FIRST REGULAR SESSION

HOUSE COMMITTEE SUBSTITUTE FOR

SENATE BILL NO. 161

97TH GENERAL ASSEMBLY

0231H.06C D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 334.108, 354.410, 354.415, 354.430, 354.603, 376.405, 376.426, 376.777, 376.961, 376.962, 376.964, 376.966, 376.968, 376.970, 376.973, and 376.1363, RSMo, and to enact in lieu thereof twenty-two new sections relating to health insurance, with penalty provisions and an effective date.

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

Section A. Sections 334.108, 354.410, 354.415, 354.430, 354.603, 376.405, 376.426, 376.777, 376.961, 376.962, 376.964, 376.966, 376.968, 376.970, 376.973, and 376.1363, RSMo, are repealed and twenty-two new sections enacted in lieu thereof, to be known as sections 334.108, 354.410, 354.415, 354.430, 354.603, 376.405, 376.426, 376.777, 376.961, 376.962, 376.964, 376.966, 376.968, 376.970, 376.973, 376.1192, 376.1226, 376.1237, 376.1363, 376.1575, 376.1578, and 376.1900, to read as follows:

334.108. 1. Prior to prescribing any drug, controlled substance, or other treatment through the internet, a physician shall establish a valid physician-patient relationship. This relationship shall include:

(1) Obtaining a reliable medical history and performing a physical examination of the patient **whether in person or via telehealth, as defined in section 208.670**, adequate to establish the diagnosis for which the drug is being prescribed and to identify underlying conditions or contraindications to the treatment recommended or provided;

(2) Having sufficient dialogue with the patient regarding treatment options and the risks and benefits of treatment or treatments;

(3) If appropriate, following up with the patient to assess the therapeutic outcome;

(4) Maintaining a contemporaneous medical record that is readily available to the patient and, subject to the patient's consent, to the patient's other health care professionals; and

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.

(5) Including the electronic prescription information as part of the patient's medical record.

2. The requirements of subsection 1 of this section may be satisfied by the prescribing physician's designee when treatment is provided in:

(1) A hospital as defined in section 197.020;

(2) A hospice program as defined in section 197.250;

(3) Home health services provided by a home health agency as defined in section 197.400;

(4) Accordance with a collaborative practice agreement as defined in section 334.104;

(5) Conjunction with a physician assistant licensed pursuant to section 334.738;

(6) Consultation with another physician who has an ongoing physician-patient relationship with the patient, and who has agreed to supervise the patient's treatment, including use of any prescribed medications; or

(7) On-call or cross-coverage situations.

354.410. 1. The director shall issue or deny a certificate of authority to any person filing an application pursuant to section 354.405. Issuance of a certificate of authority may then be granted upon payment of the application fee prescribed in section 354.500 if the director is satisfied that the following conditions are met:

(1) The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy, and possess good reputations;

(2) The health care organization constitutes an appropriate mechanism whereby the health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis through insurance or otherwise, except to the extent of **[**reasonable**]** requirements for co-payments**, coinsurance or deductibles**;

(3) The health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the director may consider:

(a) The financial soundness of the arrangements for health care services and the schedule of charges used in connection therewith;

(b) The adequacy of working capital;

(c) Any agreement with an insurer, a government, or any other organization for insuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the health maintenance organization;

(d) Any agreement with providers for the provision of health care services; and

(e) Any deposit of cash or securities submitted in accordance with subsection 2;

(4) The health maintenance organization's arrangements for health care services and the schedule of charges used in connection therewith are financially sound;

(5) The working capital be adequate;

(6) Any agreement with an insurer, a health service corporation, a government, or any other organization for insuring the payment of the cost of health care services contain a provision for the automatic applicability of alternative coverage in the event of discontinuance of the health maintenance organization;

(7) There be an agreement with providers for the provision of health care services;

(8) The enrollees shall be afforded an opportunity to participate in matters of policy and operation pursuant to section 354.420;

(9) Nothing in the proposed method of operation, as shown by the information submitted pursuant to section 354.405 or by independent investigation, is contrary to the public interest;

(10) The health maintenance organization is able to provide its enrollees with adequate access to health care providers.

2. Unless otherwise provided below, each health maintenance organization shall deposit with the director, or with any organization or trustee acceptable to the director through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that is acceptable to the director in the amount set forth in this subsection:

(1) The amount for an organization that is beginning operation shall be the greater of: (a) five percent of its estimated expenditures for health care services for its first year of operation, (b) twice its estimated average monthly uncovered expenditures for its first year of operation, or (c) one hundred fifty thousand dollars for a medical group/staff model, or three hundred thousand dollars for an individual practice association. At the beginning of each succeeding year, unless not applicable, the organization shall deposit with the director, or organization or trustee, cash, securities, or any combination of these or other measures acceptable to the director, in an amount equal to four percent of its estimated annual uncovered expenditures for that year.

(2) Unless not applicable, an organization that is in operation on September 28, 1983, shall make a deposit equal to the larger of: (a) one percent of the preceding twelve months' uncovered expenditures, or (b) one hundred fifty thousand dollars for a medical group/staff model, or three hundred thousand dollars for an individual practice association on the first day of the first calendar year beginning six months or more after September 28, 1983. In the second calendar year, if applicable, the amount of the additional deposit shall be equal to two percent of its estimated annual uncovered expenditures. In the third calendar year, if applicable, the additional deposit shall be equal to three percent of its estimated annual uncovered expenditures for that year, and in the fourth calendar year and subsequent years, if applicable, the additional

deposit shall be equal to four percent of its estimated annual uncovered expenditures for each year. Each year's estimate, after the first year of operation, shall reasonably reflect the prior years' operating experience and delivery arrangements. The director may waive any of the deposit requirements set forth in subdivisions (1) and (2) above, whenever satisfied that the organization has sufficient net worth and an adequate history of generating net income to assure its financial viability for the next year, or its performance and obligations are guaranteed by an organization with sufficient net worth and an adequate history of generating net income, or the assets of the organization or its contracts with insurers, hospital or medical service corporations, governments, or other organizations are sufficient to reasonably assure the performance of its obligations.

3. When an organization has achieved a net worth not including land, buildings, and equipment, of at least one million dollars or has achieved a net worth including organization-related land, buildings, and equipment of at least five million dollars, the annual deposit requirements shall not apply. The annual deposit requirement shall not apply to an organization if the total amount of the deposit is equal to twenty-five percent of its estimated annual uncovered expenditures for the next calendar year, or the capital and surplus requirements for the formation or admittance of an accident and health insurer in this state, whichever is less. If the organization has a guaranteeing organization which has been in operation for at least five years and has a net worth not including land, buildings, and equipment of at least one million dollars or which has been in operation for at least ten years and has a net worth including organization-related land, buildings, and equipment of at least five million dollars, the annual deposit requirement shall not apply; provided, however, that if the guaranteeing organization is sponsoring more than one organization, the net worth requirement shall be increased by a multiple equal to the number of such organizations. This requirement to maintain a deposit in excess of the deposit required of an accident and health insurer shall not apply during any time that the guaranteeing organization maintains a net worth at least equal to the capital and surplus requirements for an accident and health insurer for each organization it sponsors.

4. All income from deposits shall belong to the depositing organization and shall be paid to it as it becomes available. A health maintenance organization that has made a securities deposit may withdraw the securities deposit or any part thereof, first having deposited, in lieu thereof, a deposit of cash, securities, or any combination of these or other measures of equal amount and value to that withdrawn. Any securities shall be approved by the director before being substituted.

5. In any year in which an annual deposit is not required of an organization, at its request the director shall reduce the required deposit by one hundred thousand dollars for each two hundred fifty thousand dollars of net worth in excess of the amount that allows it not to make an

annual deposit. If the amount of net worth no longer supports a reduction of its required deposit, the organization shall immediately redeposit one hundred thousand dollars for each two hundred fifty thousand dollars of reduction in net worth, provided that its total deposit shall not exceed the maximum required under this section. Notwithstanding any provisions of sections 354.400 to 354.636, the deposit held by the director shall in no case be less than one hundred fifty thousand dollars for a group staff/model or three hundred thousand dollars for an individual practice association model.

6. Each health maintenance organization that obtains a certificate of authority after September 28, 1983, shall have and maintain a capital account of at least one hundred fifty thousand dollars for a medical group/staff model, or three hundred thousand dollars for an individual practice association in addition to any deposit requirements under this section. The capital account shall be net of any accrued liabilities and be in the form of cash, securities or any combination of these or other measures acceptable to the director.

7. A certificate of authority shall be denied only after compliance with the requirements of section 354.490.

354.415. 1. The powers of a health maintenance organization include, but are not limited to, the power to:

(1) Purchase, lease, construct, renovate, operate, and maintain hospitals, medical facilities, or both, and their ancillary equipment, and such property as may reasonably be required for the organization's principal office or for such other purposes as may be necessary in the transaction of the business of the organization;

(2) Make loans to a medical group under contract with it in furtherance of its program, or to make loans to any corporation under its control for the purpose of acquiring or constructing medical facilities and hospitals or in the furtherance of a program providing health care services to enrollees;

(3) Furnish health care services through providers which are under contract with, or employed by, the health maintenance organization;

(4) Contract with any person for the performance, on the organization's behalf, of certain functions such as marketing, enrollment, and administration;

(5) Contract with an insurance company licensed in this state, or with a health services corporation authorized to do business in this state, for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization;

(6) Offer, in addition to basic health care services:

(a) Additional health care services;

(b) Indemnity benefits covering out-of-area or emergency services; and

(c) Indemnity benefits, in addition to those relating to out-of-area and emergency services, provided through insurers or health services corporations**;**

(7) Offer as an option one or more health benefit plans which contain deductibles, coinsurance, coinsurance differentials, or variable co-payments. Health benefit plans offered under this section that contain deductibles shall be permitted only when combined with any health savings account or health reimbursement account as described in the Medicare Reform Act, P.L. No. 108-173, Title XII, Section 1201, provided that:

(a) The total out-of-pocket expenses paid for the receipt of basic health services under the plan shall not exceed the annual contribution limits for health savings accounts as determined by the Internal Revenue Service;

(b) The health savings account or health reimbursement account must be funded at a level equal to or greater than the out-of-pocket maximum limits defined for the high deductible health plan; and

(c) A distribution from the health savings account or health reimbursement account to pay a health care provider for a qualified medical expense is made within thirty days of the submission of a claim.

2. Prior to the exercise of any power granted in subdivision (1) or (2) of subsection 1 of this section, involving an amount in excess of five hundred thousand dollars, a health maintenance organization shall file notice, with adequate supporting information, with the director. The director shall disapprove such exercise of power if, in his opinion, it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. If the director does not disapprove such exercise of power within sixty days of the filing, it shall be deemed approved.

3. The director may exempt from the filing requirement of subsection 2 of this section those activities having minimal effect.

354.430. 1. Every enrollee residing in this state is entitled to evidence of coverage. If the enrollee obtains coverage through an insurance policy or a contract issued by a health services corporation, whether by option or otherwise, the insurer or the health services corporation shall issue the evidence of coverage. Otherwise the health maintenance organization shall issue the evidence of coverage.

2. No evidence of coverage, or amendment thereto, shall be issued or delivered to any person in this state until a copy of the form of the evidence of coverage, or amendment thereto, has been filed with the director.

3. An evidence of coverage shall contain:

(1) No provisions or statements which are unjust, unfair, inequitable, misleading, or deceptive, or which encourage misrepresentation, or which are untrue, misleading, or deceptive as defined in subsection 1 of section 354.460; and

(2) A clear and complete statement, if a contract, or a reasonably complete summary, if a certificate, of:

(a) The health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(b) Any limitations on the services, kind of services, benefits or kinds of benefits to be provided, including any deductible or co-payment**, coinsurance, or other cost-sharing** feature **as requested by the group contract holder or, in the case of non-group coverage, the individual certificate holder**;

(c) Where and in what manner information is available as to how services may be obtained;

(d) The total amount of payment for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts; and

(e) A clear and understandable description of the health maintenance organization's method for resolving enrollee complaints, including the health maintenance organization's toll-free customer service number and the department of insurance, financial institutions and professional registration's consumer complaint hot line number.

4. Any subsequent change in an evidence of coverage may be made in a separate document issued to the enrollee.

5. A copy of the form of the evidence of coverage to be used in this state, and any amendment thereto, shall be subject to the filing of subsection 2 of this section unless it is subject to the jurisdiction of the director under the laws governing health insurance or health services corporations, in which event the filing provisions of those laws shall apply.

354.603. 1. A health carrier shall maintain a network that is sufficient in number and types of providers to assure that all services to enrollees shall be accessible without unreasonable delay. In the case of emergency services, enrollees shall have access twenty-four hours per day, seven days per week. The health carrier's medical director shall be responsible for the sufficiency and supervision of the health carrier's network. Sufficiency shall be determined by the director in accordance with the requirements of this section and by reference to any reasonable criteria, including but not limited to provider-enrollee ratios by specialty, primary care provider-enrollee ratios, geographic accessibility, reasonable distance accessibility criteria for pharmacy and other services, waiting times for appointments with participating providers, hours of operation, and the volume of technological and specialty services available to serve the needs of enrollees requiring technologically advanced or specialty care.

(1) In any case where the health carrier has an insufficient number or type of participating providers to provide a covered benefit, the health carrier shall ensure that the enrollee obtains the covered benefit at no greater cost than if the benefit was obtained from a participating provider, or shall make other arrangements acceptable to the director.

(2) The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers, including local pharmacists, to the business or personal residence of enrollees. In determining whether a health carrier has complied with this provision, the director shall give due consideration to the relative availability of health care providers in the service area under, especially rural areas, consideration.

(3) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, and legal authority of its providers to furnish all contracted benefits to enrollees. The provisions of this subdivision shall not be construed to require any health care provider to submit copies of such health care provider's income tax returns to a health carrier. A health carrier may require a health care provider to obtain audited financial statements if such health care provider received ten percent or more of the total medical expenditures made by the health carrier.

(4) A health carrier shall make its entire network available to all enrollees unless a contract holder has agreed in writing to a different or reduced network.

2. A health carrier shall file with the director, in a manner and form defined by rule of the department of insurance, financial institutions and professional registration, an access plan meeting the requirements of sections 354.600 to 354.636 for each of the managed care plans that the health carrier offers in this state. The health carrier may request the director to deem sections of the access plan as proprietary or competitive information that shall not be made public. For the purposes of this section, information is proprietary or competitive if revealing the information will cause the health carrier's competitors to obtain valuable business information. The health carrier shall provide such plans, absent any information deemed by the director to be proprietary, to any interested party upon request. The health carrier shall prepare an access plan prior to offering a new managed care plan, and shall update an existing access plan whenever it makes any change as defined by the director to an existing managed care plan. The director shall approve or disapprove the access plan, or any subsequent alterations to the access plan, within sixty days of filing. The access plan shall describe or contain at a minimum the following:

(1) The health carrier's network;

(2) The health carrier's procedures for making referrals within and outside its network;

(3) The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of enrollees of the managed care plan;

(4) The health carrier's methods for assessing the health care needs of enrollees and their satisfaction with services;

(5) The health carrier's method of informing enrollees of the plan's services and features, including but not limited to the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;

(6) The health carrier's system for ensuring the coordination and continuity of care for enrollees referred to specialty physicians, for enrollees using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(7) The health carrier's process for enabling enrollees to change primary care professionals;

(8) The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, in the event of a reduction in service area or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how enrollees shall be notified of the contract termination, reduction in service area or the health carrier's insolvency or other modification or cessation of operations, and transferred to other health care professionals in a timely manner; and

(9) Any other information required by the director to determine compliance with the provisions of sections 354.600 to 354.636.

3. In reviewing an access plan filed pursuant to subsection 2 of this section, the director shall deem a managed care plan's network to be adequate if it meets one or more of the following criteria:

(1) The managed care plan is a Medicare **[**+ Choice**]** **Advantage** coordinated care plan offered by the health carrier pursuant to a contract with the federal Centers for Medicare and Medicaid Services;

(2) The managed care plan is being offered by a health carrier that has been accredited by the National Committee for Quality Assurance at a level of "accredited" or better, and such accreditation is in effect at the time the access plan is filed;

(3) The managed care plan's network has been accredited by the Joint Commission on the Accreditation of Health Organizations for Network Adequacy, and such accreditation is in effect at the time the access plan is filed. If the accreditation applies to only a portion of the managed care plan's network, only the accredited portion will be deemed adequate; or

(4) The managed care plan is being offered by a health carrier that has been accredited by the Utilization Review Accreditation Commission at a level of "accredited" or better, and such accreditation is in effect at the time the access plan is filed.

4. Notwithstanding any other provision of law to the contrary, a health carrier, as defined in section 354.600, may offer a health benefit plan that is a managed care plan that

requires all health care services to be delivered by a participating provider in the health carrier's network, except for emergency services, as defined in section 354.600, and the services described in subsection 4 of section 376.811. Such a provision shall be disclosed in the policy form.

376.405. 1. No insurance company licensed to transact business in this state shall deliver or issue for delivery in this state any policy of group accident or group health insurance, or group accident and health insurance, including insurance against hospital, medical or surgical expenses, covering a group in this state, unless such policy form shall have been approved by the director of the department of insurance, financial institutions and professional registration of the state of Missouri.

2. The director of the department of insurance, financial institutions and professional registration shall have authority to make such reasonable rules and regulations concerning the filing and submission of **[**such policy forms**]** **policies** as are necessary, proper or advisable. Such rules and regulations shall provide, among other things, that if a policy form is disapproved, **[**the reasons therefor**]** **all specific reasons for noncompliance** shall be stated in writing **within forty-five days from the date of filing**; that a hearing shall be granted upon such disapproval, if so requested; and that the failure of the director of the department of insurance, financial institutions and professional registration to take action approving or disapproving a submitted policy form within **[**a stipulated time, not to exceed sixty**]** **forty-five** days from the date of filing, shall be deemed an approval thereof **[**until such time as the director of the department of insurance, financial institutions and professional registration shall notify the submitting company, in writing, of his disapproval thereof**]**. **If at any time after a policy form is approved or deemed approved, the director determines that any provision of the filing is contrary to state law, the director shall notify the health carrier of the specific provision that is contrary to state law and request that the health carrier file an amendment form that modifies the provision to conform to state law. The failure of the director of the department of insurance, financial institutions and professional registration to take action approving or disapproving a submitted amendment form within forty-five days from the date of filing shall be deemed an approval thereof. In the event that a policy form is approved or deemed approved and is subsequently amended for state law compliance upon the department's request as provided herein, the department shall not retroactively enforce the amended policy form if the health carrier files the amendment form within thirty days of the request from the department.**

3. The director of the department of insurance, financial institutions and professional registration shall approve only those policy forms which are in compliance with the insurance laws of this state and which contain such words, phraseology, conditions and provisions which

are specific, certain and unambiguous and reasonably adequate to meet needed requirements for the protection of those insured. The disapproval of any policy form shall be based upon the requirements of the laws of this state or of any regulation lawfully promulgated thereunder.

4. The director of the department of insurance, financial institutions and professional registration may, by order or bulletin, exempt from the approval requirements of this section for so long as he deems proper any insurance policy, document, or form or type thereof, as specified in such order or bulletin, to which, in his opinion, this section may not practicably be applied, or the approval of which is, in his opinion, not desirable or necessary for the protection of the public.

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 the department of insurance, financial institutions and professional registration are more favorable to the persons insured or at least as favorable to the persons insured and more favorable to the policyholder; except that: provisions in subdivisions (5), (7), (12), (15), and (16) of this section shall not apply to policies insuring debtors; standard provisions required for individual health insurance policies shall not apply to group health insurance policies; and if any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the director, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(13) A provision that the insurer shall have the right and opportunity, at the insurer's own expense, to examine the person of the individual for whom claim is made when and so often as it may reasonably require during the pendency of the claim under the policy and also the right

and opportunity, at the insurer's own expense, to make an autopsy in case of death where it is not prohibited by law;

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

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

(16) A provision stating that if a policy provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in the policy, such policy, so long as it remains in force, shall be deemed to provide that attainment of such limiting age does not operate to terminate the hospital and medical coverage of such child while the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the certificate holder for support and maintenance. Proof of such incapacity and dependency must be furnished to the insurer by the certificate holder at least 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**;**

(19) Notwithstanding any other provision of law to the contrary, a health carrier, as defined in section 376.1350, may offer a health benefit plan that is a managed care plan that requires all health care services to be delivered by a participating provider in the health carrier's network, except for emergency services, as defined in section 354.600, and the services described in subsection 4 of section 376.811. Such a provision shall be disclosed in the policy form.

376.777. 1. Required provisions. Except as provided in subsection 3 of this section each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this subsection in the words in which the same appear in this section; provided, however, that the insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the director of the department of insurance, financial institutions and professional registration which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the director of the department of insurance, financial institutions and professional registration may approve.

(1) A provision as follows: "ENTIRE CONTRACT; CHANGES: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions".

(When under the provisions of subdivision (2) of subsection 1 of section 376.775 the effective and termination dates are stated in the premium receipt, the insurer shall insert in the first sentence of the foregoing policy provision immediately following the comma after the word "any", the following words: "and the insurer's official premium receipt when executed").

(2) A provision as follows: "TIME LIMIT ON CERTAIN DEFENSES: (a) After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to

deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two-year period".

(The foregoing policy provision shall not be so construed as to affect any legal requirements for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of subdivisions (1), (2), (3), (4) and (5) of subsection 2 of this section in the event of misstatement with respect to age or occupation or other insurance.)

(A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age fifty or, (2) in the case of a policy issued after age forty-four, for at least five years from its date of issue, may contain in lieu of the foregoing the following provision (from which the clause in parentheses may be omitted at the insurer's option) under the caption "UNCONTESTABLE": "After this policy has been in force for a period of three years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become uncontestable as to the statements contained in the application). (b) No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy."

(3) A provision as follows: "GRACE PERIOD:

A grace period of . . . (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force."

(A policy which contains a cancellation provision may add, at the end of the above provision, subject to the right of the insurer to cancel in accordance with the cancellation provision hereof. A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision, "Unless not less than five days prior to the premium due date the insurer has delivered to the insured or has mailed to his last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted").

(4) A provision as follows: "REINSTATEMENT:

If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer, or,

lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement".

(The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age fifty or, (2) in the case of a policy issued after age forty-four, for at least five years from its date of issue.)

(5) A provision as follows: "NOTICE OF CLAIM:

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, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insured at ..... (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer".

(In a policy providing a loss-of-time benefit which may be payable for at least two years, an insurer may at its option insert the following between the first and second sentences of the above provision: "Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, he shall, at least once in every six months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given").

(6) A provision as follows: "CLAIM FORMS:

The insurer upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice the claimant shall be deemed to have complied with the

requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made".

(7) A provision as follows: "PROOFS OF LOSS:

Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give 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, later than one year from the time proof is otherwise required".

(8) A provision as follows: "TIME OF PAYMENT OF CLAIMS:

Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid ..... (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof".

(9) A provision as follows: "PAYMENT OF CLAIMS:

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured".

(The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer: "If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $..... (insert an amount which shall not exceed one thousand dollars), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment. Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the

insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person").

(10) A provision as follows: "PHYSICAL EXAMINATIONS AND AUTOPSY:

The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law".

(11) A provision as follows: "LEGAL ACTIONS:

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished".

(12) A provision as follows: "CHANGE OF BENEFICIARY:

Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to change of beneficiary or beneficiaries, or to any other changes in this policy".

(The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option).

2. Other provisions. Except as provided in subsection 3 of this section, no such policy delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section; provided, however, that the insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording approved by the director of the department of insurance, financial institutions and professional registration which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the director of the department of insurance, financial institutions and professional registration may approve.

(1) A provision as follows: "CHANGE OF OCCUPATION:

If the insured be injured or contract sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his occupation to one classified by the insurer as less hazardous than that stated

in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation".

(2) A provision as follows: "MISSTATEMENT OF AGE:

If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age".

(3) A provision as follows: "OTHER INSURANCE IN THIS INSURER:

If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for ..... (insert type of coverage or coverages) in excess of $..... (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate, or in lieu thereof. Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies".

(4) A provision as follows: "INSURANCE WITH OTHER INSURERS:

If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage".

(If the foregoing policy provision is included in a policy which also contains the next following policy provision there shall be added to the caption of the foregoing provision the phrase "EXPENSE INCURRED BENEFITS". The insurer may, at its option, include in this provision a definition of "other valid coverage", approved as to form by the director of the department of insurance, financial institutions and professional registration, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the director of the department of insurance, financial institutions and professional registration. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employees benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage").

(5) A provision as follows: "INSURANCE WITH OTHER INSURERS:

If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined".

(If the foregoing policy provision is included in a policy which also contains the next preceding policy provision there shall be added to the caption of the foregoing provision the phrase "OTHER BENEFITS". The insurer may, at its option, include in this provision a definition of "other valid coverage", approved as to form by the director of the department of insurance, financial institutions and professional registration which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the director of the department of insurance, financial institutions and professional registration. In the absence of

such definition such term shall not include group insurance, or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage", of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage").

(6) A provision as follows: "RELATION OF EARNINGS TO INSURANCE:

If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of two hundred dollars or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time".

(The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age fifty or, (2) in the case of a policy issued after age forty-four, for at least five years from this date of issue. The insurer may, at its option, include in this provision a definition of "valid loss of time coverage", approved as to form by the director of the department of insurance, financial institutions and professional registration, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the director of the department of insurance, financial institutions and professional registration or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any

workers' compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations).

(7) A provision as follows: "UNPAID PREMIUM:

Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom".

(8) A provision as follows: "CANCELLATION:

The insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to his last address as shown by the records of the insurer, stating when, not less than five days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation".

(9) A provision as follows: "CONFORMITY WITH STATE STATUTES:

Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes".

(10) A provision as follows: "ILLEGAL OCCUPATION:

The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation".

(11) A provision as follows: "INTOXICANTS AND NARCOTICS:

The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician".

3. Inapplicable or inconsistent provisions. 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 of the department of insurance, financial institutions and professional registration, shall omit from such policy an 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.

4. Order of certain policy provisions. The provisions which are the subject of subsections 1 and 2 of this section, or any corresponding provisions which are used in lieu thereof in accordance with such subsections, shall be printed in the consecutive order of the provisions in such subsections or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued.

5. Third party ownership. The word "insured" as used in sections 376.770 to 376.800, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits and rights provided therein.

6. Requirements of other jurisdictions.

(1) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of sections 376.770 to 376.800 and which is prescribed or required by the law of the state under which the insurer is organized.

(2) Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

7. Approval of policies.

(1) No policy subject to sections 376.770 to 376.800 shall be delivered or issued for delivery to any person in this state unless such policy, including any rider, endorsement or other provisions, supplementary thereto, shall have been approved by the director of the department of insurance, financial institutions and professional registration.

(2) The director of the department of insurance, financial institutions and professional registration shall have authority to make such reasonable rules and regulations concerning the filing and submission of policies as are necessary, proper or advisable. Such rules and regulations shall provide, among other things, that if a policy form is disapproved, **[**the reasons therefor**]** **all specific reasons for noncompliance** shall be stated in writing **within forty-five days from the date of filing**; that a hearing shall be granted upon such disapproval, if so requested; and that the failure of the director of the department of insurance, financial institutions and professional registration to take action approving or disapproving a submitted policy form within **[**a stipulated time, not to exceed sixty**]** **forty-five** days from the date of filing, shall be deemed an approval thereof **[**until such time as the director of the department of insurance, financial institutions and professional registration shall notify the submitting company, in writing, of his disapproval thereof**]**. **If at any time after a policy form is approved or deemed approved, the director determines that any provision of the filing is contrary to state law,**

the director shall notify the health carrier of the specific provision that is contrary to state law and request that the health carrier file an amendment form that modifies the provision to conform to state law. The failure of the director of the department of insurance, financial institutions and professional registration to take action approving or disapproving a submitted amendment form within forty-five days from the date of filing shall be deemed an approval thereof. In the event that a policy form is approved or deemed approved and is subsequently amended for state law compliance upon the department's request as provided herein, the department shall not retroactively enforce the amended policy form if the health carrier files the amendment form within thirty days of the request from the department.

(3) The director of the department of insurance, financial institutions and professional registration shall approve only those policies which are in compliance with the insurance laws of this state and which contain such words, phraseology, conditions and provisions which are specific, certain and unambiguous and reasonably adequate to meet needed requirements for the protection of those insured. The disapproval of any policy form shall be based upon the requirements of the laws of this state or of any regulation lawfully promulgated thereunder.

(4) The director of the department of insurance, financial institutions and professional registration may, by order or bulletin, exempt from the approval requirements of this section for so long as he deems proper any insurance policy, document, or form or type thereof, as specified in such order or bulletin, to which, in his opinion, this section may not practicably be applied, or the approval of which is, in his opinion, not desirable or necessary for the protection of the public.

(5) Notwithstanding any other provision of law to the contrary, a health carrier, as defined in section 376.1350, may offer a health benefit plan that is a managed care plan that requires all health care services to be delivered by a participating provider in the health carrier's network, except for emergency services, as defined in section 354.600, and the services described in subsection 4 of section 376.811. Such a provision shall be disclosed in the policy form.

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

2. Beginning January 1, 2007, the board of directors shall consist of the director of the department of insurance, financial institutions and professional registration or the director's designee, and eight members appointed by the director. Of the initial eight members appointed, three shall serve a three-year term, three shall serve a two-year term, and two shall serve a one-year term. All subsequent appointments to the board shall be for three-year terms. Members

of the board shall have a background and experience in health insurance plans or health maintenance organization plans, in health care finance, or as a health care provider or a member of the general public; except that, the director shall not be required to appoint members from each of the categories listed. The director may reappoint members of the board. The director shall fill vacancies on the board in the same manner as appointments are made at the expiration of a member's term and may remove any member of the board for neglect of duty, misfeasance, malfeasance, or nonfeasance in office.

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

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

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

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

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

5. Beginning on August 28, 2013, the board of directors, on behalf of the pool, the executive director, and any other employees of the pool, shall have the authority to provide assistance or resources to any department, agency, public official, employee, or agent of the federal government for the specific purpose of transitioning individuals enrolled in the pool to coverage outside of the pool beginning on or before January 1, 2014. Such authority does not extend to authorizing the pool to implement, establish, create, administer, or otherwise operate a state-based exchange.

376.962. 1. The board of directors on behalf of the pool shall submit to the director a plan of operation for the pool and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the pool. After notice and hearing, the director shall approve the plan of operation, provided it is determined to be suitable to assure the fair, reasonable and equitable administration of the pool, and it provides for the sharing of pool gains

or losses on an equitable proportionate basis. The plan of operation shall become effective upon approval in writing by the director consistent with the date on which the coverage under sections 376.960 to 376.989 becomes available. If the pool fails to submit a suitable plan of operation within one hundred eighty days after the appointment of the board of directors, or at any time thereafter fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this section. Such rules shall continue in force until modified by the director or superseded by a plan submitted by the pool and approved by the director.

2. In its plan, the board of directors of the pool shall:

(1) Establish procedures for the handling and accounting of assets and moneys of the pool;

(2) Select an administering insurer **or third-party administrator** in accordance with section 376.968;

(3) Establish procedures for filling vacancies on the board of directors; **and**

(4) Establish procedures for the collection of assessments from all members to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made. The level of payments shall be established by the board pursuant to the provisions of section 376.973. Assessment shall occur at the end of each calendar year and shall be due and payable within thirty days of receipt of the assessment notice**[**;

(5) Develop and implement a program to publicize the existence of the plan, the eligibility requirements, and procedures for enrollment, and to maintain public awareness of the plan**]**.

3. On or before September 1, 2013, the board shall submit the amendments to the plan of operation as are necessary or suitable to ensure a reasonable transition period to allow for the termination of issuance of policies by the pool.

4. The amendments to the plan of operation submitted by the board shall include all of the requirements outlined in subsection 2 of this section and shall address the transition of individuals covered under the pool to alternative health insurance coverage as it is available after January 1, 2014. The plan of operation shall also address procedures for finalizing the financial matters of the pool, including assessments, claims expenses, and other matters identified in subsection 2 of this section.

5. The director shall review the plan of operation submitted under subsection 3 of this section and shall promulgate rules to effectuate the transitional plan of operation. Such rule shall be effective no later than October 1, 2013. Any rule or portion of a rule, as that term is defined in section 536.010, 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 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 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, 2013, shall be invalid and void.

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

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

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

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

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

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

(6) **Prior to January 1, 2014,** issue policies of insurance in accordance with the requirements of sections 376.960 to 376.989**. In no event shall new policies of insurance be issued on or after January 1, 2014**;

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

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

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

(10) Administer separate accounts to separate federally defined eligible individuals and trade act eligible individuals who qualify for plan coverage from the other eligible individuals entitled to pool coverage and apportion the costs of administration among such separate accounts.

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

2. **Prior to January 1, 2014,** 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 two hundred percent of rates established by the board as applicable for individual standard risks;

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

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

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

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

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

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

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

(7) Any person who is eligible for 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.

6. Coverage under the pool shall expire on January 1, 2014.

376.968. The board shall select an insurer **[**or**] ,** insurers**, or third-party administrators** through a competitive bidding process to administer the pool. The board shall evaluate bids submitted based on criteria established by the board which shall include:

(1) The insurer's proven ability to handle individual accident and health insurance;

(2) The efficiency of the insurer's claim-paying procedures;

(3) An estimate of total charges for administering the plan;

(4) The insurer's ability to administer the pool in a cost-efficient manner.

376.970. 1. The administering insurer shall serve for a period of three years subject to removal for cause. At least one year prior to the expiration of each three-year period of service by an administering insurer, the board shall invite all insurers, including the current administering insurer, to submit bids to serve as the administering insurer for the succeeding three-year period. Selection of the administering insurer for the succeeding period shall be made at least six months prior to the end of the current three-year period.

2. The administering insurer shall:

(1) Perform all eligibility and administrative claim-payment functions relating to the pool;

(2) Establish a premium billing procedure for collection of premium from insured persons. Billings shall be made on a period basis as determined by the board;

(3) Perform all necessary functions to assure timely payment of benefits to covered persons under the pool including:

(a) Making available information relating to the proper manner of submitting a claim for benefits to the pool and distributing forms upon which submission shall be made;

(b) Evaluating the eligibility of each claim for payment by the pool;

(4) Submit regular reports to the board regarding the operation of the pool. The frequency, content and form of the report shall be determined by the board;

(5) Following the close of each calendar year, determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the board and the department on a form prescribed by the director;

(6) Be paid as provided in the plan of operation for its expenses incurred in the performance of its services.

3. On or before September 1, 2013, the board shall invite all insurers and third-party administrators, including the current administering insurer, to submit bids to serve

as the administering insurer or third-party administrator for the pool. Selection of the administering insurer or third-party administrator shall be made prior to January 1, 2014.

4. Beginning January 1, 2014, the administering insurer or third-party administrator shall:

(1) Submit to the board and director a detailed plan outlining the winding down of operations of the pool. The plan shall be submitted no later than January 31, 2014, and shall be updated quarterly thereafter;

(2) Perform all administrative claim-payment functions relating to the pool;

(3) Perform all necessary functions to assure timely payment of benefits to covered persons under the pool including:

(a) Making available information relating to the proper manner of submitting a claim for benefits to the pool and distributing forms upon which submission shall be made;

(b) Evaluating the eligibility of each claim for payment by the pool;

(4) Submit regular reports to the board regarding the operation of the pool. The frequency, content and form of the report shall be determined by the board;

(5) Following the close of each calendar year, determine the expense of administration, and the paid and incurred losses for the year, and report such information to the board and department on a form prescribed by the director;

(6) Be paid as provided in the plan of operation for its expenses incurred in the performance of its services.

376.973. 1. Following the close of each fiscal year, the pool administrator shall determine the net premiums (premiums less administrative expense allowances), the pool expenses of administration and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. Health insurance premiums and benefits paid by an insurance arrangement that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments. The total cost of pool operation shall be the amount by which all program expenses, including pool expenses of administration, incurred losses for the year, and other appropriate losses exceeds all program revenues, including net premiums, investment income, and other appropriate gains.

2. Each insurer's assessment shall be determined by multiplying the total cost of pool operation by a fraction, the numerator of which equals that insurer's premium and subscriber contract charges for health insurance written in the state during the preceding calendar year and the denominator of which equals the total of all premiums, subscriber contract charges written in the state and one hundred ten percent of all claims paid by insurance arrangements in the state during the preceding calendar year; provided, however, that the assessment for each health

maintenance organization shall be determined through the application of an equitable formula based upon the value of services provided in the preceding calendar year.

3. Each insurance arrangement's assessment shall be determined by multiplying the total cost of pool operation calculated under subsection 1 of this section by a fraction, the numerator of which equals one hundred ten percent of the benefits paid by that insurance arrangement on behalf of insureds in this state during the preceding calendar year and the denominator of which equals the total of all premiums, subscriber contract charges and one hundred ten percent of all benefits paid by insurance arrangements made on behalf of insureds in this state during the preceding calendar year. Insurance arrangements shall report to the board claims payments made in this state on an annual basis on a form prescribed by the director.

4. If assessments exceed actual losses and administrative expenses of the pool, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" include reserves for incurred but not paid claims.

5. Assessments shall continue until such a time as the executive director of the pool provides notice to the board and director that all claims have been paid.

6. Any assessment funds remaining at the time the executive director provides notice that all claims have been paid shall be deposited in the state general revenue fund.

376.1192. 1. As used in this section, "health benefit plan" and "health carrier" shall have the same meaning as such terms are defined in section 376.1350.

2. Beginning September 1, 2013, the oversight division of the joint committee on legislative research shall perform an actuarial analysis of the cost impact to health carriers, insureds with a health benefit plan, and other private and public payers if state mandates were enacted to provide health benefit plan coverage for the following:

(1) Orally administered anticancer medication that is used to kill or slow the growth of cancerous cells charged at the same co-payment, deductible, or coinsurance amount as intravenously administered or injected cancer medication that is provided, regardless of formulation or benefit category determination by the health carrier administering the health benefit plan;

(2) Diagnosis and treatment of eating disorders that include anorexia nervosa, bulimia, binge eating, eating disorders nonspecified, and any other severe eating disorders contained in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. The actuarial analysis shall assume the following are included in health benefit plan coverage:

(a) Residential treatment for eating disorders, if such treatment is medically necessary in accordance with the Practice Guidelines for the Treatment of Patients with Eating Disorders, as most recently published by the American Psychiatric Association; and

(b) Access to medical treatment that provides coverage for integrated care and treatment as recommended by medical and mental health care professionals, including but not limited to psychological services, nutrition counseling, physical therapy, dietician services, medical monitoring, and psychiatric monitoring.

3. By December 31, 2013, the director of the oversight division of the joint committee on legislative research shall submit a report of the actuarial findings prescribed by this section to the speaker of the house of representatives, the president pro tempore of the senate, and the chairpersons of the house of representatives committee on health insurance and the senate small business, insurance and industry committee, or the committees having jurisdiction over health insurance issues if the preceding committees no longer exist.

4. For the purposes of this section, the actuarial analysis of health benefit plan coverage shall assume that such coverage:

(1) Shall not be subject to any greater deductible or co-payment than other health care services provided by the health benefit plan; and

(2) Shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policies of six months' or less duration, or any other supplemental policy.

5. The cost for each actuarial analysis shall not exceed thirty thousand dollars and the oversight division of the joint committee on legislative research may utilize any actuary contracted to perform services for the Missouri consolidated health care plan to perform the analysis required under this section.

6. The provisions of this section shall expire on December 31, 2013.

376.1226. 1. No contract between a health carrier or health benefit plan and a dentist for the provision of dental services under a dental plan shall require that the dentist provide dental services to insureds in the dental plan at a fee established by the health carrier or health benefit plan if such dental services are not covered services under the dental plan.

2. For purposes of this section, the following terms shall mean:

(1) "Covered services", services reimbursable by a health carrier or health benefit plan under an applicable dental plan, subject to such contractual limitations on benefits as may apply, including but not limited to deductibles, waiting periods, or frequency limitations;

(2) "Dental plan", any policy or contract of insurance which provides for coverage of dental services;

(3) "Health benefit plan", the same meaning as such term is defined in section 376.1350;

(4) "Health carrier", the same meaning as such term is defined in section 376.1350.

376.1237. 1. Each health carrier or health benefit plan that offers or issues health benefit plans which are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2014, and that provides coverage for prescription eye drops shall provide coverage for the refilling of an eye drop prescription prior to the last day of the prescribed dosage period without regard to a coverage restriction for early refill of prescription renewals as long as the prescribing health care provider authorizes such early refill and the health carrier or the health benefit plan is notified.

2. For the purposes of this section, "health carrier" and "health benefit plan" shall have the same meaning as defined in section 376.1350.

3. The coverage required by this section shall not be subject to any greater deductible or co-payment than other similar health care services provided by the health benefit plan.

4. The provisions of this section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policies of six months' or less duration, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

5. The provisions of this section shall terminate on January 1, 2017.

376.1363. 1. A health carrier shall maintain written procedures for making utilization review decisions and for notifying enrollees and providers acting on behalf of enrollees of its decisions. For purposes of this section, "enrollee" includes the representative of an enrollee.

2. For initial determinations, a health carrier shall make the determination within two working days of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required:

(1) In the case of a determination to certify an admission, procedure or service, the carrier shall notify the provider rendering the service by telephone **or electronically** within twenty-four hours of making the initial certification, and provide written or electronic confirmation of **[**the**]** **a** telephone **or electronic** notification to the enrollee and the provider within two working days of making the initial certification;

(2) In the case of an adverse determination, the carrier shall notify the provider rendering the service by telephone **or electronically** within twenty-four hours of making the adverse determination; and shall provide written or electronic confirmation of **[**the**]** **a** telephone **or electronic** notification to the enrollee and the provider within one working day of making the adverse determination.

3. For concurrent review determinations, a health carrier shall make the determination within one working day of obtaining all necessary information:

(1) In the case of a determination to certify an extended stay or additional services, the carrier shall notify by telephone **or electronically** the provider rendering the service within one working day of making the certification, and provide written or electronic confirmation to the enrollee and the provider within one working day after **[**the**]** telephone **or electronic** notification. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services;

(2) In the case of an adverse determination, the carrier shall notify by telephone **or electronically** the provider rendering the service within twenty-four hours of making the adverse determination, and provide written or electronic notification to the enrollee and the provider within one working day of **[**the**]** **a** telephone **or electronic** notification. The service shall be continued without liability to the enrollee until the enrollee has been notified of the determination.

4. For retrospective review determinations, a health carrier shall make the determination within thirty working days of receiving all necessary information. A carrier shall provide notice in writing of the carrier's determination to an enrollee within ten working days of making the determination.

5. A written notification of an adverse determination shall include the principal reason or reasons for the determination, the instructions for initiating an appeal or reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination. A health carrier shall provide the clinical rationale in writing for an adverse determination, including the clinical review criteria used to make that determination, to any party who received notice of the adverse determination and who requests such information.

6. A health carrier shall have written procedures to address the failure or inability of a provider or an enrollee to provide all necessary information for review. In cases where the provider or an enrollee will not release necessary information, the health carrier may deny certification of an admission, procedure or service.

376.1575. As used in sections 376.1575 to 376.1580, the following terms shall mean:

(1) "Completed application", a practitioner's application to a health carrier that seeks the health carrier's authorization for the practitioner to provide patient care services as a member of the health carrier's network and does not omit any information which is clearly required by the application form or the accompanying instructions;

(2) "Credentialing", a health carrier's process of assessing and validating the qualifications of a practitioner to provide patient care services and act as a member of the health carrier's provider network;

(3) "Health carrier", the same meaning as such term is defined in section 376.1350;

(4) "Practitioner":

(a) A physician or physician assistant eligible to provide treatment services under chapter 334;

(b) A pharmacist eligible to provide services under chapter 338;

(c) A dentist eligible to provide services under chapter 332;

(d) A chiropractor eligible to provide services under chapter 331;

(e) An optometrist eligible to provide services under chapter 336;

(f) A podiatrist eligible to provide services under chapter 330;

(g) A psychologist or licensed clinical social worker eligible to provide services under chapter 337; or

(h) An advanced practice nurse eligible to provide services under chapter 335.

376.1578. 1. Within forty-eight hours after receipt of an electronically filed credentialing application by a health carrier, the carrier shall provide a practitioner with electronic access to the carrier's internet web portal to verify the receipt of the practitioner's application.

2. A health carrier shall assess a health care practitioner's credentialing information and make a decision as to whether to approve or deny the practitioner's credentialing application within ninety calendar days of the date of receipt of the completed application. The ninety-day deadline established in this section shall not apply if the application or subsequent verification of information indicates that the practitioner has:

(1) A history of behavioral disorders or other impairments affecting the practitioner's ability to practice, including but not limited to substance abuse;

(2) Licensure disciplinary actions against the practitioner's license to practice imposed by any state or territory or foreign jurisdiction;

(3) Had the practitioner's hospital admitting or surgical privileges or other organizational credentials or authority to practice revoked, restricted, or suspended based on the practitioner's clinical performance; or

(4) A judgment or judicial award against the practitioner arising from a medical malpractice liability lawsuit.

3. The department of insurance, financial institutions and professional registration shall establish a mechanism for reporting alleged violations of this section to the department.

376.1900. 1. As used in this section, the following terms shall mean:

(1) "Electronic visit", or "e-Visit", an online electronic medical evaluation and management service completed using a secured website for a single patient encounter. An electronic visit shall be initiated by a patient or by the guardian of a patient with the health care provider, be completed using a HIPAA compliant online connection, and include a permanent record of the electronic visit;

(2) "Health benefit plan" shall have the same meaning ascribed to it in section 376.1350;

(3) "Health care provider" shall have the same meaning ascribed to it in section 376.1350;

(4) "Health care service", a service for the diagnosis, prevention, treatment, cure or relief of a physical or mental health condition, illness, injury or disease;

(5) "Health carrier" shall have the same meaning ascribed to it in section 376.1350;

(6) "Telehealth" shall have the same meaning ascribed to it in section 208.670.

2. Each health carrier or health benefit plan that offers or issues health benefit plans which are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2014, shall not deny coverage for a health care service on the basis that the health care service is provided through telehealth if the same service would be covered if provided through face-to-face diagnosis, consultation, or treatment.

3. A health carrier may not exclude an otherwise covered health care service from coverage solely because the service is provided through telehealth rather than face-to-face consultation or contact between a health care provider and a patient. Subject to approval by the health carrier, health care services may be provided by telehealth providers without any prior face-to-face consultation or contact between a health care provider and a patient.

4. A health carrier shall not be required to reimburse a telehealth provider or a consulting provider for site origination fees or costs for the provision of telehealth services; however, subject to correct coding, a health carrier shall reimburse a health care provider for the diagnosis, consultation, or treatment of an insured or enrollee when the health care service is delivered through telehealth on the same basis that the health carrier covers the service when it is delivered in person.

5. A health care service provided through telehealth shall not be subject to any greater deductible, copayment, or coinsurance amount than would be applicable if the same health care service was provided through face-to-face diagnosis, consultation, or treatment.

6. A health carrier shall not impose upon any person receiving benefits under this section any copayment, coinsurance, or deductible amount, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the policy, contract, or health benefit plan.

7. Nothing in this section shall preclude a health carrier from undertaking utilization review to determine the appropriateness of telehealth as a means of delivering a health care service; provided that the determinations shall be made in the same manner as those regarding the same service when it is delivered in person.

8. A health carrier or health benefit plan may limit coverage for health care services that are provided through telehealth to health care providers that are in a network approved by the plan or the health carrier.

9. Nothing in this section shall be construed to require a health care provider to be physically present with a patient where the patient is located unless the health care provider who is providing health care services by means of telehealth determines that the presence of a health care provider is necessary.

10. The provisions of this section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policies of six months' or less duration, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

Section B. The enactment of section 376.1900 shall become effective January 1, 2014.

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