

SECOND REGULAR SESSION

HOUSE BILL NO. 1570

95TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE ERVIN.

4284L.011

D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 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 seventeen new sections relating to health insurance.

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

Section A. Sections 354.536, 376.397, 376.401, 376.421, 376.424, 376.426, 376.450, 2 376.453, 376.776, 376.960, 376.966, 376.986, 376.995, 379.930, 379.940, and 379.952, RSMo, 3 are repealed and seventeen new sections enacted in lieu thereof, to be known as sections 354.536, 4 376.397, 376.401, 376.421, 376.424, 376.426, 376.450, 376.453, 376.776, 376.960, 376.966, 5 376.986, 376.995, 376.1600, 379.930, 379.940, and 379.952, to read as follows:

354.536. 1. If a health maintenance organization plan provides that coverage of a 2 dependent child terminates upon attainment of the limiting age for dependent children, such 3 coverage shall continue while the child is and continues to be both incapable of self-sustaining 4 employment by reason of mental or physical handicap and chiefly dependent upon the enrollee 5 for support and maintenance. Proof of such incapacity and dependency must be furnished to the 6 health maintenance organization by the enrollee [at least] **within** thirty-one days after the child's 7 attainment of the limiting age. The health maintenance organization may require at reasonable 8 intervals during the two years following the child's attainment of the limiting age subsequent 9 proof of the child's disability and dependency. After such two-year period, the health 10 maintenance organization may require subsequent proof not more than once each year.

11 2. If a health maintenance organization plan provides that coverage of a dependent child 12 terminates upon attainment of the limiting age for dependent children, such plan, so long as it 13 remains in force, until the dependent child attains the limiting age, shall remain in force at the

EXPLANATION — Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

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

- 17 (1) Unmarried and no more than twenty-five years of age; and
18 (2) A resident of this state; and
19 (3) Not provided coverage as a named subscriber, insured, enrollee, or covered person
20 under any group or individual health benefit plan, or entitled to benefits under Title XVIII of the
21 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
2 employees or members for hospital, surgical or major medical insurance on an expense incurred
3 or service basis, other than for specific diseases or for accidental injuries only, shall provide that
4 an employee or member whose insurance under the group policy has been terminated shall be
5 entitled to have a converted policy issued to him by the insurer under whose group policy he was
6 insured, without evidence of insurability, subject to the following terms and conditions:

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

- 9 (a) Because he failed to make timely payment of any required contribution; or
10 (b) For any other reason, and he had not been continuously covered under the group
11 policy, and for similar benefits under any group policy which it replaced, during the entire three
12 months' period ending with such termination; or

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

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

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

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

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

- 27 (a) Such person is or could be covered for similar benefits by another individual policy;
28 such person is or could be covered for similar benefits under any arrangement of coverage for

29 individuals in a group, whether insured or uninsured; or similar benefits are provided for or
30 available to such person, by reason of any state or federal law; and

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

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

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

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

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

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

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

54 (8) The converted policy shall not exclude, as a preexisting condition, any condition
55 covered by the group policy; provided, however, that the converted policy may provide for a
56 reduction of its hospital, surgical or medical benefits by the amount of any such benefits payable
57 under the group policy after the individual's insurance terminates thereunder. The converted
58 policy may also provide that during the first policy year the benefits payable under the converted
59 policy, together with the benefits payable under the group policy, shall not exceed those that
60 would have been payable had the individual's insurance under the group policy remained in force
61 and effect;

62 (9) Subject to the provisions and conditions of sections 376.395 to 376.404, if the group
63 insurance policy from which conversion is made insures the employee or member for basic
64 hospital or surgical expense insurance, the employee or member shall be entitled to obtain a

65 converted policy providing, at his option, coverage on an expense incurred basis under any of
66 the following plans:

67 (a) Plan A, which shall include:

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

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

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

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

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

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

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

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

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

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

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

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

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

129 (11) At the option of the insurer, benefit plans set forth in subdivisions (9) and (10) of
130 this section may be provided under one policy or, in lieu of the benefit plans set forth in
131 subdivisions (9) and (10) of this section, the insurer may provide a policy for comprehensive
132 medical expense benefits without first dollar coverage. Such policy shall conform to the
133 requirements of subdivision (10) of this section; provided, however, that an insurer electing to
134 provide such a policy shall make available a low deductible option, not to exceed one hundred
135 dollars, a high deductible option between five hundred dollars and one thousand dollars, and a
136 third deductible option midway between the high and low deductible options. Alternatively,

137 such a policy may provide for deductible options equal to the greater of the benefits deductible
138 and the amount specified in the preceding sentence.

139 2. (1) The insurer may, at its option, offer alternative plans for converted policies from
140 group policies in addition to those required by sections 376.395 to 376.404. Furthermore, if any
141 insurer customarily offers individual policies on a service basis, that insurer may, in lieu of
142 converted policies on an expense incurred basis, make available converted policies on a service
143 basis which, in the opinion of the director of the department of insurance, financial institutions
144 and professional registration, satisfy the intent of sections 376.395 to 376.404.

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

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

152 4. All converted policies shall become effective on the day immediately following the
153 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
2 employee following his retirement, but prior to the time he is or could be covered by Medicare,
3 the employee or member may elect, in lieu of such continuation of group insurance, to have the
4 same conversion rights as would apply had that insurance terminated at retirement. [The
5 converted policy may provide for reduction or termination of coverage of any person upon his
6 eligibility for coverage under Medicare or under any other state or federal law providing for
7 benefits similar to those provided by the converted policy.]

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

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

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

18 (3) A child, solely with respect to himself, upon termination of his coverage by reason
19 of ceasing to be a qualified family member under the group policy, if a conversion privilege is
20 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
2 insurance shall be delivered in this state unless it conforms to one of the following descriptions:

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

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

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

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

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

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

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

32 (2) A policy issued to a creditor or its parent holding company or to a trustee or trustees
33 or agent designated by two or more creditors, which creditor, holding company, affiliate, trustee,

34 trustees or agent shall be deemed the policyholder, to insure debtors of the creditor or creditors
35 with respect to their indebtedness subject to the following requirements:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

97 (a) The persons eligible for insurance shall be all of the employees of the employers or
98 all of the members of the unions or organizations, or all of any class or classes thereof. The
99 policy may provide that the term employees shall include the employees of one or more
100 subsidiary corporations, and the employees, individual proprietors, and partners of one or more
101 affiliated corporations, proprietorships or partnerships if the business of the employer and of such
102 affiliated corporations, proprietorships or partnerships is under common control. The policy may
103 provide that the term employees shall include the individual proprietor or partners if the
104 employer is an individual proprietorship or partnership. The policy may provide that the term
105 employees shall include retired employees, former employees and directors of a corporate

106 employer. The policy may provide that the term employees shall include the trustees or their
107 employees, or both, if their duties are principally connected with such trusteeship;

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

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

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

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

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

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

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

138 (e)] If the health benefit plan, as defined in section 376.1350, is delivered, issued for
139 delivery, continued or renewed, is providing coverage to any resident of this state, and is
140 providing coverage to sole proprietors, self-employed persons, small employers as defined in
141 subsection 2 of section 379.930, RSMo, and large employers, the insurer providing the coverage

142 to the association or trust or trustees of a fund established, created, and maintained for the benefit
143 of members of one or more associations may be exempt from subdivision (1) of subsection 1 of
144 section 379.936, RSMo, as it relates to the association plans established under this section. The
145 director shall find that an exemption would be in the public interest and approved and that
146 additional classes of business may be approved under subsection 4 of section 379.934, RSMo,
147 if the director determines that the health benefit plan:

148 a. Is underwritten and rated as a single employer;
149 b. Has a uniform health benefit plan design option or options for all participating
150 association members or employers;

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

154 d. Complies with all other federal and state insurance requirements, including but not
155 limited to the small employer health insurance and availability act under sections 379.930 to
156 379.952, RSMo;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 (1) The] premium for the insurance shall be paid either from funds contributed by the
6 employer, union, association or other person to whom the policy has been issued or from funds
7 contributed by the covered persons, or from both. [Except as provided in subdivision (2) of this
8 section,] A policy on which no part of the premium for the family members' or dependents'
9 coverage is to be derived from funds contributed by the covered persons must insure all eligible
10 employees or members with respect to their family members or dependents, or any class or
11 classes thereof[;

12 (2) An insurer may exclude or limit the coverage on any family member or dependent
13 as to whom evidence of individual insurability is not satisfactory to the insurer, subject to

14 sections 376.406 and 376.776 in a policy insuring fewer than ten employees or members and in
15 a policy insuring ten or more employees or members if:

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

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

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

376.426. No policy of group health insurance shall be delivered in this state unless it
2 contains in substance the following provisions, or provisions which in the opinion of the director
3 of insurance, financial institutions and professional registration are more favorable to the persons
4 insured or at least as favorable to the persons insured and more favorable to the policyholder;
5 except that: provisions in subdivisions (5), (7), (12), (15), and (16) of this section shall not apply
6 to policies insuring debtors; standard provisions required for individual health insurance policies
7 shall not apply to group health insurance policies; and if any provision of this section is in whole
8 or in part inapplicable to or inconsistent with the coverage provided by a particular form of
9 policy, the insurer, with the approval of the director, shall omit from such policy any inapplicable
10 provision or part of a provision, and shall modify any inconsistent provision or part of the
11 provision in such manner as to make the provision as contained in the policy consistent with the
12 coverage provided by the policy:

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

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

26 based upon the person's ineligibility for coverage under the policy or upon other provisions in
27 the policy;

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

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

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

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

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

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

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

58 (8) A provision that written notice of claim must be given to the insurer within twenty
59 days after the occurrence or commencement of any loss covered by the policy. Failure to give
60 notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have

61 been reasonably possible to give such notice and that notice was given as soon as was reasonably
62 possible;

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

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

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

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

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

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

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

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

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

- 132 (a) Unmarried and no more than [that] twenty-five years of age; and
133 (b) A resident of this state; and
134 (c) Not provided coverage as a named subscriber, insured, enrollee, or covered person
135 under any group or individual health benefit plan, or entitled to benefits under Title XVIII of the
136 Social Security Act, P.L. 89-97, 42 U.S.C. Section 1395, et seq.;
- 137 (18) In the case of a policy insuring debtors, a provision that the insurer shall furnish to
138 the policyholder for delivery to each debtor insured under the policy a certificate of insurance
139 describing the coverage and specifying that the benefits payable shall first be applied to reduce
140 or extinguish the indebtedness.

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

- 8 (1) "Affiliation period", a period which, under the terms of the coverage offered by a
9 health maintenance organization, must expire before the coverage becomes effective. The
10 organization is not required to provide health care services or benefits during such period and
11 no premium shall be charged to the participant or beneficiary for any coverage during the period;
- 12 (2) "Beneficiary", the same meaning given such term under Section 3(8) of the Employee
13 Retirement Income Security Act of 1974 and Public Law 104-191;
- 14 (3) "Bona fide association", an association which:
15 (a) Has been actively in existence for at least five years;
16 (b) Has been formed and maintained in good faith for purposes other than obtaining
17 insurance;
18 (c) Does not condition membership in the association on any health status-related factor
19 relating to an individual (including an employee of an employer or a dependent of an employee);
20 (d) Makes health insurance coverage offered through the association available to all
21 members regardless of any health status-related factor relating to such members (or individuals
22 eligible for coverage through a member); and
23 (e) Does not make health insurance coverage offered through the association available
24 other than in connection with a member of the association; and
25 (f) Meets all other requirements for an association set forth in subdivision (5) of
26 subsection 1 of section 376.421 that are not inconsistent with this subdivision;
- 27 (4) "COBRA continuation provision":

- 28 (a) Section 4980B of the Internal Revenue Code (26 U.S.C. 4980B), as amended, other
29 than subsection (f)(1) of such section as it relates to pediatric vaccines;
- 30 (b) Title I, Subtitle B, Part 6, excluding Section 609, of the Employee Retirement Income
31 Security Act of 1974; or
- 32 (c) Title XXII of the Public Health Service Act, 42 U.S.C. 300dd, et seq.;
- 33 (5) "Creditable coverage", with respect to an individual:
- 34 (a) Coverage of the individual under any of the following:
- 35 a. A group health plan;
- 36 b. Health insurance coverage;
- 37 c. Part A or Part B of Title XVIII of the Social Security Act;
- 38 d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits
39 under Section 1928 of such act;
- 40 e. Chapter 55 of Title 10, United States Code;
- 41 f. A medical care program of the Indian Health Service or of a tribal organization;
- 42 g. A state health benefits risk pool;
- 43 h. A health plan offered under Title 5, Chapter 89, of the United States Code;
- 44 i. A public health plan as defined in federal regulations authorized by Section
45 2701(c)(1)(I) of the Public Health Services Act, as [amended] **added** by Public Law 104-191;
- 46 j. A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. [2504(3)]
47 **2504(e)**);
- 48 **k. Title XXI of the Social Security Act (SCHIP);**
- 49 (b) Creditable coverage does not include coverage consisting solely of excepted benefits;
- 50 (6) "Department", the Missouri department of insurance, financial institutions and
51 professional registration;
- 52 (7) "Director", the director of the Missouri department of insurance, financial institutions
53 and professional registration;
- 54 (8) "Enrollment date", with respect to an individual covered under a group health plan
55 or health insurance coverage, the date of enrollment of the individual in the plan or coverage or,
56 if earlier, the first day of the waiting period for such enrollment;
- 57 (9) "Excepted benefits":
- 58 (a) Coverage only for accident (including accidental death and dismemberment)
59 insurance;
- 60 (b) Coverage only for disability income insurance;
- 61 (c) Coverage issued as a supplement to liability insurance;
- 62 (d) Liability insurance, including general liability insurance and automobile liability
63 insurance;

- 64 (e) Workers' compensation or similar insurance;
- 65 (f) Automobile medical payment insurance;
- 66 (g) Credit-only insurance;
- 67 (h) Coverage for on-site medical clinics;
- 68 (i) Other similar insurance coverage, as approved by the director, under which benefits
69 for medical care are secondary or incidental to other insurance benefits;
- 70 (j) If provided under a separate policy, certificate or contract of insurance, any of the
71 following:
- 72 a. Limited scope dental or vision benefits;
- 73 b. Benefits for long-term care, nursing home care, home health care, community-based
74 care, or any combination thereof;
- 75 c. Other similar limited benefits as specified by the director;
- 76 (k) If provided under a separate policy, certificate or contract of insurance, any of the
77 following:
- 78 a. Coverage only for a specified disease or illness;
- 79 b. Hospital indemnity or other fixed indemnity insurance;
- 80 (l) If offered as a separate policy, certificate, or contract of insurance, any of the
81 following:
- 82 a. Medicare supplemental coverage (as defined under Section 1882(g)(1) of the Social
83 Security Act);
- 84 b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United
85 States Code;
- 86 c. Similar supplemental coverage provided to coverage under a group health plan;
- 87 (10) "Group health insurance coverage", health insurance coverage offered in connection
88 with a group health plan;
- 89 (11) "Group health plan", an employee welfare benefit plan as defined in Section 3(1)
90 of the Employee Retirement Income Security Act of 1974 and Public Law 104-191 to the extent
91 that the plan provides medical care, as defined in this section, and including any item or service
92 paid for as medical care to an employee or the employee's dependent, as defined under the terms
93 of the plan, directly or through insurance, reimbursement or otherwise, but not including
94 excepted benefits;
- 95 (12) "Health insurance coverage", or "health benefit plan" as defined in section 376.1350
96 and benefits consisting of medical care, including items and services paid for as medical care,
97 that are provided directly, through insurance, reimbursement, or otherwise under a policy,
98 certificate, membership contract, or health services agreement offered by a health insurance
99 issuer, but not including excepted benefits;

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

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

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

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

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

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

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

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

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

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

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

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

133 (22) "Plan sponsor", the same meaning given such term under Section 3(16)(B) of the
134 Employee Retirement Income Security Act of 1974 **and Public Law 104-191**;

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

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

143 (25) "Small group market", the health insurance market under which individuals obtain
144 health insurance coverage directly or through an arrangement, on behalf of themselves and their
145 dependents, through a group health plan maintained by a small employer as defined in section
146 379.930, RSMo;

147 (26) "Waiting period", [with respect to a group health plan and an individual who is a
148 potential participant or beneficiary in a group health plan,] the period that must pass [with respect
149 to the individual before the individual is] **before coverage for an employee or dependent who
150 is otherwise** eligible to [be covered for benefits] **enroll** under the terms of [the] a group health
151 plan **can become effective. If an employee or dependent enrolls as a late enrollee or special
152 enrollee, any period before such late or special enrollment is not a waiting period. If an
153 individual seeks coverage in the individual market, a waiting period begins on the date the
154 individual submits a substantially complete application for coverage and ends on:**

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

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

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

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

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

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

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

169 (1) A period of creditable coverage shall not be counted, with respect to enrollment of
170 an individual under group health insurance coverage, if, after such period and before the

171 enrollment date, there was a sixty-three day period during all of which the individual was not
172 covered under any creditable coverage;

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

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

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

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

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

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

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

203 (2) Subject to subdivision (4) of this subsection, a health insurance issuer offering group
204 health insurance coverage shall not impose any preexisting condition exclusion in the case of a
205 child who is adopted or placed for adoption before attaining eighteen years of age and who, as
206 of the last day of the thirty-day period beginning on the date of the adoption or placement for

207 adoption, is covered under creditable coverage. The previous sentence shall not apply to
208 coverage before the date of such adoption or placement for adoption;

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

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

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

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

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

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

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

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

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

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

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

239 (2) (a) A group health plan shall provide for a dependent special enrollment period
240 described in paragraph (b) of this subdivision during which an employee who is eligible but not
241 enrolled and a dependent may be enrolled under the group health plan and, in the case of the birth

242 or adoption **or placement for adoption** of a child, the spouse of the employee may be enrolled
243 as a dependent if the spouse is otherwise eligible for coverage.

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

247 (3) The coverage becomes effective:

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

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

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

253 **(4) A group health plan shall permit an employee or a dependent of an employee**
254 **who is eligible but not enrolled for coverage under the terms of the plan to enroll for**
255 **coverage if either of the following conditions is met:**

256 **(a) The employee or dependent is covered under a Medicaid plan under Title XIX**
257 **of the Social Security Act or under the state child health plan under Title XXI of the Social**
258 **Security Act and coverage of the employee or dependent under such a plan is terminated**
259 **as a result of loss of eligibility for such coverage and the employee requests coverage under**
260 **the group health plan not later than sixty days after the date of termination of such**
261 **coverage; or**

262 **(b) The employee or dependent becomes eligible for assistance, with respect to**
263 **coverage under the group health plan under such Medicaid plan or state child health plan,**
264 **including any waiver or demonstration project conducted under or in relation to such a**
265 **plan, if the employee requests coverage under the group health plan not later than sixty**
266 **days after the date the employee or dependent is determined to be eligible for such**
267 **assistance.**

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

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

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

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

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

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

376.453. 1. An employer that provides health insurance coverage for which any portion
2 of the premium is payable by the [employer] **employee** shall not provide such coverage unless
3 the employer has established a premium-only cafeteria plan as permitted under federal law, 26
4 U.S.C. Section 125 **or a health reimbursement arrangement as permitted under federal law,**
5 **26 U.S.C. Section 105.** The provisions of this subsection shall not apply to employers who offer
6 health insurance through any self-insured or self-funded group health benefit plan of any type
7 or description.

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

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

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

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

20 (1) Is a resident of this state;

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

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

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

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

- 2 (1) "Benefit plan", the coverages to be offered by the pool to eligible persons pursuant
3 to the provisions of section 376.986;
- 4 (2) "Board", the board of directors of the pool;
- 5 (3) "Church plan", a plan as defined in Section 3(33) of the Employee Retirement
6 Income Security Act of 1974, as amended;
- 7 (4) "Creditable coverage", with respect to an individual:
- 8 (a) Coverage of the individual provided under any of the following:
- 9 a. A group health plan;
- 10 b. Health insurance coverage;
- 11 c. Part A or Part B of Title XVIII of the Social Security Act;
- 12 d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits
13 under Section 1928;
- 14 e. Chapter 55 of Title 10, United States Code;
- 15 f. A medical care program of the Indian Health Service or of a tribal organization;
- 16 g. A state health benefits risk pool;
- 17 h. A health plan offered under Chapter 89 of Title 5, United States Code;
- 18 i. A public health plan as defined in federal regulations; [or]
- 19 j. A health benefit plan under Section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e);
- 20 **and**
- 21 **k. Title XXI of the Social Security Act (SCHIP);**
- 22 (b) Creditable coverage does not include coverage consisting solely of excepted benefits;
- 23 (5) "Department", the Missouri department of insurance, financial institutions and
24 professional registration;
- 25 (6) "Dependent", a resident spouse [or resident] ; **an unmarried child [under the age of**
26 **nineteen years, a child who is a student under the age of twenty-five years and who is financially**
27 **dependent upon the parent,] who is a resident of this state, is under the age of nineteen years,**
28 **and is not provided coverage as a named subscriber, insured, enrollee, or covered person**
29 **under any group or individual health benefit plan, or entitled to benefits under Title XVIII**
30 **of the federal Social Security Act, 42 U.S.C. Section 1395, et seq.; or [a] an unmarried child**
31 **of any age who is medically certified as disabled and dependent upon the parent;**
- 32 (7) "Director", the director of the Missouri department of insurance, financial institutions
33 and professional registration;
- 34 (8) "Excepted benefits":
- 35 (a) Coverage only for accident, including accidental death and dismemberment,
36 insurance;

- 37 (b) Coverage only for disability income insurance;
- 38 (c) Coverage issued as a supplement to liability insurance;
- 39 (d) Liability insurance, including general liability insurance and automobile liability
40 insurance;
- 41 (e) Workers' compensation or similar insurance;
- 42 (f) Automobile medical payment insurance;
- 43 (g) Credit-only insurance;
- 44 (h) Coverage for on-site medical clinics;
- 45 (i) Other similar insurance coverage, as approved by the director, under which benefits
46 for medical care are secondary or incidental to other insurance benefits;
- 47 (j) If provided under a separate policy, certificate or contract of insurance, any of the
48 following:
- 49 a. Limited scope dental or vision benefits;
- 50 b. Benefits for long-term care, nursing home care, home health care, community-based
51 care, or any combination thereof;
- 52 c. Other similar, limited benefits as specified by the director;
- 53 (k) If provided under a separate policy, certificate or contract of insurance, any of the
54 following:
- 55 a. Coverage only for a specified disease or illness;
- 56 b. Hospital indemnity or other fixed indemnity insurance;
- 57 (l) If offered as a separate policy, certificate or contract of insurance, any of the
58 following:
- 59 a. Medicare supplemental coverage (as defined under Section 1882(g)(1) of the Social
60 Security Act);
- 61 b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United
62 States Code;
- 63 c. Similar supplemental coverage provided to coverage under a group health plan;
- 64 (9) "Federally defined eligible individual", an individual:
- 65 (a) For whom, as of the date on which the individual seeks coverage through the pool,
66 the aggregate of the periods of creditable coverage as defined in this section is eighteen or more
67 months and whose most recent prior creditable coverage was under a group health plan,
68 governmental plan, church plan, or health insurance coverage offered in connection with any
69 such plan;
- 70 (b) Who is not eligible for coverage under a group health plan, Part A or Part B of Title
71 XVIII of the Social Security Act, or state plan under Title XIX of such act or any successor
72 program, and who does not have other health insurance coverage;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

123 (22) "Plan of operation", the plan of operation of the pool, including articles, bylaws and
124 operating rules, adopted by the board pursuant to the provisions of sections 376.961, 376.962 and
125 376.964;

126 (23) "Pool", the state health insurance pool created in sections 376.961, 376.962 and
127 376.964;

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

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

136 (26) "Trade act eligible individual", an individual who is eligible for the federal health
137 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
2 of his or her employer on the grounds that such employee may subsequently enroll in the pool.
3 The department shall have authority to promulgate rules and regulations to enforce this
4 subsection.

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

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

- 8 (a) A notice of rejection or refusal to issue substantially similar health insurance for
9 health reasons by at least two insurers; or
- 10 (b) A refusal by an insurer to issue health insurance except at a rate exceeding the plan
11 rate for substantially similar health insurance;
- 12 (2) A federally defined eligible individual who has not experienced a significant break
13 in coverage;
- 14 (3) A trade act eligible individual;
- 15 (4) Each resident dependent of a person who is eligible for plan coverage;
- 16 (5) Any person, regardless of age, that can be claimed as a dependent of a trade act
17 eligible individual on such trade act eligible individual's tax filing;
- 18 (6) Any person whose health insurance coverage is involuntarily terminated for any
19 reason other than nonpayment of premium or fraud, and who is not otherwise ineligible under
20 subdivision (4) of subsection 3 of this section. If application for pool coverage is made not later
21 than sixty-three days after the involuntary termination, the effective date of the coverage shall
22 be the date of termination of the previous coverage;
- 23 (7) Any person whose premiums for health insurance coverage have increased above the
24 rate established by the board under paragraph (a) of subdivision (1) of subsection 3 of this
25 section;
- 26 (8) Any person currently insured who would have qualified as a federally defined eligible
27 individual or a trade act eligible individual between the effective date of the federal Health
28 Insurance Portability and Accountability Act of 1996, Public Law 104-191 and the effective date
29 of this act.
- 30 3. The following individual persons shall not be eligible for coverage under the pool:
- 31 (1) Persons who have, on the date of issue of coverage by the pool, or obtain coverage
32 under health insurance or an insurance arrangement substantially similar to or more
33 comprehensive than a plan policy, or would be eligible to have coverage if the person elected to
34 obtain it, except that:
- 35 (a) This exclusion shall not apply to a person who has such coverage but whose
36 premiums have increased to [one hundred fifty percent to] **beyond the eligibility limit set by**
37 **the board. The board shall not set the eligibility limit in excess of** two hundred percent of
38 rates established by the board as applicable for individual standard risks;
- 39 (b) A person may maintain other coverage for the period of time the person is satisfying
40 any preexisting condition waiting period under a pool policy; [and]
- 41 (c) A person may maintain plan coverage for the period of time the person is satisfying
42 a preexisting condition waiting period under another health insurance policy intended to replace
43 the pool policy; **and**

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

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

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

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

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

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

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

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

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

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

63 (2) A notice of reduction or limitation of coverage, including restrictive riders, if the
64 effect of the reduction or limitation is to substantially reduce coverage compared to the coverage
65 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
2 eligible for coverage under section 376.966. The coverage to be issued by the pool and its
3 schedule of benefits, exclusions and other limitations, shall be established by the board with the
4 advice and recommendations of the pool members, and such plan of pool coverage shall be
5 submitted to the director for approval. The pool shall also offer coverage for drugs and supplies
6 requiring a medical prescription and coverage for patient education services, to be provided at
7 the direction of a physician, encompassing the provision of information, therapy, programs, or
8 other services on an inpatient or outpatient basis, designed to restrict, control, or otherwise cause
9 remission of the covered condition, illness or defect.

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

15 3. The pool shall establish premium rates for pool coverage as provided in subsection
16 4 of this section. Separate schedules of premium rates based on age, sex and geographical
17 location may apply for individual risks. Premium rates and schedules shall be submitted to the
18 director for approval prior to use.

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

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

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

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

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

50 7. No preexisting condition exclusion shall be applied to the following:

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

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

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

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

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

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

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

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

12 (2) Section 375.995, RSMo;

13 (3) Section 376.406;

14 (4) Section 376.428;

15 (5) Section 376.782;

16 (6) Section 376.816;

17 (7) Section 376.1210;

18 (8) Section 376.1215; and

19 (9) Section 376.1219.

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

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

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

30 [(3)] (2) Clearly disclose in all sales, promotional and advertising material related thereto
31 that the product is a limited mandate health insurance policy or contract.

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

35 6. Notwithstanding any other provision of this section to the contrary, the provisions of
36 paragraph (b) of subdivision (11) of section 375.936, RSMo, shall apply to limited mandate
37 health insurance policies with respect to physician services covered under such policies, which
38 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
2 professional registration is authorized to allow employees to use funds from one or more
3 employer health reimbursement arrangement only plans to help pay for coverage in the
4 individual health insurance market. This will encourage employer financial support of
5 health insurance or health-related expenses recognized under the rules of the federal
6 Internal Revenue Service. Health reimbursement arrangement only plans that are not sold
7 in connection with or packaged with individual health insurance policies shall not be
8 considered insurance under this chapter.**

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

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

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

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

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

 379.930. 1. Sections 379.930 to 379.952 shall be known and may be cited as the "Small
2 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
5 of Actuaries or other individual acceptable to the director that a small employer carrier is in
6 compliance with the provisions of section 379.936, based upon the person's examination,
7 including a review of the appropriate records and of the actuarial assumptions and methods used
8 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
10 or more intermediaries, controls or is controlled by, or is under common control with, a specified
11 entity or person;

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

 (4) "Board" [means] , the board of directors of the program established pursuant to
17 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
21 insurance;

 (c) Does not condition membership in the association on any health status-related factor
23 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
25 members regardless of any health status-related factor relating to such members (or individuals
26 eligible for coverage through a member);

 (e) Does not make health insurance coverage offered through the association available
28 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
30 subsection 1 of section 376.421, RSMo, that are not inconsistent with this subdivision;

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

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

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

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

45 (10) "Committee", the health benefit plan committee created pursuant to section
46 379.944;

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

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

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

50 a. A group health plan;

51 b. Health insurance coverage;

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

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

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

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

57 g. A state health benefits risk pool;

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

59 i. A public health plan, as defined in federal regulations authorized by Section
60 2701(c)(1)(I) of the Public Health Services Act, as [amended] **added** by Public Law 104-191;

61 [and]

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

63 **and**

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

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

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

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

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

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

85 (17) "Excepted benefits":

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

88 (b) Coverage only for disability income insurance;

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

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

92 (e) Workers' compensation or similar insurance;

93 (f) Automobile medical payment insurance;

94 (g) Credit-only insurance;

95 (h) Coverage for on-site medical clinics;

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

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

100 a. Limited scope dental or vision benefits;

- 101 b. Benefits for long-term care, nursing home care, home health care, community-based
102 care, or any combination thereof;
- 103 c. Other similar, limited benefits as specified by the director.
- 104 (k) If provided under a separate policy, certificate or contract of insurance, any of the
105 following:
- 106 a. Coverage only for a specified disease or illness;
- 107 b. Hospital indemnity or other fixed indemnity insurance.
- 108 (l) If offered as a separate policy, certificate or contract of insurance, any of the
109 following:
- 110 a. Medicare supplemental coverage (as defined under Section 1882(g)(1) of the Social
111 Security Act);
- 112 b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United
113 States Code;
- 114 c. Similar supplemental coverage provided to coverage under a group health plan;
- 115 (18) "Governmental plan", the meaning given such term under Section 3(32) of the
116 Employee Retirement Income Security Act of 1974 or any federal government plan;
- 117 (19) "Group health plan", an employee welfare benefit plan as defined in Section 3(1)
118 of the Employee Retirement Income Security Act of 1974 and Public Law 104-191 to the extent
119 that the plan provides medical care, as defined in this section, and including any item or service
120 paid for as medical care to an employee or the employee's dependent, as defined under the terms
121 of the plan, directly or through insurance, reimbursement or otherwise, but not including
122 excepted benefits;
- 123 (20) "Health benefit plan" or "health insurance coverage", benefits consisting of medical
124 care, including items and services paid for as medical care, that are provided directly, through
125 insurance, reimbursement, or otherwise, under a policy, certificate, membership contract, or
126 health services agreement offered by a health insurance issuer, but not including excepted
127 benefits or a policy that is individually underwritten;
- 128 (21) "Health status-related factor", any of the following:
- 129 (a) Health status;
- 130 (b) Medical condition, including both physical and mental illnesses;
- 131 (c) Claims experience;
- 132 (d) Receipt of health care;
- 133 (e) Medical history;
- 134 (f) Genetic information;
- 135 (g) Evidence of insurability, including a condition arising out of an act of domestic
136 violence;

- 137 (h) Disability;
- 138 (22) "Index rate", for each class of business as to a rating period for small employers
139 with similar case characteristics, the arithmetic mean of the applicable base premium rate and
140 the corresponding highest premium rate;
- 141 (23) "Late enrollee", an eligible employee or dependent who requests enrollment in a
142 health benefit plan of a small employer following the initial enrollment period for which such
143 individual is entitled to enroll under the terms of the health benefit plan, provided that such
144 initial enrollment period is a period of at least thirty days. However, an eligible employee or
145 dependent shall not be considered a late enrollee if:
- 146 (a) The individual meets each of the following:
- 147 a. The individual was covered under creditable coverage at the time of the initial
148 enrollment;
- 149 b. The individual lost coverage under creditable coverage as a result of cessation of
150 employer contribution, termination of employment or eligibility, reduction in the number of
151 hours of employment, the involuntary termination of the creditable coverage, death of a spouse,
152 dissolution or legal separation;
- 153 c. The individual requests enrollment within thirty days after termination of the
154 creditable coverage;
- 155 (b) The individual is employed by an employer that offers multiple health benefit plans
156 and the individual elects a different plan during an open enrollment period; or
- 157 (c) A court has ordered coverage be provided for a spouse or minor or dependent child
158 under a covered employee's health benefit plan and request for enrollment is made within thirty
159 days after issuance of the court order;
- 160 (24) "Medical care", an amount paid for:
- 161 (a) The diagnosis, care, mitigation, treatment or prevention of disease, or for the purpose
162 of affecting any structure or function of the body;
- 163 (b) Transportation primarily for and essential to medical care referred to in paragraph
164 (a) of this subdivision; or
- 165 (c) Insurance covering medical care referred to in paragraphs (a) and (b) of this
166 subdivision;
- 167 (25) "Network plan", health insurance coverage offered by a health insurance issuer
168 under which the financing and delivery of medical care, including items and services paid for as
169 medical care, are provided, in whole or in part, through a defined set of providers under contract
170 with the issuer;
- 171 (26) "New business premium rate", for each class of business as to a rating period, the
172 lowest premium rate charged or offered, or which could have been charged or offered, by the

173 small employer carrier to small employers with similar case characteristics for newly issued
174 health benefit plans with the same or similar coverage;

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

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

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

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

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

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

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

192 (34) "Small employer", in connection with a group health plan with respect to a calendar
193 year and a plan year, any person, firm, corporation, partnership, association, or political
194 subdivision that is actively engaged in business that employed an average of at least two but no
195 more than fifty [eligible] employees on business days during the preceding calendar year and that
196 employs at least two employees on the first day of the plan year. All persons treated as a single
197 employer under subsection (b), (c), (m) or (o) of Section 414 of the Internal Revenue Code of
198 1986 shall be treated as one employer. Subsequent to the issuance of a health plan to a small
199 employer and for the purpose of determining continued eligibility, the size of a small employer
200 shall be determined annually. Except as otherwise specifically provided, the provisions of
201 sections 379.930 to 379.952 that apply to a small employer shall continue to apply at least until
202 the plan anniversary following the date the small employer no longer meets the requirements of
203 this definition. In the case of an employer which was not in existence throughout the preceding
204 calendar year, the determination of whether the employer is a small or large employer shall be
205 based on the average number of employees that it is reasonably expected that the employer will
206 employ on business days in the current calendar year. Any reference in sections 379.930 to
207 379.952 to an employer shall include a reference to any predecessor of such employer;

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

210 3. Other terms used in sections 379.930 to 379.952 not set forth in subsection 2 of this
211 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
2 business in this state with small employers, actively offer to small employers all health benefit
3 plans it actively markets to small employers in this state, except for plans developed for health
4 benefit trust funds.

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

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

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

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

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

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

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

26 (1) A health benefit plan shall comply with the provisions of sections 376.450 and
27 376.451, RSMo.

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

32 eligible employees applying for coverage or receiving coverage from the small employer carrier.

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

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

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

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

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

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

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

54 (c) An eligible employee may choose to retain their individually underwritten health
55 benefit plan at the time such eligible employee is entitled to enroll in a small employer health
56 benefit plan. If the eligible employee retains their individually underwritten health benefit plan,
57 a small employer may provide a defined contribution through the establishment of a cafeteria 125
58 plan under section [379.953] **376.453**. Small employers shall establish an equal amount of
59 defined contribution for all plans. If an eligible employee retains their individually underwritten
60 health benefit plan under this subdivision, the provisions of sections 379.930 to 379.952 shall
61 not apply to the individually underwritten health benefit plan.

62 3. (1) Subject to subdivision (3) of this subsection, a small employer carrier shall not
63 be required to offer coverage or accept applications pursuant to subsection 1 of this section in
64 the case of the following:

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

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

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

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

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

82 4. A small employer carrier shall not be required to provide coverage to small employers
83 pursuant to subsection 1 of this section for any period of time for which the director determines
84 that requiring the acceptance of small employers in accordance with the provisions of subsection
85 1 of this section would place the small employer carrier in a financially impaired condition, and
86 the small employer is applying this subsection uniformly to all small employers in the small
87 group market in this state consistent with applicable state law and without regard to the claims
88 experience of a small employer and its employees and their dependents or any health
89 status-related factor relating to such employees and their dependents.

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

4 2. (1) Except as provided in subdivision (2) of this subsection, no small employer carrier
5 or agent or broker shall, directly or indirectly, engage in the following activities:

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

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

12 (2) The provisions of subdivision (1) of this subsection shall not apply with respect to
13 information provided by a small employer carrier or agent or broker to a small employer

14 regarding the established geographic service area or a restricted network provision of a small
15 employer carrier.

16 3. (1) Except as provided in subdivision (2) of this subsection, no small employer carrier
17 shall, directly or indirectly, enter into any contract, agreement or arrangement with an agent or
18 broker that provides for or results in the compensation paid to an agent or broker for the sale of
19 a health benefit plan to be varied because of the health status, claims experience, industry,
20 occupation or geographic location of the small employer.

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

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

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

32 6. No small employer carrier or producer shall induce or otherwise encourage a small
33 employer to separate or otherwise exclude an employee from health coverage or benefits
34 provided in connection with the employee's employment; except that, a carrier may offer a policy
35 to a small employer that charges a reduced premium rate or deductible for employees who do not
36 smoke or use tobacco products, and such carrier shall not be considered in violation of sections
37 379.930 to 379.952 or any unfair trade practice, as defined in section [379.936] **375.936**, even
38 if only some small employers elect to purchase such a policy and other small employers do not.
39 **In offering a policy that charges a reduced premium rate or deductible for employees who**
40 **do not smoke or use tobacco products, carriers must comply with the nondiscrimination**
41 **provisions of the Health Insurance Portability and Accountability Act, Public Law 104-191,**
42 **and federal regulations promulgated thereunder.**

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

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

47 9. (1) A violation of this section by a small employer carrier or a producer shall be an
48 unfair trade practice under sections 375.930 to 375.949, RSMo.

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

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