shall conform to the guidelines to be established by the Internal Revenue Service for the 2009 tax year but in no case shall a qualified employee or retiree be required to contribute more than the minimum amount allowed by law. A qualified employee may contribute up to the maximum allowed by law. In order for a qualified individual to obtain a high deductible health plan through the Missouri consolidated health care plan, such individual shall present evidence, in a manner prescribed by regulation, to the board that he or she has established a health savings account in compliance with 26 U.S.C. Section 223, and any amendments and regulations promulgated thereto.

3. The board is authorized to promulgate rules and regulations for the administration and implementation of this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2007, shall be invalid and void.

4. The board shall issue a request for proposals from companies interested in offering a high deductible health plan in connection with a health savings account.

103.085. Except as otherwise provided by sections 103.003 to **[**103.175**]** **103.080**, medical benefits coverage as provided by sections 103.003 to **[**103.175**]** **103.080** shall terminate when the member ceases to be an active employee; except persons receiving or entitled to receive an annuity or retirement benefit or disability benefit or the spouse of or unemancipated children

of deceased persons receiving or entitled to receive an annuity or retirement benefit or disability benefit from the state, participating member agency, institution, political subdivision or governmental entity may elect to continue coverage, provided the individuals to be covered have been continuously covered for health care benefits:

(1) Under a separate group or individual policy for the six-month period immediately preceding the member's date of death or disability or eligibility for normal or early retirement; or

(2) Pursuant to sections 103.003 to **[**103.175**] 103.080**, since the effective date of the most recent open enrollment period prior to the member's date of death or disability or eligibility for normal or early retirement; or

(3) From the initial date of eligibility for the benefits provided by sections 103.003 to **[**103.175**] 103.080**.

Cost for coverage continued pursuant to this section shall be determined by the board. If an eligible person does not elect to continue the coverage within thirty-one days of the first day of the month following the date on which the eligible person ceases to be an employee, he or she may not later elect to be covered pursuant to this section.

143.118. 1. For all taxable years beginning on or after January 1, 2007, an individual taxpayer shall be allowed to subtract from the taxpayer's Missouri adjusted gross income to determine Missouri taxable income an amount equal to the amount which the taxpayer has paid during the taxable year as a member of a health care sharing ministry as defined in section 376.1750, RSMo, and shall only be deductible to the extent that such amounts are not deducted on the taxpayer's federal income tax return for that taxable year.

2. The director of the department of revenue shall promulgate rules and regulations to administer the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2007, shall be invalid and void.

143.119. 1. A self employed taxpayer, as such term is used in the federal internal revenue code, who is otherwise ineligible for the Federal income tax health insurance

deduction under Section 162 of the Federal internal revenue code shall be entitled to a credit against the tax otherwise due under chapter 143, RSMo, excluding withholding tax imposed by sections 143.191 to 143.265, RSMo, in an amount equal to the portion of such taxpayers federal tax liability incurred due to such taxpayers inclusion of such payments in federal adjusted gross income. The tax credits authorized under this section shall be nontransferable. To the extent tax credit issued under this section exceed a taxpayer's state income tax liability, such excess shall be considered an overpayment of tax and shall be refunded to the taxpayer.

2. The director of the department of revenue shall promulgate rules and regulations to administer the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2007, shall be invalid and void.

143.121. 1. The Missouri adjusted gross income of a resident individual shall be the taxpayer's federal adjusted gross income subject to the modifications in this section.

2. There shall be added to the taxpayer's federal adjusted gross income:

(a) The amount of any federal income tax refund received for a prior year which resulted in a Missouri income tax benefit;

(b) Interest on certain governmental obligations excluded from federal gross income by Section 103 of the Internal Revenue Code. The previous sentence shall not apply to interest on obligations of the state of Missouri or any of its political subdivisions or authorities and shall not apply to the interest described in subdivision (a) of subsection 3 of this section. The amount added pursuant to this paragraph shall be reduced by the amounts applicable to such interest that would have been deductible in computing the taxable income of the taxpayer except only for the application of Section 265 of the Internal Revenue Code. The reduction shall only be made if it is at least five hundred dollars;

(c) The amount of any deduction that is included in the computation of federal taxable income pursuant to Section 168 of the Internal Revenue Code as amended by the Job Creation and Worker Assistance Act of 2002 to the extent the amount deducted relates to property purchased on or after July 1, 2002, but before July 1, 2003, and to the extent the amount

deducted exceeds the amount that would have been deductible pursuant to Section 168 of the Internal Revenue Code of 1986 as in effect on January 1, 2002; and

(d) The amount of any deduction that is included in the computation of federal taxable income for net operating loss allowed by Section 172 of the Internal Revenue Code of 1986, as amended, other than the deduction allowed by Section 172(b)(1)(G) and Section 172(i) of the Internal Revenue Code of 1986, as amended, for a net operating loss the taxpayer claims in the tax year in which the net operating loss occurred or carries forward for a period of more than twenty years and carries backward for more than two years. Any amount of net operating loss taken against federal taxable income but disallowed for Missouri income tax purposes pursuant to this paragraph after June 18, 2002, may be carried forward and taken against any income on the Missouri income tax return for a period of not more than twenty years from the year of the initial loss.

3. There shall be subtracted from the taxpayer's federal adjusted gross income the following amounts to the extent included in federal adjusted gross income:

(a) Interest or dividends on obligations of the United States and its territories and possessions or of any authority, commission or instrumentality of the United States to the extent exempt from Missouri income taxes pursuant to the laws of the United States. The amount subtracted pursuant to this paragraph shall be reduced by any interest on indebtedness incurred to carry the described obligations or securities and by any expenses incurred in the production of interest or dividend income described in this paragraph. The reduction in the previous sentence shall only apply to the extent that such expenses including amortizable bond premiums are deducted in determining the taxpayer's federal adjusted gross income or included in the taxpayer's Missouri itemized deduction. The reduction shall only be made if the expenses total at least five hundred dollars;

(b) The portion of any gain, from the sale or other disposition of property having a higher adjusted basis to the taxpayer for Missouri income tax purposes than for federal income tax purposes on December 31, 1972, that does not exceed such difference in basis. If a gain is considered a long-term capital gain for federal income tax purposes, the modification shall be limited to one-half of such portion of the gain;

(c) The amount necessary to prevent the taxation pursuant to this chapter of any annuity or other amount of income or gain which was properly included in income or gain and was taxed pursuant to the laws of Missouri for a taxable year prior to January 1, 1973, to the taxpayer, or to a decedent by reason of whose death the taxpayer acquired the right to receive the income or gain, or to a trust or estate from which the taxpayer received the income or gain;

(d) Accumulation distributions received by a taxpayer as a beneficiary of a trust to the extent that the same are included in federal adjusted gross income;

(e) The amount of any state income tax refund for a prior year which was included in the federal adjusted gross income;

(f) The portion of capital gain specified in section 135.357, RSMo, that would otherwise be included in federal adjusted gross income;

(g) The amount that would have been deducted in the computation of federal taxable income pursuant to Section 168 of the Internal Revenue Code as in effect on January 1, 2002, to the extent that amount relates to property purchased on or after July 1, 2002, but before July 1, 2003, and to the extent that amount exceeds the amount actually deducted pursuant to Section 168 of the Internal Revenue Code as amended by the Job Creation and Worker Assistance Act of 2002;

(h) For all tax years beginning on or after January 1, 2005, the amount of any income received for military service while the taxpayer serves in a combat zone which is included in federal adjusted gross income and not otherwise excluded therefrom. As used in this section, "combat zone" means any area which the President of the United States by Executive Order designates as an area in which armed forces of the United States are or have engaged in combat. Service is performed in a combat zone only if performed on or after the date designated by the President by Executive Order as the date of the commencing of combat activities in such zone, and on or before the date designated by the President by Executive Order as the date of the termination of combatant activities in such zone; and

(i) For all tax years ending on or after July 1, 2002, with respect to qualified property that is sold or otherwise disposed of during a taxable year by a taxpayer and for which an addition modification was made under paragraph (c) of subsection 2 of this section, the amount by which addition modification made under paragraph (c) of subsection 2 of this section on qualified property has not been recovered through the additional subtractions provided in paragraph (g) of this subsection.

4. There shall be added to or subtracted from the taxpayer's federal adjusted gross income the taxpayer's share of the Missouri fiduciary adjustment provided in section 143.351.

5. There shall be added to or subtracted from the taxpayer's federal adjusted gross income the modifications provided in section 143.411.

6. In addition to the modifications to a taxpayer's federal adjusted gross income in this section, to calculate Missouri adjusted gross income there shall be subtracted from the taxpayer's federal adjusted gross income any gain recognized pursuant to Section 1033 of the Internal Revenue Code of 1986, as amended, arising from compulsory or involuntary conversion of property as a result of condemnation or the imminence thereof.

7. (1) As used in this subsection, "qualified health insurance premium" means the amount paid during the tax year by such taxpayer for any insurance policy primarily

providing health care coverage for the taxpayer, the taxpayer's spouse, or the taxpayer's dependents.

(2) In addition to the subtractions in subsection 3 of this section, one hundred percent of the amount of qualified health insurance premiums shall be subtracted from the taxpayer's federal adjusted gross income to the extent the amount paid for such premiums is included in federal taxable income. The taxpayer shall provide the department of revenue with proof of the amount of qualified health insurance premiums paid.

143.782. As used in sections 143.782 to 143.788, unless the context clearly requires otherwise, the following terms shall mean and include:

(1) "Court", the supreme court, court of appeals, or any circuit court of the state;

(2) "Debt", any sum due and legally owed to any state agency which has accrued through contract, subrogation, tort, or operation of law regardless of whether there is an outstanding judgment for that sum, court costs as defined in section 488.010, RSMo, fines and fees owed, or any support obligation which is being enforced by the division of family services on behalf of a person who is receiving support enforcement services pursuant to section 454.425, RSMo**, or any claim for unpaid health care services which is being enforced by the department of health and senior services on behalf of a hospital or healthcare provider under section 143.790**;

(3) "Debtor", any individual, sole proprietorship, partnership, corporation or other legal entity owing a debt;

(4) "Department", the department of revenue of the state of Missouri;

(5) "Refund", the Missouri income tax refund which the department determines to be due any taxpayer pursuant to the provisions of this chapter. The amount of a refund shall not include any senior citizens property tax credit provided by sections 135.010 to 135.035, RSMo, unless such refund is being offset for a delinquency or debt relating to individual income tax or a property tax credit; and

(6) "State agency", any department, division, board, commission, office, or other agency of the state of Missouri, including public community college district.

143.790. 1. Any hospital or healthcare provider who has provided health care services to an individual who was not covered by a health insurance policy or was not eligible to receive benefits under the state's medical assistance program of needy persons, Title XIX, P.L. 89-97, 1965 amendments to the federal Social Security Act, 42 U.S.C. Section 301, et seq., under chapter 208, RSMo, and the health insurance for uninsured children under sections 208.631 to 208.657, RSMo, at the time such health care services were administered, and such person has failed to pay for such services for a period greater than ninety days, may submit a claim to the director of the department of health and senior

services for the unpaid health care services. The director of the department of health and senior services shall review such claim. If the claim appears meritorious on its face, the claim for the unpaid medical services shall constitute a debt of the department of health and senior services for purposes of sections 143.782 to 143.788, and the director may certify the debt to the department of revenue in order to set off the debtor's income tax refund. Once the debt has been certified, the director of the department of health and senior services shall submit the debt to the department of revenue under the set off procedure established under section 143.783.

2. At the time of certification, the director of the department of health and senior services shall supply any information necessary to identify each debtor whose refund is sought to be set off pursuant to section 143.784 and certify the amount of the debt or debts owed by each such debtor.

3. If a debtor identified by the director of the department of health and senior services is determined by the department of revenue to be entitled to a refund, the department of revenue shall notify the department of health and senior services that a refund has been set off on behalf of the department of health and senior services for purposes of this section and shall certify the amount of such setoff, which shall not exceed the amount of the claimed debt certified. When the refund owed exceeds the claimed debt, the department shall send the excess amount to the debtor within a reasonable time after such excess is determined.

4. The department of revenue shall notify the debtor by certified mail the taxpayer whose refund is sought to be set off that such setoff will be made. The notice shall contain the provisions contained in subsection 3 of section 143.794, including the opportunity for a hearing to contest the setoff provided therein, and shall otherwise substantially comply with the provisions of subsection 3 of section 143.784.

5. Once a debt has been setoff and finally determined under the applicable provisions of sections 143.782 to 143.788, and the department of health and senior services has received the funds transferred from the department of revenue, the department of health and senior services shall settle with each hospital or healthcare provider for the amounts that the department of revenue setoff for such party. At the time of each settlement, each hospital or healthcare provider shall be charged for administration expenses which shall not exceed twenty percent of the collected amount.

6. Lottery prize payouts made under section 313.321, RSMo, shall also be subject to the set off procedures established in this section and any rules and regulations promulgated thereto.

7. The director of the department of revenue shall have priority to offset any delinquent tax owed to the state of Missouri. Any remaining refund shall be offset to pay a state agency debt or to meet a child support obligation that is enforced by the division of family services on behalf of a person who is receiving support enforcement services under section 454.425, RSMo.

8. The director of the department of revenue and the director of the department of health and senior services shall promulgate rules and regulations necessary to administer the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2007, shall be invalid and void.

191.912. 1. The general assembly of the state of Missouri hereby finds and declares that pregnant women who choose to undergo prenatal screening should have access to timely and informative counseling about the conditions being tested for, the accuracy of such tests, and resources for obtaining support services for such conditions. Informed consent is a critical component of all genetic testing and prenatal screening, particularly as the results of such testing or screening, and the counseling that follows may lead to the unnecessary abortion of unborn humans with Down Syndrome or other prenatally diagnosed conditions.

2. As used in this section, the following terms shall mean:

(1) "Down Syndrome", a chromosomal disorder caused by an error in cell division that results in the presence of an extra whole or partial copy of chromosome 21;

(2) "Health care provider", any person or entity licensed, accredited, or certified by the state of Missouri to perform specified health services;

(3) "Prenatally diagnosed condition", any adverse fetal health condition identified by prenatal genetic testing or indicated by prenatal screening procedures;

(4) "Prenatal test", a diagnostic procedure or screening procedure performed upon a pregnant woman or her unborn offspring to obtain information about her offspring's health or development.

3. When a prenatally diagnosed condition, including but not limited to Down Syndrome, becomes known as a result of one or more prenatal tests, the physician or other

health care professional who requested or ordered prenatal tests, or his or her designee, shall provide the patient with current information about the conditions that were tested for, the accuracy of such tests, and resources for obtaining support services for such conditions, including information hotlines specific to Down Syndrome or other prenatally diagnosed conditions, resource centers, and clearinghouses for such conditions, support programs for parents and families, and the alternatives to abortion services program under section 188.325, RSMo.

4. The department of health and senior services shall establish a clearinghouse of information concerning supportive services providers, information hotlines specific to Down Syndrome or other prenatally diagnosed conditions, resource centers, education, other support programs for parents and families, and the alternatives to abortion services program under section 188.325, RSMo.

313.321. 1. The money received by the Missouri state lottery commission from the sale of Missouri lottery tickets and from all other sources shall be deposited in the "State Lottery Fund", which is hereby created in the state treasury. At least forty-five percent, in the aggregate, of the money received from the sale of Missouri lottery tickets shall be appropriated to the Missouri state lottery commission and shall be used to fund prizes to lottery players. Amounts in the state lottery fund may be appropriated to the Missouri state lottery commission for administration, advertising, promotion, and retailer compensation. The general assembly shall appropriate remaining moneys not previously allocated from the state lottery fund by transferring such moneys to the general revenue fund. The lottery commission shall make monthly transfers of moneys not previously allocated from the state lottery fund to the general revenue fund as provided by appropriation.

2. The commission may also purchase and hold title to any securities issued by the United States government or its agencies and instrumentalities thereof that mature within the term of the prize for funding multi-year payout prizes.

3. The "Missouri State Lottery Imprest Prize Fund" is hereby created. This fund is to be established by the state treasurer and funded by warrants drawn by the office of administration from the state lottery fund in amounts specified by the commission. The commission may write checks and disburse moneys from this fund for the payment of lottery prizes only and for no other purpose. All expenditures shall be made in accordance with rules and regulations established by the office of administration. Prize payments may also be made from the state lottery fund. Prize payouts made pursuant to this section shall be subject to the provisions of section 143.781, RSMo; and prize payouts made pursuant to this section shall be subject to set off for delinquent child support payments as assessed by a court of competent jurisdiction or pursuant to section 454.410, RSMo. **Prize payouts made under this section shall be subject**

to set off for unpaid healthcare services provided by hospitals and healthcare providers under the procedure established in section 143.790, RSMo.

4. Funds of the state lottery commission not currently needed for prize money, administration costs, commissions and promotion costs shall be invested by the state treasurer in interest-bearing investments in accordance with the investment powers of the state treasurer contained in chapter 30, RSMo. All interest earned by funds in the state lottery fund shall accrue to the credit of that fund.

5. No state or local sales tax shall be imposed upon the sale of lottery tickets or shares of the state lottery or on any prize awarded by the state lottery. No state income tax or local earnings tax shall be imposed upon any lottery game prizes which accumulate to an amount of less than six hundred dollars during a prize winner's tax year. The state of Missouri shall withhold for state income tax purposes from a lottery game prize or periodic payment of six hundred dollars or more an amount equal to four percent of the prize.

6. The director of revenue is authorized to enter into agreements with the lottery commission, in conjunction with the various state agencies pursuant to sections 143.782 to 143.788, RSMo, in an effort to satisfy outstanding debts to the state from the lottery winning of any person entitled to receive lottery payments which are subject to federal withholding. **The director of revenue is also authorized to enter into agreements with the lottery commission in conjunction with the department of health and senior services pursuant to section 143.790, RSMo, in an effort to satisfy outstanding debts owed to hospitals and healthcare providers for unpaid healthcare services of any person entitled to receive lottery payments which are subject to federal withholding.**

7. In addition to the restrictions provided in section 313.260, no person, firm, or corporation whose primary source of income is derived from the sale or rental of sexually oriented publications or sexually oriented materials or property shall be licensed as a lottery game retailer and any lottery game retailer license held by any such person, firm, or corporation shall be revoked.

354.536. 1. If a health maintenance organization plan provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children, such coverage shall continue while the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the enrollee for support and maintenance. Proof of such incapacity and dependency must be furnished to the health maintenance organization by the enrollee at least thirty-one days after the child's attainment of the limiting age. The health maintenance organization may require at reasonable intervals during the two years following the child's attainment of the limiting age subsequent proof of the child's disability and dependency. After such

two-year period, the health maintenance organization may require subsequent proof not more than once each year.

2. If a health maintenance organization plan provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children, such plan, so long as it remains in force, until the dependent child attains the limiting age, shall remain in force at the option of the enrollee. The enrollee's election for continued coverage under this section shall be furnished to the health maintenance organization within thirty-one days after the child's attainment of the limiting age. As used in this subsection, a dependent child is a person who is:

(1) Unmarried and no more than twenty-five years of age; and

(2) A resident of this state; and

(3) Not provided coverage as a named subscriber, insured, enrollee, or covered person under any group or individual health benefit plan, or entitled to benefits under Title XVIII of the Social Security Act, P.L. 89-97, 42 U.S.C. Section 1395, et seq.

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

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

(1) A provision that the policyholder is entitled to a grace period of thirty-one days for the payment of any premium due except the first, during which grace period the policy shall continue in force, unless the policyholder shall have given the insurer written notice of

discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such grace period;

(2) A provision that the validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue, and that no statement made by any person covered under the policy relating to insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime nor unless it is contained in a written instrument signed by the person making such statement; except that, no such provision shall preclude the assertion at any time of defenses based upon the person's ineligibility for coverage under the policy or upon other provisions in the policy;

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

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

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

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

(b) The end of the two-year period commencing on the effective date of the person's coverage;

(6) If the premiums or benefits vary by age, there shall be a provision specifying an equitable adjustment of premiums or of benefits, or both, to be made in the event the age of the

covered person has been misstated, such provision to contain a clear statement of the method of adjustment to be used;

(7) A provision that the insurer shall issue to the policyholder, for delivery to each person insured, a certificate setting forth a statement as to the insurance protection to which that person is entitled, to whom the insurance benefits are payable, and a statement as to any family member's or dependent's coverage;

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

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

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

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

(12) A provision that benefits for accidental loss of life of a person insured shall be payable to the beneficiary designated by the person insured or, if the policy contains conditions

pertaining to family status, the beneficiary may be the family member specified by the policy terms. In either case, payment of these benefits is subject to the provisions of the policy in the event no such designated or specified beneficiary is living at the death of the person insured. All other benefits of the policy shall be payable to the person insured. The policy may also provide that if any benefit is payable to the estate of a person, or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay such benefit, up to an amount not exceeding two thousand dollars, to any relative by blood or connection by marriage of such person who is deemed by the insurer to be equitably entitled thereto;

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

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

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

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

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

(17) A provision stating that if a policy provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in the policy, such policy, so long as it remains in force, until the dependent child attains the limiting age, shall remain in force at the option of the certificate holder. Eligibility for continued coverage shall be established where the dependent child is:

(a) Unmarried and no more than that twenty-five years of age; and

(b) A resident of this state; and

(c) Not provided coverage as a named subscriber, insured, enrollee, or covered person under any group or individual health benefit plan, or entitled to benefits under Title XVIII of the Social Security Act, P.L. 89-97, 42 U.S.C. Section 1395, et seq.

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

376.450. 1. 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;

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

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

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

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

(4) "COBRA continuation provision":

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

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

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

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

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

a. A group health plan;

b. Health insurance coverage;

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

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

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

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

g. A state health benefits risk pool;

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

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

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

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

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

(7) "Director", the director of the Missouri department of insurance, financial institutions and professional registration;

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

(9) "Excepted benefits":

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

(b) Coverage only for disability income insurance;

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

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

(e) Workers' compensation or similar insurance;

(f) Automobile medical payment insurance;

(g) Credit-only insurance;

(h) Coverage for onsite medical clinics;

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

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

a. Limited scope dental or vision benefits;

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

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

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

a. Coverage only for a specified disease or illness;

b. Hospital indemnity or other fixed indemnity insurance;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) The coverage becomes effective:

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

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

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

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

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

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

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

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

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

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

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

(a) Health status;

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

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information;

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

(h) Disability;

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

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

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

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

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

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

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

copayments or deductibles in return for adherence to programs of health promotion and disease prevention. Premium discount or rebates established under this subsection shall not be included when computing a small group rate band under section 379.936, RSMo.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

376.453. 1. An employer that provides health insurance coverage for which any portion of the premium is payable by the employer shall not provide such coverage unless the employer has established a premium only cafeteria plan as permitted under federal law, 26 U.S.C. Section 125. The provisions of this subsection shall not apply to employers who offer health insurance through any self-insured or self-funded group health benefit plan of any type or description.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

376.776. 1. This section applies to the hospital and medical expense provisions of an accident or sickness insurance policy.

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

subsequent proof of the child's disability and dependency. After such two-year period, the insurer may require subsequent proof not more than once each year.

3. **If a policy provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in the policy, such policy, so long as it remains in force until the dependent child attains the limiting age, shall remain in force at the option of the policyholder. The policyholder's election for continued coverage under this section shall be furnished by the policyholder to the insurer within thirty-one days after the child's attainment of the limiting age. As used in this subsection, a dependent child is a person who:**

(1) Is a resident of this state;

(2) Is unmarried and no more than twenty-five years of age; and

(3) Not provided coverage as a named subscriber, insured, enrollee, or covered person under any group or individual health benefit plan, or entitled to benefits under Title XVIII of the Social Security Act, P.L. 89-97, 42 U.S.C. Section 1395, et seq.

4. This section applies only to policies delivered or issued for delivery in this state more than one hundred twenty days after October 13, 1967.

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

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

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

(3) **[**"Director", the director of the Missouri department of insurance**] "Church plan", a plan as defined in Section 3(33) of the Employee Retirement Income Security Act of 1974, as amended;**

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

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

a. A group health plan;

b. Health insurance coverage;

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

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

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

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

g. A state health benefits risk pool;

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

i. A public health plan as defined in federal regulations; or

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

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

[(4)**] (5)** "Department", the Missouri department of insurance**, financial institutions and professional registration**;

(6) "Dependent", a resident spouse or resident unmarried child under the age of nineteen years, a child who is a student under the age of twenty-five years and who is financially dependent upon the parent, or a child of any age who is disabled and dependent upon the parent;

(7) "Director", the director of the Missouri department of insurance, financial institutions and professional registration;

(8) "Excepted benefits":

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

(b) Coverage only for disability income insurance;

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

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

(e) Workers' compensation or similar insurance;

(f) Automobile medical payment insurance;

(g) Credit-only insurance;

(h) Coverage for onsite medical clinics;

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

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

a. Limited scope dental or vision benefits;

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

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

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

a. Coverage only for a specified disease or illness;

b. Hospital indemnity or other fixed indemnity insurance;

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

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

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

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

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

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

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

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

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

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

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

[(5)**] (12)** "Health insurance", any hospital and medical expense incurred policy, nonprofit health care service for benefits other than through an insurer, nonprofit health care service plan contract, health maintenance organization subscriber contract, preferred provider arrangement or contract, or any other similar contract or agreement for the provisions of health care benefits. The term "health insurance" does not include **[**short-term,**]** accident, fixed indemnity, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile

medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(26) "Trade act eligible individual", an individual who is eligible for the federal 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 Health Insurance Pool". All insurers issuing health insurance in this state and insurance arrangements providing health plan benefits in this state shall be members of the pool.

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

3. Beginning August 28, 2007, the board of directors shall consist of fourteen members. The board shall consist of the director and the eight members described in subsection 2 of this section and shall consist of the following additional five members:

(1) One member from a hospital located in Missouri, appointed by the governor, with the advice and consent of the senate;

(2) Two members of the senate, with one member from the majority party appointed by the president pro tem of the senate and one member of the minority party

appointed by the president pro tem of the senate with the concurrence of the minority floor leader of the senate; and

(3) Two members of the house of representatives, with one member from the majority party appointed by the speaker of the house of representatives and one member of the minority party appointed by the speaker of the house of representatives with the concurrence of the minority floor leader of the house of representatives.

4. The members appointed under subsection 3 of this section shall serve in an ex officio capacity. The terms of the members of the board of directors appointed under subsection 3 of this section shall expire on December 31, 2009. On such date, the membership of the board shall revert back to nine members as provided for in subsection 2 of this section.

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

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of sections 376.960 to 376.989, including the authority, with the approval of the director **[**of insurance**]**, to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

(2) Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against pool members;

(3) Take such legal actions as necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

(4) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas and any other actuarial function appropriate to the operation of the pool. Rates shall not be unreasonable in relation to the coverage provided, the risk experience and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim costs and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices;

(5) Assess members of the pool in accordance with the provisions of this section, and to make advance interim assessments as may be reasonable and necessary for the organizational and interim operating expenses. Any such interim assessments are to be credited as offsets against any regular assessments due following the close of the fiscal year;

(6) Issue policies of insurance in accordance with the requirements of sections 376.960 to 376.989;

(7) Appoint, from among members, appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy or other contract design, and any other function within the authority of the pool;

(8) Establish rules, conditions and procedures for reinsuring risks of pool members desiring to issue pool plan coverages in their own name. Such reinsurance facility shall not subject the pool to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers;

(9) Negotiate rates of reimbursement with health care providers on behalf of the association and its members**;**

(10) Administer separate accounts to separate federally defined eligible individuals and trade act eligible individuals who qualify for plan coverage from the other eligible individuals entitled to pool coverage and apportion the costs of administration among such 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 above the rate established by the board under paragraph (a) of subdivision (1) of subsection 3 of this section;

(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**:**

(a) This exclusion shall not apply to a person who has such coverage but whose premiums have increased to **[**three**] one** hundred **fifty** percent **[**or more**] to two hundred percent** of rates established by the board as applicable for individual standard risks**. After December 31, 2009, this exclusion shall not apply to a person who has such coverage but whose premiums have increased to three hundred percent or more of rates established by the board as applicable for individual standard risks**;

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

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

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

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

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

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

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

(7) **[**Any person who is eligible for continuation or conversion of insurance coverage 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 376.395 to 376.404, or section 376.428, except that this exclusion shall not apply to a person who has such coverage but whose premiums have increased to three hundred percent or more of rates established by the board as applicable for individual standard risks; or

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

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

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

5. If an insurer issues one or more of the following or takes any other action based wholly or partially on medical underwriting considerations which is likely to render any person eligible for pool coverage, the insurer shall notify all persons affected of the existence of the pool, as well as the eligibility requirements and methods of applying for pool coverage:

(1) A notice of rejection or cancellation of coverage;

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

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

2. In establishing the pool coverage the board shall take into consideration the levels of health insurance provided in this state and medical economic factors as may be deemed

appropriate, and shall promulgate benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of and commensurate with health insurance provided through a representative number of insurers in this state.

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

4. The pool**, with the assistance of the director,** shall determine the standard risk rate by **[**calculating the average individual standard rate charged by the five insurers with the largest number of individual contracts in force. In the event five insurers do not offer comparable coverage,**]** **considering the premium rates charged by other insurers offering health insurance coverage to individuals.** The standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Initial rates for pool coverage shall not be less than one hundred **[**fifty**]** **twenty-five** percent of rates established as applicable for individual standard risks. **Subject to the limits provided in this subsection,** subsequent rates shall be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein. In no event shall pool rates exceed **[**two hundred percent of rates applicable to individual standard risks. All rates and rate schedules shall be submitted to the director for approval**]** **the following:**

(1) For federally defined eligible individuals and trade act eligible individuals, rates shall be equal to the percent of rates applicable to individual standard risks actuarially determined to be sufficient to recover the sum of the cost of benefits paid under the pool for federally defined and trade act eligible individuals plus the proportion of the pool's administrative expense applicable to federally defined and trade act eligible individuals enrolled for pool coverage, provided that such rates shall not exceed one hundred fifty percent of rates applicable to individual standard risks; and

(2) For all other individuals covered under the pool, one hundred fifty percent of rates applicable to individual standard risks.

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

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

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

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

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

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

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

376.987. 1. The board shall offer to all eligible persons for pool coverage under section 376.966 the option of receiving health insurance coverage through a high deductible health plan and the establishment of a health savings account. In order for a qualified individual to obtain a high deductible health plan through the pool, such individual shall present evidence, in a manner prescribed by regulation, to the board that he or she has established a health savings account in compliance with 26 U.S.C. Section 223, and any amendments and regulations promulgated thereto.

2. As used in this section, the term "health savings account" shall have the same meaning ascribed to it as in 26 U.S.C. Section 223(d), as amended. The term "high deductible health plan" shall mean a policy or contract of health insurance or health care plan that meets the criteria established in 26 U.S.C. Section 223(c)(2), as amended, and any regulations promulgated thereunder.

3. The board is authorized to promulgate rules and regulations for the administration and implementation of this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2007, shall be invalid and void.

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

376.990. The board of directors of the state health insurance pool is hereby directed to conduct a study regarding the financing of the state health insurance pool. Such study shall include, but not be limited to, research and findings of how other states finance their state high risk pools. The study shall consider alternative assessment approaches to the current assessment method employed in section 376.975. In addition to studying alternative financing mechanisms employed by other state high risk pools, the board shall explore the ramifications of eliminating or reducing a carrier's ability to offset their assessments against their premium tax liability. The polestar of the study shall be establishing a stable funding source for the Missouri state health insurance pool while providing adequate health insurance coverage to Missouri's uninsurable population. The board of directors of the state health insurance pool shall submit a report of its findings and recommendations to each member of the general assembly no later than January 1, 2008.

376.1500. As used sections 376.1500 to 376.1532, the following words or phrases mean:

(1) "Director", the director of the department of insurance, financial and professional regulation;

(2) "Discount card", a card or any other purchasing mechanism or device, which is not insurance, that purports to offer discounts or access to discounts in health-related purchases from health care providers;

(3) "Discount medical plan", a business arrangement or contract in which a person, in exchange for fees, dues, charges, or other consideration, provides access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. The term does not include any product regulated as an insurance product, group health service product or membership in a health maintenance organization in this state or discounts provided by an insurer, group health service, or health maintenance organizations where those discounts are provided at no cost to the insured or member and are offered due to coverage with a licensed insurer, group health service, or health maintenance organization. The term does not include an arrangement where the discounts or prices are sold, rented, or otherwise provided to another licensed carrier, self-insured or self-funded employer sponsored plan, Taft-Hartley trust, or licensed third party administrator;

(4) "Discount medical plan organization", a person or an entity that operates a discount medical plan;

(5) "Health care provider", any person or entity licensed by this state to provide health care services including, but not limited to physicians, hospitals, home health agencies, pharmacies, and dentists;

(6) "Health care provider network", an entity which directly contracts with physicians and hospitals and has contractual rights to negotiate on behalf of those health care providers with a discount medical plan organization to provide medical services to members of the discount medical plan organization;

(7) "Marketer", a person or entity who markets, promotes, sells or distributes a discount medical plan, including a private label entity that places its name on and markets or distributes a discount medical plan but does not operate a discount medical plan;

(8) "Medical services", any care, service or treatment of illness or dysfunction of, or injury to, the human body including, but not limited to, physician care, inpatient care, hospital surgical services, emergency services, ambulance services, dental care services, vision care services, mental health services, substance abuse services, chiropractic services, podiatric care services, laboratory services, and medical equipment and supplies. The term does not include pharmaceutical supplies or prescriptions;

(9) "Member", any person who pays fees, dues, charges, or other consideration for the right to receive the purported benefits of a discount medical plan; and

(10) "Person", an individual, corporation, business trust, estate, trust, partnership, association, joint venture, limited liability company, or any other government or commercial entity.

376.1502. 1. It is unlawful to transact business in this state as a discount medical plan organization, unless the organization is a corporation, limited liability corporation, partnership, limited liability partnership or other legal entity organized under the laws of this state or, if a foreign entity, authorized to transact business in this state, and is registered as a discount medical plan organization with the director or duly authorized by the director as an insurance company, licensed health maintenance organization, licensed group health service organization, or third party administrator.

2. An individual person, employee, or agent of a registered entity described in subsection 1 of this section may also transact business in this state on behalf of such entity.

376.1504. 1. To register as a discount medical plan organization, an applicant shall:

(1) File with the director an application on a form approved and adopted by the director; and

(2) Pay to the director an application fee of two hundred fifty dollars.

2. A registration is valid for a one-year term and expires one year following the registration date unless it is renewed as provided in this section.

3. Before it expires, a registrant may renew the registration for an additional one-year term if the registrant:

(1) Otherwise is qualified to receive a registration;

(2) Files with the director a renewal application on a form approved and adopted by the director; and

(3) Pays a renewal fee of two hundred fifty dollars.

4. All amounts collected as registration or renewal fees shall be deposited into the insurance dedicated fund.

5. Nothing in this subsection shall require a provider who provides discounts to his or her own patients to obtain and maintain a registration as a discount medical plan organization.

376.1506. 1. If the director has a reason to believe that the discount medical plan organization is not complying with the requirements of sections 376.1500 to 376.1532, the director may examine or investigate the business and affairs of any discount medical plan organization under the authority of sections 374.190 and 374.202 to 374.207, RSMo. The director may require any discount medical plan organization or applicant to produce any

records, books, files, advertising and solicitation materials, or other information and may take statements under oath to determine whether the discount medical plan organization or applicant is in violation of the law. Reasonable expenses incurred in conducting any examination shall be paid by the discount medical plan organization under sections 374.202 to 374.207, RSMo.

2. Failure by the discount medical plan organization to pay the expenses incurred under this subsection shall be grounds for denial or revocation of the discount medical plan organization's registration.

376.1508. 1. A discount medical plan organization may charge a reasonable one-time processing fee and a periodic charge as long as the fee is disclosed to the applicant.

2. If the member cancels the membership within the first thirty days after receipt of the discount card and other membership materials, the member shall receive a reimbursement of all periodic charges paid. The return of all periodic charges shall be made within thirty days of the date of the cancellation. If all of the periodic charges have not been paid within thirty days, interest shall be assessed and paid on the proceeds at a rate of the treasury bill rate of the preceding calendar year, plus two percentage points.

3. The right of cancellation shall be set out in the written membership materials on the first page, in ten-point type or larger.

4. If a discount medical plan organization cancels a membership for any reason other than nonpayment of charges by the member, the discount medical plan organization shall make a pro rata reimbursement of all periodic charges to the member.

376.1510. A discount medical plan organization shall not:

(1) Use in its advertisements, marketing material, brochures, and discount cards the terms "health plan", "coverage", "copay", "copayments", "preexisting conditions", "guaranteed issue", "premium", "PPO", "preferred provider organization", or other terms in a manner that could reasonably mislead a person to believe that the discount medical plan is health insurance;

(2) Except for hospital services, have restrictions on free access to plan providers including waiting periods and notification periods;

(3) Pay providers any fees for medical services;

(4) Collect or accept money from a member for payment to a provider for specific medical services furnished or to be furnished to the member, unless the organization is licensed by the director to act as an administrator;

(5) Except as otherwise provided in sections 376.1500 to 376.1532, as a disclaimer of any relationship between discount medical plan benefits and insurance, or as a

description of an insurance product connected with a discount medical plan, use in its advertisements, marketing material, brochures, and discount cards the term "insurance".

376.1512. 1. The following disclosures, to be printed in bold and in not less than twelve-point type, shall be made in writing to any prospective member and shall appear on the first page of any advertisements, marketing materials or brochures relating to a discount medical plan:

(1) The plan is not insurance;

(2) The plan provides discounts with certain health care providers for medical services;

(3) The plan does not make payments directly to the providers of medical services;

(4) The plan member is obligated to pay for all health care services but will receive a discount from those health care providers who have contracted with the discount plan organization; and

(5) The name and the location of the registered discount medical plan organization, including the current telephone number of the registered discount medical plan organization or other entity responsible for customer service for the plan, if different from the registered discount medical plan organization.

2. If the discount medical plan is sold, marketed, or solicited by telephone, the disclosures required by this section shall be made orally and provided in the initial written materials that describe the benefits under the discount medical plan provided to the prospective or new member.

3. Each discount card or any other plan identifier issued to a plan member shall state in bold and prominent type on the front face of the card that "THIS IS NOT INSURANCE".

376.1514. 1. All providers offering medical services to members under a discount medical plan shall provide such services pursuant to a written agreement. The agreement may be entered into directly by the health care provider or by a health care provider network to which the provider belongs if the provider network has contracts with the health care provider that allow the provider network to contract on behalf of the health care provider.

2. A health care provider agreement shall provide the following:

(1) A description of the services and products to be provided at a discount;

(2) The amount or amounts of the discounts or, alternatively, a fee schedule which reflects the health care provider's discounted rates; and

(3) A provision that the health care provider will not charge members more than the discounted rates.

3. A health care provider agreement with a health care provider network shall require that the health care provider network have written agreements with its health care providers that:

(1) Contain the terms described in this subsection;

(2) Authorize the health care provider network to contract with the discount medical plan organization on behalf of the provider; and

(3) Require the network to maintain an up-to-date list of its contracted health care providers and to provide that list on a quarterly basis to the discount medical plan organization.

4. A health care provider agreement between a discount medical plan organization and an entity that contracts with a health care provider network shall require that the entity, in its contract with the health care provider network, require the health care provider network to have written agreements with its providers that comply with subsection 3 of this section.

5. The discount medical plan organization shall maintain a copy of each active health care provider agreement into which it has entered.

376.1516. 1. Each benefit under the discount medical plan and every disclosure required under sections 376.1500 to 376.1532, shall be included in the written membership materials between the discount medical plan organization and the member. The written membership materials shall also include a statement notifying the members of their right to cancel under section 376.1508, and such materials shall also list all of the disclosures required by section 376.1512.

2. All forms used, including written membership materials, shall be filed with the director prior to any sale, marketing or advertising of the discount medical plan in this state. Every form filed shall be identified by a unique form number placed in the lower left corner of each form. A filing fee of twenty-five dollars per form shall be payable to the director for deposit into the insurance dedicated fund.

376.1518. 1. Each discount medical plan organization registered pursuant to sections 376.1500 to 376.1532, shall at all times maintain a net worth of at least one hundred fifty thousand dollars.

2. The director may not allow a registration unless the discount medical plan organization has a net worth of at least one hundred fifty thousand dollars.

376.1520. Each discount medical plan organization required to be registered pursuant to this section shall provide the director at least thirty days' advance notice of any change in the discount medical plan organization's name, address, principal business address, or mailing address.

376.1522. Each discount medical plan organization shall maintain a current list of the names and addresses of the providers with which it has contracted on a web site page, the address of which shall be prominently displayed on all its advertisements, marketing materials, brochures, and discount cards. This section applies to those providers with whom the discount medical plan organization has contracted directly, as well as those who are members of a provider network with which the discount medical plan organization has contracted.

376.1524. 1. All advertisements, marketing materials, brochures and discount cards used by marketers shall be approved in writing for such use by the discount medical plan organization.

2. The discount medical plan organization shall have an executed written agreement with a marketer prior to the marketer's marketing, promoting, selling, or distributing the discount medical plan.

376.1528. The director under the provisions of section 374.045, RSMo, may promulgate rules to administer and interpret the provisions of sections 376.1500 to 376.1532.

376.1530. 1. The director may deny a registration to an applicant or refuse to renew, suspend, or revoke the registration of a registrant if the applicant or registrant, or an officer, director, or employee of the applicant or registrant:

(1) Makes a material misstatement or misrepresentation in an application for registration;

(2) Fraudulently or deceptively obtains or attempts to obtain a registration for the applicant or registrant or for another;

(3) Has advertised, merchandised or attempted to merchandise its services in such a manner as to misrepresent its services or capacity for service or has engaged in deceptive, misleading or unfair practices with respect to advertising or merchandising;

(4) In connection with the advertisement, offer, sale or administration of a health care discount program, makes any untrue statement of material fact, conceals any material fact, uses any deception or commits fraud or engages in any dishonest activity;

(5) Is not fulfilling its obligations as a discount medical plan organization;

(6) Does not have the minimum net worth as required by sections 376.1500 to 376.1532; or

(7) Violates any provision of sections 376.1500 to 376.1532, or any law or regulation of this state relating to insurance or the provision of medical care.

2. If the director has cause to believe that grounds for the suspension or revocation of a registration exist, the director shall notify the discount medical plan organization in

writing, specifically stating the grounds for suspension or revocation, and shall provide opportunity for a hearing on the matter before the director.

3. When the registration of a discount medical plan organization is surrendered or revoked, such organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs transacted under the registration. The organization may not engage in any further advertising, solicitation, collecting of fees, or renewal of contracts.

376.1532. 1. If the director determines that a person has engaged, is engaging, or has taken a substantial step toward engaging in a violation of sections 376.1500 to 376.1532, or a rule adopted or order issued pursuant thereto, or that a person has materially aided or is materially aiding an act, practice, omission, or course of business constituting a violation of sections 376.1500 to 376.1532 or a rule adopted or order issued pursuant thereto, the director may issue such administrative orders as authorized under section 374.046, RSMo. A violation of sections 376.1500 to 376.1532 is a level two violation under section 374.049, RSMo. The director of insurance may also suspend or revoke the license or certificate of authority of such person for any willful violation.

2. If the director believes that a person has engaged, is engaging, or has taken a substantial step toward engaging in a violation of sections 376.1500 to 376.1532 or a rule adopted or order issued pursuant thereto, or that a person has materially aided or is materially aiding an act, practice, omission or course of business constituting a violation of sections 376.1500 to 376.1532 or a rule adopted or order issued pursuant thereto, the director may maintain a civil action for relief authorized under section 374.048, RSMo. A violation of sections 376.1500 to 376.1532 is a level two violation under section 374.049, RSMo.

376.1750. 1. The provisions of this chapter relating to health insurance, health maintenance organizations, health benefit plans, group health services, and health carriers shall not apply to a health care sharing ministry. A health care sharing ministry which, through its publication to members or subscribers, solicits funds for the payment of medical expenses of other subscribers or members, shall not be considered to be engaging in the business of insurance for purposes of this chapter or any provision of Title XXIV, RSMo, and shall not be subject to the jurisdiction of the director if the requirements of subsection 2 of this section are met.

2. As used in this section, a "health care sharing ministry" is a faith based non-profit organization tax exempt under the Internal Revenue Code that:

(1) Limits its membership to those who are of a similar faith;

(2) Acts as an organizational clearinghouse for information between members or subscribers who have financial, physical, or medical needs and members or subscribers with the present ability to assist those with present financial or medical needs;

(3) Provides for the financial or medical needs of a member or subscriber through gifts directly from one member or subscriber to another. The requirements of this subdivision can be satisfied by a trust established solely for the benefit of members or subscribers, which trust is audited annually by an independent auditing firm;

(4) Provides amounts that members or subscribers may give with no assumption of risk or promise to pay either among the members or subscribers or between the members or subscribers and such organization;

(5) Provides a written monthly statement to all members or subscribers, listing the total dollar amount of qualified needs submitted to such organization, as well as the amount actually published or assigned to members or subscribers for voluntary payment; and

(6) Provides the following written disclaimer on or accompanying all promotional or informational documents distributed by or on behalf of the organization, including applications, and guideline materials.

"NOTICE

This publication is not an insurance company nor is it offered through an insurance company. Whether anyone chooses to assist you with your medical bills will be totally voluntary, as no other subscriber or member will be compelled to contribute toward your medical bills. As such, this publication should never be considered to be insurance. Whether you receive any payments for medical expenses and whether or not this publication continues to operate, you are always personally responsible for the payment of your own medical bills.".

376.1753. Notwithstanding any law to the contrary, any person who holds current ministerial or tocological certification by an organization accredited by the National Organization for Competency Assurance (NOCA) may provide services as defined in 42 U.S.C. 1396 r-6(b)(4)(E)(ii)(I).

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

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

(1) "Actuarial certification" **[**means**] ,** a written statement by a member of the American Academy of Actuaries or other individual acceptable to the director that a small employer carrier is in compliance with the provisions of section 379.936, based upon the person's examination,

including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. A group health plan;

b. Health insurance coverage;

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

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

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

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

g. A state health benefits risk pool;

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

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

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

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

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

(14) "Director" **[**means**] ,** the director of the department of insurance**, financial institutions and professional registration** of this state;

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

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

(17) **"Excepted benefits":**

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

(b) Coverage only for disability income insurance;

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

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

(e) Workers' compensation or similar insurance;

(f) Automobile medical payment insurance;

(g) Credit-only insurance;

(h) Coverage for onsite medical clinics;

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

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

a. Limited scope dental or vision benefits;

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

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

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

a. Coverage only for a specified disease or illness;

b. Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

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

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

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

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

(a) Health status;

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

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information;

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

(h) Disability;

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

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

(a) The individual meets each of the following:

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

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

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

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

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

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

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

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

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

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

[(20)**] (26)** "New business premium rate" **[**means**]**, for each class of business as to a rating period, the lowest premium rate charged or offered, or which could have been charged or

offered, by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage;

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

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

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

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

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

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

(a) Medicare or Medicaid;

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

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

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

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

[(28)**] (34)** "Small employer" **[**means**] , in connection with a group health plan with respect to a calendar year and a plan year,** any person, firm, corporation, partnership **[**or**] ,** association**, or political subdivision** that is actively engaged in business that**[**, on at least fifty percent of its working days during the preceding calendar quarter, employed not less than three nor**] employed an average of at least two but no** more than **[**twenty-five**] fifty** eligible employees**[**, the majority of whom were employed within this state. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer**] on**

business days during the preceding calendar year and that employs at least two employees on the first day of the plan year. All persons treated as a single employer under subsection (b), (c), (m) or (o) of Section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining continued eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, the provisions of sections 379.930 to 379.952 that apply to a small employer shall continue to apply at least until the plan anniversary following the date the small employer no longer meets the requirements of this definition. In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected that the employer will employ on business days in the current calendar year. Any reference in sections 379.930 to 379.952 to an employer shall include a reference to any predecessor of such employer;

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

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

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

379.936. 1. Premium rates for health benefit plans subject to sections 379.930 to 379.952 shall be subject to the following provisions:

(1) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent;

(2) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to such employers under the rating system for that class of business shall not vary from the index rate by more than **[**twenty-five**] thirty-five** percent of the index rate;

(3) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for

the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;

(b) Any adjustment, not to exceed fifteen percent annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business; and

(c) Any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual for the class of business;

(4) Adjustments in rates for claim experience, health status and duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer;

(5) Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any assessments paid or payable by small employer carriers pursuant to sections 379.942 and 379.943;

(6) A small employer carrier may utilize the employer's industry as a case characteristic in establishing premium rates, provided that the rate factor associated with any industry classification shall not vary by more than ten percent from the arithmetic mean of the highest and lowest rate factors associated with all industry classifications;

(7) In the case of health benefit plans issued prior to July 1, 1993, a premium rate for a rating period may exceed the ranges set forth in subdivisions (1) and (2) of this subsection for a period of three years following July 1, 1993. In such case, the percentage increase in the premium rate charged to a small employer for a new rating period shall not exceed the sum of the following:

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;

(b) Any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the carrier's rate manual for the class of business;

(8) (a) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups which differ only by amounts attributable to plan design

and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans;

(b) A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period;

(9) For the purposes of this subsection, a health benefit plan that utilizes a restricted provider network shall not be considered similar coverage to a health benefit plan that does not utilize such a network, provided that utilization of the restricted provider network results in substantial differences in claims costs;

(10) A small employer carrier shall not use case characteristics, other than age, sex, industry, geographic area, family composition, and group size without prior approval of the director;

(11) The director may promulgate rules to implement the provisions of this section and to assure that rating practices used by small employer carriers are consistent with the purposes of sections 379.930 to 379.952, including:

(a) Assuring that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans; and

(b) Prescribing the manner in which case characteristics may be used by small employer carriers.

2. A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage.

3. The director may suspend for a specified period the application of subdivision (1) of subsection 1 of this section as to the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the director either that the suspension is reasonable in light of the financial condition of the small employer carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

4. In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

(1) The extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or actual or expected variation in health status of the employees of the small employer and their dependents;

(2) The provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and factors, other than claim experience, that affect changes in premium rates;

(3) The provisions relating to renewability of policies and contracts; and

(4) The provisions relating to any preexisting condition provision.

5. (1) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(2) Each small employer carrier shall file with the director annually on or before March fifteenth an actuarial certification certifying that the carrier is in compliance with sections 379.930 to 379.952 and that the rating methods of the small employer carrier are actuarially sound. Such certification shall be in a form and manner, and shall contain such information, as specified by the director. A copy of the certification shall be retained by the small employer carrier at its principal place of business.

(3) A small employer carrier shall make the information and documentation described in subdivision (1) of this section available to the director upon request.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) An eligible employee may choose to retain their individually underwritten health benefit plan at the time such eligible employee is entitled to enroll in a small employer health benefit plan. If the eligible employee retains their individually underwritten health benefit plan, a small employer may provide a defined contribution through the establishment of a cafeteria 125 plan under section 379.953. Small employers shall establish an equal amount of defined contribution for all plans. If an eligible employee retains their individually underwritten health benefit plan under this subdivision, the provisions of sections 379.930 to 379.952, RSMo, shall not apply to the individually underwritten health benefit plan.

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

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

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

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

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

which the carrier notifies the director that it has regained capacity to deliver services to small employer groups.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[379.942. 1. There is hereby created a nonprofit entity to be known as the "Missouri Small Employer Health Reinsurance Program". All small employer carriers shall participate in the program as reinsuring carriers for a minimum of three years beginning July 1, 1993. After the expiration of such

three years, a small employer carrier may apply to the director to opt out of the program. The director shall decide whether to grant such an application to opt out, and shall consider in making such determination only: the carrier's financial condition and the financial condition of its guaranteeing or reinsuring corporation, if any; its history of assuming and managing risk; its ability to assume and manage the risk of enrolling small employers without the protection of the program; and its commitment to market fairly to all small employers in its service area. If the director grants such application, the small employer carrier shall participate in the program neither as a ceding nor reinsuring carrier.

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

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

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

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

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

3. Within sixty days of July 1, 1993, each small employer carrier shall make a filing with the director containing the carrier's net health insurance

premium derived from health benefit plans delivered or issued for delivery to small employers in this state in the previous calendar year.**]**

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

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

3. The plan of operation shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The board annually shall adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and

utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the Consumer Price Index for All Urban Consumers of the federal Department of Labor, Bureau of Labor Statistics, unless the board proposes and the director approves a lower adjustment factor.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount

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

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

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

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

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

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

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

(4) If assessments exceed net losses of the program, the excess shall be held at interest and used by the board to offset future losses or to reduce program

premiums. As used in this paragraph, "future losses" includes reserves for incurred but not reported claims.

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

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

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

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

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

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

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

manner and for the same purposes as other assessments pursuant to section 379.942 and this section.

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

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

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

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

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

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

3. The committee shall recommend benefit levels, cost sharing levels, exclusions and limitations for the basic health benefit plan and the standard health benefit plan. The committee shall also design a basic health benefit plan and a standard health benefit plan which contain benefit and cost sharing levels that are consistent with the basic method of operation and the benefit plans of health maintenance organizations, including any restrictions imposed by federal law.

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

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

(b) Case management;

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

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

(e) Other managed care provisions.

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

Section B. The provisions of sections 143.782, 143.790, 313.321, 354.536, 376.392, 376.426, 376.450, 376.451, 376.452, 376.453, 376.454, 376.776, 376.960, 376.964, 376.966, 376.986, 376.987, 376.989, 376.1500, 376.1502, 376.1504, 376.1506, 376.1508, 376.1510, 376.1512, 376.1514, 376.1516, 376.1518, 376.1520, 376.1522, 376.1524, 376.1528, 376.1530, 376.1532, 379.930, 379.936, 379.938, 379.940, and 379.952 of this act shall become effective January 1, 2008.

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