

SECOND REGULAR SESSION
HOUSE COMMITTEE SUBSTITUTE FOR
SENATE COMMITTEE SUBSTITUTE FOR
SENATE BILL NO. 1008
94TH GENERAL ASSEMBLY

Reported from the Special Committee on Health Insurance April 10, 2008 with recommendation that House Committee Substitute for Senate Committee Substitute for Senate Bill No. 1008 Do Pass by Consent. Referred to the Committee on Rules pursuant to Rule 25(21)(f).

D. ADAM CRUMBLISS, Chief Clerk

4529L.08C

AN ACT

To repeal sections 354.536, 376.426, 376.450, 376.453, 376.776, 376.960, 376.966, 379.118, 379.930, 379.940, and 379.952, RSMo, and to enact in lieu thereof thirteen new sections relating to health insurance.

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

Section A. Sections 354.536, 376.426, 376.450, 376.453, 376.776, 376.960, 376.966, 2 379.118, 379.930, 379.940, and 379.952, RSMo, are repealed and thirteen new sections enacted 3 in lieu thereof, to be known as sections 354.536, 374.056, 374.057, 376.426, 376.450, 376.453, 4 376.776, 376.960, 376.966, 379.118, 379.930, 379.940, and 379.952, to read as follows:

354.536. 1. If a health maintenance organization plan provides that coverage of a 2 dependent child terminates upon attainment of the limiting age for dependent children, such 3 coverage shall continue while the child is and continues to be both incapable of self-sustaining 4 employment by reason of mental or physical handicap and chiefly dependent upon the enrollee 5 for support and maintenance. Proof of such incapacity and dependency must be furnished to the 6 health maintenance organization by the enrollee [at least] **within** thirty-one days after the child's 7 attainment of the limiting age. The health maintenance organization may require at reasonable 8 intervals during the two years following the child's attainment of the limiting age subsequent 9 proof of the child's disability and dependency. After such two-year period, the health 10 maintenance organization may require subsequent proof not more than once each year.

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.

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

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

18 (2) A resident of this state; and

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

374.056. Except as limited by section 375.922, RSMo, the director may promulgate
2 **rules establishing the specific type of delivery method for submissions of rate and form**
3 **filings, rules, license applications, including materials requested in the course of a financial**
4 **or market conduct examination, which are required to be submitted to the department**
5 **under state law. Types of delivery methods shall be web-based interface systems such as**
6 **the System for Electronic Rate Form Filing (SERFF), the National Insurance Producer**
7 **Registry (NIPR), and the National Association of Insurance Commissioners' Internet-State**
8 **Interface Technology Enhancement (I-SITE). Such rules may only apply to insurance**
9 **companies, producers, health maintenance organizations, and any other person or entity**
10 **regulated by the department under this chapter, and chapters 325, 354, and 375 to 385,**
11 **RSMo, or a rule adopted thereunder. Any rule or portion of a rule, as that term is defined**
12 **in section 536.010, RSMo, that is created under the authority delegated in this section shall**
13 **become effective only if it complies with and is subject to all of the provisions of chapter**
14 **536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536,**
15 **RSMo, are nonseverable and if any of the powers vested with the general assembly**
16 **pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and**
17 **annul a rule are subsequently held unconstitutional, then the grant of rulemaking**
18 **authority and any rule proposed or adopted after August 28, 2008, shall be invalid and**
19 **void.**

374.057. The filing of records and signatures is authorized, when specified under
2 **this chapter, or chapters 325, 354, and 375 to 385, RSMo, or a rule adopted thereunder,**
3 **when carried out in a manner consistent with Section 104(a) of the federal Electronic**
4 **Signatures in Global and National Commerce Act, 15 U.S.C. Section 7004(a). This section**
5 **modifies, limits, and supersedes the federal Electronic Signatures in Global and National**
6 **Commerce Act, but does not modify, limit, or supersede Section 101(c) of the federal**

7 **Electronic Signatures in Global and National Commerce Act, 15 U.S.C. Section 7001(c),**
8 **or authorize the electronic delivery of any of the notices described in Section 103(b) of the**
9 **federal Electronic Signatures in Global and National Commerce Act, 15 U.S.C. Section**
10 **7003(b).**

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

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

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

28 (3) A provision that a copy of the application, if any, of the policyholder shall be
29 attached to the policy when issued, that all statements made by the policyholder or by the persons
30 insured shall be deemed representations and not warranties and that no statement made by any
31 person insured shall be used in any contest unless a copy of the instrument containing the

32 statement is or has been furnished to such person or, in the event of the death or incapacity of
33 the insured person, to the individual's beneficiary or personal representative;

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

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

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

48 (b) The end of the [two-year] **eighteen-month** period commencing on the [effective]
49 **enrollment** date of the person's coverage **in the case of a late enrollee;**

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

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

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

63 (9) A provision that the insurer shall furnish to the person making claim, or to the
64 policyholder for delivery to such person, such forms as are usually furnished by it for filing proof
65 of loss. If such forms are not furnished before the expiration of fifteen days after the insurer
66 receives notice of any claim under the policy, the person making such claim shall be deemed to
67 have complied with the requirements of the policy as to proof of loss upon submitting, within

68 the time fixed in the policy for filing proof of loss, written proof covering the occurrence,
69 character, and extent of the loss for which claim is made;

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

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

86 (12) A provision that benefits for accidental loss of life of a person insured shall be
87 payable to the beneficiary designated by the person insured or, if the policy contains conditions
88 pertaining to family status, the beneficiary may be the family member specified by the policy
89 terms. In either case, payment of these benefits is subject to the provisions of the policy in the
90 event no such designated or specified beneficiary is living at the death of the person insured. All
91 other benefits of the policy shall be payable to the person insured. The policy may also provide
92 that if any benefit is payable to the estate of a person, or to a person who is a minor or otherwise
93 not competent to give a valid release, the insurer may pay such benefit, up to an amount not
94 exceeding two thousand dollars, to any relative by blood or connection by marriage of such
95 person who is deemed by the insurer to be equitably entitled thereto;

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

101 (14) A provision that no action at law or in equity shall be brought to recover on the
102 policy prior to the expiration of sixty days after proof of loss has been filed in accordance with
103 the requirements of the policy and that no such action shall be brought at all unless brought

104 within three years from the expiration of the time within which proof of loss is required by the
105 policy;

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

114 (16) A provision stating that if a policy provides that coverage of a dependent child
115 terminates upon attainment of the limiting age for dependent children specified in the policy,
116 such policy, so long as it remains in force, shall be deemed to provide that attainment of such
117 limiting age does not operate to terminate the hospital and medical coverage of such child while
118 the child is and continues to be both incapable of self-sustaining employment by reason of
119 mental or physical handicap and chiefly dependent upon the certificate holder for support and
120 maintenance. Proof of such incapacity and dependency must be furnished to the insurer by the
121 certificate holder [at least] **within** thirty-one days after the child's attainment of the limiting age.
122 The insurer may require at reasonable intervals during the two years following the child's
123 attainment of the limiting age subsequent proof of the child's incapacity and dependency. After
124 such two-year period, the insurer may require subsequent proof not more than once each year.
125 This subdivision shall apply only to policies delivered or issued for delivery in this state on or
126 after one hundred twenty days after September 28, 1985;

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

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

133 (b) A resident of this state; and

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

137 (18) In the case of a policy insuring debtors, a provision that the insurer shall furnish to
138 the policyholder for delivery to each debtor insured under the policy a certificate of insurance

139 describing the coverage and specifying that the benefits payable shall first be applied to reduce
140 or extinguish the indebtedness.

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

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

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

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

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

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

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

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

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

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

27 (4) "COBRA continuation provision":

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

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

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

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

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

- 35 a. A group health plan;
36 b. Health insurance coverage;
37 c. Part A or Part B of Title XVIII of the Social Security Act;
38 d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits
39 under Section 1928 of such act;
40 e. Chapter 55 of Title 10, United States Code;
41 f. A medical care program of the Indian Health Service or of a tribal organization;
42 g. A state health benefits risk pool;
43 h. A health plan offered under Title 5, Chapter 89, of the United States Code;
44 i. A public health plan as defined in federal regulations authorized by Section
45 2701(c)(1)(I) of the Public Health Services Act, as amended by Public Law 104-191;
46 j. A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(3));
47 **k. Title XXI of the Social Security Act (SCHIP);**
48 (b) Creditable coverage does not include coverage consisting solely of excepted benefits;
49 (6) "Department", the Missouri department of insurance, financial institutions and
50 professional registration;
51 (7) "Director", the director of the Missouri department of insurance, financial institutions
52 and professional registration;
53 (8) "Enrollment date", with respect to an individual covered under a group health plan
54 or health insurance coverage, the date of enrollment of the individual in the plan or coverage or,
55 if earlier, the first day of the waiting period for such enrollment;
56 (9) "Excepted benefits":
57 (a) Coverage only for accident (including accidental death and dismemberment)
58 insurance;
59 (b) Coverage only for disability income insurance;
60 (c) Coverage issued as a supplement to liability insurance;
61 (d) Liability insurance, including general liability insurance and automobile liability
62 insurance;
63 (e) Workers' compensation or similar insurance;
64 (f) Automobile medical payment insurance;
65 (g) Credit-only insurance;
66 (h) Coverage for on-site medical clinics;
67 (i) Other similar insurance coverage, as approved by the director, under which benefits
68 for medical care are secondary or incidental to other insurance benefits;
69 (j) If provided under a separate policy, certificate or contract of insurance, any of the
70 following:

- 71 a. Limited scope dental or vision benefits;
- 72 b. Benefits for long-term care, nursing home care, home health care, community-based
- 73 care, or any combination thereof;
- 74 c. Other similar limited benefits as specified by the director;
- 75 (k) If provided under a separate policy, certificate or contract of insurance, any of the
- 76 following:
- 77 a. Coverage only for a specified disease or illness;
- 78 b. Hospital indemnity or other fixed indemnity insurance;
- 79 (l) If offered as a separate policy, certificate, or contract of insurance, any of the
- 80 following:
- 81 a. Medicare supplemental coverage (as defined under Section 1882(g)(1) of the Social
- 82 Security Act);
- 83 b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United
- 84 States Code;
- 85 c. Similar supplemental coverage provided to coverage under a group health plan;
- 86 (10) "Group health insurance coverage", health insurance coverage offered in connection
- 87 with a group health plan;
- 88 (11) "Group health plan", an employee welfare benefit plan as defined in Section 3(1)
- 89 of the Employee Retirement Income Security Act of 1974 and Public Law 104-191 to the extent
- 90 that the plan provides medical care, as defined in this section, and including any item or service
- 91 paid for as medical care to an employee or the employee's dependent, as defined under the terms
- 92 of the plan, directly or through insurance, reimbursement or otherwise, but not including
- 93 excepted benefits;
- 94 (12) "Health insurance coverage", or "health benefit plan" as defined in section 376.1350
- 95 and benefits consisting of medical care, including items and services paid for as medical care,
- 96 that are provided directly, through insurance, reimbursement, or otherwise under a policy,
- 97 certificate, membership contract, or health services agreement offered by a health insurance
- 98 issuer, but not including excepted benefits;
- 99 (13) "Health insurance issuer", "issuer", or "insurer", an insurance company, health
- 100 services corporation, fraternal benefit society, health maintenance organization, multiple
- 101 employer welfare arrangement specifically authorized to operate in the state of Missouri, or any
- 102 other entity providing a plan of health insurance or health benefits subject to state insurance
- 103 regulation;
- 104 (14) "Individual health insurance coverage", health insurance coverage offered to
- 105 individuals in the individual market, not including excepted benefits or short-term limited
- 106 duration insurance;

- 107 (15) "Individual market", the market for health insurance coverage offered to individuals
108 other than in connection with a group health plan;
- 109 (16) "Large employer", in connection with a group health plan, with respect to a calendar
110 year and a plan year, an employer who employed an average of at least fifty-one employees on
111 business days during the preceding calendar year and who employs at least two employees on
112 the first day of the plan year;
- 113 (17) "Large group market", the health insurance market under which individuals obtain
114 health insurance coverage directly or through any arrangement on behalf of themselves and their
115 dependents through a group health plan maintained by a large employer;
- 116 (18) "Late enrollee", a participant who enrolls in a group health plan other than during
117 the first period in which the individual is eligible to enroll under the plan, or a special enrollment
118 period under subsection 6 of this section;
- 119 (19) "Medical care", amounts paid for:
- 120 (a) The diagnosis, cure, mitigation, treatment, or prevention of disease or amounts paid
121 for the purpose of affecting any structure or function of the body;
- 122 (b) Transportation primarily for and essential to medical care referred to in paragraph
123 (a) of this subdivision; or
- 124 (c) Insurance covering medical care referred to in paragraphs (a) and (b) of this
125 subdivision;
- 126 (20) "Network plan", health insurance coverage offered by a health insurance issuer
127 under which the financing and delivery of medical care, including items and services paid for as
128 medical care, are provided, in whole or in part, through a defined set of providers under contract
129 with the issuer;
- 130 (21) "Participant", the same meaning given such term under Section 3(7) of the
131 Employer Retirement Income Security Act of 1974 and Public Law 104-191;
- 132 (22) "Plan sponsor", the same meaning given such term under Section 3(16)(B) of the
133 Employee Retirement Income Security Act of 1974;
- 134 (23) "Preexisting condition exclusion", with respect to coverage, a limitation or
135 exclusion of benefits relating to a condition based on the fact that the condition was present
136 before the date of enrollment for such coverage, whether or not any medical advice, diagnosis,
137 care, or treatment was recommended or received before such date. Genetic information shall not
138 be treated as a preexisting condition in the absence of a diagnosis of the condition related to such
139 information;
- 140 (24) "Public Law 104-191", the federal Health Insurance Portability and Accountability
141 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] **before coverage for an employee or dependent who is otherwise eligible to [be covered for benefits] enroll under the terms of [the] a group health plan can become effective. If an employee or dependent enrolls as a late enrollee or special enrollee, any period before such late or special enrollment is not a waiting period. If an individual seeks coverage in the individual market, a waiting period begins on the date the individual submits a substantially complete application for coverage and ends on:**

(a) If the application results in coverage, the date coverage begins;

(b) If the application does not result in coverage, the date on which the application is denied by the issuer or the date on which the offer of coverage lapses.

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;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 246 (3) The coverage becomes effective:
247 (a) In the case of marriage, not later than the first day of the first month beginning after
248 the date on which the completed request for enrollment is received;
249 (b) In the case of a dependent's birth, as of the date of birth; or
250 (c) In the case of a dependent's adoption or placement for adoption, the date of the
251 adoption or placement for adoption.
- 252 7. In the case of group health insurance coverage offered by a health maintenance
253 organization, the plan may provide for an affiliation period with respect to coverage through the
254 organization only if:
- 255 (1) No preexisting condition exclusion is imposed with respect to coverage through the
256 organization;
257 (2) The period is applied uniformly without regard to any health status-related factors;
258 (3) Such period does not exceed two months, or three months in the case of a late
259 enrollee;
260 (4) Such period begins on the enrollment date; and
261 (5) Such period runs concurrently with any waiting period.

376.453. 1. An employer that provides health insurance coverage for which any portion
2 of the premium is payable by the [employer] **employee** shall not provide such coverage unless
3 the employer has established a premium-only cafeteria plan as permitted under federal law, 26
4 U.S.C. Section 125 **or a health reimbursement arrangement as permitted under federal law,**
5 **26 U.S.C. Section 105.** The provisions of this subsection shall not apply to employers who offer
6 health insurance through any self-insured or self-funded group health benefit plan of any type
7 or description.

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

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

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

11 intervals during the two years following the child's attainment of the limiting age subsequent
12 proof of the child's disability and dependency. After such two-year period, the insurer may
13 require subsequent proof not more than once each year.

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

20 (1) Is a resident of this state;

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

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

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

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

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

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

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

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

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

9 a. A group health plan;

10 b. Health insurance coverage;

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

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

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

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

16 g. A state health benefits risk pool;

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

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

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

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

- 21 (5) "Department", the Missouri department of insurance, financial institutions and
22 professional registration;
- 23 (6) "Dependent", a resident spouse or resident unmarried child under the age of nineteen
24 years, a child who is a student under the age of twenty-five years and who is financially
25 dependent upon the parent, or a child of any age who is disabled and dependent upon the parent;
- 26 (7) "Director", the director of the Missouri department of insurance, financial institutions
27 and professional registration;
- 28 (8) "Excepted benefits":
- 29 (a) Coverage only for accident, including accidental death and dismemberment,
30 insurance;
- 31 (b) Coverage only for disability income insurance;
- 32 (c) Coverage issued as a supplement to liability insurance;
- 33 (d) Liability insurance, including general liability insurance and automobile liability
34 insurance;
- 35 (e) Workers' compensation or similar insurance;
- 36 (f) Automobile medical payment insurance;
- 37 (g) Credit-only insurance;
- 38 (h) Coverage for on-site medical clinics;
- 39 (i) Other similar insurance coverage, as approved by the director, under which benefits
40 for medical care are secondary or incidental to other insurance benefits;
- 41 (j) If provided under a separate policy, certificate or contract of insurance, any of the
42 following:
- 43 a. Limited scope dental or vision benefits;
- 44 b. Benefits for long-term care, nursing home care, home health care, community-based
45 care, or any combination thereof;
- 46 c. Other similar, limited benefits as specified by the director;
- 47 (k) If provided under a separate policy, certificate or contract of insurance, any of the
48 following:
- 49 a. Coverage only for a specified disease or illness;
- 50 b. Hospital indemnity or other fixed indemnity insurance;
- 51 (l) If offered as a separate policy, certificate or contract of insurance, any of the
52 following:
- 53 a. Medicare supplemental coverage (as defined under Section 1882(g)(1) of the Social
54 Security Act);
- 55 b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United
56 States Code;

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

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

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

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

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

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

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

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

78 (12) "Health insurance", any hospital and medical expense incurred policy, nonprofit
79 health care service for benefits other than through an insurer, nonprofit health care service plan
80 contract, health maintenance organization subscriber contract, preferred provider arrangement
81 or contract, or any other similar contract or agreement for the provisions of health care benefits.
82 The term "health insurance" does not include accident, fixed indemnity, limited benefit or credit
83 insurance, coverage issued as a supplement to liability insurance, insurance arising out of a
84 workers' compensation or similar law, automobile medical-payment insurance, or insurance
85 under which benefits are payable with or without regard to fault and which is statutorily required
86 to be contained in any liability insurance policy or equivalent self-insurance;

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

90 (14) "Hospital", a place devoted primarily to the maintenance and operation of facilities
91 for the diagnosis, treatment or care for not less than twenty-four hours in any week of three or
92 more nonrelated individuals suffering from illness, disease, injury, deformity or other abnormal

93 physical condition; or a place devoted primarily to provide medical or nursing care for three or
94 more nonrelated individuals for not less than twenty-four hours in any week. The term "hospital"
95 does not include convalescent, nursing, shelter or boarding homes, as defined in chapter 198,
96 RSMo;

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

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

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

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

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

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

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

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

114 (20) "Member", all insurers and insurance arrangements participating in the pool;

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

117 (22) "Plan of operation", the plan of operation of the pool, including articles, bylaws and
118 operating rules, adopted by the board pursuant to the provisions of sections 376.961, 376.962 and
119 376.964;

120 (23) "Pool", the state health insurance pool created in sections 376.961, 376.962 and
121 376.964;

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

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

128 coverage. **As used in this subdivision, "waiting period" and "affiliation period" shall have**
129 **the same meaning as such terms are defined in section 376.450;**

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

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

5 2. The following individual persons shall be eligible for coverage under the pool if they
6 are and continue to be residents of this state:

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

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

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

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

14 (3) A trade act eligible individual;

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

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

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

23 (7) Any person whose premiums for health insurance coverage have increased above the
24 rate established by the board under paragraph (a) of subdivision (1) of subsection 3 of this
25 section;

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

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

31 (1) Persons who have, on the date of issue of coverage by the pool, or obtain coverage
32 under health insurance or an insurance arrangement substantially similar to or more

33 comprehensive than a plan policy, or would be eligible to have coverage if the person elected to
34 obtain it, except that:

35 (a) This exclusion shall not apply to a person who has such coverage but whose
36 premiums have increased to [one hundred fifty percent to] **beyond the eligibility limit set by**
37 **the board. The board shall not set the eligibility limit in excess of** two hundred percent of
38 rates established by the board as applicable for individual standard risks. After December 31,
39 2009, this exclusion shall not apply to a person who has such coverage but whose premiums have
40 increased to three hundred percent or more of rates established by the board as applicable for
41 individual standard risks;

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

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

47 **(d) Such exclusion shall not apply to a federally defined eligible individual;**

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

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

52 (4) Any person on whose behalf the pool has paid out [one] **two** million dollars in
53 benefits;

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

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

59 (7) Any person who is eligible for Medicare coverage.

60 4. Any person who ceases to meet the eligibility requirements of this section may be
61 terminated at the end of such person's policy period.

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

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

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

379.118. 1. If any insurer proposes to cancel or to refuse to renew a policy of automobile
2 insurance delivered or issued for delivery in this state except at the request of the named insured
3 or for nonpayment of premium, it shall, on or before thirty days prior to the proposed effective
4 date of the action, send written notice by certificate of mailing of its intended action to the named
5 insured at his last known address. The notice shall state:

6 (1) The proposed action to be taken;
7 (2) The proposed effective date of the action;
8 (3) The insurer's actual reason for proposing to take such action, the statement of reason
9 to be sufficiently clear and specific so that a person of average intelligence can identify the basis
10 for the insurer's decision without further inquiry. Generalized terms such as "personal habits",
11 "living conditions", "poor morals", or "violation or accident record" shall not suffice to meet the
12 requirements of this subdivision;

13 (4) That the insured may be eligible for insurance through the assigned risk plan if his
14 insurance is to be canceled.

15 2. An insurer shall send an insured written notice of an automobile policy renewal at
16 least fifteen days prior to the effective date of the new policy. The notice shall be sent by first
17 class mail **or may be sent electronically, if requested by the policyholder**, and shall contain
18 the insured's name, the vehicle covered, the total premium amount, and the effective date of the
19 new policy. **Any request for electronic delivery of renewal notices shall be designated on**
20 **the application form signed by the applicant, made in writing by the policyholder, or made**
21 **in accordance with sections 432.200 to 432.295, RSMo. The insurer shall comply with any**
22 **subsequent request by a policyholder to rescind authorization for electronic delivery and**
23 **to elect to receive renewal notices by first class mail. Any delivery of a renewal notice by**
24 **electronic means shall not constitute notice of cancellation of a policy even if such notice**
25 **is included with the renewal notice.**

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

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

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

- 9 (2) "Affiliate" or "affiliated", any entity or person who directly or indirectly through one
10 or more intermediaries, controls or is controlled by, or is under common control with, a specified
11 entity or person;
- 12 (3) "Base premium rate", for each class of business as to a rating period, the lowest
13 premium rate charged or that could have been charged under the rating system for that class of
14 business, by the small employer carrier to small employers with similar case characteristics for
15 health benefit plans with the same or similar coverage;
- 16 (4) "Board" [means] , the board of directors of the program established pursuant to
17 sections 379.942 and 379.943;
- 18 (5) "Bona fide association", an association which:
- 19 (a) Has been actively in existence for at least five years;
- 20 (b) Has been formed and maintained in good faith for purposes other than obtaining
21 insurance;
- 22 (c) Does not condition membership in the association on any health status-related factor
23 relating to an individual (including an employee of an employer or a dependent of an employee);
- 24 (d) Makes health insurance coverage offered through the association available to all
25 members regardless of any health status-related factor relating to such members (or individuals
26 eligible for coverage through a member);
- 27 (e) Does not make health insurance coverage offered through the association available
28 other than in connection with a member of the association; and
- 29 (f) Meets all other requirements for an association set forth in subdivision (5) of
30 subsection 1 of section 376.421, RSMo, that are not inconsistent with this subdivision;
- 31 (6) "Carrier" or "health insurance issuer", any entity that provides health insurance or
32 health benefits in this state. For the purposes of sections 379.930 to 379.952, carrier includes
33 an insurance company, health services corporation, fraternal benefit society, health maintenance
34 organization, multiple employer welfare arrangement specifically authorized to operate in the
35 state of Missouri, or any other entity providing a plan of health insurance or health benefits
36 subject to state insurance regulation;
- 37 (7) "Case characteristics", demographic or other objective characteristics of a small
38 employer that are considered by the small employer carrier in the determination of premium rates
39 for the small employer, provided that claim experience, health status and duration of coverage
40 since issue shall not be case characteristics for the purposes of sections 379.930 to 379.952;
- 41 (8) "Church plan", the meaning given such term in Section 3(33) of the Employee
42 Retirement Income Security Act of 1974;
- 43 (9) "Class of business", all or a separate grouping of small employers established
44 pursuant to section 379.934;

- 45 (10) "Committee", the health benefit plan committee created pursuant to section
46 379.944;
- 47 (11) "Control" shall be defined in manner consistent with chapter 382, RSMo;
- 48 (12) "Creditable coverage", with respect to an individual:
- 49 (a) Coverage of the individual under any of the following:
- 50 a. A group health plan;
- 51 b. Health insurance coverage;
- 52 c. Part A or Part B of Title XVIII of the Social Security Act;
- 53 d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits
54 under Section 1928 of such act;
- 55 e. Chapter 55 of Title 10, United States Code;
- 56 f. A medical care program of the Indian Health Service or of a tribal organization;
- 57 g. A state health benefits risk pool;
- 58 h. A health plan offered under Chapter 89 of Title 5, United States Code;
- 59 i. A public health plan, as defined in federal regulations authorized by Section
60 2701(c)(1)(I) of the Public Health Services Act, as amended by Public Law 104-191; and
- 61 j. A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e));
- 62 (b) Creditable coverage shall not include coverage consisting solely of excepted benefits;
- 63 (13) "Dependent", a spouse [or] ; an unmarried child [under the age of nineteen years;
64 an unmarried child who is a full-time student under the age of twenty-three years and who is
65 financially dependent upon the parent] **who is a resident of this state, is under the age of**
66 **twenty-five years, and is not provided coverage as a named subscriber, insured, enrollee,**
67 **or covered person under any group or individual health benefit plan, or entitled to benefits**
68 **under Title XVIII of the federal Social Security Act, 42 U.S.C. Section 1395, et seq.;** or an
69 unmarried child of any age who is medically certified as disabled and dependent upon the parent;
- 70 (14) "Director", the director of the department of insurance, financial institutions and
71 professional registration of this state;
- 72 (15) "Eligible employee", an employee who works on a full-time basis and has a normal
73 work week of thirty or more hours. The term includes a sole proprietor, a partner of a
74 partnership, and an independent contractor, if the sole proprietor, partner or independent
75 contractor is included as an employee under a health benefit plan of a small employer, but does
76 not include an employee who works on a part-time, temporary or substitute basis. For purposes
77 of sections 379.930 to 379.952, a person, his spouse and his minor children shall constitute only
78 one eligible employee when they are employed by the same small employer;

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

82 (17) "Excepted benefits":

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

85 (b) Coverage only for disability income insurance;

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

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

89 (e) Workers' compensation or similar insurance;

90 (f) Automobile medical payment insurance;

91 (g) Credit-only insurance;

92 (h) Coverage for on-site medical clinics;

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

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

97 a. Limited scope dental or vision benefits;

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

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

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

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

104 b. Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

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

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

120 (20) "Health benefit plan" or "health insurance coverage", benefits consisting of medical
121 care, including items and services paid for as medical care, that are provided directly, through
122 insurance, reimbursement, or otherwise, under a policy, certificate, membership contract, or
123 health services agreement offered by a health insurance issuer, but not including excepted
124 benefits or a policy that is individually underwritten;

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

126 (a) Health status;

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

128 (c) Claims experience;

129 (d) Receipt of health care;

130 (e) Medical history;

131 (f) Genetic information;

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

134 (h) Disability;

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

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

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

144 a. The individual was covered under creditable coverage at the time of the initial
145 enrollment;

146 b. The individual lost coverage under creditable coverage as a result of cessation of
147 employer contribution, termination of employment or eligibility, reduction in the number of
148 hours of employment, the involuntary termination of the creditable coverage, death of a spouse,
149 dissolution or legal separation;

- 150 c. The individual requests enrollment within thirty days after termination of the
151 creditable coverage;
- 152 (b) The individual is employed by an employer that offers multiple health benefit plans
153 and the individual elects a different plan during an open enrollment period; or
- 154 (c) A court has ordered coverage be provided for a spouse or minor or dependent child
155 under a covered employee's health benefit plan and request for enrollment is made within thirty
156 days after issuance of the court order;
- 157 (24) "Medical care", an amount paid for:
- 158 (a) The diagnosis, care, mitigation, treatment or prevention of disease, or for the purpose
159 of affecting any structure or function of the body;
- 160 (b) Transportation primarily for and essential to medical care referred to in paragraph
161 (a) of this subdivision; or
- 162 (c) Insurance covering medical care referred to in paragraphs (a) and (b) of this
163 subdivision;
- 164 (25) "Network plan", health insurance coverage offered by a health insurance issuer
165 under which the financing and delivery of medical care, including items and services paid for as
166 medical care, are provided, in whole or in part, through a defined set of providers under contract
167 with the issuer;
- 168 (26) "New business premium rate", for each class of business as to a rating period, the
169 lowest premium rate charged or offered, or which could have been charged or offered, by the
170 small employer carrier to small employers with similar case characteristics for newly issued
171 health benefit plans with the same or similar coverage;
- 172 (27) "Plan of operation", the plan of operation of the program established pursuant to
173 sections 379.942 and 379.943;
- 174 (28) "Plan sponsor", the meaning given such term under Section 3(16)(B) of the
175 Employee Retirement Income Security Act of 1974;
- 176 (29) "Premium", all moneys paid by a small employer and eligible employees as a
177 condition of receiving coverage from a small employer carrier, including any fees or other
178 contributions associated with the health benefit plan;
- 179 (30) "Producer", the meaning given such term in section 375.012, RSMo, and includes
180 an insurance agent or broker;
- 181 (31) "Program", the Missouri small employer health reinsurance program created
182 pursuant to sections 379.942 and 379.943;
- 183 (32) "Rating period", the calendar period for which premium rates established by a small
184 employer carrier are assumed to be in effect;

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

189 (34) "Small employer", in connection with a group health plan with respect to a calendar
190 year and a plan year, any person, firm, corporation, partnership, association, or political
191 subdivision that is actively engaged in business that employed an average of at least two but no
192 more than fifty eligible employees on business days during the preceding calendar year and that
193 employs at least two employees on the first day of the plan year. All persons treated as a single
194 employer under subsection (b), (c), (m) or (o) of Section 414 of the Internal Revenue Code of
195 1986 shall be treated as one employer. Subsequent to the issuance of a health plan to a small
196 employer and for the purpose of determining continued eligibility, the size of a small employer
197 shall be determined annually. Except as otherwise specifically provided, the provisions of
198 sections 379.930 to 379.952 that apply to a small employer shall continue to apply at least until
199 the plan anniversary following the date the small employer no longer meets the requirements of
200 this definition. In the case of an employer which was not in existence throughout the preceding
201 calendar year, the determination of whether the employer is a small or large employer shall be
202 based on the average number of employees that it is reasonably expected that the employer will
203 employ on business days in the current calendar year. Any reference in sections 379.930 to
204 379.952 to an employer shall include a reference to any predecessor of such employer;

205 (35) "Small employer carrier", a carrier that offers health benefit plans covering eligible
206 employees of one or more small employers in this state.

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

379.940. 1. (1) Every small employer carrier shall, as a condition of transacting
2 business in this state with small employers, actively offer to small employers all health benefit
3 plans it actively markets to small employers in this state, except for plans developed for health
4 benefit trust funds.

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

9 (b) In the case of a small employer carrier that establishes more than one class of
10 business pursuant to section 379.934, the small employer carrier shall maintain and issue to
11 eligible small employers [all health benefit plans] in each class of business so established **all**
12 **health benefit plans it actively markets to small employers in this state.** A small employer

13 carrier may apply reasonable criteria in determining whether to accept a small employer into a
14 class of business, provided that:

15 a. The criteria are not intended to discourage or prevent acceptance of small employers
16 applying for a health benefit plan;

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

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

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

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

26 (1) A health benefit plan shall comply with the provisions of sections 376.450 and
27 376.451, RSMo.

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

33 (b) A small employer carrier shall not require a minimum participation level greater than:

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

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

38 (c) In applying minimum participation requirements with respect to a small employer,
39 a small employer carrier shall not consider employees or dependents who have qualifying
40 existing coverage in determining whether the applicable percentage of participation is met.

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

44 (3) (a) If a small employer carrier offers coverage to a small employer, the small
45 employer carrier shall offer coverage to all of the eligible employees of a small employer and
46 their dependents who apply for enrollment during the period in which the employee first
47 becomes eligible to enroll under the terms of the plan. A small employer carrier shall not offer

48 coverage to only certain individuals or dependents in a small employer group or to only part of
49 the group.

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

54 (c) An eligible employee may choose to retain their individually underwritten health
55 benefit plan at the time such eligible employee is entitled to enroll in a small employer health
56 benefit plan. If the eligible employee retains their individually underwritten health benefit plan,
57 a small employer may provide a defined contribution through the establishment of a cafeteria
58 plan **or health reimbursement arrangement** under section [379.953] **376.453, RSMo**. Small
59 employers shall establish an equal amount of defined contribution for all plans. If an eligible
60 employee retains their individually underwritten health benefit plan under this subdivision, the
61 provisions of sections 379.930 to 379.952 shall not apply to the individually underwritten health
62 benefit plan.

63 3. (1) Subject to subdivision (3) of this subsection, a small employer carrier shall not
64 be required to offer coverage or accept applications pursuant to subsection 1 of this section in
65 the case of the following:

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

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

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

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

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

83 4. A small employer carrier shall not be required to provide coverage to small employers
84 pursuant to subsection 1 of this section for any period of time for which the director determines
85 that requiring the acceptance of small employers in accordance with the provisions of subsection
86 1 of this section would place the small employer carrier in a financially impaired condition, and
87 the small employer is applying this subsection uniformly to all small employers in the small
88 group market in this state consistent with applicable state law and without regard to the claims
89 experience of a small employer and its employees and their dependents or any health
90 status-related factor relating to such employees and their dependents.

 379.952. 1. Each small employer carrier shall actively market all health benefit plans
2 sold by the carrier in the small group market to eligible employers in the state, except for plans
3 developed for health benefit trust funds.

4 2. (1) Except as provided in subdivision (2) of this subsection, no small employer carrier
5 or agent or broker shall, directly or indirectly, engage in the following activities:

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

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

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

16 3. (1) Except as provided in subdivision (2) of this subsection, no small employer carrier
17 shall, directly or indirectly, enter into any contract, agreement or arrangement with an agent or
18 broker that provides for or results in the compensation paid to an agent or broker for the sale of
19 a health benefit plan to be varied because of the health status, claims experience, industry,
20 occupation or geographic location of the small employer.

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

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

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

32 6. No small employer carrier or producer shall induce or otherwise encourage a small
33 employer to separate or otherwise exclude an employee from health coverage or benefits
34 provided in connection with the employee's employment; except that, a carrier may offer a policy
35 to a small employer that charges a reduced premium rate or deductible for employees who do not
36 smoke or use tobacco products, and such carrier shall not be considered in violation of sections
37 379.930 to 379.952 or any unfair trade practice, as defined in section [379.936] **375.936, RSMo**,
38 even if only some small employers elect to purchase such a policy and other small employers do
39 not.

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

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

44 9. (1) A violation of this section by a small employer carrier or a producer shall be an
45 unfair trade practice under sections 375.930 to 375.949, RSMo.

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

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