FIRST REGULAR SESSION

SENATE COMMITTEE SUBSTITUTE FOR

HOUSE BILL NO. 229

95TH GENERAL ASSEMBLY

Reported from the Committee on Health, Mental Health, Seniors and Families, April 23, 2009, with recommendation that the Senate Committee Substitute do pass.

TERRY L. SPIELER, Secretary.

0666L.02C

AN ACT

To repeal sections 143.111, 143.113, 354.442, 354.536, 376.397, 376.401, 376.421, 376.424, 376.426, 376.450, 376.453, 376.776, 376.960, 376.966, 376.986, 376.995, 379.930, 379.940, and 379.952, RSMo, and to enact in lieu thereof twenty new sections relating to health insurance.

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

Section A. Sections 143.111, 143.113, 354.442, 354.536, 376.397, 376.401, 376.421, 376.424, 376.426, 376.450, 376.453, 376.776, 376.960, 376.966, 376.986, 376.995, 379.930, 379.940, and 379.952, RSMo, are repealed and twenty new sections enacted in lieu thereof, to be known as sections 143.111, 354.442, 354.536, 376.397, 376.401, 376.421, 376.424, 376.426, 376.450, 376.453, 376.776, 376.960, 376.966, 376.986, 376.995, 376.1600, 376.1618, 379.930, 379.940, and 379.952, to read as follows:

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

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

(2) The Missouri deduction for personal exemptions;

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

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

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

354.442. 1. Each enrollee, and upon request each prospective enrollee

EXPLANATION–Matter enclosed in bold-faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

prior to enrollment, shall be supplied with written disclosure information. In the event of any inconsistency between any separate written disclosure statement and the enrollee contract or evidence of coverage, the terms of the enrollee contract or evidence of coverage shall be controlling. The information to be disclosed in writing shall include at a minimum the following:

(1) A description of coverage provisions, health care benefits, benefit maximums, including benefit limitations;

(2) A description of any exclusions of coverage, including the definition of medical necessity used in determining whether benefits will be covered;

(3) A description of all prior authorization or other requirements for treatments and services;

(4) A description of utilization review policies and procedures used by the health maintenance organization, including:

(a) The circumstances under which utilization review shall be undertaken;

(b) The toll-free telephone number of the utilization review agent;

(c) The time frames under which utilization review decisions shall be made for prospective, retrospective and concurrent decisions;

(d) The right to reconsideration;

(e) The right to an appeal, including the expedited and standard appeals processes and the time frames for such appeals;

(f) The right to designate a representative;

(g) A notice that all denials of claims shall be made by qualified clinical personnel and that all notices of denial shall include information about the basis of the decision; and

(h) Further appeal rights, if any;

(5) An explanation of an enrollee's financial responsibility for payment of premiums, coinsurance, co-payments, deductibles and any other charge, annual limits on an enrollee's financial responsibility, caps on payments for covered services and financial responsibility for noncovered health care procedures, treatments or services provided within the health maintenance organization;

(6) An explanation of an enrollee's financial responsibility for payment when services are provided by a health care provider who is not part of the health maintenance organization's network or by any provider without required authorization, or when a procedure, treatment or service is not a covered health care benefit;

(7) A description of the grievance procedures to be used to resolve

disputes between a health maintenance organization and an enrollee, including:

(a) The right to file a grievance regarding any dispute between an enrollee and a health maintenance organization;

(b) The right to file a grievance when the dispute is about referrals or covered benefits;

(c) The toll-free telephone number which enrollees may use to file a grievance;

(d) The department of insurance, financial institutions and professional registration's toll-free consumer complaint hot line number;

(e) The time frames and circumstances for expedited and standard grievances;

(f) The right to appeal a grievance determination and the procedures for filing such an appeal;

(g) The time frames and circumstances for expedited and standard appeals;

(h) The right to designate a representative;

(i) A notice that all disputes involving clinical decisions shall be made by qualified clinical personnel; and

(j) All notices of determination shall include information about the basis of the decision and further appeal rights, if any;

(8) A description of a procedure for providing care and coverage twenty-four hours a day, seven days a week, for emergency services. Such description shall include the definition of emergency services and emergency medical condition, notice that emergency services are not subject to prior approval, and shall describe the enrollee's financial and other responsibilities regarding obtaining such services, including when such services are received outside the health maintenance organization's service area;

(9) A description of procedures for enrollees to select and access the health maintenance organization's primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients;

(10) A description of the procedures for changing primary and specialty care providers within the health maintenance organization;

(11) Notice that an enrollee may obtain a referral for covered services to a health care provider outside of the health maintenance organization's network or panel when the health maintenance organization does not have a health care provider with appropriate training and experience in the network or panel to

meet the particular health care needs of the enrollee and the procedure by which the enrollee may obtain such referral;

(12) A description of the mechanisms by which enrollees may participate in the development of the policies of the health maintenance organization;

(13) Notice of all appropriate mailing addresses and telephone numbers to be utilized by enrollees seeking information or authorization;

(14) A listing by specialty, which may be in a separate document that is updated annually, of the names, addresses and telephone numbers of all participating providers, including facilities, and in addition in the case of physicians, board certification**. Such listing may be provided electronically unless a paper copy is requested by the enrollee**; and

(15) The director of the department of insurance, financial institutions and professional registration shall develop a standard credentialing form which shall be used by all health carriers when credentialing health care professionals in a managed care plan. If the health carrier demonstrates a need for additional information, the director of the department of insurance, financial institutions and professional registration may approve a supplement to the standard credentialing form. All forms and supplements shall meet all requirements as defined by the National Committee of Quality Assurance.

2. Each health maintenance organization shall, upon request of an enrollee or prospective enrollee, provide the following:

(1) A list of the names, business addresses and official positions of the membership of the board of directors, officers, controlling persons, owners or partners of the health maintenance organization;

(2) A copy of the most recent annual certified financial statement of the health maintenance organization, including a balance sheet and summary of receipts and disbursements prepared by a certified public accountant;

(3) A copy of the most recent individual, direct pay enrollee contracts;

(4) Information relating to consumer complaints compiled annually by the department of insurance, financial institutions and professional registration;

(5) The procedures for protecting the confidentiality of medical records and other enrollee information;

(6) An opportunity to inspect drug formularies used by such health maintenance organization and any financial interest in a pharmacy provider utilized by such organization. The health maintenance organization shall also disclose the process by which an enrollee or his representative may seek to have

an excluded drug covered as a benefit;

(7) A written description of the organizational arrangements and ongoing procedures of the health maintenance organization's quality assurance program;

(8) A description of the procedures followed by the health maintenance organization in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials;

(9) Individual health practitioner affiliations with participating hospitals, if any;

(10) Upon written request, written clinical review criteria relating to conditions or diseases and, where appropriate, other clinical information which the organization may consider in its utilization review. The health maintenance organization may include with the information a description of how such information will be used in the utilization review process;

(11) The written application procedures and minimum qualification requirements for health care providers to be considered by the health maintenance organization;

(12) A description of the procedures followed by the health maintenance organization in making decisions about which drugs to include in the health maintenance organization's drug formulary.

3. Nothing in this section shall prevent a health maintenance organization from changing or updating the materials that are made available to enrollees.

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

2. If a health maintenance organization plan provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children, such plan, so long as it remains in force, until the dependent child

attains the limiting age, shall remain in force at the option of the enrollee. The enrollee's election for continued coverage under this section shall be furnished to the health maintenance organization within thirty-one days after the child's attainment of the limiting age. As used in this subsection, a dependent child is a person who is:

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

(2) A resident of this state; and

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

376.397. 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.

376.450. 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); **and**

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

(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) A resident spouse **[**or resident**]; or**

(b) An 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, a**] 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

(c) An unmarried child of any age who is **medically certified as** disabled and dependent upon the parent;

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

(8) "Excepted benefits":

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

(b) Coverage only for disability income insurance;

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

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

(e) Workers' compensation or similar insurance;

(f) Automobile medical payment insurance;

(g) Credit-only insurance;

(h) Coverage for on-site medical clinics;

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

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

a. Limited scope dental or vision benefits;

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

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

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

a. Coverage only for a specified disease or illness;

b. Hospital indemnity or other fixed indemnity insurance;

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

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

b. Coverage supplemental to the coverage provided under Chapter 55 of

Title 10, United States Code;

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

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

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

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

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

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

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

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

(12) "Health insurance", any hospital and medical expense incurred policy, nonprofit health care service for benefits other than through an insurer, nonprofit health care service plan contract, health maintenance organization subscriber contract, preferred provider arrangement or contract, or any other similar contract or agreement for the provisions of health care benefits. The term "health insurance" does not include accident, fixed indemnity, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile

medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;

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

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

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

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

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

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

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

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

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

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

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

the pool;

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

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

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

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

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

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

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

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

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

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

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

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

(3) A trade act eligible individual;

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

(5) Any person, regardless of age, that can be claimed as a dependent of

a trade act eligible individual on such trade act eligible individual's tax filing;

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

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

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

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

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

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

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

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

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

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

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

(4) Any person on whose behalf the pool has paid out one 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.

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 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 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 percent of rates applicable to individual standard risks; and

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

5. 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. 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. 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. 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. Medical expenses shall include expenses for comparable benefits for those who rely solely on spiritual means through prayer for healing.

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.

376.1600. 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.

376.1618. 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.

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

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

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