FIRST REGULAR SESSION

HOUSE COMMITTEE SUBSTITUTE FOR

SENATE SUBSTITUTE FOR

SENATE COMMITTEE SUBSTITUTE FOR

SENATE BILL NO. 306

95TH GENERAL ASSEMBLY

0817L.10C D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 143.111, 143.113, 208.152, 208.215, 354.535, 354.536, 374.184, 376.384, 376.397, 376.401, 376.421, 376.424, 376.426, 376.428, 376.450, 376.453, 376.776, 376.960, 376.966, 376.986, 376.987, 376.995, 376.1450, 379.930, 379.940, and 379.952, RSMo, and to enact in lieu thereof seventy-three new sections relating to health care services, with emergency clauses for certain sections.

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

Section A. Sections 143.111, 143.113, 208.152, 208.215, 354.535, 354.536, 374.184, 376.384, 376.397, 376.401, 376.421, 376.424, 376.426, 376.428, 376.450, 376.453, 376.776, 376.960, 376.966, 376.986, 376.987, 376.995, 376.1450, 379.930, 379.940, and 379.952, RSMo, are repealed and seventy-three new sections enacted in lieu thereof, to be known as sections 143.111, 191.015, 191.940, 191.1005, 191.1008, 191.1010, 191.1127, 191.1130, 191.1200, 191.1250, 191.1256, 191.1259, 191.1265, 191.1271, 197.550, 197.553, 197.556, 197.559, 197.562, 197.565, 197.568, 197.571, 197.574, 197.577, 197.580, 197.586, 205.202, 208.152, 208.215, 354.535, 354.536, 374.184, 376.384, 376.391, 376.394, 376.397, 376.401, 376.421, 376.424, 376.426, 376.428, 376.437, 376.439, 376.443, 376.450, 376.453, 376.776, 376.960, 376.966, 376.985, 376.986, 376.987, 376.995, 376.1232, 376.1450, 376.1600, 376.1603, 376.1618, 379.930, 379.940, 379.952, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, and 12, to read as follows:

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

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

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.

(2) The Missouri deduction for personal exemptions;

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

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

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

191.015. 1. This section shall be known and may be cited as the "Missouri Patient Privacy Act".

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

(1) "Disease state management programs", delivery of services for patients with chronic illness, including education, health management support, and coordination of health care services;

(2) "Health care provider", a provider of services as defined in Section 1861(u) of the Social Security Act, 42 U.S.C. Section 1395x(s), or a provider of medical or health services as defined in Section 1861(s) of the Social Security Act, 42 U.S.C. Section 1395x(s), or any other person furnishing health care services or supplies;

(3) "Personal health information", any identifiable information, in electronic or physical form, regarding an individual's health, medical history, medical treatment, or diagnosis by a health care provider that is:

(a) Created or stored by the health care provider or health carrier in the normal course of its business operations; and

(b) Not otherwise publicly available or in the public domain.

3. No personal health information of a patient which can be identified as specific to such patient shall be disclosed to any employer, public or private payor, or employee or agent of a state department or agency without the written consent of the patient, excluding information submitted as part of a medical claim; except that, such information may be disclosed to a health insurer, labor benefit trust, employer, state employee, the Missouri consolidated health care plan, the department of health and senior services, the department of insurance, financial institutions and professional registration, or the MO HealthNet division within the department of social services, or agents of any such entities, in connection with the performance of such employee's official duties. Such official duties shall be for purposes allowed under 45 CFR 164.512, as amended, including but not limited to:

(1) Oversight of state health programs, including disease state management programs;

(2) Tracking of infectious or communicable diseases throughout the state;

(3) State wellness initiatives and programs;

(4) Research state medical trends; and

(5) Programs accessing the quality and affordability of health care.

4. Nothing in this section shall be construed as prohibiting disclosure of personal health information of a patient consistent with federal law, including the federal Health Insurance Portability and Accountability Act (HIPAA) and the privacy rules set forth in this section.

5. No health care provider shall be required to redact information when disclosing personal health information under this section.

191.940. 1. This section shall be known and may be cited as the "Evan de Mello Reimbursement Program".

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

(1) "Child", a resident of this state who is less than twenty-one years of age;

(2) "Condition or impairment", any disease, defect, or diagnosis that:

(a) Requires immediate lifesaving medical treatment; or

(b) Can cause a crippling disability if not treated; or

(c) Requires prolonged outpatient care; or

(d) Has a poor to fair prognosis regardless of treatment or a variable prognosis;

(3) "Departments", the departments of health and senior services, and mental health;

(4) "Payer of last resort", the Evan de Mello reimbursement program is the last financial resource for reimbursement after all other available sources of payment have been exhausted;

(5) "Services", the same as such term is defined in section 201.010, RSMo.

3. The department of health and senior services and the department of mental health shall establish a program to provide financial assistance for the cost of transportation and ancillary services associated with receipt of medical treatment of an eligible child.

4. To be eligible for assistance under the program, a child shall be:

(1) Suffering from a condition or impairment that results in severe physical illness or physical impairments;

(2) In need of transportation or ancillary services due to the child's condition;

(3) Certified by a physician of the child's choice as a child who will likely benefit from medical services;

(4) Required to travel a distance of one hundred miles or more for medical services, as defined in section 201.010, RSMo, is financially unable to pay for such transportation

or ancillary services, and the child's parents, guardian, or person legally responsible for the child's support is unable to pay for such travel expenses.

5. Subject to appropriations, recipients under the program shall receive reimbursement for transportation or ancillary services; except that, if any person, firm, corporation, or public or private agency is liable by contract or otherwise to the parents or a recipient of such services due to personal injury to or disability or disease of the recipient of such services, the service is subrogated to the right of the parent or recipient to recover from that part of the award or settlement an amount equal to the amount expended by the service for such services which are not otherwise recoverable from the parent or recipient. The acceptance of such services from the service constitutes acknowledgment of subrogation rights by the service, and the service may take any and all action necessary to enforce the subrogation rights.

6. The program established under this section is a payer of last resort.

7. The departments shall promulgate rules to implement the provisions of this section. Such rules shall include, but shall not be limited to:

(1) An application and review process for program eligibility determinations;

(2) Any per-recipient dollar cap on benefits under the program, which shall not be less than five thousand dollars per recipient; and

(3) The household income eligibility limits under the program, which shall not exceed a household income of three hundred fifty percent of the federal poverty level.

8. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2009, shall be invalid and void.

191.1005. 1. For purposes of this section, the following terms shall mean:

(1) "Estimate of cost", an estimate given prior to the provision of medical services which is based on specific patient information or general assumptions about typical utilization and costs for medical services. Upon written request by a patient, a provider or insurer shall be required to provide the patient a timely estimate of cost for any elective or nonemergent health care service. Such requirement shall not apply to emergency health care services or any provider documenting to consumers the cost of the provider's twenty most common charges electronically or in paper format, or to any referral services that the

provider does not provide directly to a patient. Any estimate of cost may include a disclaimer noting the actual amount billed may be different from the estimate of cost. An estimate of cost shall not be deemed an authorization for the provision of services;

(2) "Insurer", the same meaning as the term "health carrier" is defined in section 376.1350, RSMo, and includes the state of Missouri for purposes of the rendering of health care services by providers under a medical assistance program of the state.

2. Programs of insurers that publicly assess and compare the quality and cost efficiency of health care providers shall conform to the following criteria:

(1) The insurers shall retain, at their own expense, the services of a nationally-recognized independent health care quality standard-setting organization to review the plan's programs for consumers that measure, report, and tier providers based on their performance. Such review shall include a comparison to national standards and a report detailing the measures and methodologies used by the health plan. The scope of the review shall encompass all elements described in this section and section 191.1008;

(2) The program measures shall provide performance information that reflects consumers' health needs. Programs shall clearly describe the extent to which they encompass particular areas of care, including primary care and other areas of specialty care;

(3) Performance reporting for consumers shall include both quality and cost efficiency information. While quality information may be reported in the absence of cost-efficiency, cost-efficiency information shall not be reported without accompanying quality information;

(4) When any individual measures or groups of measures are combined, the individual scores, proportionate weighting, and any other formula used to develop composite scores shall be disclosed. Such disclosure shall be done both when quality measures are combined and when quality and cost efficiency are combined;

(5) Consumers or consumer organizations shall be solicited to provide input on the program, including methods used to determine performance strata;

(6) A clearly defined process for receiving and resolving consumer complaints shall be a component of any program;

(7) Performance information presented to consumers shall include context, discussion of data limitations, and guidance on how to consider other factors in choosing a provider;

(8) Relevant providers and provider organizations shall be solicited to provide input on the program, including the methods used to determine performance strata;

(9) Providers shall be given reasonable prior notice before their individual performance information is publicly released;

(10) A clearly defined process for providers to request review of their own performance results and the opportunity to present information that supports what they believe to be inaccurate results, within a reasonable time frame, shall be a component of any program. Results determined to be inaccurate after the reconsideration process shall be corrected;

(11) Information about the comparative performance of providers shall be accessible and understandable to consumers and providers and shall recognize cost factors associated with medical education and research, patient characteristics, and specialized services;

(12) Information about factors that might limit the usefulness of results shall be publicly disclosed;

(13) Measures used to assess provider performance and the methodology used to calculate scores or determine rankings shall be published and made readily available to the public. Elements shall be assessed against national standards as defined in subdivisions (17) and (18) of this subsection. Examples of measurement elements that shall be assessed against national standards include: risk and severity adjustment, minimum observations, and statistical standards utilized. Examples of other measurement elements that shall be fully disclosed include: data used, how providers' patients are identified, measure specifications and methodologies, known limitations of the data, and how episodes are defined;

(14) The rationale and methodologies supporting the unit of analysis reported shall be clearly articulated, including a group practice model versus the individual provider;

(15) Sponsors of provider measurement and reporting shall work collaboratively to aggregate data whenever feasible to enhance its consistency, accuracy, and use. Sponsors of provider measurement and reporting shall also work collaboratively to align and harmonize measures used to promote consistency and reduce the burden of collection. The nature and scope of such efforts shall be publicly reported;

(16) The program shall be regularly evaluated to assess its effectiveness, accuracy, reliability, validity, and any unintended consequences, including any effect on access to health care;

(17) Measures developed for programs used to compare the quality and cost efficiency of health care providers shall follow the criteria established by the National Committee for Quality Assurance;

(18) All entities, including those offering individual or group health insurance policies providing coverage on an expense-incurred basis, individual or group service or indemnity type contracts issued by a health services corporation, or individual or group service contracts issued by a health maintenance organization, all self-insured group arrangements to the extent not preempted by federal law, and all managed care delivery entities of any type or description are prohibited from entering into new contracts or amending existing contracts that are delivered, issued for delivery, continued, or renewed on or after January 1, 2011, if such contracts limit the use of medical claims data to payment of claims or otherwise preclude such entities from responding to the need of consumers or employers for comparative cost, quality, efficiency, or other performance information on health care services and health care providers. Such entities:

(a) Shall have the ability to use reliable data which is collected from medical records review or from other sources, including but not limited to the federal Centers for Medicare and Medicaid Services, in order to assist such entities in comparing the cost and quality of health care services and health care providers;

(b) May use claims and contracted rate data to report on cost, quality, and efficiency consistent with the patient charter or other nationally recognized standards, such as those issued by the National Committee for Quality Assurance; and

(c) Shall be prohibited from using the information in a manner that violates any state or federal law; and

(19) A health plan shall be deemed compliant with this section if the health plan receives certification from the National Committee for Quality Assurance (NCQA) on programs that evaluate the quality of physicians and hospitals. The health plan is deemed to be in compliance for the length of time the NCQA certification has been granted or awarded.

191.1008. 1. Any person who sells or otherwise distributes to the public health care quality and cost efficiency data for disclosure in comparative format to the public shall identify the measure source or evidence-based science behind the measure and the national consensus, multi-stakeholder, or other peer review process, if any, used to confirm the validity of the data and its analysis as an objective indicator of health care quality.

2. Articles or research studies on the topic of health care quality or cost efficiency that are published in peer-reviewed academic journals that neither receive funding from nor are affiliated with a health care insurer or by state or local government shall be exempt from the requirements of subsection 1 of this section.

3. (1) Upon receipt of a complaint of an alleged violation of this section by a person or entity other than a health carrier, the department of health and senior services shall

investigate the complaint and, upon finding that a violation has occurred, shall be authorized to impose a penalty in an amount not to exceed one thousand dollars. The department shall promulgate rules governing its processes for conducting such investigations and levying fines authorized by law.

(2) Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2009, shall be invalid and void.

191.1010. All alleged violations of sections 191.1005 to 191.1008 by a health insurer shall be investigated and enforced by the department of insurance, financial institutions and professional registration under the department's powers and responsibilities to enforce the insurance laws of this state in accordance with chapter 374, RSMo.

191.1127. The MO HealthNet program and the health care for uninsured children program under sections 208.631 to 208.659, RSMo, in consultation with statewide organizations focused on premature infant health care, shall:

(1) Examine and improve hospital discharge and follow-up care procedures for premature infants born earlier than thirty-seven weeks gestational age to ensure standardized and coordinated processes are followed as premature infants leave the hospital from either a well-baby nursery, step down or transitional nursery, or neonatal intensive care unit and transition to follow-up care by a health care provider in the community;

(2) Urge hospitals serving infants eligible for medical assistance under the MO HealthNet and health care for uninsured children programs to report to the state the causes and incidence of all rehospitalizations of infants born premature at earlier than thirty-seven weeks gestational age within their first six months of life; and

(3) Use guidance from the Centers for Medicare and Medicaid Services' Neonatal Outcomes Improvement Project to implement programs to improve newborn outcomes, reduce newborn health costs, and establish ongoing quality improvement for newborns.

191.1130. 1. The department of health and senior services shall, by December 31, 2009, prepare written educational publications containing information about the possible complications, proper care and support associated with newborn infants who are born

premature at earlier than thirty-seven weeks gestational age. The written information, at a minimum, shall include the following:

(1) The unique health issues affecting infants born premature, such as:

(a) Increased risk of developmental problems;

(b) Nutritional challenges;

(c) Infection;

(d) Chronic lung disease (bronchopulmonary dysplasia);

(e) Vision and hearing impairment;

(d) Breathing problems;

(f) Fine motor skills;

(g) Feeding;

(h) Maintaining body temperature;

(i) Jaundice;

(j) Hyperactivity;

(k) Infant mortality as well as long-term complications associated with growth and nutrition;

(l) Respiratory; and

(m) Reading, writing, mathematics, and speaking;

(2) The proper care needs of premature infants, developmental screenings and monitoring and health care services available to premature infants through the MO HealthNet program and other public or private health programs;

(3) Methods, vaccines, and other preventative measures to protect premature infants from infectious diseases, including viral respiratory infections;

(4) The emotional and financial burdens and other challenges that parents and family members of premature infants experience and information about community resources available to support them.

2. The publications shall be written in clear language to educate parents of premature infants across a variety of socioeconomic statuses. The department may consult with community organizations that focus on premature infants or pediatric health care. The department shall update the publications every two years.

3. The department shall distribute these publications to children's health providers, maternal care providers, hospitals, public health departments, and medical organizations and encourage those organizations to provide the publications to parents or guardians of premature infants.

191.1200. 1. The general assembly shall appropriate four hundred thousand dollars from the health care technology fund created in section 208.975, RSMo, to the

department of social services for the purpose of awarding a grant to implement an Internet web-based primary care access pilot project designed as a collaboration between private and public sectors to connect, where appropriate, a patient with a primary care medical home, and schedule patients into available community-based appointments as an alternative to nonemergency use of the hospital emergency room. The grantee shall establish a program that diverts patients presenting at an emergency room for nonemergency care to more appropriate outpatient settings as is consistent with federal law and regulations. The program shall refer the patient to an appropriate health care professional based on the patient's health care needs and situation. The program shall provide the patient with a scheduled appointment that is timely, with an appropriate provider who is conveniently located. If the patient is uninsured and potentially eligible for MO HealthNet, the program shall connect the patient to a primary care provider, community clinic, or agency that can assist the patient with the application process. The program shall also ensure that discharged patients are connected with a community-based primary care provider and assist in scheduling any necessary follow-up visits before the patient is discharged.

2. The program shall not require a provider to pay a fee for accepting charity care patients in a Missouri public health care program.

3. The grantee shall report to the director on a quarterly basis the following information:

(1) The total number of appointments available for scheduling by specialty;

(2) The average length of time between scheduling and actual appointment;

(3) The total number of patients referred and whether the patient was insured or uninsured; and

(4) The total number of appointments resulting in visits completed and number of patients continuing services with the referring clinic.

4. The director, in consultation with the Missouri Hospital Association, or a successor organization, shall conduct an evaluation of the emergency room diversion pilot project and submit the results to the general assembly by January 15, 2011. The evaluation shall compare the number of nonemergency visits and repeat visits to hospital emergency rooms for the period before the commencement of the project and one year after the commencement, and an estimate of the costs saved from any documented reductions.

191.1250. As used in sections 191.1250 to 191.1277, the following terms shall mean:

(1) "Chronic condition", any regularly recurring, potentially life-threatening medical condition that requires regular supervision by a primary care physician and/or medical specialist;

(2) "Department", the department of health and senior services;

(3) "EMR" or "electronic medical record", refers to a patient's medical history that is stored in real-time using information technology and which can be amended, updated, or supplemented by the patient or the physician using the electronic medical record;

(4) "HIPAA", the federal Health Insurance Portability and Accountability Act of 1996;

(5) "Originating site", a place where a patient may receive health care via telehealth. An originating site may include:

(a) A licensed inpatient center;

(b) An ambulatory surgical center;

(c) Any practice location, office, or clinic of a licensed health care professional;

(d) A skilled nursing facility;

(e) A residential treatment facility;

(f) A home health agency;

(g) A diagnostic laboratory or imaging center;

(h) An assisted living facility;

(i) A school-based health program;

(j) A mobile clinic;

(k) A mental health clinic;

(l) A rehabilitation or other therapeutic health setting;

(m) The patient's residence;

(n) The patient's place of employment; or

(o) The patient's then-current location if the patient is away from the patient's residence or place of employment;

(6) "Telehealth", the use of telephonic and other electronic means of communications to provide and support health care delivery, diagnosis, consultation, and treatment when distance separates the patient and the health care provider;

(7) "Telehealth practitioner", a person who is a licensed health care professional and who utilizes telehealth to diagnose, consult with, or treat patients without having conducted an in-person consultation with a particular patient.

191.1256. Sections 191.1250 to 191.1277 do not:

(1) Alter the scope of practice of any health care practitioner; or

(2) Limit a patient's right to choose in-person contact with a health care professional for the delivery of health care services for which telehealth is available.

191.1259. The delivery of health care via telehealth is recognized and encouraged as a safe, practical and necessary practice in this state. No health care provider or operator

of an originating site shall be disciplined for or discouraged from participating in sections 191.1250 to 191.1277. In using telehealth procedures, health care providers and operators of originating sites shall comply with all applicable federal and state guidelines and shall follow established federal and state rules regarding security, confidentiality and privacy protections for health care information.

191.1265. Only telehealth practitioners qualified under sections 191.1250 to 191.1277 may practice telehealth care in this state. Telehealth practitioners may reside outside this state but shall be licensed by an appropriate board within the division of professional registration. Beginning July 1, 2010, all health carriers, as defined under section 376.1350, RSMo, shall reimburse services provided through telehealth in the same manner they would reimburse a standard office visit or consultation by the provider or specialist. The department of social services shall promulgate rules for the MO HealthNet program consistent with the provisions of this section.

191.1271. By January 1, 2010, the department shall promulgate quality control rules and regulations to be used in removing and improving the services of telehealth practitioners. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2009, shall be invalid and void.

197.550. As used in sections 197.550 to 197.586, the following terms shall mean:

(1) "Identifiable information", information that is presented in a form or manner that allows the identification of any provider, patient, or reporter of patient safety work product. With respect to patients, such information includes any individually identifiable health information, as defined in federal regulations promulgated under Section 264(c) of the Health Insurance Portability and Accountability Act of 1996, as amended;

(2) "Nonidentifiable information", information that is presented in a form and manner that prevents the identification of any provider, patient, or reporter of patient safety work product. With respect to patients, such information shall be de-identified consistent with the federal regulations promulgated under Section 264(c) of the Health Insurance Portability and Accountability Act of 1996, as amended;

(3) "Patient safety organization", any entity which:

(a) Is organized as an independent nonprofit corporation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended, and applicable state law governing nonprofit corporations;

(b) Meets the statutory and regulatory criteria for certification as a patient safety organization under the federal Patient Safety and Quality Improvement Act of 2005, 42 U.S.C. Section 299b-21, et seq., as amended, and regulations promulgated thereunder;

(c) Has a governing board or advisory committee that includes representatives of hospitals, physicians, an employer or group representing employers, an insurance company or group representing insurance companies, the long-term care industry, and a federally-recognized quality improvement organization that contracts with the federal government to review medical necessity and quality assurance in the Medicare program;

(d) Conducts, as the organization's primary activity, efforts to improve patient safety and the quality of health care delivery;

(e) Collects and analyzes patient safety work product that is submitted by providers;

(f) Develops and disseminates evidence-based information to providers with respect to improving patient safety, such as recommendations, protocols, or information regarding best practices;

(g) Utilizes patient safety work product to carry out activities limited to those described under this section and for the purposes of encouraging a culture of safety and of providing direct feedback and assistance to providers to effectively minimize patient risk;

(h) Maintains confidentiality with respect to identifiable information under federal and state law and regulations;

(i) Implements appropriate security measures with respect to patient safety work product;

(j) Submits, if authorized by its governing board and certified by federal law and regulation, nonidentifiable information to a national patient safety database;

(k) Provides technical support to health care providers in the collection, submission, and analysis of data and patient safety activities as described in sections 197.553 and 197.562;

(4) "Patient safety work product", the same meaning as such term is defined in federal regulations promulgated to implement the federal Patient Safety and Quality Improvement Act of 2005, 42 U.S.C. Section 299b-21, et seq., as amended;

(5) "Provider", the same meaning as such term is defined in federal regulations promulgated to implement the federal Patient Safety and Quality Improvement Act of 2005, 42 U.S.C. Section 299b-21, et seq., as amended;

(6) "Reportable incident", an occurrence of a serious reportable event in health care as such event is defined in this section;

(7) "Reportable incident prevention plan", a written plan that:

(a) Defines, based on a root cause analysis, specific changes in organizational policies and procedures designed to reduce the risk of similar incidents occurring in the future or that provides a rationale that no such changes are warranted;

(b) Sets deadlines for the implementation of such changes;

(c) Establishes who is responsible for making the changes; and

(d) Provides a mechanism for evaluating the effectiveness of such changes;

(8) "Root cause analysis", a structure process for identifying basic or causal factors that underlie variation in performance, including but not limited to the occurrence and possible occurrence of a reportable incident. A root cause analysis focuses primarily on systems and processes rather than individual performance and progresses from special causes in clinical processes to common causes in organization processes and identifies potential improvements in processes or systems that would tend to decrease the likelihood of such events in the future, or determines after analysis that no such improvement opportunities exists;

(9) "Serious reportable event in health care", an occurrence of one or more of the actions or outcomes included in the list of serious adverse events in health care as initially defined by the National Quality Forum in its March 2002 report and subsequently updated by the National Quality Forum, including all criteria established for identifying such events.

197.553. 1. Beginning January 1, 2010, a hospital shall report each reportable incident to a federally-designated patient safety organization, as defined by the federal Patient Safety and Quality Improvement Act of 2005, as amended. The hospital's initial report of the incident shall be submitted to the patient safety organization no later than the close of business on the next business day following discovery of the incident. The initial report shall include a description of immediate actions to be taken by the hospital to minimize the risk of harm to patients and prevent a reoccurrence and verification that the hospital's patient safety and performance improvement review processes are responding to the reportable incident. The hospital shall, within forty-five days after the incident is discovered, submit a completed root cause analysis and a reportable incident prevention plan to the patient safety organization.

2. Upon request of the hospital, a patient safety organization may provide technical assistance in the development of a root cause analysis or reportable incident prevention plan relating to a reportable incident.

3. All hospitals shall establish a policy whereby the patient or the patient's legally authorized representative is notified of the occurrence of a serious reportable event in health care. Such notification shall be provided not later than one business day after the hospital or its agent becomes aware of the occurrence. The time, date, participants, and content of the notification shall be documented in the patient's medical record. The provision of notice to a patient under this section shall not, in any action or proceeding, be considered an acknowledgment or admission of liability.

197.556. Under paragraphs (f) and (g) of subdivision (3) of section 197.550 and 42 U.S.C. Section 299b-21, et seq., the patient safety organization shall assess the information provided regarding the reportable incident and furnish the hospital with a report of its findings and recommendations as to how to prevent future incidents.

197.559. 1. The provisions of sections 197.550 to 197.586 shall not be construed to:

(1) Restrict the availability of information gleaned from original sources;

(2) Limit the disclosure or use of information from original sources regarding a reportable incident to:

(a) State or federal agencies or law enforcement under law or regulation; or

(b) Health care facility accreditation agencies.

2. Nothing in sections 197.550 to 197.586 shall modify the duty of a hospital to report disciplinary actions or medical malpractice actions against a health care professional under law.

197.562. As permitted by the Patient Safety and Quality Improvement Act of 2005, the patient safety organization shall publish an annual report to the public on reportable incidents. The first report and each subsequent annual report shall include twelve months of reported data and shall be published not more than fifteen months after the date data collection begins. The first report and each subsequent annual report shall indicate the number of reportable events by the then current National Quality Forum category of reportable incident and rate per patient encounter by region and by category of reportable incident, and by facility as such categories are established by the National Quality Forum in defining reportable incidents, and may identify reportable incidents by type of facility. The report for the previous year shall be made public no later than April thirtieth.

197.565. No person shall disclose the actions, decisions, proceedings, discussions, or deliberations occurring at a meeting of a patient safety organization except to the extent

necessary to carry out one or more of the purposes of a patient safety organization. A meeting of the patient safety organization shall include:

(1) Any meetings of:

(a) The patient safety organization;

(b) The organization's staff;

(c) The organization's governing body;

(d) Any and all committees, work groups, and task forces of the organization, whether or not formally appointed by the governing body;

(e) The organization's president and chairperson; and

(2) Any meeting in any setting in which patient safety work product is discussed in the normal course of carrying out business of the patient organization.

The proceedings and records of a patient safety organization shall not be subject to discovery or introduction into evidence in any civil action against a provider arising out of the matter or matters that are the subject of consideration by a patient safety organization. Information, documents, or records otherwise available from original sources shall not be immune from discovery or use in any civil action merely because they were presented during proceedings of a patient safety organization. The provisions of this section shall not be construed to prevent a person from testifying to or reporting information obtained independently of the activities of a patient safety organization or which is public information.

197.568. Patient safety work product shall be privileged and confidential under the federal Patient Safety and Quality Improvement Act of 2005, 42 U.S.C. Section 299b-21, et seq., as amended, and regulations promulgated thereunder.

197.571. 1. Any reference to or offer into evidence in the presence of the jury or other fact finder or admission into evidence of patient safety work product during any proceeding that is contrary to sections 197.550 to 197.586 shall constitute grounds for a mistrial or a similar termination of the proceeding and reversible error on appeal from any judgment or order entered in favor of any party who so discloses or offers into evidence patient safety work product.

2. The prohibition against discovery, disclosure, or admission into evidence of patient safety work product is in addition to any other protections provided by law.

197.574. A patient safety organization may disclose nonidentifiable information and nonidentifiable aggregate trend data identifying the number and types of patient safety events that occur. A patient safety organization shall publish educational and evidence-

based information from the summary reports that can be used by all providers to improve the care provided.

197.577. 1. The confidentiality of patient safety work product shall in no way be impaired or otherwise adversely affected solely by reason of the submission of the same to a patient safety organization. The confidentiality of patient safety work product submitted in compliance with sections 197.550 to 197.586 to a patient safety organization shall not be adversely affected if the entity later ceases to meet the statutory definition of a patient safety organization.

2. The exchange or disclosure of patient safety work product by a patient safety organization shall not constitute a waiver of confidentiality or privilege by the health care provider who submitted the data.

197.580. Any provider furnishing services to a patient safety organization shall not be liable for civil damages as a result of such acts, omissions, decisions, or other such conduct in connection with the lawful duties on behalf of a patient safety organization, except for acts, omissions, decisions, or conduct done with actual malice, fraudulent intent, or bad faith.

197.586. 1. Beginning January 1, 2010, any hospital that reports a reportable incident shall not charge for or bill any entity, including third-party payors and patients, for all services related to the reportable incident. If a third-party payor denies a claim, in whole or in part, because there is no coverage for services that resulted in any of the reportable incidents described in sections 197.550 to 197.586, the health care professional or facility that provided such services is prohibited from billing the patient for such services.

2. For purposes of this section, "third-party payor" means a health carrier as defined in section 376.1350, RSMo, an organization entered into a preferred provider agreement, and a third-party administrator for a self-funded health benefit plan.

205.202. 1. The governing body of any hospital district established under sections 205.160 to 205.379 in any county of the third classification without a township form of government and with more than thirteen thousand five hundred but fewer than thirteen thousand six hundred inhabitants may, by resolution, abolish the property tax levied in such district under this chapter and impose a sales tax on all retail sales made within the district which are subject to sales tax under chapter 144, RSMo. The tax authorized in this section shall be not more than one percent, and shall be imposed solely for the purpose of funding the hospital district. The tax authorized in this section shall be in addition to all other sales taxes imposed by law, and shall be stated separately from all other charges and taxes.

2. No such resolution adopted under this section shall become effective unless the governing body of the hospital district submits to the voters residing within the district at a state general, primary, or special election a proposal to authorize the governing body of the district to impose a tax under this section. If a majority of the votes cast on the question by the qualified voters voting thereon are in favor of the question, then the tax shall become effective on the first day of the second calendar quarter after the director of revenue receives notification of adoption of the local sales tax. If a majority of the votes cast on the question by the qualified voters voting thereon are opposed to the question, then the tax shall not become effective unless and until the question is resubmitted under this section to the qualified voters and such question is approved by a majority of the qualified voters voting on the question.

3. All revenue collected under this section by the director of the department of revenue on behalf of the hospital district, except for one percent for the cost of collection which shall be deposited in the state's general revenue fund, shall be deposited in a special trust fund, which is hereby created and shall be known as the "Hospital District Sales Tax Fund", and shall be used solely for the designated purposes. Moneys in the fund shall not be deemed to be state funds, and shall not be commingled with any funds of the state. The director may make refunds from the amounts in the fund and credited to the district for erroneous payments and overpayments made, and may redeem dishonored checks and drafts deposited to the credit of such district. Any funds in the special fund which are not needed for current expenditures shall be invested in the same manner as other funds are invested. Any interest and moneys earned on such investments shall be credited to the fund.

4. The governing body of any hospital district that has adopted the sales tax authorized in this section may submit the question of repeal of the tax to the voters on any date available for elections for the district. If a majority of the votes cast on the question by the qualified voters voting thereon are in favor of the repeal, that repeal shall become effective on December thirty-first of the calendar year in which such repeal was approved. If a majority of the votes cast on the question by the qualified voters voting thereon are opposed to the repeal, then the sales tax authorized in this section shall remain effective until the question is resubmitted under this section to the qualified voters and the repeal is approved by a majority of the qualified voters voting on the question.

5. Whenever the governing body of any hospital district that has adopted the sales tax authorized in this section receives a petition, signed by a number of registered voters of the district equal to at least ten percent of the number of registered voters of the district voting in the last gubernatorial election, calling for an election to repeal the sales tax

imposed under this section, the governing body shall submit to the voters of the district a proposal to repeal the tax. If a majority of the votes cast on the question by the qualified voters voting thereon are in favor of the repeal, the repeal shall become effective on December thirty-first of the calendar year in which such repeal was approved. If a majority of the votes cast on the question by the qualified voters voting thereon are opposed to the repeal, then the sales tax authorized in this section shall remain effective until the question is resubmitted under this section to the qualified voters and the repeal is approved by a majority of the qualified voters voting on the question.

6. If the tax is repealed or terminated by any means, all funds remaining in the special trust fund shall continue to be used solely for the designated purposes, and the hospital district shall notify the director of the department of revenue of the action at least ninety days before the effective date of the repeal and the director may order retention in the trust fund, for a period of one year, of two percent of the amount collected after receipt of such notice to cover possible refunds or overpayment of the tax and to redeem dishonored checks and drafts deposited to the credit of such accounts. After one year has elapsed after the effective date of abolition of the tax in such district, the director shall remit the balance in the account to the district and close the account of that district. The director shall notify each district of each instance of any amount refunded or any check redeemed from receipts due the district.

208.152. 1. MO HealthNet payments shall be made on behalf of those eligible needy persons as defined in section 208.151 who are unable to provide for it in whole or in part, with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the MO HealthNet division, unless otherwise hereinafter provided, for the following:

(1) Inpatient hospital services, except to persons in an institution for mental diseases who are under the age of sixty-five years and over the age of twenty-one years; provided that the MO HealthNet division shall provide through rule and regulation an exception process for coverage of inpatient costs in those cases requiring treatment beyond the seventy-fifth percentile professional activities study (PAS) or the MO HealthNet children's diagnosis length-of-stay schedule; and provided further that the MO HealthNet division shall take into account through its payment system for hospital services the situation of hospitals which serve a disproportionate number of low-income patients**; and provided further that the hospital does not have in force as of January 1, 2011, any contracts with health carriers, as defined in section 376.1350, RSMo, that limit the use of medical claims data to payment of claims or otherwise preclude health carriers from responding to the need of consumers for comparative cost, quality,**

and efficiency information, or other performance information on health care services and health care providers, as defined in section 376.1350, RSMo;

(2) All outpatient hospital services, payments therefor to be in amounts which represent no more than eighty percent of the lesser of reasonable costs or customary charges for such services, determined in accordance with the principles set forth in Title XVIII A and B, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. 301, et seq.), but the MO HealthNet division may evaluate outpatient hospital services rendered under this section and deny payment for services which are determined by the MO HealthNet division not to be medically necessary, in accordance with federal law and regulations**; and provided further that the hospital does not have in force as of January 1, 2011, any contracts with health carriers, as defined in section 376.1350, RSMo, that limit the use of medical claims data to payment of claims or otherwise preclude health carriers from responding to the need of consumers for comparative cost, quality, and efficiency information, or other performance information on health care services and health care providers, as defined in section 376.1350, RSMo**;

(3) Laboratory and X-ray services;

(4) Nursing home services for participants, except to persons with more than five hundred thousand dollars equity in their home or except for persons in an institution for mental diseases who are under the age of sixty-five years, when residing in a hospital licensed by the department of health and senior services or a nursing home licensed by the department of health and senior services or appropriate licensing authority of other states or government-owned and -operated institutions which are determined to conform to standards equivalent to licensing requirements in Title XIX of the federal Social Security Act (42 U.S.C. 301, et seq.), as amended, for nursing facilities. The MO HealthNet division may recognize through its payment methodology for nursing facilities those nursing facilities which serve a high volume of MO HealthNet patients. The MO HealthNet division when determining the amount of the benefit payments to be made on behalf of persons under the age of twenty-one in a nursing facility may consider nursing facilities furnishing care to persons under the age of twenty-one as a classification separate from other nursing facilities;

(5) Nursing home costs for participants receiving benefit payments under subdivision (4) of this subsection for those days, which shall not exceed twelve per any period of six consecutive months, during which the participant is on a temporary leave of absence from the hospital or nursing home, provided that no such participant shall be allowed a temporary leave of absence unless it is specifically provided for in his plan of care. As used in this subdivision, the term "temporary leave of absence" shall include all periods of time during which a participant is away from the hospital or nursing home overnight because he is visiting a friend or relative;

(6) Physicians' services, whether furnished in the office, home, hospital, nursing home, or elsewhere**; and provided further that the physician does not have in force as of January 1, 2011, any contracts with health carriers, as defined in section 376.1350, RSMo, that limit the use of medical claims data to payment of claims or otherwise preclude health carriers from responding to the need of consumers for comparative cost, quality, and efficiency information, or other performance information on health care services and health care providers, as defined in section 376.1350, RSMo**;

(7) Drugs and medicines when prescribed by a licensed physician, dentist, or podiatrist; except that no payment for drugs and medicines prescribed on and after January 1, 2006, by a licensed physician, dentist, or podiatrist may be made on behalf of any person who qualifies for prescription drug coverage under the provisions of P.L. 108-173;

(8) Emergency ambulance services and, effective January 1, 1990, medically necessary transportation to scheduled, physician-prescribed nonelective treatments;

(9) Early and periodic screening and diagnosis of individuals who are under the age of twenty-one to ascertain their physical or mental defects, and health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby. Such services shall be provided in accordance with the provisions of Section 6403 of P.L. 101-239 and federal regulations promulgated thereunder;

(10) Home health care services;

(11) Family planning as defined by federal rules and regulations; provided, however, that such family planning services shall not include abortions unless such abortions are certified in writing by a physician to the MO HealthNet agency that, in his professional judgment, the life of the mother would be endangered if the fetus were carried to term;

(12) Inpatient psychiatric hospital services for individuals under age twenty-one as defined in Title XIX of the federal Social Security Act (42 U.S.C. 1396d, et seq.);

(13) Outpatient surgical procedures, including presurgical diagnostic services performed in ambulatory surgical facilities which are licensed by the department of health and senior services of the state of Missouri; except, that such outpatient surgical services shall not include persons who are eligible for coverage under Part B of Title XVIII, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended, if exclusion of such persons is permitted under Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended;

(14) Personal care services which are medically oriented tasks having to do with a person's physical requirements, as opposed to housekeeping requirements, which enable a person to be treated by his physician on an outpatient rather than on an inpatient or residential basis in a hospital, intermediate care facility, or skilled nursing facility. Personal care services shall be

rendered by an individual not a member of the participant's family who is qualified to provide such services where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a licensed nurse. Persons eligible to receive personal care services shall be those persons who would otherwise require placement in a hospital, intermediate care facility, or skilled nursing facility. Benefits payable for personal care services shall not exceed for any one participant one hundred percent of the average statewide charge for care and treatment in an intermediate care facility for a comparable period of time. Such services, when delivered in a residential care facility or assisted living facility licensed under chapter 198, RSMo, shall be authorized on a tier level based on the services the resident requires and the frequency of the services. A resident of such facility who qualifies for assistance under section 208.030 shall, at a minimum, if prescribed by a physician, qualify for the tier level with the fewest services. The rate paid to providers for each tier of service shall be set subject to appropriations. Subject to appropriations, each resident of such facility who qualifies for assistance under section 208.030 and meets the level of care required in this section shall, at a minimum, if prescribed by a physician, be authorized up to one hour of personal care services per day. Authorized units of personal care services shall not be reduced or tier level lowered unless an order approving such reduction or lowering is obtained from the resident's personal physician. Such authorized units of personal care services or tier level shall be transferred with such resident if her or she transfers to another such facility. Such provision shall terminate upon receipt of relevant waivers from the federal Department of Health and Human Services. If the Centers for Medicare and Medicaid Services determines that such provision does not comply with the state plan, this provision shall be null and void. The MO HealthNet division shall notify the revisor of statutes as to whether the relevant waivers are approved or a determination of noncompliance is made;

(15) Mental health services. The state plan for providing medical assistance under Title XIX of the Social Security Act, 42 U.S.C. 301, as amended, shall include the following mental health services when such services are provided by community mental health facilities operated by the department of mental health or designated by the department of mental health as a community mental health facility or as an alcohol and drug abuse facility or as a child-serving agency within the comprehensive children's mental health service system established in section 630.097, RSMo. The department of mental health shall establish by administrative rule the definition and criteria for designation as a community mental health facility and for designation as an alcohol and drug abuse facility. Such mental health services shall include:

(a) Outpatient mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately

established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

(b) Clinic mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

(c) Rehabilitative mental health and alcohol and drug abuse services including home and community-based preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health or alcohol and drug abuse professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management. As used in this section, mental health professional and alcohol and drug abuse professional shall be defined by the department of mental health pursuant to duly promulgated rules. With respect to services established by this subdivision, the department of social services, MO HealthNet division, shall enter into an agreement with the department of mental health. Matching funds for outpatient mental health services, clinic mental health services, and rehabilitation services for mental health and alcohol and drug abuse shall be certified by the department of mental health to the MO HealthNet division. The agreement shall establish a mechanism for the joint implementation of the provisions of this subdivision. In addition, the agreement shall establish a mechanism by which rates for services may be jointly developed;

(16) Such additional services as defined by the MO HealthNet division to be furnished under waivers of federal statutory requirements as provided for and authorized by the federal Social Security Act (42 U.S.C. 301, et seq.) subject to appropriation by the general assembly;

(17) Beginning July 1, 1990, the services of a certified pediatric or family nursing practitioner with a collaborative practice agreement to the extent that such services are provided in accordance with chapters 334 and 335, RSMo, and regulations promulgated thereunder;

(18) Nursing home costs for participants receiving benefit payments under subdivision (4) of this subsection to reserve a bed for the participant in the nursing home during the time that the participant is absent due to admission to a hospital for services which cannot be performed on an outpatient basis, subject to the provisions of this subdivision:

(a) The provisions of this subdivision shall apply only if:

a. The occupancy rate of the nursing home is at or above ninety-seven percent of MO HealthNet certified licensed beds, according to the most recent quarterly census provided to the

department of health and senior services which was taken prior to when the participant is admitted to the hospital; and

b. The patient is admitted to a hospital for a medical condition with an anticipated stay of three days or less;

(b) The payment to be made under this subdivision shall be provided for a maximum of three days per hospital stay;

(c) For each day that nursing home costs are paid on behalf of a participant under this subdivision during any period of six consecutive months such participant shall, during the same period of six consecutive months, be ineligible for payment of nursing home costs of two otherwise available temporary leave of absence days provided under subdivision (5) of this subsection; and

(d) The provisions of this subdivision shall not apply unless the nursing home receives notice from the participant or the participant's responsible party that the participant intends to return to the nursing home following the hospital stay. If the nursing home receives such notification and all other provisions of this subsection have been satisfied, the nursing home shall provide notice to the participant or the participant's responsible party prior to release of the reserved bed;

(19) Prescribed medically necessary durable medical equipment. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(20) Hospice care. As used in this **[**subsection**]** **subdivision**, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO HealthNet division to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

(21) Prescribed medically necessary dental services. Such services shall be subject to appropriations. An electronic web-based prior authorization system using best medical evidence

and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(22) Prescribed medically necessary optometric services. Such services shall be subject to appropriations. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(23) The MO HealthNet division shall, by January 1, 2008, and annually thereafter, report the status of MO HealthNet provider reimbursement rates as compared to one hundred percent of the Medicare reimbursement rates and compared to the average dental reimbursement rates paid by third-party payors licensed by the state. The MO HealthNet division shall, by July 1, 2008, provide to the general assembly a four-year plan to achieve parity with Medicare reimbursement rates and for third-party payor average dental reimbursement rates. Such plan shall be subject to appropriation and the division shall include in its annual budget request to the governor the necessary funding needed to complete the four-year plan developed under this subdivision.

2. Additional benefit payments for medical assistance shall be made on behalf of those eligible needy children, pregnant women and blind persons with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the division of medical services, unless otherwise hereinafter provided, for the following:

(1) Dental services;

(2) Services of podiatrists as defined in section 330.010, RSMo;

(3) Optometric services as defined in section 336.010, RSMo;

(4) Orthopedic devices or other prosthetics, including eye glasses, dentures, hearing aids, and wheelchairs;

(5) Hospice care. As used in this subsection, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO HealthNet division to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would have been paid for facility services in that nursing home facility for that patient,

in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

(6) Comprehensive day rehabilitation services beginning early posttrauma as part of a coordinated system of care for individuals with disabling impairments. Rehabilitation services must be based on an individualized, goal-oriented, comprehensive and coordinated treatment plan developed, implemented, and monitored through an interdisciplinary assessment designed to restore an individual to optimal level of physical, cognitive, and behavioral function. The MO HealthNet division shall establish by administrative rule the definition and criteria for designation of a comprehensive day rehabilitation service facility, benefit limitations and payment mechanism. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this subdivision shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2005, shall be invalid and void.

3. The MO HealthNet division may require any participant receiving MO HealthNet benefits to pay part of the charge or cost until July 1, 2008, and an additional payment after July 1, 2008, as defined by rule duly promulgated by the MO HealthNet division, for all covered services except for those services covered under subdivisions (14) and (15) of subsection 1 of this section and sections 208.631 to 208.657 to the extent and in the manner authorized by Title XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.) and regulations thereunder. When substitution of a generic drug is permitted by the prescriber according to section 338.056, RSMo, and a generic drug is substituted for a name-brand drug, the MO HealthNet division may not lower or delete the requirement to make a co-payment pursuant to regulations of Title XIX of the federal Social Security Act. A provider of goods or services described under this section must collect from all participants the additional payment that may be required by the MO HealthNet division under authority granted herein, if the division exercises that authority, to remain eligible as a provider. Any payments made by participants under this section shall be in addition to and not in lieu of payments made by the state for goods or services described herein except the participant portion of the pharmacy professional dispensing fee shall be in addition to and not in lieu of payments to pharmacists. A provider may collect the co-payment at the time a service is provided or at a later date. A provider shall not refuse to provide a service if a participant is unable to pay a required payment. If it is the routine business practice of a provider to terminate future services to an individual with an unclaimed debt, the provider may include

uncollected co-payments under this practice. Providers who elect not to undertake the provision of services based on a history of bad debt shall give participants advance notice and a reasonable opportunity for payment. A provider, representative, employee, independent contractor, or agent of a pharmaceutical manufacturer shall not make co-payment for a participant. This subsection shall not apply to other qualified children, pregnant women, or blind persons. If the Centers for Medicare and Medicaid Services does not approve the Missouri MO HealthNet state plan amendment submitted by the department of social services that would allow a provider to deny future services to an individual with uncollected co-payments, the denial of services shall not be allowed. The department of social services shall inform providers regarding the acceptability of denying services as the result of unpaid co-payments.

4. The MO HealthNet division shall have the right to collect medication samples from participants in order to maintain program integrity.

5. Reimbursement for obstetrical and pediatric services under subdivision (6) of subsection 1 of this section shall be timely and sufficient to enlist enough health care providers so that care and services are available under the state plan for MO HealthNet benefits at least to the extent that such care and services are available to the general population in the geographic area, as required under subparagraph (a)(30)(A) of 42 U.S.C. 1396a and federal regulations promulgated thereunder.

6. Beginning July 1, 1990, reimbursement for services rendered in federally funded health centers shall be in accordance with the provisions of subsection 6402(c) and Section 6404 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989) and federal regulations promulgated thereunder.

7. Beginning July 1, 1990, the department of social services shall provide notification and referral of children below age five, and pregnant, breast-feeding, or postpartum women who are determined to be eligible for MO HealthNet benefits under section 208.151 to the special supplemental food programs for women, infants and children administered by the department of health and senior services. Such notification and referral shall conform to the requirements of Section 6406 of P.L. 101-239 and regulations promulgated thereunder.

8. Providers of long-term care services shall be reimbursed for their costs in accordance with the provisions of Section 1902 (a)(13)(A) of the Social Security Act, 42 U.S.C. 1396a, as amended, and regulations promulgated thereunder.

9. Reimbursement rates to long-term care providers with respect to a total change in ownership, at arm's length, for any facility previously licensed and certified for participation in the MO HealthNet program shall not increase payments in excess of the increase that would result from the application of Section 1902 (a)(13)(C) of the Social Security Act, 42 U.S.C. 1396a (a)(13)(C).

10. The MO HealthNet division, may enroll qualified residential care facilities and assisted living facilities, as defined in chapter 198, RSMo, as MO HealthNet personal care providers.

11. Any income earned by individuals eligible for certified extended employment at a sheltered workshop under chapter 178, RSMo, shall not be considered as income for purposes of determining eligibility under this section.

208.215. 1. MO HealthNet is payer of last resort unless otherwise specified by law. When any person, corporation, institution, public agency or private agency is liable, either pursuant to contract or otherwise, to a participant receiving public assistance on account of personal injury to or disability or disease or benefits arising from a health insurance plan to which the participant may be entitled, payments made by the department of social services or MO HealthNet division shall be a debt due the state and recoverable from the liable party or participant for all payments made **[**in**] on** behalf of the participant and the debt due the state shall not exceed the payments made from MO HealthNet benefits provided under sections 208.151 to 208.158 and section 208.162 and section 208.204 on behalf of the participant, minor or estate for payments on account of the injury, disease, or disability or benefits arising from a health insurance program to which the participant may be entitled. **Any health benefit plan as defined in section 376.1350, RSMo, third party administrator, administrative service organization, and pharmacy benefits manager, shall process and pay all properly submitted medical assistance subrogation claims or MO HealthNet subrogation claims:**

(1) For a period of three years from the date services were provided or rendered, regardless of any other timely filing requirement otherwise imposed by such entity, and the entity shall not deny such claims on the basis of the type or format of the claim form, failure to present proper documentation of coverage at the point of sale, or failure to obtain prior authorization; and

(2) If any action by the state to enforce its rights with respect to such claim is commenced within six years of the state's submission of such claim.

2. **(1) Each such health benefit plan, third-party administrator, administrative service organization, pharmacy benefits manager, and each vendor of the division with whom they contract for third party liability services shall provide the MO HealthNet division with the coverage and eligibility data needed by the state to identify potentially liable third parties to include new sources of eligibility coverage information such as health information exchange for pharmacy services and electronic prescribing. If the division determines that a potentially liable third party exists, the division shall attempt to ensure that the provider bills the third party prior to submitting the claim to the state. The division shall establish rules for cost avoidance, consistent with the Centers for Medicare**

& Medicaid Services (CMS) guidance, through third-party liability process optimization, information exchange, and data analysis.

(2) For the purposes of this section, the term "coverage and eligibility data" means information or records regarding a health benefit plan member or subscriber, including demographic information, social security number, date of birth, gender, address for each covered person, enrollment date, full beginning and ending benefits coverage dates and benefits limitations, disenrollment and reenrollment dates, that is stored or maintained on any electronic or paper record maintained by a health benefit plan, even if it is not present on the eligibility record or file. In the event that the health benefit plan does not currently capture full demographic data on or from a covered life, the health benefit plan shall, at the state's specific request, make every reasonable attempt to capture said data in a timely manner and report this information back to the state in the prescribed electronic format.

(3) Health benefit plans shall provide coverage and eligibility data for all covered persons residing in the state, or with a parental or member or subscriber relationship to any beneficiary residing in the state or border states for a minimum of three years historically from the effective date of this section.

(4) Health benefit plans shall provide a full file of current covered lives on a quarterly basis in a format that is consistent with instruction from the secretary of the federal Department of Health and Human Services for implementation of the federal Deficit Reduction Act of 2005, as amended. All organizations covered and required to supply coverage and eligibility data shall provide monthly change updates to such records when there is a relevant change to a beneficiary record regarding the beneficiary's demographic status, new enrollment or disenrollment, plan coverage, or plan limitation.

(5) Health benefit plans shall provide the MO HealthNet division with the ability to perform real-time validation into any system that currently supports electronic eligibility verification; the necessary submitter and provider identifiers, in the form of tax identifications, atypical provider identifiers or pseudo provider identifications shall be granted to facilitate such access.

3. The department of social services, MO HealthNet division, or its contractor may maintain an appropriate action to recover funds paid by the department of social services or MO HealthNet division or its contractor that are due under this section in the name of the state of Missouri against the person, corporation, institution, public agency, or private agency liable to the participant, minor or estate.

[3.**]** **4.** Any participant, minor, guardian, conservator, personal representative, estate, including persons entitled under section 537.080, RSMo, to bring an action for wrongful death who pursues legal rights against a person, corporation, institution, public agency, or private

agency liable to that participant or minor for injuries, disease or disability or benefits arising from a health insurance plan to which the participant may be entitled as outlined in subsection 1 of this section shall upon actual knowledge that the department of social services or MO HealthNet division has paid MO HealthNet benefits as defined by this chapter promptly notify the MO HealthNet division as to the pursuit of such legal rights.

[4.**] 5.** Every applicant or participant by application assigns his right to the department of social services or MO HealthNet division of any funds recovered or expected to be recovered to the extent provided for in this section. All applicants and participants, including a person authorized by the probate code, shall cooperate with the department of social services, MO HealthNet division in identifying and providing information to assist the state in pursuing any third party who may be liable to pay for care and services available under the state's plan for MO HealthNet benefits as provided in sections 208.151 to 208.159 and sections 208.162 and 208.204. All applicants and participants shall cooperate with the agency in obtaining third-party resources due to the applicant, participant, or child for whom assistance is claimed. Failure to cooperate without good cause as determined by the department of social services, MO HealthNet division in accordance with federally prescribed standards shall render the applicant or participant ineligible for MO HealthNet benefits under sections 208.151 to 208.159 and sections 208.162 and 208.204. A **[**recipient**] participant** who has notice or who has actual knowledge of the department's rights to third-party benefits who receives any third-party benefit or proceeds for a covered illness or injury is either required to pay the division within sixty days after receipt of settlement proceeds the full amount of the third-party benefits up to the total MO HealthNet benefits provided or to place the full amount of the third-party benefits in a trust account for the benefit of the division pending judicial or administrative determination of the division's right to third-party benefits.

[5.**] 6.** Every person, corporation or partnership who acts for or on behalf of a person who is or was eligible for MO HealthNet benefits under sections 208.151 to 208.159 and sections 208.162 and 208.204 for purposes of pursuing the applicant's or participant's claim which accrued as a result of a nonoccupational or nonwork-related incident or occurrence resulting in the payment of MO HealthNet benefits shall notify the MO HealthNet division upon agreeing to assist such person and further shall notify the MO HealthNet division of any institution of a proceeding, settlement or the results of the pursuit of the claim and give thirty days' notice before any judgment, award, or settlement may be satisfied in any action or any claim by the applicant or participant to recover damages for such injuries, disease, or disability, or benefits arising from a health insurance program to which the participant may be entitled.

[6.**] 7.** Every participant, minor, guardian, conservator, personal representative, estate, including persons entitled under section 537.080, RSMo, to bring an action for wrongful death,

or his attorney or legal representative shall promptly notify the MO HealthNet division of any recovery from a third party and shall immediately reimburse the department of social services, MO HealthNet division, or its contractor from the proceeds of any settlement, judgment, or other recovery in any action or claim initiated against any such third party. A judgment, award, or settlement in an action by a **[**recipient**]** **participant** to recover damages for injuries or other third-party benefits in which the division has an interest may not be satisfied without first giving the division notice and a reasonable opportunity to file and satisfy the claim or proceed with any action as otherwise permitted by law.

[7.**] 8.** The department of social services, MO HealthNet division or its contractor shall have a right to recover the amount of payments made to a provider under this chapter because of an injury, disease, or disability, or benefits arising from a health insurance plan to which the participant may be entitled for which a third party is or may be liable in contract, tort or otherwise under law or equity. Upon request by the MO HealthNet division, all third-party payers shall provide the MO HealthNet division with information contained in a 270/271 Health Care Eligibility Benefits Inquiry and Response standard transaction mandated under the federal Health Insurance Portability and Accountability Act, except that third-party payers shall not include accident-only, specified disease, disability income, hospital indemnity, or other fixed indemnity insurance policies.

[8.**] 9.** The department of social services or MO HealthNet division shall have a lien upon any moneys to be paid by any insurance company or similar business enterprise, person, corporation, institution, public agency or private agency in settlement or satisfaction of a judgment on any claim for injuries or disability or disease benefits arising from a health insurance program to which the participant may be entitled which resulted in medical expenses for which the department or MO HealthNet division made payment. This lien shall also be applicable to any moneys which may come into the possession of any attorney who is handling the claim for injuries, or disability or disease or benefits arising from a health insurance plan to which the participant may be entitled which resulted in payments made by the department or MO HealthNet division. In each case, a lien notice shall be served by certified mail or registered mail, upon the party or parties against whom the applicant or participant has a claim, demand or cause of action. The lien shall claim the charge and describe the interest the department or MO HealthNet division has in the claim, demand or cause of action. The lien shall attach to any verdict or judgment entered and to any money or property which may be recovered on account of such claim, demand, cause of action or suit from and after the time of the service of the notice.

[9.**] 10.** On petition filed by the department, or by the participant, or by the defendant, the court, on written notice of all interested parties, may adjudicate the rights of the parties and enforce the charge. The court may approve the settlement of any claim, demand or cause of

action either before or after a verdict, and nothing in this section shall be construed as requiring the actual trial or final adjudication of any claim, demand or cause of action upon which the department has charge. The court may determine what portion of the recovery shall be paid to the department against the recovery. In making this determination the court shall conduct an evidentiary hearing and shall consider competent evidence pertaining to the following matters:

(1) The amount of the charge sought to be enforced against the recovery when expressed as a percentage of the gross amount of the recovery; the amount of the charge sought to be enforced against the recovery when expressed as a percentage of the amount obtained by subtracting from the gross amount of the recovery the total attorney's fees and other costs incurred by the participant incident to the recovery; and whether the department should, as a matter of fairness and equity, bear its proportionate share of the fees and costs incurred to generate the recovery from which the charge is sought to be satisfied;

(2) The amount, if any, of the attorney's fees and other costs incurred by the participant incident to the recovery and paid by the participant up to the time of recovery, and the amount of such fees and costs remaining unpaid at the time of recovery;

(3) The total hospital, doctor and other medical expenses incurred for care and treatment of the injury to the date of recovery therefor, the portion of such expenses theretofore paid by the participant, by insurance provided by the participant, and by the department, and the amount of such previously incurred expenses which remain unpaid at the time of recovery and by whom such incurred, unpaid expenses are to be paid;

(4) Whether the recovery represents less than substantially full recompense for the injury and the hospital, doctor and other medical expenses incurred to the date of recovery for the care and treatment of the injury, so that reduction of the charge sought to be enforced against the recovery would not likely result in a double recovery or unjust enrichment to the participant;

(5) The age of the participant and of persons dependent for support upon the participant, the nature and permanency of the participant's injuries as they affect not only the future employability and education of the participant but also the reasonably necessary and foreseeable future material, maintenance, medical rehabilitative and training needs of the participant, the cost of such reasonably necessary and foreseeable future needs, and the resources available to meet such needs and pay such costs;

(6) The realistic ability of the participant to repay in whole or in part the charge sought to be enforced against the recovery when judged in light of the factors enumerated above.

[10.**]** **11.** The burden of producing evidence sufficient to support the exercise by the court of its discretion to reduce the amount of a proven charge sought to be enforced against the recovery shall rest with the party seeking such reduction.

[11.**] 12.** The court may reduce and apportion the department's or MO HealthNet division's lien proportionate to the recovery of the claimant. The court may consider the nature and extent of the injury, economic and noneconomic loss, settlement offers, comparative negligence as it applies to the case at hand, hospital costs, physician costs, and all other appropriate costs. The department or MO HealthNet division shall pay its pro rata share of the attorney's fees based on the department's or MO HealthNet division's lien as it compares to the total settlement agreed upon. This section shall not affect the priority of an attorney's lien under section 484.140, RSMo. The charges of the department or MO HealthNet division or contractor described in this section, however, shall take priority over all other liens and charges existing under the laws of the state of Missouri with the exception of the attorney's lien under such statute.

[12.**] 13.** Whenever the department of social services or MO HealthNet division has a statutory charge under this section against a recovery for damages incurred by a participant because of its advancement of any assistance, such charge shall not be satisfied out of any recovery until the attorney's claim for fees is satisfied, **[**irrespective**] regardless** of whether **[**or not**]** an action based on participant's claim has been filed in court. Nothing herein shall prohibit the director from entering into a compromise agreement with any participant, after consideration of the factors in subsections **[**9 to 13**] 10 to 14** of this section.

[13.**] 14.** This section shall be inapplicable to any claim, demand or cause of action arising under the workers' compensation act, chapter 287, RSMo. From funds recovered pursuant to this section the federal government shall be paid a portion thereof equal to the proportionate part originally provided by the federal government to pay for MO HealthNet benefits to the participant or minor involved. The department or MO HealthNet division shall enforce TEFRA liens, 42 U.S.C. 1396p, as authorized by federal law and regulation on permanently institutionalized individuals. The department or MO HealthNet division shall have the right to enforce TEFRA liens, 42 U.S.C. 1396p, as authorized by federal law and regulation on all other institutionalized individuals. For the purposes of this subsection, "permanently institutionalized individuals" includes those people who the department or MO HealthNet division determines cannot reasonably be expected to be discharged and return home, and "property" includes the homestead and all other personal and real property in which the participant has sole legal interest or a legal interest based upon co-ownership of the property which is the result of a transfer of property for less than the fair market value within thirty months prior to the **[**participant's**] participants** entering the nursing facility. The following provisions shall apply to such liens:

(1) The lien shall be for the debt due the state for MO HealthNet benefits paid or to be paid on behalf of a participant. The amount of the lien shall be for the full amount due the state at the time the lien is enforced;

(2) The MO HealthNet division shall file for record, with the recorder of deeds of the county in which any real property of the participant is situated, a written notice of the lien. The notice of lien shall contain the name of the participant and a description of the real estate. The recorder shall note the time of receiving such notice, and shall record and index the notice of lien in the same manner as deeds of real estate are required to be recorded and indexed. The director or the director's designee may release or discharge all or part of the lien and notice of the release shall also be filed with the recorder. The department of social services, MO HealthNet division, shall provide payment to the recorder of deeds the fees set for similar filings in connection with the filing of a lien and any other necessary documents;

(3) No such lien may be imposed against the property of any individual prior to the individual's death on account of MO HealthNet benefits paid except:

(a) In the case of the real property of an individual:

a. Who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution, to spend for costs of medical care all but a minimal amount of his or her income required for personal needs; and

b. With respect to whom the director of the MO HealthNet division or the director's designee determines, after notice and opportunity for hearing, that he cannot reasonably be expected to be discharged from the medical institution and to return home. The hearing, if requested, shall proceed under the provisions of chapter 536, RSMo, before a hearing officer designated by the director of the MO HealthNet division; or

(b) Pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual;

(4) No lien may be imposed under paragraph (b) of subdivision (3) of this subsection on such individual's home if one or more of the following persons is lawfully residing in such home:

(a) The spouse of such individual;

(b) Such individual's child who is under twenty-one years of age, or is blind or permanently and totally disabled; or

(c) A sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution;

(5) Any lien imposed with respect to an individual pursuant to subparagraph b of paragraph (a) of subdivision (3) of this subsection shall dissolve upon that individual's discharge from the medical institution and return home.

[14.**] 15.** The debt due the state provided by this section is subordinate to the lien provided by section 484.130, RSMo, or section 484.140, RSMo, relating to an attorney's lien and to the participant's expenses of the claim against the third party.

[15.**] 16.** Application for and acceptance of MO HealthNet benefits under this chapter shall constitute an assignment to the department of social services or MO HealthNet division of any rights to support for the purpose of medical care as determined by a court or administrative order and of any other rights to payment for medical care.

[16.**] 17.** All participants receiving benefits as defined in this chapter shall cooperate with the state by reporting to the family support division or the MO HealthNet division, within thirty days, any occurrences where an injury to their persons or to a member of a household who receives MO HealthNet benefits is sustained, on such form or forms as provided by the family support division or MO HealthNet division.

[17.**] 18.** If a person fails to comply with the provision of any judicial or administrative decree or temporary order requiring that person to maintain medical insurance on or be responsible for medical expenses for a dependent child, spouse, or ex-spouse, in addition to other remedies available, that person shall be liable to the state for the entire cost of the medical care provided pursuant to eligibility under any public assistance program on behalf of that dependent child, spouse, or ex-spouse during the period for which the required medical care was provided. Where a duty of support exists and no judicial or administrative decree or temporary order for support has been entered, the person owing the duty of support shall be liable to the state for the entire cost of the medical care provided on behalf of the dependent child or spouse to whom the duty of support is owed.

[18.**] 19.** The department director or the director's designee may compromise, settle or waive any such claim in whole or in part in the interest of the MO HealthNet program. Notwithstanding any provision in this section to the contrary, the department of social services, MO HealthNet division is not required to seek reimbursement from a liable third party on claims for which the amount it reasonably expects to recover will be less than the cost of recovery or for which recovery efforts will not be cost-effective. Cost-effectiveness is determined based on the following:

(1) Actual and legal issues of liability as may exist between the **[**recipient**] participant** and the liable party;

(2) Total funds available for settlement; and

(3) An estimate of the cost to the division of pursuing its claim.

354.535. 1. If a pharmacy, operated by or contracted with by a health maintenance organization, is closed or is unable to provide health care services to an enrollee in an emergency, a pharmacist may take an assignment of such enrollee's right to reimbursement, if the policy or contract provides for such reimbursement, for those goods or services provided to an enrollee of a health maintenance organization. No health maintenance organization shall refuse to pay the pharmacist any payment due the enrollee under the terms of the policy or contract.

2. No health maintenance organization, conducting business in the state of Missouri, shall contract with a pharmacy, pharmacy distributor or wholesale drug distributor, nonresident or otherwise, unless such pharmacy or distributor has been granted a permit or license from the Missouri board of pharmacy to operate in this state.

3. Every health maintenance organization shall apply the same coinsurance, co-payment and deductible factors to all drug prescriptions filled by a pharmacy provider who participates in the health maintenance organization's network if the provider meets the contract's explicit product cost determination. If any such contract is rejected by any pharmacy provider, the health maintenance organization may offer other contracts necessary to comply with any network adequacy provisions of this act. However, nothing in this section shall be construed to prohibit the health maintenance organization from applying different coinsurance, co-payment and deductible factors between generic and brand name drugs.

4. **If the co-payment applied by a health maintenance organization exceeds the usual and customary retail price of the prescription drug, enrollees shall only be required to pay the usual and customary retail price of the prescription drug, and no further charge to the enrollee or plan sponsor shall be incurred on such prescription.**

5. Health maintenance organizations shall not set a limit on the quantity of drugs which an enrollee may obtain at any one time with a prescription, unless such limit is applied uniformly to all pharmacy providers in the health maintenance organization's network.

[5.**] 6.** Health maintenance organizations shall not insist or mandate any physician or other licensed health care practitioner to change an enrollee's maintenance drug unless the provider and enrollee agree to such change. For the purposes of this provision, a maintenance drug shall mean a drug prescribed by a practitioner who is licensed to prescribe drugs, used to treat a medical condition for a period greater than thirty days. Violations of this provision shall be subject to the penalties provided in section 354.444. Notwithstanding other provisions of law to the contrary, health maintenance organizations that change an enrollee's maintenance drug without the consent of the provider and enrollee shall be liable for any damages resulting from such change. Nothing in this subsection, however, shall apply to the dispensing of generically

equivalent products for prescribed brand name maintenance drugs as set forth in section 338.056, RSMo.

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

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

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

(2) A resident of this state; and

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

374.184. 1. The director of the department of insurance, financial institutions and professional registration shall prescribe by rule**[**,**] ;**

(1) After due consultation with providers of health care or treatment and their respective licensing boards, **[**accident and sickness insurers, health services corporations and health maintenance organizations,**]** and after a public hearing, uniform claim forms for reporting by health care providers. Such prescribed forms shall include but need not be limited to information regarding the medical diagnosis, treatment and prognosis of the patient, together with the details of charges incident to the providing of such care, treatment or services, sufficient for the purpose of meeting the proof requirements of an accident and sickness insurance or hospital, medical or dental services contract. Such prescribed forms shall be based upon the UB-82 form, with respect to hospital claims, and the HCFA 1500 form, with respect to physician claims, as such forms are modified or amended from time to time by the National Uniform Billing Committee or the federal Health Care Financing Administration**; and**

(2) After due consultation with accident and sickness insurers, health services corporations, health maintenance organizations, and insurance producers, and after a public hearing, uniform application forms for group health insurance policies. This subdivision shall not apply to individually underwritten health insurance policies, certificates, or plans.

2. The adoption of any uniform claim forms **or uniform application forms** by the director pursuant to this section shall not preclude an insurer, health services corporation, or health maintenance organization from requesting any necessary additional information in connection with a claims investigation from the claimant, provider of health care or treatment, or certifier of coverage**, or in connection with an application for insurance from the applicant**. The provisions of this section shall not be deemed or construed to apply to electronic claims submission. Insurers and providers may by contract provide for modifications to the uniform billing document where both insurers and providers feel that such modifications streamline claims processing procedures relating to the claims of the insurer involved in such contract modification. However, a refusal by the provider to agree to modification of the uniform billing format shall not be used by the insurer as grounds for refusing to enter into a contract with the provider for reimbursement or payment for health services rendered to an insured of the insurer.

3. Rules adopted or promulgated pursuant to this act shall be subject to notice and hearing as provided in chapter 536, RSMo. The regulations so adopted shall specify an effective date, which shall not be less than one hundred eighty days after the date of adoption, after which no accident and sickness insurer, health services corporation or health maintenance organization shall require providers of health care or treatment to complete forms differing from those prescribed by the director pursuant to this section, **[**and**]** after which no health care provider shall submit claims except upon such prescribed forms; provided that the provisions of this section shall not preclude the use by any insurer, health services corporation or health maintenance organization of the UB-82 form or the HCFA 1500 form**, and after which no insurer shall require applicants for insurance coverage to complete forms differing from those prescribed by the director under this section, other than a request for additional information from such applicants under subsection 2 of this section**.

376.384. 1. All health carriers shall:

(1) Permit nonparticipating health care providers to file a claim for reimbursement for a health care service provided in this state as defined in section 376.1350 for a period of up to one year from the date of service;

(2) Permit participating health care providers to file a claim for reimbursement for a health care service provided in this state for a period of up to six months from the date of service,

unless the contract between the health carrier and health care provider specifies a different standard;

(3) Not request a refund or offset against a claim more than twelve months after a health carrier has paid a claim except in cases of fraud or misrepresentation by the health care provider;

(4) Issue within one working day a confirmation of receipt of an electronically filed claim.

2. On or after January 1, 2003, all claims for reimbursement for a health care service provided in this shall be submitted in an electronic format consistent with federal administrative simplification standards adopted pursuant to the Health Insurance Portability and Accountability Act of 1996. Any claim submitted by a health care provider after January 1, 2003, in a nonelectronic format shall not be subject to the provisions of section 376.383. Any health carrier shall provide readily accessible electronic filing after this date to health care providers.

3. On or after January 1, 2002, the director of the department of insurance, financial institutions and professional registration shall monitor health carrier compliance with the provisions of this section and section 376.383. Examinations, which may be based upon statistical samplings, to determine compliance may be conducted by the department or the director may contract with a qualified private entity. Compliance shall be defined as properly processing and paying ninety-five percent of all claims received in a given calendar year in accordance with the provisions of this section and section 376.383. The director may assess an administrative penalty in addition to the penalties outlined in section 376.383 of up to twenty-five dollars per claim for the percentage of claims found to be in noncompliance, but not to exceed an annual aggregate penalty of two hundred fifty thousand dollars, for any health carrier deemed to be not in compliance with this section and section 376.383. Any penalty assessed pursuant to this subsection shall be assessed in addition to penalties provided for pursuant to sections 375.942 and 375.1012, RSMo.

4. If the director finds that health carriers are failing to make interest payments to health care professionals authorized by section 376.383, the director is authorized to order such health carriers to remit such interest payments. The director is also authorized to assess a monetary penalty, payable to the state of Missouri, in a sum not to exceed twenty-five percent of the unpaid interest payment against health carriers.

5. A health carrier may request a waiver of the requirements of this section and section 376.383 if the basis for the request is an act of God or other good cause as determined by the director.

6. The director shall develop a method by which health care providers may submit complaints to the department identifying violations of this section and section 376.383 by a health carrier. The director shall consider such complaints when determining whether to

examine a health carrier's compliance. Prior to filing a complaint with the department, health care providers who believe that a health carrier has not paid a claim in accordance with this section and section 376.383 shall first contact the health carrier to determine the status of the claim to ensure that sufficient documentation supporting the claim has been provided and to determine whether the claim is considered to be complete. Complaints to the department regarding the payment of claims by a health carrier should contain information such as:

(1) The health care provider's name, address, and daytime phone number;

(2) The health carrier's name;

(3) The dates of service and the dates the claims were filed with the health carrier;

(4) Relevant correspondence between the health care provider and the health carrier, including requests from the health carrier for additional information; and

(5) Additional information which the health care provider believes would be of assistance in the department's review.

7. On or after January 1, 2003, all claims submitted electronically for reimbursement for a health care service provided in this state shall be submitted in a uniform format utilizing standard medical code sets. The uniform format and the standard medical code sets shall be promulgated by the department of insurance, financial institutions and professional registration through rules consistent with but no more stringent than the federal administrative simplification standards adopted pursuant to the Health Insurance Portability and Accountability Act of 1996.

8. **On or after January 1, 2010, a health carrier responding to a patient financial responsibility inquiry utilizing the HIPAA 270/271 electronic eligibility response transaction code sets shall include all six eligibility or benefit information codes: co-payment, co-insurance, deductible, out-of-pocket maximum, remaining deductible amount, and other cost containment elements. The department of insurance, financial institutions and professional registration shall develop a set of best practices to be used by health carriers and health care providers to standardize electronic data exchange of HIPAA 270/271 health care eligibility benefit inquiry/response transaction code sets. The best practices shall be consistent with but no more stringent than the federal administrative simplification standards adopted under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).**

9. The department shall have authority to promulgate rules for the implementation of section 376.383 and this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and if applicable, sections 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536,

RSMo, to review, to delay the effective date or to disapprove and annul a rule subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2001, shall be invalid and void.

376.391. A health benefit plan or health carrier, as defined in section 376.1350, including but not limited to preferred provider organizations, independent physicians associations, third-party administrators, or any entity that contracts with licensed health care providers shall not impose any co-payment that exceeds fifty percent of the total cost of providing any single health care service to its enrollees.

376.394. No health carrier or health benefit plan, as defined in section 376.1350, shall deny reimbursement for providing or interpreting diagnostic imaging services based solely on the specialty or professional board certification of a physician licensed under chapter 334, RSMo.

376.397. 1. A group policy delivered or issued for delivery in this state which insures employees or members for hospital, surgical or major medical insurance on an expense incurred or service basis, other than for specific diseases or for accidental injuries only, shall provide that an employee or member whose insurance under the group policy has been terminated shall be entitled to have a converted policy issued to him by the insurer under whose group policy he was insured, without evidence of insurability, subject to the following terms and conditions:

(1) A converted policy need not be made available to an employee or member if termination of his insurance under the group policy occurred:

(a) Because he failed to make timely payment of any required contribution; or

(b) For any other reason, and he had not been continuously covered under the group policy, and for similar benefits under any group policy which it replaced, during the entire three months' period ending with such termination; or

(c) Because the group policy terminated or an employer's participation terminated, and the insurance is replaced by similar coverage under another group policy within thirty-one days of the date of termination;

(2) Written application and the first premium payment for the converted policy shall be made to the insurer not later than thirty-one days after such termination;

(3) The premium for the converted policy shall be determined in accordance with the insurer's table of premium rates applicable to the age and class of risk of each person to be covered under that policy and to the type and amount of insurance provided;

(4) The converted policy shall cover the employee or member and his dependents who were covered by the group policy on the date of termination of insurance. At the option of the insurer, a separate converted policy may be issued to cover any dependent;

(5) The insurer shall not be required to issue a converted policy covering any person if such person is or could be covered by Medicare. Furthermore, the insurer shall not be required to issue a converted policy covering any person if:

(a) Such person is or could be covered for similar benefits by another individual policy; such person is or could be covered for similar benefits under any arrangement of coverage for individuals in a group, whether insured or uninsured; or similar benefits are provided for or available to such person, by reason of any state or federal law; and

(b) The benefits under sources of the kind referred to in paragraph (a) above for such person, or benefits provided or available under sources of the kind referred to in paragraph (a) above for such person, together with the converted policy's benefits would result in overinsurance according to the insurer's standards for overinsurance;

(6) A converted policy may provide that the insurer may at any time request information of any person covered thereunder as to whether he is covered for the similar benefits described in paragraph (a) of subdivision (5) above or is or could be covered for the similar benefits described in paragraph (a) of subdivision (5) above. The converted policy may provide that as of any premium due date the insurer may refuse to renew the policy or the coverage of any insured person for the following reasons only:

(a) Either those similar benefits for which such person is or could be covered, together with the converted policy's benefits, would result in overinsurance according to the insurer's standards for overinsurance, or the policyholder of the converted policy fails to provide the requested information;

(b) Fraud or material misrepresentation in applying for any benefits under the converted policy;

(c) **[**Eligibility of the insured person for coverage under Medicare or under any other state or federal law providing for benefits similar to those provided by the converted policy;

(d)**]** Other reasons approved by the director of the department of insurance, financial institutions and professional registration;

(7) An insurer shall not be required to issue a converted policy providing benefits in excess of the hospital, surgical or major medical insurance under the group policy from which conversion is made;

(8) The converted policy shall not exclude, as a preexisting condition, any condition covered by the group policy; provided, however, that the converted policy may provide for a reduction of its hospital, surgical or medical benefits by the amount of any such benefits payable under the group policy after the individual's insurance terminates thereunder. The converted policy may also provide that during the first policy year the benefits payable under the converted policy, together with the benefits payable under the group policy, shall not exceed those that

would have been payable had the individual's insurance under the group policy remained in force and effect;

(9) Subject to the provisions and conditions of sections 376.395 to 376.404, if the group insurance policy from which conversion is made insures the employee or member for basic hospital or surgical expense insurance, the employee or member shall be entitled to obtain a converted policy providing, at his option, coverage on an expense incurred basis under any of the following plans:

(a) Plan A, which shall include:

a. Hospital room and board daily expense benefits in a maximum dollar amount approximating the average semiprivate rate charged in the largest major metropolitan area of this state, for a maximum duration of seventy days;

b. Miscellaneous hospital expense benefits up to a maximum amount of ten times the hospital room and board daily expense benefits; and

c. Surgical expense benefits according to a surgical procedures schedule consistent with those customarily offered by the insurer under group or individual health insurance policies and providing a maximum benefit of eight hundred dollars;

(b) Plan B, which shall be the same as plan A, except that the maximum hospital room and board daily expense benefit is seventy-five percent of the corresponding maximum under subparagraph a of plan A, and the surgical schedule maximum is six hundred dollars;

(c) Plan C, which shall be the same as plan A, except that the maximum hospital room and board daily expense benefit is fifty percent of the corresponding maximum under subparagraph a of plan A, and the surgical schedule maximum is four hundred dollars. The maximum dollar amount for plan A's maximum hospital room and board daily expense benefit shall be determined by the director of the department of insurance, financial institutions and professional registration and may be redetermined by him from time to time as to converted policies issued subsequent to such redetermination. Such redetermination shall not be made more often than once every three years. Such plan A maximum, and the corresponding maximums in plans B and C, shall be rounded to the nearest ten dollar multiple; provided that, rounding may be to the next higher or lower multiple of ten dollars if otherwise exactly midway between two multiples;

(10) Subject to the provisions and conditions of sections 376.395 to 376.404, if the group policy from which conversion is made insures the employee or member for major medical expense insurance, the employee or member shall be entitled to obtain a converted policy providing catastrophic or major medical coverage under a plan meeting the following requirements:

(a) A maximum benefit at least equal to, at the option of the insurer, either:

a. A maximum payment per covered person for all covered medical expenses incurred during that person's lifetime, equal to the smaller of the maximum benefit provided under the group policy or two hundred fifty thousand dollars;

b. A maximum payment for each unrelated injury or sickness, equal to the smaller of the maximum benefit provided under the group policy or two hundred fifty thousand dollars;

(b) Payment of benefits at the rate of eighty percent of covered medical expenses which are in excess of the deductible, until twenty percent of such expenses in a benefit period reaches one thousand dollars, after which benefits will be paid at the rate of one hundred percent during the remainder of such benefit period. Payment of benefits for outpatient treatment of mental illness, if provided in the converted policy, may be at a lesser rate, but not less than fifty percent;

(c) A deductible for each benefit period which, at the option of the insurer, shall be the sum of the benefits deductible plus one hundred dollars, or the corresponding deductible in the group policy. The term "benefits deductible", as used herein, means the value of any benefits provided on an expense incurred basis which are provided with respect to covered medical expenses by any other group or individual hospital, surgical or medical insurance policy or medical practice or other prepayment plan, or any other plan or program, whether insured or uninsured, or by reason of any state or federal law and if, pursuant to subdivision (11) herein, the converted policy provides both basic hospital or surgical coverage and major medical coverage, the value of such basic benefits. If the maximum benefit is determined under subparagraph b of paragraph (a) of this subdivision, the insurer may require that the deductible be satisfied during a period of not less than three months if the deductible is one hundred dollars or less, and not less than six months if the deductible exceeds one hundred dollars;

(d) The benefit period shall be each calendar year when the maximum benefit is determined under subparagraph a of paragraph (a) of this subdivision or twenty-four months when the maximum benefit is determined under subparagraph b of paragraph (a) of this subdivision;

(e) The term "covered medical expenses", as used in this subdivision, shall include at least, in the case of hospital room and board charges, the lesser of the dollar amount set out in plan A under subdivision (9) and the average semiprivate room and board rate for the hospital in which the individual is confined, and at least twice such amount for charges in an intensive care unit. Any surgical procedures schedule shall be consistent with those customarily offered by the insurer under group or individual health insurance policies and must provide at least a one thousand two hundred dollar maximum benefit;

(11) At the option of the insurer, benefit plans set forth in subdivisions (9) and (10) of this section may be provided under one policy or, in lieu of the benefit plans set forth in subdivisions (9) and (10) of this section, the insurer may provide a policy for comprehensive

medical expense benefits without first dollar coverage. Such policy shall conform to the requirements of subdivision (10) of this section; provided, however, that an insurer electing to provide such a policy shall make available a low deductible option, not to exceed one hundred dollars, a high deductible option between five hundred dollars and one thousand dollars, and a third deductible option midway between the high and low deductible options. Alternatively, such a policy may provide for deductible options equal to the greater of the benefits deductible and the amount specified in the preceding sentence.

2. (1) The insurer may, at its option, offer alternative plans for converted policies from group policies in addition to those required by sections 376.395 to 376.404. Furthermore, if any insurer customarily offers individual policies on a service basis, that insurer may, in lieu of converted policies on an expense incurred basis, make available converted policies on a service basis which, in the opinion of the director of the department of insurance, financial institutions and professional registration, satisfy the intent of sections 376.395 to 376.404.

(2) Nothing in sections 376.395 to 376.404 shall preclude a health service corporation from limiting its conversion offerings to one of the plans offered by the insurer that is consistent with group policies customarily offered by the health service corporation. The employee or member under the group insurance policy from which conversion is made shall be entitled to obtain one such converted policy.

3. Notification of the conversion privilege shall be included in each certificate of coverage.

4. All converted policies shall become effective on the day immediately following the date of termination of insurance under a group policy.

376.401. 1. In the event coverage would be continued under the group policy on an employee following his retirement, but prior to the time he is or could be covered by Medicare, the employee or member may elect, in lieu of such continuation of group insurance, to have the same conversion rights as would apply had that insurance terminated at retirement. **[**The converted policy may provide for reduction or termination of coverage of any person upon his eligibility for coverage under Medicare or under any other state or federal law providing for benefits similar to those provided by the converted policy.**]**

2. Subject to the conditions set forth in this section and section 376.397, the conversion privilege shall also be available to:

(1) The surviving spouse, if any, at the death of the employee or member, with respect to the spouse and such children whose coverage under the group policy terminates by reason of such death, or if the group policy provides for continuation of dependents coverage following the employee's or member's death, at the end of such continuation;

(2) The spouse of the employee or member upon termination of coverage of the spouse, while the employee or member remains insured under the group policy, with respect to the spouse and such children whose coverage under the group policy terminates at the same time; or

(3) A child, solely with respect to himself, upon termination of his coverage by reason of ceasing to be a qualified family member under the group policy, if a conversion privilege is not otherwise provided in sections 376.395 to 376.404 with respect to such termination.

376.421. 1. Except as provided in subsection 2 of this section, no policy of group health insurance shall be delivered in this state unless it conforms to one of the following descriptions:

(1) A policy issued to an employer, or to the trustees of a fund established by an employer, which employer or trustees shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

(a) The employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any class or classes thereof. The policy may provide that the term "employees" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships, if the business of the employer and of such affiliated corporations, proprietorships or partnerships is under common control. The policy may provide that the term "employees" shall include the individual proprietor or partners if the employer is an individual proprietorship or partnership. The policy may provide that the term "employees" shall include retired employees, former employees and directors of a corporate employer. A policy issued to insure the employees of a public body may provide that the term "employees" shall include elected or appointed officials;

(b) The premium for the policy shall be paid either from the employer's funds or from funds contributed by the insured employees, or from both. **[**Except as provided in paragraph (c) of this subdivision,**]** A policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject such coverage in writing; **[**and

(c) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer in a policy insuring fewer than ten employees and in a policy insuring ten or more employees if:

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

b. The person voluntarily terminated the insurance while continuing to be eligible for insurance under the policy; or

c. After the expiration of an open enrollment period during which the person could have enrolled for the insurance or could have elected another level of benefits under the policy;**]**

(2) A policy issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by two or more creditors, which creditor, holding company, affiliate, trustee, trustees or agent shall be deemed the policyholder, to insure debtors of the creditor or creditors with respect to their indebtedness subject to the following requirements:

(a) The debtors eligible for insurance under the policy shall be all of the debtors of the creditor or creditors, or all of any class or classes thereof. The policy may provide that the term "debtors" shall include:

a. Borrowers of money or purchasers or lessees of goods, services, or property for which payment is arranged through a credit transaction;

b. The debtors of one or more subsidiary corporations; and

c. The debtors of one or more affiliated corporations, proprietorships or partnerships if the business of the policyholder and of such affiliated corporations, proprietorships or partnerships is under common control;

(b) The premium for the policy shall be paid either from the creditor's funds or from charges collected from the insured debtors, or from both. Except as provided in paragraph (c) of this subdivision, a policy on which no part of the premium is to be derived from funds contributed by insured debtors specifically for their insurance must insure all eligible debtors;

(c) **[**An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer in a policy insuring fewer than ten debtors and in a policy insuring ten or more debtors if:

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

b. The person voluntarily terminated the insurance while continuing to be eligible for insurance under the policy; or

c. After the expiration of an open enrollment period during which the person could have enrolled for the insurance or could have elected another level of benefits under the policy;

(d)**]** The total amount of insurance payable with respect to an indebtedness shall not exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor. The insurer may exclude any payments which are delinquent on the date the debtor becomes disabled as defined in the policy;

[(e)**] (d)** The insurance may be payable to the creditor or to any successor to the right, title, and interest of the creditor. Such payment or payments shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of each such payment and any excess of insurance shall be payable to the insured or the estate of the insured;

[(f)**] (e)** Notwithstanding the preceding provisions of this subdivision, insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment, and insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan;

(3) A policy issued to a labor union or similar employee organization, which shall be deemed to be the policyholder, to insure members of such union or organization for the benefit of persons other than the union or organization or any of its officials, representatives, or agents, subject to the following requirements:

(a) The members eligible for insurance under the policy shall be all of the members of the union or organization, or all of any class or classes thereof;

(b) The premium for the policy shall be paid either from funds of the union or organization or from funds contributed by the insured members specifically for their insurance, or from both. Except as provided in paragraph (c) of this subdivision, a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject such coverage in writing;

[(c) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer in a policy insuring fewer than ten members and in a policy insuring ten or more members if:

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

b. The person voluntarily terminated the insurance while continuing to be eligible for insurance under the policy; or

c. After the expiration of an open enrollment period during which the person could have enrolled for the insurance or could have elected another level of benefits under the policy;**]**

(4) A policy issued to a trust, or to the trustee of a fund, established or adopted by two or more employers, or by one or more labor unions or similar employee organizations, or by one or more employers and one or more labor unions or similar employee organizations, which trust or trustee shall be deemed the policyholder, to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations, subject to the following requirements:

(a) The persons eligible for insurance shall be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes thereof. The policy may provide that the term "employees" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of such

affiliated corporations, proprietorships or partnerships is under common control. The policy may provide that the term "employees" shall include the individual proprietor or partners if the employer is an individual proprietorship or partnership. The policy may provide that the term "employees" shall include retired employees, former employees and directors of a corporate employer. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship;

(b) The premium for the policy shall be paid from funds contributed by the employer or employers of the insured persons or by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and the employer or union or similar employee organization. Except as provided in paragraph (c) of this subdivision, a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance, must insure all eligible persons except those who reject such coverage in writing;

[(c) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer;**]**

(5) A policy issued to an association or to a trust or to the trustees of a fund established, created and maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of fifty members; shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least two years; shall have a constitution and bylaws which provide that the association or associations shall hold regular meetings not less than annually to further the purposes of the members; shall, except for credit unions, collect dues or solicit contributions from members; and shall provide the members with voting privileges and representation on the governing board and committees. The policy shall be subject to the following requirements:

(a) The policy may insure members of such association or associations, employees thereof, or employees of members, or one or more of the preceding, or all of any class or classes thereof for the benefit of persons other than the employee's employer;

(b) The premium for the policy shall be paid from funds contributed by the association or associations or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations, or employer members;

(c) Except as provided in paragraph (d) of this subdivision, a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for their insurance must insure all eligible persons, except those who reject such coverage in writing;

(d) **[**An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer;

(e)**]** If the health benefit plan, as defined in section 376.1350, is delivered, issued for delivery, continued or renewed, is providing coverage to any resident of this state, and is providing coverage to both small employers as defined in subsection 2 of section 379.930, RSMo, and large employers, the insurer providing the coverage to the association or trust or trustees of a fund established, created, and maintained for the benefit of members of one or more associations may be exempt from subdivision (1) of subsection 1 of section 379.936, RSMo, as it relates to the association plans established under this section. The director shall find that an exemption would be in the public interest and approved and that additional classes of business may be approved under subsection 4 of section 379.934, RSMo, if the director determines that the health benefit plan:

a. Is underwritten and rated as a single employer;

b. Has a uniform health benefit plan design option or options for all participating association members or employers;

c. Has guarantee issue to all association members and all eligible employees, as defined in subsection 2 of section 379.930, RSMo, of any participating association member company; and

d. Complies with all other federal and state insurance requirements, including but not limited to the small employer health insurance and availability act under sections 379.930 to 379.952, RSMo;

(6) A policy issued to a credit union or to a trustee or trustees or agent designated by two or more credit unions, which credit union, trustee, trustees or agent shall be deemed the policyholder, to insure members of such credit union or credit unions for the benefit of persons other than the credit union or credit unions, trustee or trustees, or agent or any of their officials, subject to the following requirements:

(a) The members eligible for insurance shall be all of the members of the credit union or credit unions, or all of any class or classes thereof;

(b) The premium for the policy shall be paid by the policyholder from the credit union's funds and, except as provided in paragraph (c) of this subdivision, must insure all eligible members;

[(c) An insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer;**]**

(7) A policy issued to cover persons in a group where that group is specifically described by a law of this state as one which may be covered for group life insurance. The provisions of such law relating to eligibility and evidence of insurability shall apply.

2. Group health insurance offered to a resident of this state under a group health insurance policy issued to a group other than one described in subsection 1 of this section shall be subject to the following requirements:

(1) No such group health insurance policy shall be delivered in this state unless the director finds that:

(a) The issuance of such group policy is not contrary to the best interest of the public;

(b) The issuance of the group policy would result in economies of acquisition or administration; and

(c) The benefits are reasonable in relation to the premiums charged;

(2) No such group health insurance coverage may be offered in this state by an insurer under a policy issued in another state unless this state or another state having requirements substantially similar to those contained in subdivision (1) of this subsection has made a determination that such requirements have been met;

(3) The premium for the policy shall be paid either from the policyholder's funds, or from funds contributed by the covered persons, or from both**[**;

(4) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer**]**.

3. As used in this section, insurer shall have the same meaning as the definition of health carrier under section 376.1350, and "class" means a predefined group of persons eligible for coverage under a group insurance policy where members of a class represent the same or essentially the same hazard; except that, an insurer may offer a policy to an employer that charges a reduced premium rate or deductible for employees who do not smoke or use tobacco products as authorized under section 290.145, RSMo, and such insurer shall not be considered to be in violation of any unfair trade practice, as defined in section 379.936, RSMo, even if only some employers elect to purchase such a policy and other employers do not. **In offering a policy that charges a reduced premium rate or deductible for employees who do not smoke or use tobacco products, insurers shall comply with the nondiscrimination provisions of the federal Health Insurance Portability and Accountability Act, P.L. 104-191, and federal regulations promulgated thereunder.**

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

(1) The**]** premium for the insurance shall be paid either from funds contributed by the employer, union, association or other person to whom the policy has been issued or from funds contributed by the covered persons, or from both. **[**Except as provided in subdivision (2) of this

section,**]** A policy on which no part of the premium for the family members' or dependents' coverage is to be derived from funds contributed by the covered persons must insure all eligible employees or members with respect to their family members or dependents, or any class or classes thereof**[**;

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

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

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

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

376.426. No policy of group health insurance shall be delivered in this state unless it contains in substance the following provisions, or provisions which in the opinion of the director of insurance, 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 **recommended or** received by the person during the **[**twelve**]** **six** months prior to the **[**effective**] enrollment** date of the person's coverage. In no event shall such exclusion or limitation apply to loss incurred or disability commencing after the earlier of:

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

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

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

(7) A provision that the insurer shall issue to the policyholder, for delivery to each person insured, a certificate setting forth a statement as to the insurance protection to which that

person is entitled, to whom the insurance benefits are payable, and a statement as to any family member's or dependent's coverage;

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

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

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

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

(12) A provision that benefits for accidental loss of life of a person insured shall be payable to the beneficiary designated by the person insured or, if the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms. In either case, payment of these benefits is subject to the provisions of the policy in the event no such designated or specified beneficiary is living at the death of the person insured. All other benefits of the policy shall be payable to the person insured. The policy may also provide

that if any benefit is payable to the estate of a person, or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay such benefit, up to an amount not exceeding two thousand dollars, to any relative by blood or connection by marriage of such person who is deemed by the insurer to be equitably entitled thereto;

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

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

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

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

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

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

(b) A resident of this state; and

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

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

376.428. 1. A group policy delivered or issued for delivery in this state **[**on or after one hundred twenty days following September 28, 1985, by an insurance company, health service corporation or health maintenance organization**] by a health carrier or health benefit plan, as defined in section 376.1350**, which insures employees or members and their eligible dependents for hospital, surgical or major medical insurance on an expense-incurred or service basis, other than for specific diseases or for accidental injuries only, shall provide that employees or members whose coverage under the group policy, which includes coverage for their eligible dependents, would otherwise terminate because of termination of employment or membership shall be entitled to continue their hospital, surgical or major medical coverage, including coverage for their eligible dependents, under that group policy **[**subject to the following terms and conditions:

(1) Continuation shall only be available to an employee or member who has been continuously insured under the group policy, and for similar benefits under any group policy which it replaced, during the entire three-month period ending with such termination. If employment is reinstated during the continuation period, then coverage under the group policy will be reinstated for the employee and any dependents who were covered under continuation;

(2) Continuation shall not be available for any person covered under the group policy who is or could be covered by Medicare, nor any person who is or could be covered by any other insured or uninsured arrangement which provides hospital, surgical or major medical coverage for individuals in a group and under which the person was not covered immediately prior to such termination;

(3) Continuation need not include dental, vision care or prescription drug benefits or any other benefits provided under the group policy in addition to its hospital, surgical or major

medical benefits, but continuation must include maternity benefits if those benefits are provided under the group policy;

(4) The employee or member must request such continuation in writing within thirty-one days of the date coverage would otherwise terminate and must pay to the group policyholder, on a monthly basis, the amount of contribution required to continue the coverage. Such premium contribution shall not be more than the group rate of the insurance being continued on the due date of each payment; but, if any benefits are omitted as provided by subdivision (3) of this subsection, such premium contribution shall be reduced accordingly. The employee's or member's written request for continuation, together with the first required premium contribution, must be given to the group policyholder within thirty-one days of the date the coverage would otherwise terminate. Employers must notify their employees and members, in writing, of the duties of such employees and members under this subdivision no later than the date on which coverage would otherwise terminate;

(5) Continuation of coverage under the group policy for any covered person shall terminate upon failure to satisfy subdivision (2) of this subsection or, if earlier, at the first to occur of the following:

(a) The date nine months after the date the employee's or member's coverage under the group would have terminated because of termination of employment or membership;

(b) If the employee or member fails to make timely payment of a required premium contribution, the end of the period for which contributions were made;

(c) The date on which the group policy is terminated or, in the case of an employee, the date the employer terminates participation under a group policy. However, if this condition applies and the coverage ceasing by reason of termination is replaced by similar coverage under another group policy, then:

a. The employee or member shall have the right to become covered under that other group policy for the balance of the period that he would have remained covered under the prior group policy in accordance with the conditions of this section;

b. The minimum level of benefits to be provided by the other group policy shall be the applicable level of benefits of the prior group policy reduced by any benefits payable under that prior policy; and

c. The prior group policy shall continue to provide benefits to the extent of its accrued liabilities and extensions of benefits as if the replacement had not occurred**] in the same manner as continuation of coverage is required under the continuation of coverage provisions set forth in the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), as amended**.

2. The spouse of an employee or member whose coverage under the group policy would otherwise terminate due to dissolution of marriage or death of the employee or member shall have the same continuation privilege accorded under sections 376.421 to 376.442, 376.694 to 376.696, and 376.779 to the employee or member upon termination of employment or membership.

3. The right to a converted policy pursuant to sections 376.395 to 376.404 for an employee or member entitled to continuation of coverage under sections 376.421 to 376.442, 376.694 to 376.696, and 376.779 shall commence upon termination of the continued coverage provided for in sections 376.421 to 376.442, 376.694 to 376.696, and 376.779.

4. This section shall only apply to those persons who are not subject to the continuation and conversion provisions set forth in Title I, Subtitle B, Part 6 of the Employment Retirement Income Security Act of 1974 or Title XXII of the Public Health Service Act, as said acts were in effect on January 1, 1987.

376.437. 1. Any group policy, contract, or health benefit plan which is issued, delivered, issued for delivery, or renewed in this state on or after January 1, 2010, providing coverage for hospital or medical expenses other than for specific diseases or for accidental injuries only, shall contain a provision that a group member or employee whose insurance coverage under the policy or health benefit plan otherwise terminates after the expiration of the period of continuation of coverage for which the individual is eligible under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), or section 376.428 shall be entitled to continue coverage under that group policy or health benefit plan for himself or herself and his or her eligible dependents if the member or employee was fifty-five years of age or older at the time of the expiration of coverage provided by the federal Consolidated Omnibus Budget Reconciliation Act or section 376.428.

2. In the event and to the extent that this section is applicable, the election by the group member or employee to obtain continuation of coverage as provided under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or under the provisions of section 376.428 shall constitute election of continuation of coverage under this section without further action by the group member or employee. The provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or of section 376.428, whichever is applicable, regarding notice to a group member or an employee of the right to continue coverage shall apply to the continuation of coverage provided under this section.

3. If an eligible group member or employee elects continuation of coverage under the provisions of this section, the monthly premium contribution for the continuation

coverage shall not be greater than one hundred two percent of the total of the amount that would be charged if the eligible group member or employee were a current group member or employee of the group contract, policy, or health benefit plan plus an amount that the group policyholder would contribute toward the premium if the eligible group member or employee were a current group member or employee.

4. The first premium for the continuation of coverage under this section shall be paid by the eligible group member or employee on the first regular due date following the expiration of the eligible person's benefits under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or under the provisions of section 376.428.

5. Failure of the employee or member to exercise the election in accordance with subsection 2 of this section shall terminate the right to continuation of benefits under subsection 1 of this section.

6. The right to extended continuation coverage under the provisions of this section shall terminate upon the earliest of any of the following:

(1) The failure to pay premiums or required premium contributions, if applicable, when due, including any grace period allowed by the policy;

(2) The date that the group policy or plan is terminated as to all group members or employees except that if a different group policy or plan is made available to group members, the eligible group member or employee shall be eligible for continuation of coverage as if the original policy had not been terminated;

(3) The date on which the eligible member or employee becomes insured under any other group health policy;

(4) The date on which the eligible member or employee becomes eligible for coverage under the federal Medicare Program pursuant to Title XVIII of the federal Social Security Act;

(5) The date on which the member or employee attains his or her sixty-fifth birthday.

7. As used in this section, the term "policy, contract, or plan" shall mean a group insurance policy or health benefit plan providing group health insurance coverage on an expense incurred basis, or a group service or indemnity contract issued by a health carrier as defined in section 376.1350.

8. The director shall promulgate such rules and regulations as may be necessary to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter

536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2009, shall be invalid and void.

376.439. All group policies delivered, issued for delivery, or renewed in this state on or after January 1, 2010, that provide continuation coverage to individuals and their eligible dependents pursuant to section 376.428, shall have their continuation of coverage experience pooled across all fully insured group business in Missouri. The rating system or methodology in which the premium for all persons covered under a continuation of coverage provision shall be based on the experience of all persons covered by a continuation of coverage provision with any cost of the pool experience spread over all fully insured premiums in Missouri on an equal percentage basis. The health benefit plan under which continuation coverage is provided under section 376.428 shall not have the plan's premium directly affected by those within the group plan who are exercising their continuation rights under section 376.428.

376.443. In addition to the group policy under which an employee or group member may continue coverage under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) or section 376.428, the health carrier shall offer the employee, group member, or any qualifying eligible individual the option of continuation of coverage through a high deductible health plan, or its actuarial equivalent, that is eligible for use with a health savings account under the applicable provisions of Section 223 of the Internal Revenue Code. Such high deductible health plan shall have health insurance premiums that are consistent with the underlying group plan of coverage rated relative to the standard or manual rates for the benefits provided. As used in this section, a "high deductible health plan" shall mean a health savings account eligible plan that meets the criteria established in 26 U.S.C. Section 223(c)(2), as amended, and any regulations promulgated thereunder.

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

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

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

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

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

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

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

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

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

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

(4) "COBRA continuation provision":

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

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

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

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

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

a. A group health plan;

b. Health insurance coverage;

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

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

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

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

g. A state health benefits risk pool;

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

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

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

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

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

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

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

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

(9) "Excepted benefits":

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

(b) Coverage only for disability income insurance;

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

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

(e) Workers' compensation or similar insurance;

(f) Automobile medical payment insurance;

(g) Credit-only insurance;

(h) Coverage for on-site medical clinics;

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

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

a. Limited scope dental or vision benefits;

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

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

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

a. Coverage only for a specified disease or illness;

b. Hospital indemnity or other fixed indemnity insurance;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

is otherwise eligible to **[**be covered for benefits**] enroll** under the terms of **[**the**] a** group health plan **can become effective. If an employee or dependent enrolls as a late enrollee or special enrollee, any period before such late or special enrollment is not a waiting period. If an individual seeks coverage in the individual market, a waiting period begins on the date the individual submits a substantially complete application for coverage and ends on:**

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

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

2. A health insurance issuer offering group health insurance coverage may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if:

(1) Such exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date;

(2) Such exclusion extends for a period of not more than twelve months, or eighteen months in the case of a late enrollee, after the enrollment date; and

(3) The period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage, if any, applicable to the participant as of the enrollment date.

3. For the purposes of applying subdivision (3) of subsection 2 of this section:

(1) A period of creditable coverage shall not be counted, with respect to enrollment of an individual under group health insurance coverage, if, after such period and before the enrollment date, there was a sixty-three day period during all of which the individual was not covered under any creditable coverage;

(2) Any period of time that an individual is in a waiting period for coverage under group health insurance coverage, or is in an affiliation period, shall not be taken into account in determining whether a sixty-three day break under subdivision (1) of this subsection has occurred;

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

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

coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) The coverage becomes effective:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Is a resident of this state;

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

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

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

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

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

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

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

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

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

a. A group health plan;

b. Health insurance coverage;

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

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

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

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

g. A state health benefits risk pool;

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

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

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

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

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

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

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

(8) "Excepted benefits":

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

(b) Coverage only for disability income insurance;

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

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

(e) Workers' compensation or similar insurance;

(f) Automobile medical payment insurance;

(g) Credit-only insurance;

(h) Coverage for on-site medical clinics;

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

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

a. Limited scope dental or vision benefits;

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

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

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

a. Coverage only for a specified disease or illness;

b. Hospital indemnity or other fixed indemnity insurance;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) A trade act eligible individual;

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

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

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

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

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

(9) Any person who has exhausted his or her maximum in benefits from a health insurer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. When an insurer determines an insured has exhausted eighty-five percent of his or her total lifetime benefits, the insurer shall notify any affected person of the existence of the pool, of the person's eligibility for the pool when all lifetime benefits have been exhausted, and of methods of applying for pool coverage. When any affected person has exhausted one hundred percent of his or her total lifetime benefits, the insurer shall notify the affected person of his or her eligibility for pool coverage and of the methods of applying for such coverage. The insurer shall provide a copy of such notice to the pool with the name and address of such affected person.

376.985. 1. On or before January 1, 2010, the pool shall offer at least two plans for an individual eligible for coverage under the health insurance pool and also eligible under the show-me health coverage plan established under sections 1 to 8 of this act that meets the criteria of the federal Centers for Medicare and Medicaid for such program. For purposes of this section and section 376.986, an individual eligible for coverage under the health insurance pool shall be defined by the eligibility criteria in subsection 2 of section 376.966.

2. Any individual receiving health insurance coverage under the state health insurance pool whose income is less than two hundred twenty-five percent of the federal poverty level may apply for participation in the show-me health coverage plan. The pool shall provide information to pool participants on how to apply for participation in the show-me health coverage plan.

3. Subject to available funds, the board may establish a premium subsidy program for low-income persons who are eligible for participation in the high-risk pool in accordance with the premiums established under section 376.986. The program may include incentives designed to encourage and promote healthy lifestyle choices which are appropriate and attainable for such participants, taking into consideration any limitations on lifestyle choices which exist based on the medical conditions and needs of the population served under the high-risk pool.

376.986. 1. The pool shall offer major medical expense coverage to every person eligible for coverage under section 376.966. The coverage to be issued by the pool and its schedule of benefits, exclusions and other limitations, shall be established by the board with the advice and recommendations of the pool members, and such plan of pool coverage shall be submitted to the director for approval. The pool shall also offer coverage for drugs and supplies requiring a medical prescription and coverage for patient education services, to be provided at the direction of a physician, encompassing the provision of information, therapy, programs, or other services on an inpatient or outpatient basis, designed to restrict, control, or otherwise cause remission of the covered condition, illness or defect.

2. In establishing the pool coverage the board shall take into consideration the levels of health insurance provided in this state and medical economic factors as may be deemed appropriate, and shall promulgate benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of and commensurate with health insurance provided through a representative number of insurers in this state.

3. The pool shall establish premium rates for pool coverage as provided in subsection 4 of this section. Separate schedules of premium rates based on age, sex**, family size,** and

geographical location may apply for individual risks. Premium rates and schedules shall be submitted to the director for approval prior to use.

4. The pool, with the assistance of the director, shall determine the standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. **[**Initial rates for pool coverage shall not be less than one hundred twenty-five percent of rates established as applicable for individual standard risks.**]** Subject to the limits provided in this subsection, **[**subsequent**]** rates shall be established **in accordance with the premium rate schedule in subsection 5 of this section** to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein. In no event shall pool rates exceed the following:

(1) For federally defined eligible individuals and trade act eligible individuals, rates shall be equal to the percent of rates applicable to individual standard risks actuarially determined to be sufficient to recover the sum of the cost of benefits paid under the pool for federally defined and trade act eligible individuals plus the proportion of the pool's administrative expense applicable to federally defined and trade act eligible individuals enrolled for pool coverage, provided that such rates shall not exceed one hundred **[**fifty**]** **twenty-five** percent of rates applicable to individual standard risks; and

(2) For all other individuals covered under the pool, one hundred **[**fifty**]** **twenty-five** percent of rates applicable to individual standard risks.

5. **Premium rates for pool coverage shall be established in accordance with the following schedule:**

(1) For individuals with incomes of less than two hundred twenty-five percent of the federal poverty level, a premium rate equal to one hundred percent of the standard risk rates;

(2) For individuals with incomes of two hundred twenty-five percent of the federal poverty level or more, one hundred twenty-five percent of the standard risk rates established by rule.

6. For uninsurable individuals eligible for the show-me health coverage plan established under sections 1 to 8 of this act, the pool shall offer the coverage required under subsection 1 of section 376.985 to such individuals at one hundred percent of the standard risk rates of the pool subject to the following:

(1) The department of social services shall pay all or a portion of the premium for such coverage for an individual in the same manner authorized under the show-me health coverage plan;

(2) If the premium exceeds the amount paid by the department under this subsection, the individual covered shall be responsible for payment of any premium for such coverage not paid by the department;

(3) For show-me health coverage plan participants who are eligible for federal participation moneys, the losses covered under the pool for such individuals may, in accordance with the requirements of the federal waiver for such program, exceed the standard risk rates of the pool; and

(4) Premiums shall be certified as actuarially sound in accordance with the requirements established by the federal Centers for Medicare and Medicaid Services.

7. All agents and brokers selling or renewing Missouri health insurance pool policies shall receive a seven and one-half percent commission from the pool upon approval of a new application or renewal of coverage under a health insurance pool policy. Such commissions shall not be paid by enrollees or included in the premium rates established for policies under the pool. The board shall provide that agents and brokers selling show-me health coverage qualified plans comply with the federal Centers for Medicare and Medicaid Services requirements concerning marketing and plan enrollment for show-me health coverage plan participants eligible for federal participation.

8. Pool coverage established pursuant to this section shall provide an appropriate high and low deductible to be selected by the pool applicant. The deductibles and coinsurance factors may be adjusted annually in accordance with the medical component of the consumer price index.

[6.**] 9.** Pool coverage shall exclude charges or expenses incurred during the first twelve months following the effective date of coverage as to any condition for which medical advice, care or treatment was recommended or received as to such condition during the six-month period immediately preceding the effective date of coverage. Such preexisting condition exclusions shall be waived to the extent to which similar exclusions, if any, have been satisfied under any prior health insurance coverage which was involuntarily terminated, if application for pool coverage is made not later than sixty-three days following such involuntary termination and, in such case, coverage in the pool shall be effective from the date on which such prior coverage was terminated.

[7.**] 10.** No preexisting condition exclusion shall be applied to the following:

(1) A federally defined eligible individual who has not experienced a significant **[**gap**]** **break** in coverage; or

(2) A trade act eligible individual who maintained creditable health insurance coverage for an aggregate period of three months prior to loss of employment and who has not experienced a significant **[**gap**]** **break** in coverage since that time.

[8.**] 11.** Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other health insurance, or insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program except Medicaid. The insurer or the pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the pool may be reduced or refused as a setoff against any amount recoverable under this subsection.

[9.**] 12.** Medical expenses shall include expenses for comparable benefits for those who rely solely on spiritual means through prayer for healing.

13. In providing coverage to enrollees under the health insurance pool and payments to providers for providing health care services to enrollees under the pool, the board shall take into consideration the special needs of Missouri's Tier I Safety Net providers so that they are not disproportionately impacted by rules promulgated by the board as it implements the provisions of sections 376.960 to 376.990.

376.987. 1. The board shall offer to all eligible persons for pool coverage under section 376.966 the option of receiving health insurance coverage through a high-deductible health plan and the establishment of a health savings account**, or other similar account. The high-deductible health plans shall be offered to all eligible persons on a guaranteed-issue basis**. In order for a qualified individual to obtain a high-deductible health plan through the pool, such individual shall present evidence, in a manner prescribed by regulation, to the board that he or she has established a health savings account in compliance with 26 U.S.C. Section 223, and any amendments and regulations promulgated thereto.

2. As used in this section, the term "health savings account" shall have the same meaning ascribed to it as in 26 U.S.C. Section 223(d), as amended. The term "high-deductible health plan" shall mean a policy or contract of health insurance or health care plan that meets the criteria established in 26 U.S.C. Section 223(c)(2), as amended, and any regulations promulgated thereunder.

3. **The utilization of high deductible plans and the establishment of health savings accounts or other similar accounts shall be reviewed and reassessed annually by the appropriate legislative committees of the general assembly.**

4. The board is authorized to promulgate rules and regulations for the administration and implementation of this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo,

and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2007, shall be invalid and void.

376.995. 1. This section shall be known as the "Limited Mandate Health Insurance Act".

2. Limited mandate health insurance policies and contracts shall mean those policies and contracts of health insurance as defined in section 376.960 and which cover individuals and their families (but not including any Medicare supplement policy or contract) and groups sponsored by an employer who employs fifty or fewer persons.

3. No law requiring the coverage of a particular health care service or benefit, or requiring the reimbursement, utilization or inclusion of a specific category of licensed health care practitioner, shall apply to limited mandate health insurance policies and contracts, except the following provisions:

(1) Subsection 1 of section 354.095, RSMo, to the extent that it regulates maternity benefits;

(2) Section 375.995, RSMo;

(3) Section 376.406;

(4) Section 376.428;

(5) Section 376.782;

(6) Section 376.816;

(7) Section 376.1210;

(8) Section 376.1215; and

(9) Section 376.1219.

4. In order for an insurer as defined in section 376.960 to be eligible to market, sell or issue limited mandate health insurance, the insurer shall:

(1) **[**Restrict its marketing and sales efforts to only those persons or groups as defined in subsection 2 of this section which currently do not have health insurance coverage or to those persons or employers which certify in writing to the insurer that they will terminate the coverage they currently have at the time they would otherwise renew coverage because of cost;

(2)**]** Fully and clearly disclose to the person or group to whom the limited mandate health insurance policy or contract is to be issued that the reason coverage for this product is less expensive than other coverage is because the policy or contract does not contain coverages or health professional payment mechanisms that are required by subsection 3 of this section;

[(3)**] (2)** Clearly disclose in all sales, promotional and advertising material related thereto that the product is a limited mandate health insurance policy or contract.

5. The provisions of section 376.441 shall not apply to any group which replaces its current coverage with a limited mandate health insurance policy or contract if the benefit to be extended is one for services which are not covered by the replacing policy or contract.

6. Notwithstanding any other provision of this section to the contrary, the provisions of paragraph (b) of subdivision (11) of section 375.936, RSMo, shall apply to limited mandate health insurance policies with respect to physician services covered under such policies, which can be provided by persons licensed pursuant to section 332.181, RSMo.

376.1232. 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, 2010, shall offer coverage for prosthetic devices and services, including original and replacement devices, as prescribed by a physician acting within the scope of his or her practice.

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 amount of the benefit for prosthetic devices and services under this section shall be no less than the annual and lifetime benefit maximums applicable to the basic health care services required to be provided under the health benefit plan. If the health benefit plan does not include any annual or lifetime maximums applicable to basic health care services, the amount of the benefit for prosthetic devices and services shall not be subject to an annual or lifetime maximum benefit level. Any co-payment, coinsurance, deductible, and maximum out-of-pocket amount applied to the benefit for prosthetic devices and services shall be no more than the most common amounts applied to the basic health care services required to be provided under 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.

376.1450. An enrollee, as defined in section 376.1350, may **[**waive his or her right to**]** receive documents and materials from a managed care entity in printed **or electronic** form so long as such documents and materials are readily accessible **[**electronically through the entity's Internet site. An enrollee may revoke such waiver at any time by notifying the managed care entity by phone or in writing or annually. Any enrollee who does not execute such a waiver and prospective enrollees shall have documents and materials from the managed care entity provided**]** in printed form **upon request**. For purposes of this section, "managed care entity" includes, but

is not limited to, a health maintenance organization, preferred provider organization, point of service organization and any other managed health care delivery entity of any type or description.

376.1600. 1. The director of the department of insurance, financial institutions and professional registration is authorized to allow employees to use funds from one or more employer health reimbursement arrangement only plans to help pay for coverage in the individual health insurance market. This will encourage employer financial support of health insurance or health-related expenses recognized under the rules of the federal Internal Revenue Service. Health reimbursement arrangement only plans that are not sold in connection with or packaged with individual health insurance policies shall not be considered insurance under this chapter.

2. As used in this section, the term "health reimbursement arrangement" shall mean an employee benefit plan provided by an employer which:

(1) Establishes an account or trust which is funded solely by the employer and not through a salary reduction or otherwise under a cafeteria plan established pursuant to Section 125 of the Internal Revenue Code of 1986;

(2) Reimburses the employee for qualified medical care expenses, as defined by 26 U.S.C. Section 213(d), incurred by the employee and the employee's spouse and dependents;

(3) Provides reimbursements up to a maximum stated dollar amount for a defined coverage period; and

(4) Carries forward any unused portion of the maximum dollar amount at the end of the coverage period to increase the maximum reimbursement amount in subsequent coverage periods.

376.1603. 1. The director shall develop flexible guidelines for coverage and approval of health savings account eligible high deductible health plans which are designed to qualify under federal and state requirements as high deductible health plans for use with health savings accounts which comply with federal requirements under the applicable provisions of the federal Internal Revenue Code.

2. The director is authorized to encourage and promote the marketing of health savings account eligible high deductible plans by health carriers in this state; provided, however, that nothing in this section shall be construed to authorize the interstate sales of insurance.

3. The director shall conduct a national study of health savings account eligible high deductible health plans available in other states and determine if and how these products serve the uninsured and if they should be made available to Missourians.

4. The director shall develop an automatic or fast track approval process for health savings account eligible high deductible plans already approved under the laws and regulations of this state or other states.

5. The director is authorized to promulgate such rules and regulations as he or she deems necessary and appropriate for the design, promotion, and regulation of health savings account eligible high deductible plans, including rules and regulations for the expedited review of standardized policies, advertisements and solicitations, and other matters deemed relevant by the director. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2009, shall be invalid and void.

376.1618. The director shall study and recommend to the general assembly changes to remove any unnecessary application and marketing barriers that limit the entry of new health insurance products into the Missouri market. The director shall examine state statutory and regulatory requirements along with market conditions which create barriers for the entry of new health insurance products and health insurance companies. The director shall also examine proposals adopted in other states that streamline the regulatory environment to make it easier for health insurance companies to market new and existing products. The director shall submit a report of his or her findings and recommendations to each member of the general assembly no later than January 1, 2010.

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

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

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

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

(3) "Base premium rate", for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business, by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. A group health plan;

b. Health insurance coverage;

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

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

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

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

g. A state health benefits risk pool;

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

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

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

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

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

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

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

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

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

(17) "Excepted benefits":

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

(b) Coverage only for disability income insurance;

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

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

(e) Workers' compensation or similar insurance;

(f) Automobile medical payment insurance;

(g) Credit-only insurance;

(h) Coverage for on-site medical clinics;

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

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

a. Limited scope dental or vision benefits;

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

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

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

a. Coverage only for a specified disease or illness;

b. Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

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

(19) "Group health plan", an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 and Public Law 104-191 to the extent that the plan provides medical care, as defined in this section, and including any item or service paid for as medical care to an employee or the employee's dependent, as defined under the terms

of the plan, directly or through insurance, reimbursement or otherwise, but not including excepted benefits;

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

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

(a) Health status;

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

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information;

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

(h) Disability;

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

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

(a) The individual meets each of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) A small employer carrier shall not modify a health benefit plan with respect to a small employer or any eligible employee or dependent through riders, endorsements or

otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

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

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

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

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

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

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

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

4. A small employer carrier shall not be required to provide coverage to small employers pursuant to subsection 1 of this section for any period of time for which the director determines that requiring the acceptance of small employers in accordance with the provisions of subsection 1 of this section would place the small employer carrier in a financially impaired condition, and the small employer is applying this subsection uniformly to all small employers in the small

group market in this state consistent with applicable state law and without regard to the claims experience of a small employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents.

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

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

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

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

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

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

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

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

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

6. No small employer carrier or producer shall induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits

provided in connection with the employee's employment; except that, a carrier may offer a policy to a small employer that charges a reduced premium rate or deductible for employees who do not smoke or use tobacco products, and such carrier shall not be considered in violation of sections 379.930 to 379.952 or any unfair trade practice, as defined in section **[**379.936**] 375.936, RSMo**, even if only some small employers elect to purchase such a policy and other small employers do not. **In offering a policy that charges a reduced premium rate or deductible for employees who do not smoke or use tobacco products, carriers shall comply with the nondiscrimination provisions of the federal Health Insurance Portability and Accountability Act, P.L. 104-191, and federal regulations promulgated thereunder.**

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

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

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

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

Section 1. 1. As used in sections 1 to 10 of this act, the following terms shall mean:

(1) "Department", the department of social services;

(2) "Health insurance pool" or "pool", the health insurance pool established under sections 376.960 to 376.991, RSMo;

(3) "Preventative care services", medically appropriate and age appropriate care that is provided to an individual to prevent and diagnose disease, and promote good health and a healthy lifestyle;

(4) "Qualified plan", any health benefit plan available through the health insurance pool established under sections 376.960 to 376.991, RSMo, that is determined by the department of insurance, financial institutions and professional registration to meet the minimum benefit design contained in the federal waiver authorizing the show-me health coverage plan;

(5) "Show-me health coverage plan" or "plan", the show-me health coverage plan established in sections 1 to 10 of this act.

2. Subject to appropriations, there is hereby established within the department of social services the "Show-me Health Coverage Plan" to provide health care coverage through the health insurance pool to low-income adults residing in this state. The

department shall apply to the United States Department of Health and Human Services for approval of a Section 1115 demonstration waiver to develop and implement the plan, provided that any reduction of disproportionate share hospital funds applied to the cost of the plan as required by such waiver shall not be disproportionate to the impact the program has on Missouri's low-income uninsured. The provisions of sections 1 to 10 of this act shall be void and of no effect if there are no funds of the United States appropriated by Congress to be provided to the state on the basis of a state plan or waiver approved by the federal government under the federal Social Security Act or if there are no disproportionate share hospital funds applied to the program. Such submitted waiver shall include but not be limited to:

(1) A provision that allows for transitional participation in the plan as set forth in subsection 3 of section 6 of this act; and

(2) For individuals receiving coverage through the state's health insurance pool, a provision that allows for:

(a) Federal participation moneys to be used to provide such individuals with pool coverage under the plan; and

(b) Actuarially sound premium rates for coverage for such individuals that exceed the standard risk rates of the health insurance pool based on the aggregate losses for all such individuals eligible for federal participation moneys.

3. Prior to the submission of an application for a federal waiver under subsection 2 of this section, the department shall submit the proposed application for such waiver to the joint committee on MO HealthNet for the committee's review, recommendations, and approval.

4. The department of insurance, financial institutions and professional registration and the MO HealthNet division of the department of social services shall provide oversight of the marketing practices of the plan. The department of social services and the health insurance pool shall promote the plan and provide information to potential eligible individuals.

5. The plan is not an entitlement program. The maximum enrollment of individuals who may participate in the plan is dependent on funding appropriated for the plan by the general assembly. The department of social services and the health insurance pool shall, to the extent possible, ensure that enrollment in the plan is distributed throughout Missouri in proportion to the number of individuals who are eligible for participation in the plan. Eligibility for the plan may be phased in incrementally on the basis of actions taken by the general assembly in the appropriations process.

6. Notwithstanding any other provision of sections 1 to 10 of this act to the contrary, for individuals receiving coverage through the state's health insurance pool, such individuals shall be eligible for participation under the plan as long as they are otherwise eligible for participation in the plan and their incomes do not exceed two hundred twenty-five percent of the federal poverty level.

7. The department and the health insurance pool shall establish standards for consumer protection, including the following:

(1) Quality of care standards;

(2) A uniform process for participant grievances and appeals;

(3) Standardized reporting concerning provider performance, consumer experience, and cost.

8. The show-me health coverage plan shall pay one hundred percent of the premium costs for all participants in the plan, except for any participant whose balance in his or her show-me health coverage account at the end of the plan year exceeds the total annual required contribution amount under subdivision (2) of subsection 2 of section 5 of this act. Any funds remaining in the health care account of an individual who renews participation in the plan at the end of the individual's twelve-month plan period shall remain in the account. The state's contribution to an individual's account shall be suspended the month after the ending account balance exceeds one thousand dollars and shall resume the month after the ending account balance is less than one thousand dollars.

Section 2. 1. Subject to appropriations, an individual shall be eligible for participation in the plan if the individual is eligible for coverage under the health insurance pool and meets the following requirements:

(1) The individual is at least nineteen years of age and less than sixty-five years of age and:

(a) Income in the amount of the difference between the income standard established for eligibility under section 208.145, RSMo, and fifty percent of the federal poverty level is disregarded; or

(b) The individual:

a. Has an annual household income of not more than the level established by appropriation, not to exceed one hundred percent of the federal poverty level;

b. Has household earned income above the temporary assistance for needy families limit; and

c. Does not have household unearned income above the temporary assistance for needy families limit, excluding unemployment insurance benefits up to one thousand dollars per month, child support up to five hundred dollars per month, and a child's

federal Old-Age Survivors or Disability Insurance (OASDI) benefit up to one thousand dollars per month.

The four-month thirty dollar plus one-third of earned income disregard nor the eight-month thirty dollar disregard shall not be allowed under this subdivision. The combined amount of earned and unearned income shall not exceed one hundred percent of the federal poverty level;

(c) The individual has an annual household income of not more than two hundred twenty-five percent of the federal income poverty level; or

(2) The individual meets all of the following requirements:

(a) The individual is at least nineteen years of age and less than sixty-five years of age;

(b) The individual is a United States citizen or qualified legal alien and a resident of Missouri;

(c) The individual has an annual household income of not more than two hundred twenty-five percent of the federal income poverty level;

(d) The individual has not had health insurance coverage for at least six months;

(e) The individual has household earned income that exceeds the maximum income for eligibility for Temporary Assistance for Needy Families (TANF) benefits;

(f) The individual does not have household unearned income that exceeds the maximum income for eligibility for Temporary Assistance for Needy Families (TANF) benefits limit, excluding unemployment insurance benefits up to one thousand dollars per month, child support up to five hundred dollars per month, and a child's OASDI benefit up to one thousand dollars per month; and

(g) The combined amount of earned and unearned income shall not exceed the income eligibility level set by appropriation, not to exceed two hundred twenty-five percent of the federal poverty level.

2. The following individuals shall not be eligible for the plan:

(1) An individual who participates in the federal Medicare program, 42 U.S.C. Section 1395, et seq.;

(2) A pregnant woman for purposes of pregnancy-related services who is eligible for health care coverage under chapter 208, RSMo;

(3) An individual who has resources or owns assets with a value in excess of two hundred twenty-five thousand dollars.

3. The eligibility requirements specified in subsection 1 of this section are subject to approval for federal financial participation by the United States Department of Health and Human Services.

4. The department and the health insurance pool shall provide for enrollment with the plan through the department's Internet web site and family support division offices.

Section 3. 1. The plan shall include the following medically necessary services in a manner and to the extent determined by the department and the health insurance pool:

(1) Inpatient hospital services;

(2) Outpatient hospital and ambulatory surgical center services;

(3) Emergency room services;

(4) Physician and advanced practice nurse services;

(5) Federally qualified health center and rural health clinic services;

(6) Laboratory, radiology, and other diagnostic services;

(7) Prescription drug coverage;

(8) Mental health and substance abuse treatment. The plan shall not permit treatment limitations or financial requirements on the coverage of mental health care services or substance abuse services if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions;

(9) Home health services;

(10) Durable medical equipment;

(11) Family planning services:

(a) Including contraceptives and sexually transmitted disease testing, as described in federal Medicaid law, 42 U.S.C. Section 1396, et seq.; and

(b) Not including abortion or abortifacients, except as required in federal Medicaid law, 42 U.S.C. Section 1396, et seq.;

(12) Personal care services;

(13) Emergency ground and air transportation services;

(14) Hospice services;

(15) Prevention and wellness services;

(16) Case management, care coordination, and disease management;

(17) Urgent care center services;

(18) Preventive care services; and

(19) Therapy services, including physical, occupational, and speech therapy.

2. The plan shall, at no cost to the individual, provide payment for one physician office visit and at least two hundred dollars of qualifying preventative care services per year for an individual who is eligible under subdivision (2) of subsection 1 of section 2 of

this act. Any additional physician office visits and preventative care services covered under the plan and received by an individual who is eligible under subdivision (2) of subsection 1 of section 2 of this act shall be subject to the deductible and co-payment requirements of the plan.

3. The plan may include incentives designed to encourage and promote healthy lifestyle choices which are medically appropriate, age appropriate, and attainable for individual participants, taking into consideration any limitations on lifestyle choices which may exist based on medical conditions and the needs of the population serviced under the plan.

4. The plan shall, subject to appropriations, provide to an individual who participates in the plan a list of health care services that qualify as preventive care services for the age, gender, and preexisting conditions of the individual. The plan shall consult with the federal U.S. Preventive Services Task Force for a list of recommended preventive care services.

Section 4. 1. Every individual eligible under subsection 1 of section 2 of this act who participates in the plan shall have an individual show-me health coverage account, such as a health savings account or other similar account, to which payments may be made for the individual's participation in the plan by any of the following:

(1) The individual;

(2) An employer;

(3) The state, including any incentive payments contributed by the state;

(4) Any philanthropic or charitable contributor; or

(5) The health insurance pool that operates wellness and health promotion programs, disease and condition management programs, health risk appraisal programs, and other similar programs. Such requirements shall not be considered to be engaging in unfair trade practices under section 375.936, RSMo, with respect to the practices of illegal inducements, unfair discrimination, and rebating.

2. The minimum funding amount for an individual show-me health coverage account is the amount required under section 5 of this act.

3. An individual show-me health coverage account shall be used to pay the individual's deductible and co-payments for health care services under the plan.

4. An individual may make payments to his or her individual show-me health coverage account as follows:

(1) An employer withholding or causing to be withheld from an employee's wages or salary, after taxes are deducted from the wages or salary, the individual's contribution under this section and distributed equally throughout the calendar year;

(2) Submission of the individual's contribution under sections 1 to 10 of this act to the department to deposit in the participant's individual show-me health coverage account in a manner prescribed by the department;

(3) Another method determined by the department and the health insurance pool.

5. An employer may make, from moneys not payable by the employer to the employee, not more than fifty percent of an individual's required payment to his or her individual show-me health coverage account.

6. Any employer making any contributions for a participant in the show-me health coverage plan may make such contribution to the employee's individual show-me health coverage account or may make such contribution towards the payment of any premiums for coverage of the employee under the plan.

Section 5. 1. For individuals required to contribute to a an individual show-me health coverage account, an individual's participation in the plan shall not begin until an initial payment is made for the individual's participation in the plan. A required payment to the plan for the individual's participation shall not exceed one-twelfth of the annual payment required under subsection 2 of this section.

2. To participate in the plan, an individual shall:

(1) Apply for the plan in a manner prescribed by the department. The department and health insurance pool may develop and allow a joint application for a household;

(2) If the individual is approved by the department to participate in the plan, contribute to an individual show-me health coverage account the lesser of the following:

(a) The federal minimum amount for a health savings account in the first year adjusted annually each year thereafter by the Consumer Price Index, less any amounts paid by the individual under:

a. The MO HealthNet program;

b. The children's health insurance program; and

c. The Medicare program, 42 U.S.C. Section 1395, et seq., as determined by the department; or

(b) Not more than the following applicable percentage of the individual's annual household income per year, less any amounts paid under the MO HealthNet program, the children's health insurance program, and the Medicare program, 42 U.S.C. Section 1395, et seq., as determined by the department and the health insurance pool:

a. One percent of the annual household income per year for incomes up to one hundred percent of the federal poverty level;

b. Two percent of the annual household income per year if the individual has an annual household income of more than one hundred percent and not more than one hundred twenty-five percent of the federal poverty level;

c. Three percent of the annual household income per year if the individual has an annual household income of more than one hundred twenty-five percent and not more than one hundred fifty percent of the federal poverty level;

d. Four percent of the annual household income per year if the individual has an annual household income of more than one hundred fifty percent and not more than two hundred percent of the federal poverty level; or

e. Five percent of the annual household income per year if the individual has an annual household income of more than two hundred and not more than two hundred twenty-five percent of the federal poverty level.

3. In no case shall the combined household contribution to the health savings account and other deductible or co-pay exceed five percent of the annual household income.

4. The state shall contribute the difference to the individual's account if the individual's payment required under subdivision (2) of subsection 2 of this section is less than the federal minimum amount for a health savings account in the first year or the amount each year thereafter as adjusted by the federal consumer price index.

5. If an individual's required payment to the plan is not made within ninety days after the required payment date, the individual or individuals shall be terminated from participation in the plan. The individual or individuals shall receive written notice before being terminated from the plan.

6. If an individual is terminated from the plan for fraud or under subsection 5 of this section, the individual shall not reapply for participation in the plan within six months of termination.

7. The deductible that is required of an individual eligible for the plan under subsection 1 of section 2 of this act shall not be greater than the amount in the individual's show-me health coverage plan account. The plan shall pay for any covered health services if the individual has made the required contribution to the individual's show-me health coverage plan account.

Section 6. 1. An individual who is approved to participate in the plan is eligible for a twelve-month plan period unless the individual fails to make the required contribution. An individual who participates in the plan without a break in service shall not be refused renewal of participation in the plan:

(1) For the sole reason that the plan has reached the plan's maximum enrollment; or

(2) If the individual is eligible for transitional participation under subsection 3 of this section.

2. If the individual chooses to renew participation in the plan, the individual shall complete a renewal application and any necessary documentation, and submit to the show-me health coverage plan the documentation and application on a form prescribed by the department and the health insurance pool. At the time of renewal under the plan, a participant may change qualified plans for his or her receipt of benefits under the plan.

3. If an individual is eligible and participates in the plan without a break in service and such individual's income subsequently exceeds the current income limitations for participation in the plan, based on appropriations, at the time of such individual's renewal, but otherwise remains eligible for participation in the plan, the individual may choose and shall be eligible for transitional participation in the plan; except that, such individual's participation in the plan shall terminate if his or her income exceeds two hundred twenty-five percent of the federal poverty level. A transitional participant shall receive coverage under a qualified plan and shall be responsible for the required payments in the same manner established under the plan in accordance with sections 1 to 10 of this act.

4. Any moneys remaining in an individual show-me health coverage account of a participant who renews participation in the plan at the end of the individual's twelve-month plan period shall be used to reduce the individual's payments for the subsequent plan period. The state's contribution to an individual's account shall be suspended the month after the ending account balance exceeds the minimum amount required under federal law for a health savings account and shall resume the month after the ending account balance is less than such minimum amount.

5. If an individual is no longer eligible for the plan, does not renew participation in the plan at the end of the plan period or is terminated from the plan for nonpayment of a required payment, the department shall, as determined by rule and not more than ninety days after the last date of participation in the plan, refund to the individual the amount of any balance remaining in the individual show-me health coverage account less any outstanding individual obligations under the plan.

Section 7. 1. An individual approved for participation in the plan shall seek health care coverage through a qualified plan available through the health insurance pool.

2. The deductible for any qualified plan under the plan shall not exceed two thousand five hundred dollars.

3. The premium required of the qualified plan shall be certified as actuarially sound in accordance with the requirements established by the federal Centers for Medicare and Medicaid Services.

4. The department of social services and the health insurance pool, in consultation and coordination with the department of insurance, financial institutions and professional registration and the board of directors for the health insurance pool, shall ensure that individuals approved for participation in the plan are able to seek and obtain health insurance coverage under the health insurance pool.

5. The department of social services, the department of insurance, financial institutions and professional registration, and the board of directors for the health insurance pool may promulgate rules and/or joint rules to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after the effective date of this section shall be invalid and void.

Section 8. 1. The health insurance pool providing health insurance coverage to an individual that participates in the plan:

(1) Is responsible for the claim processing for the coverage;

(2) Is responsible for provider reimbursement;

(3) Is responsible for providing and maintaining health savings accounts for each participant; and

(4) Shall not deny coverage to an eligible individual who has been approved by the department of social services to participate in the plan.

2. The state shall not provide funding for health insurance coverage received under this section. The individual participant shall be responsible for the required contribution to the health savings account and for payment of the monthly premium established by the MO HealthNet division.

Section 9. The department of social services and health insurance pool shall promulgate rules and regulations for the implementation of sections 1 to 10 of this act. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section

536.028, RSMo. Sections 1 to 10 of this act and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after the effective date of sections 1 to 10 of this act shall be invalid and void.

Section 10. Under section 23.253, RSMo, of the Missouri Sunset Act:

(1) The provisions of the new program authorized under sections 1 to 10 of this act shall automatically sunset six years after the effective date of sections 1 to 10 of this act unless reauthorized by an act of the general assembly; and

(2) If such program is reauthorized, the program authorized under sections 1 to 10 of this act shall automatically sunset twelve years after the effective date of the reauthorization of sections 1 to 10 of this act; and

(3) Sections 1 to 10 of this act shall terminate on September first of the calendar year immediately following the calendar year in which the program authorized under sections 1 to 10 of this act is sunset.

Section 11. 1. If the income of a taxpayer who reports the absence of health care coverage for a dependent child does not exceed one hundred fifty percent of the federal poverty level, the department of revenue shall send a notice, to be developed by the department of social services, to the taxpayer indicating that the dependent child may be eligible for the MO HealthNet for Kids program and provides information about how to enroll in the program.

2. Beginning with the 2009 Missouri tax returns, the taxpayer shall report on the income tax return in the form required by the department of revenue the presence or absence of health care coverage for each dependent child for whom an exception is claimed.

3. Notwithstanding any other provision of law, a taxpayer shall not be penalized in any manner for not providing or providing inaccurately the information required under this section.

4. The department of revenue shall not send any notice of information with the applications and enrollment instructions required in this section, other than the notice developed by the department of social services.

Section 12. Subject to appropriations, the department of social services shall establish a rate for the reimbursement of physicians, optometrists, podiatrists, and psychologists for services rendered to patients under the MO HealthNet program which provides equal reimbursement for the same or similar services rendered.

[143.113. 1. For all taxable years beginning on or after January 1, 2000, an individual taxpayer who is an employee within the meaning of Section 401(c)(1) of the Internal Revenue Code of 1986, as amended, shall be allowed to

subtract from the taxpayer's Missouri adjusted gross income to determine Missouri taxable income an amount equal to the amount which the taxpayer has paid during the taxable year for insurance which constitutes medical care for the taxpayer, the taxpayer's spouse, and dependents to the extent that such amounts qualify as deductible pursuant to Section 162(l) of the Internal Revenue Code of 1986, as amended, for the same taxable year, and shall only be deductible to the extent that such amounts are not deducted on the taxpayer's federal income tax return for that taxable year.

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

Section B. Because of the need to ensure that employees or members in this state may continue health care coverage upon termination of employment or membership to the same extent as similarly situated employees or members in other states, the repeal and reenactment of section 376.428 of section A of this act is deemed necessary for the immediate preservation of the public health, welfare, peace and safety, and is hereby declared to be an emergency act within the meaning of the constitution, and the repeal and reenactment of section 376.428 of section A of this act shall be in full force and effect upon its passage and approval.

Section C. Because immediate action is necessary to allow certain hospital districts to lower their property tax levies, the enactment of section 205.202 of section A of this act is deemed necessary for the immediate preservation of the public health, welfare, peace, and safety, and is hereby declared to be an emergency act within the meaning of the constitution, and the enactment of section 205.202 of section A of this act shall be in full force and effect upon its passage and approval.

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