SECOND REGULAR SESSION

HOUSE BILL NO. 1616

100TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE COLEMAN (97).

4194H.01I DANA RADEMAN MILLER, Chief Clerk

AN ACT

To amend chapter 376, RSMo, by adding thereto one new section relating to health insurance.

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

Section A. Chapter 376, RSMo, is amended by adding thereto one new section, to be known as section 376.760, to read as follows:

376.760. 1. This act may be cited as the "Ensuring Coverage for Patients with Preexisting Conditions Act".

2. Subject to subsections 2 to 6 of this section, each health carrier, as defined in section 376.1350, that offers health insurance coverage in this state shall accept every employer and individual in this state that applies for such coverage.

(1) A health carrier may restrict enrollment to open or special enrollment periods.

(2) A health carrier shall establish special enrollment periods for qualifying events.

3. In the case of a health carrier that offers health insurance coverage in the group and individual market through a network plan, the health carrier may:

(1) Limit the employers that may apply for such coverage to those with eligible individuals who live, work, or reside in the service area for such network plan; and

(2) Within the service area of such plan, deny such coverage to such employers and individuals if the health carrier has demonstrated, if required, to the department of commerce and insurance (hereafter, the "department") that:

(a) It does not have the capacity to deliver services adequately to enrollees of any additional groups or any additional individuals because of its obligations to existing group contract holders and enrollees; 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.

(b) It is applying subsection 3 of this section uniformly to all employers and individuals without regard to the claims experience of those individuals, employers, employees and their dependents, or any health status-related factor relating to such individuals, employees, and dependents.

4. A health carrier, upon denying health insurance coverage in any service area under subsection 3 of this section, may not offer coverage in the group or individual market within such service area for a period of one hundred eighty days after the date such coverage is denied.

5. A health carrier may deny health insurance coverage in the group or individual market if the issuer has demonstrated, if required, to the department that:

(1) It does not have the financial reserves necessary to underwrite additional coverage; and

(2) It is applying subsection 3 of this section uniformly to all employers and individuals in the group or individual market in the state consistent with applicable state law and without regard to the claims experience of those individuals, employers, employees and their dependents, or any health status-related factor relating to such individuals, employees, and dependents.

6. A health carrier denying health insurance coverage under subsection 5 of this section may not offer coverage in connection with group health plans in the group or individual market for one hundred eighty days after the date such coverage is denied or until the health carrier has demonstrated to the department that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later. The department may provide for the application of this subsection on a service-area specific basis.

7. A health carrier offering group or individual health insurance coverage shall not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(1) Health status;

(2) Medical condition, including physical and mental illnesses;

(3) Claims experience;

(4) Receipt of health care;

(5) Medical history;

(6) Genetic information;

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

(8) Disability; and

(9) Any other health status-related factor determined appropriate by the department.

8. A health carrier offering group or individual health insurance coverage shall not require any individual, as a condition of enrollment or continued enrollment under the plan, to pay a premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual. Nothing in this subsection shall be construed to:

(1) Restrict the amount that an employer or individual may be charged for coverage under a group health plan, except as provided in subsection 9 of this section, or individual health coverage; or

(2) Prevent a health carrier from offering group health insurance coverage, from establishing premium discounts or rebates, or modifying otherwise applicable co-payments or deductibles in return for adherence to programs of health promotion and disease prevention.

9. (1) For purposes of this section, a health carrier offering group health insurance coverage in connection with a group health plan may not adjust premium or contribution amounts for the group covered under such plan on the basis of genetic information.

(2) Nothing in subdivision (1) of subsection 9 of this section or in subsection 13 of this section shall be construed to limit the ability of a health carrier offering group or individual health insurance coverage to increase the premium for an employer based on the manifestation of a disease or disorder of an individual who is enrolled in the plan. In such case, the manifestation of a disease or disorder in an individual shall not also be used as genetic information about other group members and to further increase the premium for the employer.

10. A health carrier offering health insurance coverage in connection with a group health plan shall not request or require an individual or a family member of such individual to undergo a genetic test. This subsection shall not be construed to limit the authority of a health care professional who is providing health care services to an individual to request that such individual undergo a genetic test. Additionally, nothing in this subsection shall be construed to preclude a group health plan, or a health carrier offering health insurance coverage in connection with a group health plan, from obtaining and using the results of a genetic test in making a determination regarding payment for services.

11. A health carrier offering health insurance coverage in connection with a group health plan may request only the minimum amount of information necessary to accomplish the intended purpose.

12. Notwithstanding subsection 10 of this section, a health carrier offering health insurance coverage in connection with a group plan may request, but shall not require, that a participant or beneficiary undergo a genetic test if each of the following conditions are met:

(1) The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent federal regulations, and any applicable state law or regulation for the protection of human subjects in research;

(2) The plan or issuer clearly indicates to each participant or beneficiary, or in the case of a minor child, to the legal guardian of such beneficiary, to whom the request is made that:

(a) Compliance with the request is voluntary; and

(b) Noncompliance will have no effect on enrollment status or premium contribution amounts;

(3) No genetic information collected or acquired under this subsection shall be used for underwriting purposes;

(4) The health carrier notifies the department in writing that the health carrier is conducting activities pursuant to the exception provided under this subsection, including a description of the activities conducted; and

(5) The health carrier complies with such other conditions as the department may by regulation require for activities conducted under this section.

13. A health carrier offering health insurance coverage with a group health plan shall not:

(1) Request, require, or purchase genetic information for underwriting purposes; or

(2) Request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the plan or coverage in connection with such enrollment.

14. If a health carrier offering health insurance coverage in connection with a group health plan obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of subsection 13 of this section if such request, requirement, or purchase is not in violation of subdivision (1) of subsection 13 of this section.

15. Any reference to genetic information concerning an individual or family member of an individual shall:

(1) With respect to such an individual or family member of an individual who is a pregnant person, include genetic information of any fetus carried by such pregnant person; and

(2) With respect to an individual or family member utilizing an assisted reproductive technology, include genetic information of any embryo legally held by the individual or family member.

16. Under this section, "program of health promotion or disease prevention", or "wellness program", means a program offered by an employer that is designed to promote health or prevent disease and meets the applicable requirements of this section.

(1) If none of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program are based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals and the requirements of subsection 17 of this section are met;

(2) If any of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program are based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if the requirements of subsection 18 of this section are met.

17. If none of the conditions for obtaining a premium discount or rebate or other reward under a wellness program, as described under subdivision (1) of subsection 16 of this section, are based on an individual satisfying a standard that is related to a health status factor, the wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals. The following programs shall not be required to comply with the requirements of subsection 18 of this section if participation in the program is made available to all similarly situated individuals:

(1) A program that reimburses all or part of the cost for memberships in a fitness center;

(2) A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes;

(3) A program that encourages preventive care related to a health condition through the waiver of the co-payment or deductible requirement under a group health plan for the costs of certain items or services related to a health condition, such as prenatal care or well-baby visits;

(4) A program that reimburses individuals for the costs of smoking cessation programs without regard to whether the individual quits smoking; and

(5) A program that provides a reward to individuals for attending a periodic health education seminar.

18. If any of the conditions for obtaining a premium discount, rebate, or reward under a wellness program as described under subdivision (2) of subsection 16 are based on an individual satisfying a standard that is related to a health status factor, the wellness program shall not violate this section if the following requirements are met:

(1) The reward for the wellness program, together with the reward for other wellness programs with respect to the plan that requires satisfaction of a standard related to a health status factor, shall not exceed thirty percent of the cost of employee-only coverage under the plan. If, in addition to employees or individuals, any class of dependents, such as spouses or spouses and dependent children, may participate fully in the wellness program, such reward shall not exceed thirty percent of the cost of the coverage in which an employee or individual and any dependents are enrolled. For purposes of this subdivision, the cost of coverage shall be determined based on the total amount of employer and employee contributions for the benefit package under which the employee is, or the employee and any dependents are, receiving coverage. A reward may be in the form of a discount or rebate of a premium or contribution; a waiver of all or part of a cost-sharing mechanism such as deductibles, co-payments, or coinsurance; the absence of a surcharge; or the value of a benefit that would otherwise not be provided under the plan. The department may increase the reward available under this subdivision by up to fifty percent of the cost of coverage if the department determines that such an increase is appropriate;

(2) The wellness program shall be reasonably designed to promote health or prevent disease. A program complies with this subdivision if the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease;

(3) The plan shall give individuals eligible for the program the opportunity to qualify for the reward under the program at least once each year;

(4) The full reward under the wellness program shall be made to all similarly situated individuals. For such purpose:

(a) The reward is not available to all similarly situated individuals for a period unless the wellness program allows for:

a. A reasonable alternative standard, or waiver of the otherwise applicable standard, for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

b. A reasonable alternative standard, or waiver of the otherwise applicable standard, for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard;

(b) If reasonable under the circumstances, the plan or issuer may seek verification, such as a statement from an individual's physician, that a health status factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard;

(5) The health carrier involved shall disclose in all plan materials describing the terms of the wellness program the availability of a reasonable alternative standard, or the possibility of waiver of the otherwise applicable standard, required under subdivision (4) of this subsection. If plan materials disclose that such a program is available, without describing its terms, the disclosure under this subdivision shall not be required.

19. The director may promulgate all necessary rules and regulations for the administration of this section. 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, 2020, shall be invalid and void.

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