SECOND REGULAR SESSION

HOUSE COMMITTEE SUBSTITUTE FOR

HOUSE BILL NO. 2282

94TH GENERAL ASSEMBLY

Reported from the Special Committee on Health Insurance April 9, 2008 with recommendation that House Committee Substitute for House Bill No. 2282 Do Pass. Referred to the Committee on Rules pursuant to Rule 25(21)(f).

D. ADAM CRUMBLISS, Chief Clerk

5094L.07C

AN ACT

To repeal sections 143.111, 143.113, 143.782, 143.790, 313.321, 354.536, 376.426, 376.450, 376.453, 376.776, 376.960, 376.966, 379.930, 379.940, and 379.952, RSMo, and to enact in lieu thereof fourteen new sections relating to health insurance.

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

Section A. Sections 143.111, 143.113, 143.782, 143.790, 313.321, 354.536, 376.426, 376.450, 376.453, 376.776, 376.960, 376.966, 379.930, 379.940, and 379.952, RSMo, are repealed and fourteen new sections enacted in lieu thereof, to be known as sections 143.111, 143.782, 143.790, 313.321, 354.536, 376.426, 376.450, 376.453, 376.776, 376.960, 376.966, 379.930, 379.940, and 379.952, to read as follows:

143.111. The Missouri taxable income of a resident shall be such resident's Missouri adjusted gross income less:

(1) Either the Missouri standard deduction or the Missouri itemized deduction;

(2) The Missouri deduction for personal exemptions;

(3) The Missouri deduction for dependency exemptions; **and**

(4) The deduction for federal income taxes provided in section 143.171**[**; and

(5) The deduction for a self-employed individual's health insurance costs provided in section 143.113**]**.

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

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.

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

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

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

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

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

(6) "State agency", any department, division, board, commission, office, or other agency of the state of Missouri, including public community college districts and housing authorities as defined in section 99.020, RSMo.

143.790. 1. Any hospital or health care provider who has provided health care services to an individual who was not covered by a health insurance policy or was not eligible to receive benefits under the state's medical assistance program of needy persons, Title XIX, P.L. 89-97, 1965 amendments to the federal Social Security Act, 42 U.S.C. Section 301, et seq., under chapter 208, RSMo, and the health insurance for uninsured children under sections 208.631 to 208.657, RSMo, at the time such health care services were administered, and such person has failed to pay for such services for a period greater than ninety days, may submit a claim to the director of the department of **[**health and senior services**] revenue** for the unpaid health care services**[**. The director of the department of health and senior services shall review such claim. If the claim appears meritorious on its face, the claim for the unpaid medical services shall constitute a debt of the department of health and senior services for purposes of sections 143.782 to 143.788, and the director may certify the debt to the department of revenue in order to set off the debtor's income tax refund. Once the debt has been certified, the director of the department of health and senior services shall submit the debt to the department of revenue under the setoff procedure established under section 143.783**] on a claim form approved by the director of revenue**.

2. **The director of revenue shall promulgate a claim form for a hospital or health care provider to certify the following:**

(1) That the hospital or health care provider provided health care services to an individual who was not covered by a health insurance policy or was not eligible to receive benefits under the state's medical assistance program for needy persons, Title XIX, P.L. 89-97, 1965 amendments to the federal Social Security Act, 42 U.S.C. Section 301 et seq., under chapter 208, RSMo, and the children's health insurance program under sections 208.631 to 208.637, RSMo, at the time such health care services were administered;

(2) That such person failed to pay for such services for a period of time greater than one hundred eighty days;

(3) That the amounts billed were the true and accurate charges for the health care services provided to the individual; and

(4) That the hospital or health care provider has made reasonable attempts to notify the individual of the amounts due and has received no assurance of payment from the individual or that the individual has failed to pay the amounts due after notice and an opportunity for payment.

Such certification shall be attested to under penalty of perjury by the hospital or health care provider.

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

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

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

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

[6.**] 7.** Lottery prize payouts made under section 313.321, RSMo, shall also be subject to the setoff procedures established in this section and any rules and regulations promulgated thereto.

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

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

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

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

3. The "Missouri State Lottery Imprest Prize Fund" is hereby created. This fund is to be established by the state treasurer and funded by warrants drawn by the office of administration from the state lottery fund in amounts specified by the commission. The commission may write checks and disburse moneys from this fund for the payment of lottery prizes only and for no other purpose. All expenditures shall be made in accordance with rules and regulations established by the office of administration. Prize payments may also be made from the state lottery fund. Prize payouts made pursuant to this section shall be subject to the provisions of section 143.781, RSMo; and prize payouts made pursuant to this section shall be subject to set off for delinquent child support payments as assessed by a court of competent jurisdiction or pursuant to section 454.410, RSMo. Prize payouts made under this section shall be subject to set off for unpaid health care services provided by hospitals and health care providers under the procedure established in section 143.790, RSMo.

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

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

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

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

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

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

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

(2) A resident of this state; and

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

376.426. 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 **recommended or** received by the person during the **[**twelve**]** **six** months prior to the **[**effective**] enrollment** 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**] enrollment** 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**] eighteen-month** period commencing on the **[**effective**] enrollment** date of the person's coverage **in the case of a late enrollee**;

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

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

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

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

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

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

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

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

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

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

(16) A provision stating that if a policy provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in the policy,

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

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

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

(b) A resident of this state; and

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

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

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

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

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

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

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

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

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

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

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

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

(4) "COBRA continuation provision":

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

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

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

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

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

a. A group health plan;

b. Health insurance coverage;

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

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

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

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

g. A state health benefits risk pool;

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

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

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

k. Title XXI of the Social Security Act (SCHIP);

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

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

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

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

(9) "Excepted benefits":

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

(b) Coverage only for disability income insurance;

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

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

(e) Workers' compensation or similar insurance;

(f) Automobile medical payment insurance;

(g) Credit-only insurance;

(h) Coverage for on-site medical clinics;

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

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

a. Limited scope dental or vision benefits;

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

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

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

a. Coverage only for a specified disease or illness;

b. Hospital indemnity or other fixed indemnity insurance;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(26) "Waiting period", **[**with respect to a group health plan and an individual who is a potential participant or beneficiary in a group health plan,**]** the period that must pass **[**with respect to the individual before the individual is**] 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;

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

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

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

issuer has made such election, and include in such statements a description of the effect of this election;

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

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

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

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

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

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

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

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

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

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

(b) The employee stated in writing at the time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor

or health insurance issuer required the statement at the time and provided the employee with notice of the requirement and the consequences of the requirement at the time;

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

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

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

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

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

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

(3) The coverage becomes effective:

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

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

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

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

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

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

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

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

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

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

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

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

2. If a policy provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in the policy, such policy so long as it remains in force shall be deemed to provide that attainment of such limiting age does not operate to terminate the hospital and medical coverage of such child while the child is and continues to be both incapable of self-sustaining employment by reason of mental 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**] within** thirty-one days after the child's attainment of the limiting age. The insurer may require at reasonable intervals during the two years following the child's attainment of the limiting age subsequent proof of the child's disability and dependency. After such two-year period, the insurer may require subsequent proof not more than once each year.

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

(1) Is a resident of this state;

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

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

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

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

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

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

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

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

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

a. A group health plan;

b. Health insurance coverage;

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

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

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

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

g. A state health benefits risk pool;

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

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

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

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

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

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

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

(8) "Excepted benefits":

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

(b) Coverage only for disability income insurance;

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

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

(e) Workers' compensation or similar insurance;

(f) Automobile medical payment insurance;

(g) Credit-only insurance;

(h) Coverage for on-site medical clinics;

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

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

a. Limited scope dental or vision benefits;

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

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

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

a. Coverage only for a specified disease or illness;

b. Hospital indemnity or other fixed indemnity insurance;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(25) "Significant break in coverage", a period of sixty-three consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage**. As used in this subdivision, "waiting period" and "affiliation period" shall have the same meaning as such terms are defined in section 376.450**;

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

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

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

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

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

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

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

(3) A trade act eligible individual;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) "Base premium rate", for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of

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

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

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

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

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

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

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

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

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

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

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

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

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

(10) "Committee", the health benefit plan committee created pursuant to section 379.944;

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

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

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

a. A group health plan;

b. Health insurance coverage;

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

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

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

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

g. A state health benefits risk pool;

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

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

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

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

(13) "Dependent", a spouse **[**or**] ;** an unmarried child **[**under the age of nineteen years; an unmarried child who is a full-time student under the age of twenty-three years and who is financially dependent upon the parent**] who is a resident of this state, is under the age of twenty-five years, and is not provided coverage as a named subscriber, insured, enrollee, or covered person under any group or individual health benefit plan, or entitled to benefits under Title XVIII of the federal Social Security Act, 42 U.S.C. Section 1395, et seq.**; or an unmarried child of any age who is medically certified as disabled and dependent upon the parent;

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

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

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

(17) "Excepted benefits":

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

(b) Coverage only for disability income insurance;

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

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

(e) Workers' compensation or similar insurance;

(f) Automobile medical payment insurance;

(g) Credit-only insurance;

(h) Coverage for on-site medical clinics;

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

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

a. Limited scope dental or vision benefits;

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

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

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

a. Coverage only for a specified disease or illness;

b. Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

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

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

(20) "Health benefit plan" or "health insurance coverage", benefits consisting of medical care, including items and services paid for as medical care, that are provided directly, through

insurance, reimbursement, or otherwise, under a policy, certificate, membership contract, or health services agreement offered by a health insurance issuer, but not including excepted benefits or a policy that is individually underwritten;

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

(a) Health status;

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

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information;

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

(h) Disability;

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

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

(a) The individual meets each of the following:

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

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

c. The individual requests enrollment within thirty days after termination of the creditable coverage;

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

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

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

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

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

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

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

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

(27) "Plan of operation", the plan of operation of the program established pursuant to sections 379.942 and 379.943;

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

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

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

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

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

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

(34) "Small employer", in connection with a group health plan with respect to a calendar year and a plan year, any person, firm, corporation, partnership, association, or political subdivision that is actively engaged in business that employed an average of at least two but no more than fifty eligible employees on business days during the preceding calendar year and that employs at least two employees on the first day of the plan year. All persons treated as a single

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) An eligible employee may choose to retain their individually underwritten health benefit plan at the time such eligible employee is entitled to enroll in a small employer health benefit plan. If the eligible employee retains their individually underwritten health benefit plan,

a small employer may provide a defined contribution through the establishment of a cafeteria 125 plan **or health reimbursement arrangement** under section **[**379.953**] 376.453, RSMo**. Small employers shall establish an equal amount of defined contribution for all plans. If an eligible employee retains their individually underwritten health benefit plan under this subdivision, the provisions of sections 379.930 to 379.952 shall not apply to the individually underwritten health benefit plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. No small employer carrier or producer shall induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment; except that, a carrier may offer a policy to a small employer that charges a reduced premium rate or deductible for employees who do not smoke or use tobacco products, and such carrier shall not be considered in violation of sections

379.930 to 379.952 or any unfair trade practice, as defined in section **[**379.936**] 375.936, RSMo**, even if only some small employers elect to purchase such a policy and other small employers do not.

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

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

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

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

[143.113. 1. For all taxable years beginning on or after January 1, 2000, an individual taxpayer who is an employee within the meaning of Section 401(c)(1) of the Internal Revenue Code of 1986, as amended, shall be allowed to subtract from the taxpayer's Missouri adjusted gross income to determine Missouri taxable income an amount equal to the amount which the taxpayer has paid during the taxable year for insurance which constitutes medical care for the taxpayer, the taxpayer's spouse, and dependents to the extent that such amounts qualify as deductible pursuant to Section 162(l) of the Internal Revenue Code of 1986, as amended, for the same taxable year, and shall only be deductible to the extent that such amounts are not deducted on the taxpayer's federal income tax return for that taxable year.

2. The director of the department of revenue shall promulgate rules and regulations to administer the provisions of this section. No rule or portion of a rule promulgated pursuant to the authority of this section shall become effective unless it has been promulgated pursuant to the provisions of chapter 536, RSMo.**]**

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