FIRST REGULAR SESSION

HOUSE BILL NO. 1071

94TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES PAGE (Sponsor), BURNETT, HUGHES, FALLERT, BRINGER, DARROUGH, SCHOEMEHL, NORR, YAEGER, SCAVUZZO, HARRIS (110) AND SCHIEFFER (Co-sponsors).

Read 1st time March 6, 2007 and copies ordered printed.

D. ADAM CRUMBLISS, Chief Clerk

2590L.01I

AN ACT

To repeal sections 67.210, 103.083, 354.095, 376.424, and 376.426, RSMo, and to enact in lieu thereof five new sections relating to health insurance benefits for dependents.

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

Section A. Sections 67.210, 103.083, 354.095, 376.424, and 376.426, RSMo, are repealed and five new sections enacted in lieu thereof, to be known as sections 67.210, 103.083, 354.095, 376.424, and 376.426, to read as follows:

67.210. Any political subdivision which provides or pays for health insurance benefits for its officers and employees may also provide or pay for all or part of such benefits, as may be determined by the governing body of the political subdivision, for the dependents of its officers and employees, and for retired officers and employees and their dependents and the dependents of deceased officers and employees of the political subdivision. **If a political subdivision provides or pays for all or part of the health insurance benefits for the dependents of its officers and employees, such benefits for a dependent child with chronic illnesses or conditions shall continue until such child attains the age twenty-five or marries, whichever first occurs.**

103.083. **1.** The board shall provide or contract, or both, on its own behalf, for medical benefits coverage and services for persons covered under sections 103.003 to 103.175 and enrolled in the plan. The board may contract for medical benefits coverage with alternative

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.

delivery health care programs where available. Medical expenses shall also include expenses for comparable benefits for employees who rely solely on spiritual means through prayer for healing.

2. If the board provides or contracts for medical benefits coverage and services for the dependents of the officers, employees, and retirees of the state and members agencies of the state, such benefits for dependent children with chronic illnesses or conditions shall continue until a dependent child attains the age twenty-five or marries, whichever first occurs.

354.095. 1. A corporation subject to the provisions of sections 354.010 to 354.380 may, in the discretion of its board of directors, limit or define the classes of persons who shall be eligible to become members or beneficiaries, limit and define the benefits which it will furnish, and may define such benefits as it undertakes to furnish into classes or kinds. It may make available to its members or beneficiaries such health services, or reimbursement therefor, as the board of directors of any such corporation may approve; **except that:**

(1) If maternity benefits are provided to any members of any plan, then maternity benefits shall be provided to any member of such plan without discrimination as to whether the member is married or unmarried, and if maternity benefits are provided to a beneficiary of any plan, then maternity benefits shall be provided to such beneficiary of such plan without discrimination as to whether the beneficiary is married or unmarried**; and**

(2) If benefits are provided to the dependents of any members of any plan, such dependent benefits for children with chronic illnesses or conditions shall continue until such child attains the age twenty-five or marries, whichever first occurs.

2. If an ambulatory surgical facility as defined by subdivision (1) of section 197.200, RSMo, has received a certificate of need as provided in chapter 197, RSMo, a health services corporation shall provide benefits to the facility on the same basis as it does to all other health care facilities, whether contracting members or noncontracting members. A health services corporation shall use the same standards that are applied to any other health care facility within the same health services area in defining the benefits that the corporation will furnish to the ambulatory surgical facility, the classes to which such benefits will be furnished, and the amount of reimbursement.

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

(1) **If a policy is extended to insure dependents, coverage for a dependent child with a chronic illness or condition shall continue until such child attains the age twenty-five or marries, whichever first occurs;**

(2) The premium for the insurance shall be paid either from funds contributed by the employer, union, association or other person to whom the policy has been issued or from funds contributed by the covered persons, or from both. Except as provided in subdivision **[**(2)**] (3)** of this section, a policy on which no part of the premium for the family members' or dependents' coverage is to be derived from funds contributed by the covered persons must insure all eligible employees or members with respect to their family members or dependents, or any class or classes thereof;

[(2)**] (3)** An insurer may exclude or limit the coverage on any family member or dependent as to whom evidence of individual insurability is not satisfactory to the insurer, subject to sections 376.406 and 376.776 in a policy insuring fewer than ten employees or members and in a policy insuring ten or more employees or members if:

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

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

c. After the expiration of an open enrollment period during which the family member or dependent could have been enrolled for the insurance or could have been enrolled for another level of benefits under the policy.

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**] for dependent children**, such policy, so long as it remains in force, shall be deemed to provide **such coverage until a dependent child with a chronic illness or condition attains the age of twenty-five or marries, whichever first occurs, and** that attainment of **[**such limiting**] the** age **of twenty-five** does not operate to terminate the hospital and medical coverage of such child while the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the policyholder for support and

maintenance. Proof of such incapacity and dependency must be furnished to the insurer by the policyholder at least thirty-one days before the child's attainment of **[**the limiting**]** age **twenty-five**. The insurer may require at reasonable intervals during the two years following the child's attainment of **[**the limiting**]** age **twenty-five** 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**] January 1, 2008**;

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

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