

FIRST REGULAR SESSION
SENATE COMMITTEE SUBSTITUTE FOR
HOUSE COMMITTEE SUBSTITUTE FOR
HOUSE BILL NO. 818
94TH GENERAL ASSEMBLY

Reported from the Committee on Health and Mental Health, May 2, 2007, with recommendation that the Senate Committee Substitute do pass.

TERRY L. SPIELER, Secretary.

1261S.13C

AN ACT

To repeal sections 143.782, 313.321, 376.960, 376.961, 376.964, 376.966, 376.986, 376.989, 379.930, 379.938, 379.940, 379.942, 379.943, 379.944, and 379.952, RSMo, and to enact in lieu thereof twenty new sections relating to health insurance.

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

Section A. Sections 143.782, 313.321, 376.960, 376.961, 376.964, 376.966, 376.986, 376.989, 379.930, 379.938, 379.940, 379.942, 379.943, 379.944, and 379.952, RSMo, are repealed and twenty new sections enacted in lieu thereof, to be known as sections 143.782, 143.790, 313.321, 376.392, 376.435, 376.450, 376.451, 376.452, 376.453, 376.454, 376.960, 376.961, 376.964, 376.966, 376.986, 376.989, 379.930, 379.938, 379.940, and 379.952, to read as follows:

143.782. As used in sections 143.782 to 143.788, unless the context clearly requires otherwise, the following terms shall mean and include:

(1) "Court", the supreme court, court of appeals, or any circuit court of the state;

(2) "Debt", any sum due and legally owed to any state agency which has accrued through contract, subrogation, tort, or operation of law regardless of whether there is an outstanding judgment for that sum, court costs as defined in section 488.010, RSMo, fines and fees owed, or any support obligation which is being enforced by the division of family services on behalf of a person who is receiving support enforcement services pursuant to section 454.425, RSMo, **or any claim for unpaid health care services which is being enforced by the department of health and senior services on behalf of a hospital or**

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

13 **healthcare provider under section 143.790;**

14 (3) "Debtor", any individual, sole proprietorship, partnership, corporation
15 or other legal entity owing a debt;

16 (4) "Department", the department of revenue of the state of Missouri;

17 (5) "Refund", the Missouri income tax refund which the department
18 determines to be due any taxpayer pursuant to the provisions of this
19 chapter. The amount of a refund shall not include any senior citizens property
20 tax credit provided by sections 135.010 to 135.035, RSMo, unless such refund is
21 being offset for a delinquency or debt relating to individual income tax or a
22 property tax credit; and

23 (6) "State agency", any department, division, board, commission, office, or
24 other agency of the state of Missouri, including public community college district.

143.790. 1. Any hospital or healthcare provider who has provided
2 **health care services to an individual who was not covered by a health**
3 **insurance policy or was not eligible to receive benefits under the state's**
4 **medical assistance program of needy persons, Title XIX, Public Law 89-**
5 **97, 1965 amendments to the federal Social Security Act, 42 U.S.C.**
6 **Section 301, et seq., under chapter 208, RSMo, and the health insurance**
7 **for uninsured children under sections 208.631 to 208.657, RSMo, at the**
8 **time such health care services were administered, and such person has**
9 **failed to pay for such services for a period greater than ninety days,**
10 **may submit a claim to the director of the department of health and**
11 **senior services for the unpaid health care services. The director of the**
12 **department of health and senior services shall review such claim. If**
13 **the claim appears meritorious on its face, the claim for the unpaid**
14 **medical services shall constitute a debt of the department of senior**
15 **services for purposes of sections 143.782 to 143.788, and the director**
16 **may certify the debt to the department of revenue in order to set off**
17 **the debtor's income tax refund. Once the debt has been certified, the**
18 **director of the department of health and senior services shall submit**
19 **the debt to the department of revenue under the set off procedure**
20 **established under section 143.783.**

21 **2. At the time of certification, the director of the department of**
22 **health and senior services shall supply any information necessary to**
23 **identify each debtor whose refund is sought to be set off pursuant to**
24 **section 143.784 and certify the amount of the debt or debts owed by**
25 **each such debtor.**

26 **3. If a debtor identified by the director of the department of**

27 health and senior services is determined by the department of revenue
28 to be entitled to a refund, the department shall notify the state agency
29 that a refund has been set off on behalf of the department of health and
30 senior services for purposes of this section and shall certify the amount
31 of such setoff, which shall not exceed the amount of the claimed debt
32 certified. When the refund owed exceeds the claimed debt, the
33 department shall send the excess amount to the debtor within a
34 reasonable time after such excess is determined.

35 4. The department of revenue shall notify the debtor by certified
36 mail the taxpayer whose refund is sought to be set off that such setoff
37 will be made. The notice shall contain the provisions contained in
38 subsection 3 of section 143.794, including the opportunity for a hearing
39 to contest the setoff provided therein, and shall otherwise substantially
40 comply with the provisions of subsection 3 of section 143.784.

41 5. Once a debt has been setoff and finally determined under the
42 applicable provisions of sections 143.782 to 143.788, and the department
43 of health and senior services has received the funds transferred from
44 the department of revenue, the department of health and senior
45 services shall settle with each hospital or healthcare provider for the
46 amounts that the department of revenue setoff for such party. At the
47 time of each settlement, each hospital or healthcare provider shall be
48 charged for administration expenses which shall not exceed three
49 percent of the collected amount.

50 6. Lottery prize payouts made under section 313.321, RSMo, shall
51 also be subject to the set off procedures established in this section and
52 any rules and regulations promulgated thereto.

53 7. Nothing in this section shall be construed to authorize the
54 director of the department of revenue to setoff or otherwise retain any
55 amount of a refund that otherwise would be paid to a state agency of
56 Missouri or would be setoff to meet a child support obligation which is
57 being enforced by the division of family services on behalf of a person
58 who is receiving support enforcement services pursuant to section
59 454.425, RSMo.

60 8. The director of the department of revenue and the director of
61 the department of health and senior services shall promulgate rules
62 and regulations necessary to administer the provisions of this
63 section. Any rule or portion of a rule, as that term is defined in section
64 536.010, RSMo, that is created under the authority delegated in this

65 section shall become effective only if it complies with and is subject to
66 all of the provisions of chapter 536, RSMo, and, if applicable, section
67 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable
68 and if any of the powers vested with the general assembly pursuant to
69 chapter 536, RSMo, to review, to delay the effective date, or to
70 disapprove and annul a rule are subsequently held unconstitutional,
71 then the grant of rulemaking authority and any rule proposed or
72 adopted after August 28, 2007, shall be invalid and void.

313.321. 1. The money received by the Missouri state lottery commission
2 from the sale of Missouri lottery tickets and from all other sources shall be
3 deposited in the "State Lottery Fund", which is hereby created in the state
4 treasury. At least forty-five percent, in the aggregate, of the money received from
5 the sale of Missouri lottery tickets shall be appropriated to the Missouri state
6 lottery commission and shall be used to fund prizes to lottery players. Amounts
7 in the state lottery fund may be appropriated to the Missouri state lottery
8 commission for administration, advertising, promotion, and retailer
9 compensation. The general assembly shall appropriate remaining moneys not
10 previously allocated from the state lottery fund by transferring such moneys to
11 the general revenue fund. The lottery commission shall make monthly transfers
12 of moneys not previously allocated from the state lottery fund to the general
13 revenue fund as provided by appropriation.

14 2. The commission may also purchase and hold title to any securities
15 issued by the United States government or its agencies and instrumentalities
16 thereof that mature within the term of the prize for funding multi-year payout
17 prizes.

18 3. The "Missouri State Lottery Imprest Prize Fund" is hereby
19 created. This fund is to be established by the state treasurer and funded by
20 warrants drawn by the office of administration from the state lottery fund in
21 amounts specified by the commission. The commission may write checks and
22 disburse moneys from this fund for the payment of lottery prizes only and for no
23 other purpose. All expenditures shall be made in accordance with rules and
24 regulations established by the office of administration. Prize payments may also
25 be made from the state lottery fund. Prize payouts made pursuant to this section
26 shall be subject to the provisions of section 143.781, RSMo; and prize payouts
27 made pursuant to this section shall be subject to set off for delinquent child
28 support payments as assessed by a court of competent jurisdiction or pursuant
29 to section 454.410, RSMo. **Prize payouts made under this section shall be**
30 **subject to set off for unpaid healthcare services provided by hospitals**

31 **and healthcare providers under the procedure established in section**
32 **143.790, RSMo.**

33 4. Funds of the state lottery commission not currently needed for prize
34 money, administration costs, commissions and promotion costs shall be invested
35 by the state treasurer in interest-bearing investments in accordance with the
36 investment powers of the state treasurer contained in chapter 30, RSMo. All
37 interest earned by funds in the state lottery fund shall accrue to the credit of that
38 fund.

39 5. No state or local sales tax shall be imposed upon the sale of lottery
40 tickets or shares of the state lottery or on any prize awarded by the state lottery.
41 No state income tax or local earnings tax shall be imposed upon any lottery game
42 prizes which accumulate to an amount of less than six hundred dollars during a
43 prize winner's tax year. The state of Missouri shall withhold for state income tax
44 purposes from a lottery game prize or periodic payment of six hundred dollars or
45 more an amount equal to four percent of the prize.

46 6. The director of revenue is authorized to enter into agreements with the
47 lottery commission, in conjunction with the various state agencies pursuant to
48 sections 143.782 to 143.788, RSMo, in an effort to satisfy outstanding debts to the
49 state from the lottery winning of any person entitled to receive lottery payments
50 which are subject to federal withholding. **The director of revenue is also**
51 **authorized to enter into agreements with the lottery commission in**
52 **conjunction with the department of health and senior services pursuant**
53 **to section 143.790, RSMo, in an effort to satisfy outstanding debts owed**
54 **to hospitals and healthcare providers for unpaid healthcare services of**
55 **any person entitled to receive lottery payments which are subject to**
56 **federal withholding.**

57 7. In addition to the restrictions provided in section 313.260, no person,
58 firm, or corporation whose primary source of income is derived from the sale or
59 rental of sexually oriented publications or sexually oriented materials or property
60 shall be licensed as a lottery game retailer and any lottery game retailer license
61 held by any such person, firm, or corporation shall be revoked.

376.392. For any health carrier or health benefit plan, as defined
2 **in section 376.1350, that provides prescription drug coverage or**
3 **contracts with a third-party for prescription drug services, the health**
4 **carrier or health benefit plan shall notify enrollees presently taking a**
5 **prescription drug, in writing or electronically with the permission of**
6 **the enrollee, at least thirty days prior to any deletions, other than**
7 **generic substitutions, in the health carrier's or health benefit plan's**

8 prescription drug formulary that affect such enrollees.

376.435. 1. Beginning January 1, 2008, a health carrier providing
2 a group health benefit plan or plans as such terms are defined in
3 section 376.1350, to an employer who meets the requirements specified
4 in subsection 2 of this section shall, upon request by the employer or
5 the employer's producer of record, provide a report of the total dollar
6 amount and total number of claims paid under the plan or plans for
7 each of the prior three years or for each year coverage was in place if
8 less than three years at the time of the request. In the case of an
9 employer with multiple plans, the total dollar amounts shall be
10 aggregated into one report. The report shall be provided within thirty
11 days of the request; however, a health carrier shall not be required to
12 provide such report for the employer or the employer's producer of
13 record more than twice in any calendar year. The information
14 provided to the employer or the employer's producer of record shall be
15 furnished in a manner that does not individually identify any employee
16 or other person covered by the health benefit plan and shall comply
17 with all applicable federal and state privacy laws regarding the
18 disclosure of health records.

19 2. For purposes of subsection 1 of this section, an employer is
20 one who:

21 (1) Provides an employee health benefit plan with at least fifty-
22 one covered lives either at the time of the request or at the start of the
23 reporting period; and

24 (2) Has been insured continuously with the health carrier or a
25 carrier affiliated with the health carrier for at least the preceding
26 twenty-two months.

27 3. As used in this section, the term "covered lives" means
28 employees, their spouses, and dependents insured under the health
29 benefit plan for which a report is requested.

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

9 terms mean:

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

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

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

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

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

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

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

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

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

36 (4) "COBRA continuation provision":

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

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

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

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

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

46 a. A group health plan;

47 **b. Health insurance coverage;**
48 **c. Part A or Part B of Title XVIII of the Social Security Act;**
49 **d. Title XIX of the Social Security Act, other than coverage**
50 **consisting solely of benefits under Section 1928 of such act;**
51 **e. Chapter 55 of Title 10, United States Code;**
52 **f. A medical care program of the Indian Health Service or of a**
53 **tribal organization;**
54 **g. A state health benefits risk pool;**
55 **h. A health plan offered under Title 5, Chapter 89, of the United**
56 **States Code;**
57 **i. A public health plan as defined in federal regulations**
58 **authorized by Section 2701(c)(1)(I) of the Public Health Services Act, as**
59 **amended by Public Law 104-191;**
60 **j. A health benefit plan under Section 5(e) of the Peace Corps Act**
61 **(22 U.S.C. 2504(3));**
62 **(b) Creditable coverage does not include coverage consisting**
63 **solely of excepted benefits;**
64 **(6) "Department", the Missouri department of insurance, financial**
65 **institutions and professional registration;**
66 **(7) "Director", the director of the Missouri department of**
67 **insurance, financial institutions and professional registration;**
68 **(8) "Enrollment date", with respect to an individual covered**
69 **under a group health plan or health insurance coverage, the date of**
70 **enrollment of the individual in the plan or coverage or, if earlier, the**
71 **first day of the waiting period for such enrollment;**
72 **(9) "Excepted benefits":**
73 **(a) Coverage only for accident (including accidental death and**
74 **dismemberment) insurance;**
75 **(b) Coverage only for disability income insurance;**
76 **(c) Coverage issued as a supplement to liability insurance;**
77 **(d) Liability insurance, including general liability insurance and**
78 **automobile liability insurance;**
79 **(e) Workers' compensation or similar insurance;**
80 **(f) Automobile medical payment insurance;**
81 **(g) Credit-only insurance;**
82 **(h) Coverage for onsite medical clinics;**
83 **(i) Other similar insurance coverage, as approved by the**
84 **director, under which benefits for medical care are secondary or**

85 incidental to other insurance benefits;

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

88 a. Limited scope dental or vision benefits;

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

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

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

94 a. Coverage only for a specified disease or illness;

95 b. Hospital indemnity or other fixed indemnity insurance;

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

98 a. Medicare supplemental coverage (as defined under Section
99 1882(g)(1) of the Social Security Act);

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

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

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

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

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

121 (13) "Health insurance issuer", "issuer", or "insurer", an insurance
122 company, health services corporation, fraternal benefit society, health

123 maintenance organization, multiple employer welfare arrangement
124 specifically authorized to operate in the state of Missouri, or any other
125 entity providing a plan of health insurance or health benefits subject
126 to state insurance regulation;

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

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

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

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

142 (18) "Late enrollee", a participant who enrolls in a group health
143 plan other than during the first period in which the individual is
144 eligible to enroll under the plan, or a special enrollment period under
145 subsection 6 of section 376.450;

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

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

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

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

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

159 (21) "Participant", the same meaning given such term under
160 Section 3(7) of the Employer Retirement Income Security Act of 1974

161 and Public Law 104-191;

162 (22) "Plan sponsor", the same meaning given such term under
163 Section 3(16)(B) of the Employee Retirement Income Security Act of
164 1974;

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

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

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

179 (26) "Waiting period", with respect to a group health plan and an
180 individual who is a potential participant or beneficiary in a group
181 health plan, the period that must pass with respect to the individual
182 before the individual is eligible to be covered for benefits under the
183 terms of the group health plan.

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

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

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

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

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

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

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

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

213 (4) (a) A health insurance issuer offering group health insurance
214 coverage may elect to apply the provisions of subdivision (3) of
215 subsection 2 of this section based on coverage within any category of
216 benefits within each of several classes or categories of benefits
217 specified in regulations implementing Public Law 104-191, rather than
218 as provided under subdivision (3) of this subsection. Such election
219 shall be made on a uniform basis for all participants and
220 beneficiaries. Under such election a health insurance issuer shall
221 count a period of creditable coverage with respect to any class or
222 category of benefits if any level of benefits is covered within the class
223 or category;

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

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

236 4. A health insurance issuer offering group health insurance

237 coverage shall not apply any preexisting condition exclusion in the
238 following circumstances:

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

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

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

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

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

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

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

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

272 (b) The employee stated in writing at the time that coverage
273 under a group health plan or health insurance coverage was the reason
274 for declining enrollment, but only if the plan sponsor or health

275 insurance issuer required the statement at the time and provided the
276 employee with notice of the requirement and the consequences of the
277 requirement at the time;

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

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

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

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

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

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

301 (3) The coverage becomes effective:

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

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

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

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

312 (1) No preexisting condition exclusion is imposed with respect

313 to coverage through the organization;

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

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

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

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

376.451. 1. A health insurance issuer offering group health
2 insurance coverage shall comply with the following standards
3 prohibiting discrimination as to eligibility based upon health status:

4 (1) A health insurance issuer offering group health insurance
5 coverage shall not establish rules for eligibility, including continued
6 eligibility, of any individual to enroll under the terms of the group
7 health plan based on any of the following health status-related factors
8 of the individual or a dependent of the individual:

9 (a) Health status;

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

11 (c) Claims experience;

12 (d) Receipt of health care;

13 (e) Medical history;

14 (f) Genetic information;

15 (g) Evidence of insurability, including conditions arising out of
16 acts of domestic violence; or

17 (h) Disability;

18 (2) This subsection does not require a health insurance issuer
19 offering group health insurance coverage to provide particular benefits
20 other than those provided under the terms of the group health
21 insurance coverage, or prevent the issuer from establishing limitations
22 or restrictions on the amount, level, extent, or nature of the benefits or
23 coverage for similarly situated individuals enrolled in the group health
24 insurance coverage;

25 (3) For purposes of subdivision (1) of this subsection, rules for
26 eligibility to enroll include rules defining any applicable waiting or
27 affiliation period for such enrollment, and rules relating to late and
28 special enrollments.

29 2. A health insurance issuer offering group health insurance
30 coverage shall comply with the following standards prohibiting
31 discrimination as to premium contributions based upon health status:

32 (1) A health insurance issuer offering health insurance coverage
33 in connection with a group health plan shall not require any individual,
34 as a condition of enrollment or continued enrollment under the plan,
35 to pay a premium or contribution that is greater than the premium or
36 contribution for a similarly situated individual enrolled in the group
37 health plan on the basis of any health status-related factor in relation
38 to the individual or to an individual enrolled under the plan as a
39 dependent of the individual;

40 (2) Nothing in subdivision (1) of this subsection shall be
41 construed to:

42 (a) Restrict the amount that any employer may be charged for
43 coverage under a group health plan, other than as provided in sections
44 379.930 to 379.952, RSMo, for health insurance coverage provided in the
45 small group market; or

46 (b) Prevent a health insurance issuer offering group health
47 insurance coverage from establishing premium discounts or rebates or
48 modifying otherwise applicable copayments or deductibles in return for
49 adherence to programs of health promotion and disease prevention.

 376.452. 1. Except as provided in this section, if a health
2 insurance issuer offers health insurance coverage in the large group
3 market in connection with a group health plan, the health insurance
4 issuer shall renew or continue the coverage in force at the option of the
5 plan sponsor.

6 2. A health insurance issuer may nonrenew or discontinue health
7 insurance coverage offered in connection with a group health plan in
8 the large group market if:

9 (1) The plan sponsor has failed to pay premiums or contributions
10 in accordance with the terms of the health insurance coverage or if the
11 health insurance issuer has not received timely premium payments;

12 (2) The plan sponsor has performed an act or practice that
13 constitutes fraud or has made an intentional misrepresentation of
14 material fact under the terms of the coverage;

15 (3) The plan sponsor has failed to comply with the health
16 insurance issuer's minimum participation requirements;

17 (4) The plan sponsor has failed to comply with the health
18 insurance issuer's employer contribution requirements;

19 (5) The health insurance issuer is ceasing to offer coverage in
20 the large group market in accordance with subsection 3 of this section;

21 (6) In the case of a health insurance issuer that offers health
22 insurance coverage in the large group market through a network plan,
23 there is no longer any enrollee under the group health plan who lives,
24 resides, or works in the service area of the health insurance issuer or
25 in the area for which the issuer is authorized to do business;

26 (7) In the case of health insurance coverage that is made
27 available in the large group market only through one or more bona fide
28 associations, the membership of an employer in the bona fide
29 association ceases, but only if coverage is terminated under this
30 subdivision uniformly without regard to any health status-related
31 factor of any covered individual.

32 3. A health insurance issuer shall not discontinue offering a
33 particular type of group health insurance coverage offered in the large
34 group market unless:

35 (1) The issuer provides notice to each plan sponsor, participant
36 and beneficiary provided coverage of this type in the large group
37 market of the discontinuation at least ninety days prior to the date of
38 the discontinuation of the coverage;

39 (2) The issuer offers to each plan sponsor being provided
40 coverage of this type in the large group market the option to purchase
41 any other health insurance coverage currently being offered by the
42 health insurance issuer to a group health plan in the large group
43 market; and

44 (3) The issuer acts uniformly without regard to the claims
45 experience of those plan sponsors or any health status-related factor of
46 any participant or beneficiary covered or new participant or
47 beneficiary who may become eligible for such coverage.

48 4. (1) A health insurance issuer shall not discontinue offering all
49 health insurance coverage in the large group market unless:

50 (a) The issuer provides notice of discontinuation to the director
51 and to each plan sponsor, participant and beneficiary covered at least
52 one hundred eighty days prior to the date of the discontinuation of
53 coverage; and

54 (b) All health insurance issued or delivered for issuance in
55 Missouri in the large group market is discontinued and coverage under
56 such health insurance is not renewed.

57 (2) In the case of a discontinuation under this subsection, the
58 health insurance issuer shall not provide for the issuance of any health

59 insurance coverage in the large group market for a period of five years
60 beginning on the date of the discontinuation of the last health
61 insurance coverage not renewed.

62 5. At the time of coverage renewal, a health insurance issuer may
63 modify the health insurance coverage for a product offered to a group
64 health plan in the large group market. For purposes of this subsection,
65 renewal shall be deemed to occur not more often than annually on the
66 anniversary of the effective date of the group health plan's health
67 insurance coverage unless a longer term is specified in the policy or
68 contract.

69 6. In the case of health insurance coverage that is made available
70 by a health insurance issuer only through one or more bona fide
71 associations, a reference to "plan sponsor" in this section is deemed,
72 with respect to coverage provided to an employer member of the
73 association, to include a reference to such employer.

 376.453. 1. An employer that provides health insurance coverage
2 for which any portion of the premium is payable by the employer shall
3 not provide such coverage unless the employer has established a
4 premium only cafeteria plan as permitted under federal law, 26 U.S.C.
5 Section 125.

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

 376.454. 1. Except as provided in this section, a health insurance
2 issuer that provides individual health insurance coverage to an
3 individual shall renew or continue in force such coverage at the option
4 of the individual.

5 2. A health insurance issuer may nonrenew or discontinue health
6 insurance coverage of an individual in the individual market based
7 only on one or more of the following:

8 (1) The individual has failed to pay premiums or contributions
9 in accordance with the terms of the health insurance coverage or the
10 issuer has not received timely premium payments;

11 (2) The individual has performed an act or practice that
12 constitutes fraud or made an intentional misrepresentation of material
13 fact under the terms of the coverage;

14 (3) The issuer is ceasing to offer coverage in the individual

15 market in accordance with subsection 4 of this section;

16 (4) In the case of a health insurance issuer that offers health
17 insurance coverage in the market through a network plan, the
18 individual no longer resides, lives, or works in the service area or in an
19 area for which the issuer is authorized to do business but only if such
20 coverage is terminated under this subdivision uniformly without regard
21 to any health status-related factor of covered individuals;

22 (5) In the case of health insurance coverage that is made
23 available in the individual market only through one or more bona fide
24 associations, the membership of the individual in the association on the
25 basis of which the coverage is provided ceases, but only if such
26 coverage is terminated under this subdivision uniformly without regard
27 to any health status-related factor of covered individuals.

28 3. In any case in which an issuer decides to discontinue offering
29 a particular type of health insurance coverage offered in the individual
30 market, coverage of such type may be discontinued by the issuer only
31 if:

32 (1) The issuer provides notice to each covered individual
33 provided coverage of this type in such market of such discontinuation
34 at least ninety days prior to the date of the discontinuation of such
35 coverage;

36 (2) The issuer offers to each individual in the individual market
37 provided coverage of this type, the option to purchase any other
38 individual health insurance coverage currently being offered by the
39 issuer for individuals in such market; and

40 (3) In exercising the option to discontinue coverage of this type
41 and in offering the option of coverage under subdivision (2) of this
42 subsection, the issuer acts uniformly without regard to any health
43 status-related factor of enrolled individuals or individuals who may
44 become eligible for such coverage.

45 4. (1) In any case in which a health insurance issuer elects to
46 discontinue offering all health insurance coverage in the individual
47 market in the state, health insurance coverage may be discontinued by
48 the issuer only if:

49 (a) The issuer provides notice to the director and to each
50 individual of such discontinuation at least one hundred eighty days
51 prior to the date of the expiration of such coverage; and

52 (b) All health insurance issued or delivered for issuance in the

53 state in such market is discontinued and coverage under such health
54 insurance coverage in such market is not renewed.

55 (2) In the case of a discontinuation under subdivision (1) of this
56 subsection, the issuer shall not provide for the issuance of any health
57 insurance coverage in the individual market for a five-year period
58 beginning on the date of the discontinuation of the last health
59 insurance coverage not so renewed.

60 5. At the time of coverage renewal, a health insurance issuer may
61 modify the health insurance coverage for a policy form offered to
62 individuals in the individual market so long as such modification is
63 consistent with applicable law and effective on a uniform basis among
64 all individuals with that policy form. For purposes of this subsection,
65 renewal shall be deemed to occur not more often than annually on the
66 anniversary of the effective date of the individual's health insurance
67 coverage or as specified in the policy or contract.

68 6. In applying this section in the case of health insurance
69 coverage that is made available by a health insurance issuer in the
70 individual market to individuals only through one or more associations,
71 a reference to an individual is deemed to include a reference to such
72 an association of which the individual is a member.

73 7. An insurer shall provide a certification of creditable coverage
74 as required by Public Law 104-191 and regulations pursuant thereto.

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

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

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

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

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

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

11 a. A group health plan;

12 b. Health insurance coverage;

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

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

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

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

19 g. A state health benefits risk pool;

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

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

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

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

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

29 [(4)] (6) "Department", the Missouri department of insurance, financial
30 institutions and professional registration;

31 (7) "Dependent", a resident spouse or resident unmarried child
32 under the age of nineteen years, a child who is a student under the age
33 of twenty-three years and who is financially dependent upon the
34 parent, or a child of any age who is disabled and dependent upon the
35 parent;

36 (8) "Excepted benefits":

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

39 (b) Coverage only for disability income insurance;

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

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

43 (e) Workers' compensation or similar insurance;

44 (f) Automobile medical payment insurance;

45 (g) Credit-only insurance;

46 (h) Coverage for onsite medical clinics;

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

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

52 a. Limited scope dental or vision benefits;

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

55 c. Other similar, limited benefits as specified by the director;
56 (k) If provided under a separate policy, certificate or contract of
57 insurance, any of the following:
58 a. Coverage only for a specified disease or illness;
59 b. Hospital indemnity or other fixed indemnity insurance;
60 (l) If offered as a separate policy, certificate or contract of
61 insurance, any of the following:
62 a. Medicare supplemental coverage (as defined under Section
63 1882(g)(1) of the Social Security Act);
64 b. Coverage supplemental to the coverage provided under
65 Chapter 55 of Title 10, United States Code;
66 c. Similar supplemental coverage provided to coverage under a
67 group health plan;
68 (9) "Federally defined eligible individual", an individual:
69 (a) For whom, as of the date on which the individual seeks
70 coverage through the pool, the aggregate of the periods of creditable
71 coverage as defined in this section, is eighteen or more months and
72 whose most recent prior creditable coverage was under a group health
73 plan, governmental plan, church plan, or health insurance coverage
74 offered in connection with any such plan;
75 (b) Who is not eligible for coverage under a group health plan,
76 Part A or Part B of Title XVIII of the Social Security Act, or state plan
77 under Title XIX of such act or any successor program, and who does not
78 have other health insurance coverage;
79 (c) With respect to whom the most recent coverage within the
80 period of aggregate creditable coverage was not terminated because of
81 nonpayment of premiums or fraud;
82 (d) Who, if offered the option of continuation coverage under
83 COBRA continuation provision or under a similar state program, both
84 elected and exhausted the continuation coverage;
85 (10) "Governmental plan", a plan as defined in Section 3(32) of
86 the Employee Retirement Income Security Act of 1974 and any federal
87 governmental plan;
88 (11) "Group health plan", an employee welfare benefit plan as
89 defined in Section 3(1) of the Employee Retirement Income Security Act
90 of 1974 and Public Law 104-191 to the extent that the plan provides
91 medical care and including items and services paid for as medical care
92 to employees or their dependents as defined under the terms of the

93 **plan directly or through insurance, reimbursement or otherwise, but**
94 **not including excepted benefits;**

95 [(5)] (12) "Health insurance", any hospital and medical expense incurred
96 policy, nonprofit health care service for benefits other than through an insurer,
97 nonprofit health care service plan contract, health maintenance organization
98 subscriber contract, preferred provider arrangement or contract, or any other
99 similar contract or agreement for the provisions of health care benefits. The term
100 "health insurance" does not include [short-term,] accident, fixed indemnity,
101 limited benefit or credit insurance, coverage issued as a supplement to liability
102 insurance, insurance arising out of a workers' compensation or similar law,
103 automobile medical-payment insurance, or insurance under which benefits are
104 payable with or without regard to fault and which is statutorily required to be
105 contained in any liability insurance policy or equivalent self-insurance;

106 [(6)] (13) "Health maintenance organization", any person which
107 undertakes to provide or arrange for basic and supplemental health care services
108 to enrollees on a prepaid basis, or which meets the requirements of section 1301
109 of the United States Public Health Service Act;

110 [(7)] (14) "Hospital", a place devoted primarily to the maintenance and
111 operation of facilities for the diagnosis, treatment or care for not less than
112 twenty-four hours in any week of three or more nonrelated individuals suffering
113 from illness, disease, injury, deformity or other abnormal physical condition; or
114 a place devoted primarily to provide medical or nursing care for three or more
115 nonrelated individuals for not less than twenty-four hours in any week. The term
116 "hospital" does not include convalescent, nursing, shelter or boarding homes, as
117 defined in chapter 198, RSMo;

118 [(8)] (15) "Insurance arrangement", any plan, program, contract or other
119 arrangement under which one or more employers, unions or other organizations
120 provide to their employees or members, either directly or indirectly through a
121 trust or third party administration, health care services or benefits other than
122 through an insurer;

123 [(9)] (16) "Insured", any individual resident of this state who is eligible
124 to receive benefits from any insurer or insurance arrangement, as defined in this
125 section;

126 [(10)] (17) "Insurer", any insurance company authorized to transact
127 health insurance business in this state, any nonprofit health care service plan
128 act, or any health maintenance organization;

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

130 (a) The diagnosis, care, mitigation, treatment, or prevention of

131 **disease, or amounts paid for the purpose of affecting any structure or**
132 **function of the body;**

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

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

137 **[(11)] (19) "Medicare", coverage under both part A and part B of Title**
138 **XVIII of the Social Security Act, 42 U.S.C. 1395 et seq., as amended;**

139 **[(12)] (20) "Member", all insurers and insurance arrangements**
140 **participating in the pool;**

141 **[(13)] (21) "Physician", physicians and surgeons licensed under chapter**
142 **334, RSMo, or by state board of healing arts in the state of Missouri;**

143 **[(14)] (22) "Plan of operation", the plan of operation of the pool, including**
144 **articles, bylaws and operating rules, adopted by the board pursuant to the**
145 **provisions of sections 376.961, 376.962 and 376.964;**

146 **[(15)] (23) "Pool", the state health insurance pool created in sections**
147 **376.961, 376.962 and 376.964;**

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

151 **(25) "Significant break in coverage", a period of sixty-three**
152 **consecutive days during all of which the individual does not have any**
153 **creditable coverage, except that neither a waiting period nor an**
154 **affiliation period is taken into account in determining a significant**
155 **break in coverage;**

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

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

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

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

376.964. The board of directors and administering insurers of the pool
2 shall have the general powers and authority granted under the laws of this state
3 to insurance companies licensed to transact health insurance as defined in section
4 376.960, and, in addition thereto, the specific authority to:

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

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

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

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

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

28 (6) Issue policies of insurance in accordance with the requirements of
29 sections 376.960 to 376.989;

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

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

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

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

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

5 2. [Any individual who is a resident of this state shall be eligible for pool
6 coverage, except the following] **The following individual persons shall be**
7 **eligible for coverage under the pool if they are and continue to be**
8 **residents of this state:**

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

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

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

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

16 **(3) A trade act eligible individual;**

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

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

22 **(6) Any person whose health insurance coverage is involuntarily**
23 **terminated for any reason other than nonpayment of premium or fraud,**

24 **and who is not otherwise ineligible under subdivision (4) of subsection**
25 **3 of this section. If application for pool coverage is made not later than**
26 **sixty-three days after the involuntary termination, the effective date of**
27 **the coverage shall be the date of termination of the previous coverage;**

28 **(7) Any person whose premiums for health insurance coverage**
29 **have increased to one hundred fifty percent or more of rates**
30 **established by the board as applicable for individual standard risks;**

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

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

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

43 **(a) This exclusion shall not apply to a person who has such coverage but**
44 **whose premiums have increased to [three] one hundred fifty percent or more of**
45 **rates established by the board as applicable for individual standard risks;**

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

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

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

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

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

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

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

66 (7) [Any person who is eligible for continuation or conversion of insurance
67 coverage under 29 U.S.C. 1161 to 29 U.S.C. 1168, 42 U.S.C. 300bb-1 to 42 U.S.C.
68 300bb-8, sections 376.395 to 376.404, or section 376.428, except that this
69 exclusion shall not apply to a person who has such coverage but whose premiums
70 have increased to three hundred percent or more of rates established by the board
71 as applicable for individual standard risks; or

72 (8)] Any person who is eligible for Medicare coverage.

73 [3.] 4. Any person who ceases to meet the eligibility requirements of this
74 section may be terminated at the end of [his] **such person's** policy period.

75 [4. Any person whose health insurance coverage is involuntarily
76 terminated for any reason other than nonpayment of premium or any person
77 whose premiums have increased to three hundred percent or more of rates
78 established by the board as applicable for individual standard risks, may apply
79 for coverage under the plan. If such coverage is applied for within sixty days
80 after the involuntary termination and the application is approved and if
81 premiums are paid for the entire coverage period, the effective date of the
82 coverage shall be the date of termination of the previous coverage.]

83 5. (1) **If an insurer issues one or more of the following or takes**
84 **any other action based wholly or partially on medical underwriting**
85 **considerations which is likely to render any person eligible for pool**
86 **coverage, the insurer shall notify all persons affected of the existence**
87 **of the pool, as well as the eligibility requirements and methods of**
88 **applying for pool coverage:**

89 (a) **A notice of rejection or cancellation of coverage;**

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

376.986. 1. The pool shall offer major medical expense coverage to every
2 person eligible for coverage under section 376.966. The coverage to be issued by
3 the pool and its schedule of benefits, exclusions and other limitations, shall be
4 established by the board with the advice and recommendations of the pool
5 members, and such plan of pool coverage shall be submitted to the director for

6 approval. The pool shall also offer coverage for drugs and supplies requiring a
7 medical prescription and coverage for patient education services, to be provided
8 at the direction of a physician, encompassing the provision of information,
9 therapy, programs, or other services on an inpatient or outpatient basis, designed
10 to restrict, control, or otherwise cause remission of the covered condition, illness
11 or defect.

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

18 3. [Premiums charged for pool coverage may not be unreasonable in
19 relation to the benefits provided, the risk experience and the reasonable expenses
20 of providing the coverage.] **The pool shall establish premium rates for pool**
21 **coverage as provided in subsection 4 of this section.** Separate schedules
22 of premium rates based on age, sex and geographical location may apply for
23 individual risks. **Premium rates and schedules shall be submitted to the**
24 **director for approval prior to use.**

25 4. The pool, **with the assistance of the director**, shall determine the
26 standard risk rate by [calculating the average individual standard rate charged
27 by the five insurers with the largest number of individual contracts in force. In
28 the event five insurers do not offer comparable coverage,] **considering the**
29 **premium rates charged by other insurers offering health insurance**
30 **coverage to individuals.** The standard risk rate shall be established using
31 reasonable actuarial techniques and shall reflect anticipated experience and
32 expenses for such coverage. Initial rates for pool coverage shall not be less than
33 one hundred [fifty] **twenty-five** percent of rates established as applicable for
34 individual standard risks. **Subject to the limits provided in this**
35 **subsection**, subsequent rates shall be established to provide fully for the
36 expected costs of claims including recovery of prior losses, expenses of operation,
37 investment income of claim reserves, and any other cost factors subject to the
38 limitations described herein. In no event shall pool rates exceed [two hundred
39 percent of rates applicable to individual standard risks.

40 All rates and rate schedules shall be submitted to the director for approval] **the**
41 **following:**

42 (1) **For federally defined eligible individuals, rates shall be equal**
43 **to the percent of rates applicable to individual standard risks**

44 actuarially determined to be sufficient to recover the sum of the cost
45 of benefits paid under the pool for federally defined eligible individuals
46 plus the proportion of the pool's administrative expense applicable to
47 federally defined eligible individuals enrolled for pool coverage,
48 provided that such rates shall not exceed one hundred thirty-five
49 percent of rates applicable to individual standard risks; and

50 **(2) For all other individuals covered under the pool, one hundred**
51 **thirty-five percent of rates applicable to individual standard risks.**

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

56 6. Pool coverage shall exclude charges or expenses incurred during the
57 first twelve months following the effective date of coverage as to any condition
58 [which, during the six-month period immediately preceding the effective date of
59 coverage, had manifested itself in such a manner as would cause an ordinarily
60 prudent person to seek diagnosis, care or treatment or] for which medical advice,
61 care or treatment was recommended or received as to such condition **during the**
62 **six-month period immediately preceding the effective date of**
63 **coverage.** Such preexisting condition exclusions shall be waived to the extent
64 to which similar exclusions, if any, have been satisfied under any prior health
65 insurance coverage which was involuntarily terminated, if [that] application for
66 pool coverage is made not later than [sixty] **sixty-three** days following such
67 involuntary termination and, in such case, coverage in the pool shall be effective
68 from the date on which such prior coverage was terminated.

69 7. **No preexisting condition exclusion shall be applied to the**
70 **following:**

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

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

77 8. Benefits otherwise payable under pool coverage shall be reduced by all
78 amounts paid or payable through any other health insurance, or insurance
79 arrangement, and by all hospital and medical expense benefits paid or payable
80 under any workers' compensation coverage, automobile medical payment or
81 liability insurance whether provided on the basis of fault or nonfault, and by any

82 hospital or medical benefits paid or payable under or provided pursuant to any
83 state or federal law or program except Medicaid. The insurer or the pool shall
84 have a cause of action against an eligible person for the recovery of the amount
85 of benefits paid which are not for covered expenses. Benefits due from the pool
86 may be reduced or refused as a setoff against any amount recoverable under this
87 subsection.

88 [8.] 9. Medical expenses shall include expenses for comparable benefits
89 for those who rely solely on spiritual means through prayer for healing.

376.989. Neither the participation in the pool as members, the
2 establishment of rates, forms or procedures, nor any other joint or collective
3 action required or permitted by the provisions of sections 376.960 to 376.989 shall
4 be the basis of any legal action, criminal or civil liability or penalty against the
5 pool, **the pool administrator, the board or any of its members, or pool**
6 **employees, contractors, or consultants,** or any of its members.

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

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

5 (1) "Actuarial certification" [means], a written statement by a member of
6 the American Academy of Actuaries or other individual acceptable to the director
7 that a small employer carrier is in compliance with the provisions of section
8 379.936, based upon the person's examination, including a review of the
9 appropriate records and of the actuarial assumptions and methods used by the
10 small employer carrier in establishing premium rates for applicable health benefit
11 plans;

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

15 (3) ["Agent" means "insurance agent" as that term is defined in section
16 375.012, RSMo;

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

22 [(5) "Basic health benefit plan" means a lower cost health benefit plan
23 developed pursuant to section 379.944;

24 (6)] (4) "Board" means the board of directors of the program established

25 pursuant to sections 379.942 and 379.943;

26 [(7) "Broker" means "broker" as that term is defined in section 375.012,
27 RSMo;

28 (8)] (5) **"Bona fide association", an association which:**

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

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

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

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

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

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

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

52 [(9)] (7) **"Case characteristics" [means], demographic or other objective**
53 **characteristics of a small employer that are considered by the small employer**
54 **carrier in the determination of premium rates for the small employer, provided**
55 **that claim experience, health status and duration of coverage since issue shall not**
56 **be case characteristics for the purposes of sections 379.930 to 379.952;**

57 [(10)] (8) **"Class of business" [means], all or a separate grouping of small**
58 **employers established pursuant to section 379.934;**

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

61 [(11)] (10) **"Committee" [means], the health benefit plan committee**
62 **created pursuant to section 379.944;**

63 [(12)] **(11) "Control" shall be defined in manner consistent with chapter**
64 **382, RSMo;**

65 **(12) "Creditable coverage", with respect to an individual:**
66 **(a) Coverage of the individual under any of the following:**
67 **a. A group health plan;**
68 **b. Health insurance coverage;**
69 **c. Part A or Part B of Title XVIII of the Social Security Act;**
70 **d. Title XIX of the Social Security Act, other than coverage**
71 **consisting solely of benefits under Section 1928 of such act;**
72 **e. Chapter 55 of Title 10, United States Code;**
73 **f. A medical care program of the Indian Health Service or of a**
74 **tribal organization;**
75 **g. A state health benefits risk pool;**
76 **h. A health plan offered under Chapter 89 of Title 5, United**
77 **States Code;**
78 **i. A public health plan, as defined in federal regulations**
79 **authorized by Section 2701(c)(1)(I) of the Public Health Services Act, as**
80 **amended by Public Law 104-191; and**
81 **j. A health benefit plan under Section 5(e) of the Peace Corps Act**
82 **(22 U.S.C. 2504(e));**

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

85 (13) "Dependent" [means], a spouse or an unmarried child under the age
86 of nineteen years; an unmarried child who is a full-time student under the age
87 of twenty-three years and who is financially dependent upon the parent; or an
88 unmarried child of any age who is medically certified as disabled and dependent
89 upon the parent;

90 (14) "Director" [means], the director of the department of insurance,
91 **financial institutions and professional registration** of this state;

92 (15) "Eligible employee" [means], an employee who works on a full-time
93 basis and has a normal work week of thirty or more hours. The term includes a
94 sole proprietor, a partner of a partnership, and an independent contractor, if the
95 sole proprietor, partner or independent contractor is included as an employee
96 under a health benefit plan of a small employer, but does not include an employee
97 who works on a part-time, temporary or substitute basis. For purposes of sections
98 379.930 to 379.952, a person, his spouse and his minor children shall constitute
99 only one eligible employee when they are employed by the same small employer;

100 (16) "Established geographic service area" [means], a geographical area,

101 as approved by the director and based on the carrier's certificate of authority to
102 transact insurance in this state, within which the carrier is authorized to provide
103 coverage;

104 (17) **"Excepted benefits":**

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

107 (b) **Coverage only for disability income insurance;**

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

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

111 (e) **Workers' compensation or similar insurance;**

112 (f) **Automobile medical payment insurance;**

113 (g) **Credit-only insurance;**

114 (h) **Coverage for onsite medical clinics;**

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

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

120 a. **Limited scope dental or vision benefits;**

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

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

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

126 a. **Coverage only for a specified disease or illness;**

127 b. **Hospital indemnity or other fixed indemnity insurance.**

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

130 a. **Medicare supplemental coverage (as defined under Section**
131 **1882(g)(1) of the Social Security Act);**

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

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

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

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

147 **(20) "Health benefit plan" [means any hospital or medical policy or**
148 **certificate, health services corporation contract, or health maintenance**
149 **organization subscriber contract. Health benefit plan does not include a policy**
150 **of individual accident and sickness insurance or hospital supplemental policies**
151 **having a fixed daily benefit, or accident-only, specified disease-only, credit,**
152 **dental, vision, Medicare supplement, long-term care, or disability income**
153 **insurance, or coverage issued as a supplement to liability insurance, worker's**
154 **compensation or similar insurance, or automobile medical payment insurance] or**
155 **"health insurance coverage", benefits consisting of medical care,**
156 **including items and services paid for as medical care, that are provided**
157 **directly, through insurance, reimbursement, or otherwise, under a**
158 **policy, certificate, membership contract, or health services agreement**
159 **offered by a health insurance issuer, but not including excepted**
160 **benefits or a policy that is individually underwritten;**

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

162 **(a) Health status;**

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

165 **(c) Claims experience;**

166 **(d) Receipt of health care;**

167 **(e) Medical history;**

168 **(f) Genetic information;**

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

171 **(h) Disability;**

172 **[(18)] (22) "Index rate" [means], for each class of business as to a rating**
173 **period for small employers with similar case characteristics, the arithmetic mean**
174 **of the applicable base premium rate and the corresponding highest premium rate;**

175 **[(19)] (23) "Late enrollee" [means], an eligible employee or dependent**
176 **who requests enrollment in a health benefit plan of a small employer following**

177 the initial enrollment period for which such individual is entitled to enroll under
178 the terms of the health benefit plan, provided that such initial enrollment period
179 is a period of at least thirty days. However, an eligible employee or dependent
180 shall not be considered a late enrollee if:

181 (a) The individual meets each of the following:

182 a. The individual was covered under [qualifying previous] **creditable**
183 coverage at the time of the initial enrollment;

184 b. The individual lost coverage under [qualifying previous] **creditable**
185 coverage as a result of **cessation of employer contribution**, termination of
186 employment or eligibility, **reduction in the number of hours of**
187 **employment**, the involuntary termination of the [qualifying previous]
188 **creditable** coverage, death of a spouse [or divorce], **dissolution or legal**
189 **separation**;

190 c. The individual requests enrollment within thirty days after termination
191 of the [qualifying previous] **creditable** coverage;

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

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

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

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

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

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

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

211 [(20)] (26) "New business premium rate" [means], for each class of
212 business as to a rating period, the lowest premium rate charged or offered, or
213 which could have been charged or offered, by the small employer carrier to small
214 employers with similar case characteristics for newly issued health benefit plans

215 with the same or similar coverage;

216 [(21)] (27) "Plan of operation" [means], the plan of operation of the
217 program established pursuant to sections 379.942 and 379.943;

218 (28) "Plan sponsor", the meaning given such term under Section
219 3(16)(B) of the Employee Retirement Income Security Act of 1974;

220 [(22)] (29) "Premium" [means], all moneys paid by a small employer and
221 eligible employees as a condition of receiving coverage from a small employer
222 carrier, including any fees or other contributions associated with the health
223 benefit plan;

224 [(23)] (30) "Producer", the meaning given such term in section
225 375.012, RSMo, and includes an insurance agent or broker;

226 [(24)] (31) "Program" [means], the Missouri small employer health
227 reinsurance program created pursuant to sections 379.942 and 379.943;

228 [(25)] "Qualifying previous coverage" and "qualifying existing coverage"
229 mean benefits or coverage provided under:

230 (a) Medicare or Medicaid;

231 (b) An employer-based health insurance or health benefit arrangement
232 that provides benefits similar to or exceeding benefits provided under the basic
233 health benefit plan; or

234 (c) An individual health insurance policy (including coverage issued by a
235 health maintenance organization, health services corporation or a fraternal
236 benefit society) that provides benefits similar to or exceeding the benefits
237 provided under the basic health benefit plan, provided that such policy has been
238 in effect for a period of at least one year;

239 (26)] (32) "Rating period" [means], the calendar period for which
240 premium rates established by a small employer carrier are assumed to be in
241 effect;

242 [(27)] (33) "Restricted network provision" [means], any provision of a
243 health benefit plan that conditions the payment of benefits, in whole or in part,
244 on the use of health care providers that have entered into a contractual
245 arrangement with the carrier pursuant to section 354.400, RSMo, et seq. to
246 provide health care services to covered individuals;

247 [(28)] (34) "Small employer" [means], in connection with a group
248 health plan with respect to a calendar year and a plan year, any person,
249 firm, corporation, partnership [or], association, or political subdivision that
250 is actively engaged in business that[, on at least fifty percent of its working days
251 during the preceding calendar quarter, employed not less than three nor]
252 employed an average of at least two but no more than [twenty-five] fifty

253 eligible employees[, the majority of whom were employed within this state. In
254 determining the number of eligible employees, companies that are affiliated
255 companies, or that are eligible to file a combined tax return for purposes of state
256 taxation, shall be considered one employer] **on business days during the**
257 **preceding calendar year and that employs at least two employees on**
258 **the first day of the plan year. All persons treated as a single employer**
259 **under subsection (b), (c), (m) or (o) of Section 414 of the Internal**
260 **Revenue Code of 1986 shall be treated as one employer. Subsequent to**
261 **the issuance of a health plan to a small employer and for the purpose**
262 **of determining continued eligibility, the size of a small employer shall**
263 **be determined annually. Except as otherwise specifically provided, the**
264 **provisions of sections 379.930 to 379.952 that apply to a small employer**
265 **shall continue to apply at least until the plan anniversary following the**
266 **date the small employer no longer meets the requirements of this**
267 **definition. In the case of an employer which was not in existence**
268 **throughout the preceding calendar year, the determination of whether**
269 **the employer is a small or large employer shall be based on the average**
270 **number of employees that it is reasonably expected that the employer**
271 **will employ on business days in the current calendar year. Any**
272 **reference in sections 379.930 to 379.952 to an employer shall include a**
273 **reference to any predecessor of such employer;**

274 [(29)] **(35) "Small employer carrier" [means], a carrier that offers health**
275 **benefit plans covering eligible employees of one or more small employers in this**
276 **state[;**

277 (30) "Standard health benefit plan" means a health benefit plan developed
278 pursuant to section 379.944].

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

379.938. 1. A health benefit plan subject to sections 379.930 to 379.952
2 shall be renewable with respect to all eligible employees and dependents, at the
3 option of the small employer, except in any of the following cases:

4 (1) [Nonpayment of the required premiums] **The plan sponsor fails to**
5 **pay a premium or contribution in accordance with the terms of a health**
6 **benefit plan or the health carrier has not received a timely premium**
7 **payment;**

8 (2) [Fraud or misrepresentation of the small employer or, with respect to
9 coverage of individual insureds, the insureds or their representatives] **The plan**

10 **sponsor performs an act or practice that constitutes fraud, or makes an**
11 **intentional misrepresentation of material fact under the terms of the**
12 **coverage;**

13 (3) Noncompliance with the carrier's minimum participation requirements;

14 (4) Noncompliance with the carrier's employer contribution requirements;

15 (5) [Repeated misuse of a provider network provision; or

16 (6) The small employer carrier elects to nonrenew all of its health benefit
17 plans delivered or issued for delivery to small employers in this state. In such
18 a case the carrier shall:

19 (a) Provide advance notice of its decision under this subdivision to the
20 insurance supervisory official in each state in which it is licensed; and

21 (b) Provide notice of the decision not to renew coverage to all affected
22 small employers and to the insurance supervisory official in each state in which
23 an affected covered individual is known to reside at least one hundred eighty days
24 prior to the nonrenewal of any health benefit plan by the carrier. Notice to the
25 insurance supervisory official under this paragraph shall be provided at least
26 three working days prior to the notice to the affected small employers;

27 (7)] **In the case of a small employer carrier that offers coverage**
28 **through a network plan, there is no longer any enrollee under the**
29 **health benefit plan who lives, resides or works in the service area of**
30 **the health insurance issuer and the small employer carrier would deny**
31 **enrollment with respect to such plan under subsection 4 of this section;**

32 (6) **The small employer carrier elects to discontinue offering a**
33 **particular type of health benefit plan in the state's small group market.**
34 **A type of health benefit plan may be discontinued by a small employer**
35 **carrier in such market only if such carrier:**

36 (a) **Issues a notice to each plan sponsor provided coverage of**
37 **such type in the small group market (and participants and beneficiaries**
38 **covered under such coverage) of the discontinuation at least ninety**
39 **days prior to the date of discontinuation of the coverage;**

40 (b) **Offers to each plan sponsor provided coverage of such type**
41 **the option to purchase all other health benefit plans currently being**
42 **offered by the small employer carrier in the state's small group market;**
43 **and**

44 (c) **Acts uniformly without regard to the claims experience of**
45 **those plan sponsors or any health status-related factor relating to any**
46 **participants or beneficiaries covered or new participants or**
47 **beneficiaries who may become eligible for such coverage;**

48 **(7) A small employer carrier elects to discontinue offering all**
49 **health insurance coverage in the small group market in this state. A**
50 **small employer carrier shall not discontinue offering all health**
51 **insurance coverage in the small employer market unless:**

52 **(a) The carrier provides notice of discontinuation to the director**
53 **and to each plan sponsor (and participants and beneficiaries covered**
54 **under such coverage) at least one hundred eighty days prior to the date**
55 **of the discontinuation of coverage; and**

56 **(b) All health insurance issued or delivered for issuance in**
57 **Missouri in the small employer market is discontinued and coverage**
58 **under such health insurance is not renewed;**

59 **(8) In the case of health insurance coverage that is made**
60 **available in the small group market only through one or more bona fide**
61 **associations, the membership of an employer in the association (on the**
62 **basis of which the coverage is provided) ceases but only if such**
63 **coverage is terminated under this subdivision uniformly without regard**
64 **to any health status-related factor relating to any covered individual;**

65 **(9) The director finds that the continuation of the coverage would:**

66 **(a) Not be in the best interests of the policyholders or certificate holders;**
67 **or**

68 **(b) Impair the carrier's ability to meet its contractual obligations.**

69 **In such instance the director shall assist affected small employers in finding**
70 **replacement coverage.**

71 **2. A small employer carrier that elects not to renew a health benefit plan**
72 **under subdivision [(6)] (7) of subsection 1 of this section shall be prohibited from**
73 **writing new business in the small employer market in this state for a period of**
74 **five years from the date of notice to the director.**

75 **3. In the case of a small employer carrier doing business in one**
76 **established geographic service area of the state, the provisions of this section**
77 **shall apply only to the carrier's operations in such service area.**

78 **4. At the time of coverage renewal, a health insurance issuer may**
79 **modify the health insurance coverage for a product offered to a group**
80 **health plan in the small group market if, for coverage that is available**
81 **in such market other than only through one or more bona fide**
82 **associations, such modification is consistent with state law and**
83 **effective on a uniform basis among group health plans with that**
84 **product. For purposes of this subsection, renewal shall be deemed to**
85 **occur not more often than annually on the anniversary of the effective**

86 **date of the group health plan's health insurance coverage unless a**
87 **longer term is specified in the policy or contract.**

88 **5. In the case of health insurance coverage that is made available**
89 **by a small employer carrier only through one or more bona fide**
90 **associations, references to "plan sponsor" in this section is deemed, with**
91 **respect to coverage provided to a small employer member of the**
92 **association, to include a reference to such employer.**

379.940. 1. (1) Every small employer carrier shall, as a condition of
2 transacting business in this state with small employers, actively offer to small
3 employers [at least two health benefit plans. One plan offered by each small
4 employer carrier shall be a basic health benefit plan and one plan shall be a
5 standard health benefit plan] **all health benefit plans it actively markets**
6 **to small employers in this state.**

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

12 (b) In the case of a small employer carrier that establishes more than one
13 class of business pursuant to section 379.934, the small employer carrier shall
14 maintain and issue to eligible small employers [at least one basic health benefit
15 plan and at least one standard] **all health benefit [plan] plans** in each class of
16 business so established. A small employer carrier may apply reasonable criteria
17 in determining whether to accept a small employer into a class of business,
18 provided that:

19 a. The criteria are not intended to discourage or prevent acceptance of
20 small employers applying for a [basic or standard] health benefit plan;

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

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

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

29 [(3) A small employer is eligible under subdivision (2) of this subsection
30 if it employed at least three or more eligible employees within this state on at
31 least fifty percent of its working days during the preceding calendar quarter.

32 (4) The provisions of this subsection shall be effective one hundred eighty
33 days after the director's approval of the basic health benefit plan and the
34 standard health benefit plan developed pursuant to section 379.944, provided that
35 if the small employer health reinsurance program created pursuant to sections
36 379.942 and 379.943 is not yet in operation on such date, the provisions of this
37 subsection shall be effective on the date that such program begins operation.]

38 2. Health benefit plans covering small employers shall comply with the
39 following provisions:

40 (1) A health benefit plan shall [not deny, exclude or limit benefits for a
41 covered individual for losses incurred more than twelve months following the
42 effective date of the individual's coverage due to a preexisting condition. A health
43 benefit plan shall not define a preexisting condition more restrictively than:

44 (a) A condition that would have caused an ordinarily prudent person to
45 seek medical advice, diagnosis, care or treatment during the six months
46 immediately preceding the effective date of coverage;

47 (b) A condition for which medical advice, diagnosis, care or treatment was
48 recommended or received during the six months immediately preceding the
49 effective date of coverage; or

50 (c) A pregnancy existing on the effective date of coverage.

51 (2) A health benefit plan shall waive any time period applicable to a
52 preexisting condition exclusion or limitation period with respect to particular
53 services for the period of time an individual was previously covered by qualifying
54 previous coverage that provided benefits with respect to such services, provided
55 that the qualifying previous coverage was continuous to a date not less than
56 thirty days prior to the effective date of the new coverage. This subdivision does
57 not preclude application of any waiting period applicable to all new enrollees
58 under the health benefit plan.

59 (3) A health benefit plan may exclude coverage for late enrollees for the
60 greater of eighteen months or provide for an eighteen-month preexisting condition
61 exclusion, provided that if both a period of exclusion from coverage and a
62 preexisting condition exclusion are applicable to a late enrollee, the combined
63 period shall not exceed eighteen months from the date the individual enrolls for
64 coverage under the health benefit plan.

65 (4)] **comply with the provisions of sections 376.450 and 376.451,**
66 **RSMo.**

67 (2) (a) Except as provided in paragraph (d) of this subdivision,
68 requirements used by a small employer carrier in determining whether to provide
69 coverage to a small employer, including requirements for minimum participation

70 of eligible employees and minimum employer contributions, shall be applied
71 uniformly among all small employers with the same number of eligible employees
72 applying for coverage or receiving coverage from the small employer carrier.

73 (b) A small employer carrier [may vary application of minimum
74 participation requirements only by the size of the small employer group] **shall**
75 **not require a minimum participation level greater than:**

76 **a. One hundred percent of eligible employees working for groups**
77 **of three or less employees; and**

78 **b. Seventy-five percent of eligible employees working for groups**
79 **with more than three employees.**

80 (c) [a. Except as provided in paragraph (b) of this subdivision,] In
81 applying minimum participation requirements with respect to a small employer,
82 a small employer carrier shall not consider employees or dependents who have
83 qualifying existing coverage in determining whether the applicable percentage of
84 participation is met.

85 [b. With respect to a small employer with ten or fewer eligible employees,
86 a small employer carrier may consider employees or dependents who have
87 coverage under another health benefit plan sponsored by such small employer in
88 applying minimum participation requirements.]

89 (d) A small employer carrier shall not increase any requirement for
90 minimum employee participation or **modify** any requirement for minimum
91 employer contribution applicable to a small employer at any time after the small
92 employer has been accepted for coverage.

93 [(5)] **(3)** (a) If a small employer carrier offers coverage to a small
94 employer, the small employer carrier shall offer coverage to all of the eligible
95 employees of a small employer and their dependents **who apply for enrollment**
96 **during the period in which the employee first becomes eligible to enroll**
97 **under the terms of the plan.** A small employer carrier shall not offer coverage
98 to only certain individuals **or dependents** in a small employer group or to only
99 part of the group[, except in the case of late enrollees as provided in subdivision
100 (3) of this subsection].

101 (b) A small employer carrier shall not modify a [basic or standard] health
102 benefit plan with respect to a small employer or any eligible employee or
103 dependent through riders, endorsements or otherwise, to restrict or exclude
104 coverage for certain diseases or medical conditions otherwise covered by the
105 health benefit plan.

106 (c) **An eligible employee may choose to retain their individual**
107 **health benefit plan at the time of open enrollment in a small employer**

108 **health benefit plan. If the eligible employee retains their individual**
109 **health benefit plan, a small employer shall provide a defined**
110 **contribution through the establishment of a cafeteria 125 plan under**
111 **section 379.953. Small employers shall establish an equal amount of**
112 **defined contribution for all plans.**

113 3. (1) **Subject to subdivision (3) of this subsection,** a small employer
114 carrier shall not be required to offer coverage or accept applications pursuant to
115 subsection 1 of this section in the case of the following:

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

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

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

125 (2) A small employer carrier that cannot offer coverage pursuant to
126 paragraph (c) of subdivision (1) of this subsection may not offer coverage in the
127 applicable area to new cases of employer groups with more than [twenty-five]
128 **fifty** eligible employees or to any small employer groups until the later of one
129 hundred eighty days following each such refusal or the date on which the carrier
130 notifies the director that it has regained capacity to deliver services to small
131 employer groups.

132 **(3) A small employer carrier shall apply the provisions of this**
133 **subsection uniformly to all small employers without regard to the**
134 **claims experience of a small employer and its employees and their**
135 **dependents or any health status-related factor relating to such**
136 **employees and their dependents.**

137 4. A small employer carrier shall not be required to provide coverage to
138 small employers pursuant to subsection 1 of this section for any period of time for
139 which the director determines that requiring the acceptance of small employers
140 in accordance with the provisions of subsection 1 of this section would place the
141 small employer carrier in a financially impaired condition[.

142 5. Sections 379.930 to 379.938 and sections 379.942 to 379.950 shall
143 become effective July 1, 1993, this section and section 379.952 shall become
144 effective July 1, 1994], **and the small employer is applying this subsection**
145 **uniformly to all small employers in the small group market in this state**

146 **consistent with applicable state law and without regard to the claims**
147 **experience of a small employer and its employees and their dependents**
148 **or any health status-related factor relating to such employees and their**
149 **dependents.**

379.952. 1. Each small employer carrier shall actively market [health
2 benefit plan coverage, including the basic and standard health benefit plans, to
3 eligible small employers in the state. If a small employer carrier denies coverage
4 to a small employer on the basis of the health status or claims experience of the
5 small employer or its employees or dependents, the small employer carrier shall
6 offer the small employer the opportunity to purchase a basic health benefit plan
7 or a standard health benefit plan] **all health benefit plans sold by the**
8 **carrier in the small group market to eligible employers in the state.**

9 2. (1) Except as provided in subdivision (2) of this subsection, no small
10 employer carrier or agent or broker shall, directly or indirectly, engage in the
11 following activities:

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

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

19 (2) The provisions of subdivision (1) of this subsection shall not apply with
20 respect to information provided by a small employer carrier or agent or broker to
21 a small employer regarding the established geographic service area or a restricted
22 network provision of a small employer carrier.

23 3. (1) Except as provided in subdivision (2) of this subsection, no small
24 employer carrier shall, directly or indirectly, enter into any contract, agreement
25 or arrangement with an agent or broker that provides for or results in the
26 compensation paid to an agent or broker for the sale of a health benefit plan to
27 be varied because of the health status, claims experience, industry, occupation or
28 geographic location of the small employer.

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

34 4. A small employer carrier shall provide reasonable compensation, as

35 provided under the plan of operation of the program, to an agent or broker, if any,
36 for the sale of a basic or standard health benefit plan.

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

42 6. No small employer carrier or producer shall induce or otherwise
43 encourage a small employer to separate or otherwise exclude an employee from
44 health coverage or benefits provided in connection with the employee's
45 employment; except that, a carrier may offer a policy to a small employer that
46 charges a reduced premium rate or deductible for employees who do not smoke
47 or use tobacco products, and such carrier shall not be considered in violation of
48 sections 379.930 to 379.952 or any unfair trade practice, as defined in section
49 379.936, even if only some small employers elect to purchase such a policy and
50 other small employers do not.

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

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

57 9. (1) A violation of this section by a small employer carrier or a producer
58 shall be an unfair trade practice under sections 375.930 to 375.949, RSMo.

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

2 [379.942. 1. There is hereby created a nonprofit entity to
3 be known as the "Missouri Small Employer Health Reinsurance
4 Program". All small employer carriers shall participate in the
5 program as reinsuring carriers for a minimum of three years
6 beginning July 1, 1993. After the expiration of such three years,
7 a small employer carrier may apply to the director to opt out of the
8 program. The director shall decide whether to grant such an
9 application to opt out, and shall consider in making such
determination only: the carrier's financial condition and the

financial condition of its guaranteeing or reinsuring corporation, if any; its history of assuming and managing risk; its ability to assume and manage the risk of enrolling small employers without the protection of the program; and its commitment to market fairly to all small employers in its service area. If the director grants such application, the small employer carrier shall participate in the program neither as a ceding nor reinsuring carrier.

2. (1) The program shall operate subject to the supervision and control of the board. Subject to the provisions of subdivision (2) of this subsection, the board shall consist of nine members appointed by the director plus the director or his designated representative, who shall serve as an ex officio member of the board.

(2) (a) In selecting the members of the board, the director shall include representatives of small employers, small employer employees or their representatives and small employer carriers and such other individuals determined to be qualified by the director. At least five of the members of the board shall be representatives of reinsuring carriers and at least one of the members of the board shall be a representative of a health maintenance organization which is a small employer carrier. All members shall be selected from individuals nominated by small employer carriers in this state pursuant to procedures and guidelines developed by the director, except that the director shall select two small employers' employees, including at least one representative of a labor organization.

(b) In the event that the program becomes eligible for additional financing pursuant to subdivision (3) of subsection 8 of section 379.943, the board shall be expanded to include two additional members who shall be appointed by the director. In selecting the additional members of the board, the director shall choose individuals who represent reinsuring carriers. The expansion of the board under this paragraph shall continue for the period that the program continues to be eligible for additional financing under subdivision (3) of subsection 8 of section 379.943.

(3) The initial board members shall be appointed as follows: one-third of the members to serve a term of two years; one-third of the members to serve a term of four years; and one-third of the

48 members to serve a term of six years. Subsequent board members
49 shall serve for a term of three years. A board member's term shall
50 continue until his successor is appointed.

51 (4) A vacancy in the board shall be filled by the director. A
52 board member may be removed by the director for cause.

53 3. Within sixty days of July 1, 1993, each small employer
54 carrier shall make a filing with the director containing the carrier's
55 net health insurance premium derived from health benefit plans
56 delivered or issued for delivery to small employers in this state in
57 the previous calendar year.]

[379.943. 1. Within one hundred eighty days after the
2 appointment of the initial board, the board shall submit to the
3 director a plan of operation and thereafter any amendments thereto
4 necessary or suitable, to assure the fair, reasonable and equitable
5 administration of the program. The director may, after notice and
6 hearing, approve the plan of operation if the director determines it
7 to be suitable to assure the fair, reasonable and equitable
8 administration of the program, and provides for the sharing of
9 program gains or losses on an equitable and proportionate basis in
10 accordance with the provisions of section 379.942 and this
11 section. The plan of operation shall become effective upon approval
12 in writing by the director.

13 2. If the board fails to submit a suitable plan of operation
14 within one hundred eighty days after its appointment, the director
15 shall, after notice and hearing, promulgate and adopt a temporary
16 plan of operation. The director shall amend or rescind any plan so
17 adopted under this subsection at the time a plan of operation is
18 submitted by the board and approved by the director.

19 3. The plan of operation shall:

20 (1) Establish procedures for handling and accounting of
21 program assets and moneys and for an annual fiscal report to the
22 director;

23 (2) Establish procedures for selecting an administering
24 carrier and setting forth the powers and duties of the
25 administering carrier;

26 (3) Establish procedures for reinsuring risks in accordance
27 with the provisions of section 379.942 and this section;

28 (4) Establish procedures for collecting assessments from

29 reinsuring carriers to fund claims and administrative expenses
30 incurred or estimated to be incurred by the program; and

31 (5) Provide for any additional matters necessary for the
32 implementation and administration of the program.

33 4. The program shall have the general powers and authority
34 granted under the laws of this state to insurance companies and
35 health maintenance organizations licensed to transact business,
36 except the power to issue health benefit plans directly to either
37 groups or individuals. In addition thereto, the program shall have
38 the specific authority to:

39 (1) Enter into contracts as necessary or proper to carry out
40 the provisions and purposes of sections 379.930 to 379.952,
41 including the authority, with the approval of the director, to enter
42 into contracts with similar programs in other states for the joint
43 performance of common functions or with persons or other
44 organizations for the performance of administrative functions;

45 (2) Sue or be sued, including taking any legal actions
46 necessary or proper to recover any assessments and penalties for,
47 on behalf of, or against the program or any reinsuring carriers;

48 (3) Take any legal action necessary to avoid the payment of
49 improper claims against the program;

50 (4) Define the health benefit plans for which reinsurance
51 will be provided, and to issue reinsurance policies, in accordance
52 with the requirements of sections 379.930 to 379.952;

53 (5) Establish rules, conditions and procedures for reinsuring
54 risks under the program;

55 (6) Establish actuarial functions as appropriate for the
56 operation of the program;

57 (7) Assess carriers in accordance with the provisions of
58 subsection 8 of this section, and to make advance interim
59 assessments as may be reasonable and necessary for organizational
60 and interim operating expenses. Any interim assessments shall be
61 credited as offsets against any regular assessments due following
62 the close of the calendar year;

63 (8) Appoint appropriate legal, actuarial and other
64 committees as necessary to provide technical assistance in the
65 operation of the program, policy and other contract design, and any
66 other function within the authority of the program; and

67 (9) Borrow money to effect the purposes of the
68 program. Any notes or other evidence of indebtedness of the
69 program not in default shall be legal investments for carriers and
70 may be carried as admitted assets.

71 5. A small employer carrier participating in the program
72 may reinsure an entire small employer group with the program as
73 provided for in this subsection:

74 (1) With respect to a basic health benefit plan or a standard
75 health benefit plan, the program shall reinsure the level of
76 coverage provided and, with respect to other plans, the program
77 shall reinsure up to the level of coverage provided in a basic or
78 standard health benefit plan.

79 (2) A small employer carrier may reinsure an entire small
80 employer group within sixty days of the commencement of the
81 group's coverage under a health benefit plan or within thirty days
82 after an annual renewal of a small employer group.

83 (3) (a) The program shall not reimburse a small employer
84 carrier with respect to the claims of an employee or dependent who
85 is part of a reinsured small employer group until the carrier has
86 incurred an initial level of claims for such employee or dependent
87 of five thousand dollars in a calendar year for benefits covered by
88 the program. In addition, the small employer carrier shall be
89 responsible for ten percent of the remaining incurred claims during
90 a calendar year and the program shall reinsure the remainder. A
91 small employer carrier's liability under this paragraph shall not
92 exceed a maximum limit of twenty-five thousand dollars in any one
93 calendar year with respect to any individual who is part of a
94 reinsured small employer group.

95 (b) The board annually shall adjust the initial level of
96 claims and the maximum limit to be retained by the carrier to
97 reflect increases in costs and utilization within the standard
98 market for health benefit plans within the state. The adjustment
99 shall not be less than the annual change in the medical component
100 of the Consumer Price Index for All Urban Consumers of the
101 federal Department of Labor, Bureau of Labor Statistics, unless the
102 board proposes and the director approves a lower adjustment
103 factor.

104 (4) A small employer carrier may terminate reinsurance for

105 a small employer on any plan anniversary.

106 6. (1) The board, as part of the plan of operation, shall
107 establish a methodology for determining premium rates to be
108 charged by the program for reinsuring small employers and
109 individuals pursuant to section 379.942 and this section. The
110 methodology shall include a system for classification of small
111 employers that reflects the types of case characteristics commonly
112 used by small employer carriers in the state. The methodology
113 shall also include a system for classification of small employer
114 carriers that reflects the degree to which the small employer
115 carrier uses the cost containment features adopted by the health
116 benefit plan committee under section 379.944. The methodology
117 shall provide for the development of base reinsurance premium
118 rates, which shall be multiplied by the factors set forth in
119 subdivision (2) of this act to determine the premium rates for the
120 program. The base reinsurance premium rates shall be established
121 by the board, subject to the approval of the director, and shall be
122 set at levels which reasonably approximate gross premiums
123 charged to small employers by small employer carriers for health
124 benefit plans with benefits similar to the standard health benefit
125 plan.

126 (2) Only an entire small employer group may be reinsured,
127 and the rate for such reinsurance shall be one and one-half times
128 the base reinsurance insurance premium rate for the group
129 established pursuant to this subsection.

130 (3) The board periodically shall review the methodology
131 established under subdivisions (1) and (2) of this section, including
132 the system of classification and any rating factors, to assure that
133 it reasonably reflects the claims experience of the program. The
134 board may propose changes to the methodology which shall be
135 subject to the approval of the director.

136 7. If a health benefit plan for a small employer is reinsured
137 with the program, the premium charged to the small employer for
138 any rating period for the coverage issued shall meet the
139 requirements relating to premium rates set forth in section
140 379.936.

141 8. (1) Prior to March first of each year, the board shall
142 determine and report to the director the program net loss for the

143 previous calendar year, including administrative expenses and
144 incurred losses for the year, taking into account investment income
145 and other appropriate gains and losses.

146 (2) Any net loss for the year shall be recouped by
147 assessments of reinsuring carriers.

148 (a) The board shall establish, as part of the plan of
149 operation, a formula by which to make assessments against
150 reinsuring carriers and small employer carriers. The assessment
151 formula shall be based on:

152 a. The share of each reinsuring carrier which reinsures any
153 small employer group with the program, of the program net loss
154 described in this subsection shall be their proportionate share,
155 determined by premiums earned in the preceding calendar year
156 from health benefit plans which have been ceded to the program,
157 times one-half of the total program net loss;

158 b. Each reinsuring carrier's share of the program net loss
159 described in this subsection shall be its proportionate share,
160 determined by premiums earned in the preceding calendar year
161 from all health benefit plans delivered or issued for delivery to
162 small employers in this state by all reinsuring carriers, times
163 one-half of the total program net loss. An assessment levied or
164 paid by a reinsuring carrier pursuant to subparagraph a of this
165 paragraph shall not be credited or offset against any assessment
166 levied pursuant to this subparagraph.

167 (b) The formula established pursuant to paragraph (a) of
168 this subdivision shall not result in any reinsuring carrier having
169 an assessment share that is less than fifty percent nor more than
170 one hundred fifty percent of an amount which is based on the
171 proportion of the small employer carrier's total premiums earned
172 in the preceding calendar year from health benefit plans delivered
173 or issued for delivery to small employers in this state by small
174 employer carriers to total premiums earned in the preceding
175 calendar year from health benefit plans delivered or issued for
176 delivery to small employers in this state by all small employer
177 carriers.

178 (c) The director by rule and after a hearing thereon may
179 change the assessment formula established pursuant to paragraph
180 (a) of this subdivision from time to time as appropriate. The

181 director may provide for the shares of the assessment base
182 attributable to premiums from all health benefit plans and to
183 premiums from health benefit plans ceded to the program to vary
184 during a transition period.

185 (d) Subject to the approval of the director, the board shall
186 make an adjustment to the assessment formula for reinsuring
187 carriers that are approved health maintenance organizations which
188 are federally qualified under 42 U.S.C. Section 300, et seq., to the
189 extent, if any, that restrictions are placed on them that are not
190 imposed on other small employer carriers.

191 (e) Premiums and benefits payable by a reinsuring carrier
192 that are less than an amount determined by the board to justify the
193 cost of collection shall not be considered for purposes of
194 determining assessments.

195 (3) (a) Prior to March first of each year, the board shall
196 determine and file with the director an estimate of the assessments
197 needed to fund the losses incurred by the program in the previous
198 calendar year.

199 (b) If the board determines that the assessments needed to
200 fund the losses incurred by the program in the previous calendar
201 year will exceed the amount specified in paragraph (c) of this
202 subdivision, the board shall evaluate the operation of the program
203 and report its findings, including any recommendations for changes
204 to the plan of operation, to the director within ninety days
205 following the end of the calendar year in which the losses were
206 incurred. The evaluation shall include: an estimate of future
207 assessments, the administrative costs of the program, the
208 appropriateness of the premiums charged and the level of insurer
209 retention under the program and the costs of coverage for small
210 employers. If the board fails to file a report with the director
211 within ninety days following the end of the applicable calendar
212 year, the director may evaluate the operations of the program and
213 implement such amendments to the plan of operation the director
214 deems necessary to reduce future losses and assessments.

215 (c) For any calendar year, the amount specified in this
216 paragraph is five percent of total premiums earned in the previous
217 year from health benefit plans delivered or issued for delivery to
218 small employers in this state by reinsuring carriers.

219 (d) a. If assessments in each of two consecutive calendar
220 years exceed the amount specified in paragraph (c) of this
221 subdivision, the program shall be eligible to receive additional
222 financing as provided in subparagraph b of this paragraph.

223 b. The additional financing provided for in subparagraph a
224 of this paragraph shall be obtained from additional assessments
225 apportioned among all carriers which are not small employer
226 carriers; the amount of the assessment for each carrier determined
227 by the carrier's proportionate share of premiums earned in the
228 preceding calendar year from all health benefit plans delivered,
229 issued for delivery or continued in this state to individuals and
230 groups, other than small employer groups subject to sections
231 379.930 to 379.952, by all carriers, times the total amount of
232 additional financing to be obtained.

233 c. The additional assessment provided by subparagraph b
234 of this paragraph shall not exceed an amount equal to one percent
235 of the gross premium derived by that carrier from all health benefit
236 plans delivered, issued for delivery or continued in this state to
237 individuals and groups, other than small employer groups subject
238 to sections 379.930 to 379.952.

239 d. Any loss sustained by the program which is not
240 reimbursed by additional financing obtained pursuant to this
241 paragraph shall be carried forward to the calendar year succeeding
242 the year in which the loss is sustained, and shall be recouped by an
243 increase in premiums charged by the board for reinsurance of small
244 employer groups with the program.

245 e. Additional financing received by the program pursuant
246 to this paragraph shall be distributed to reinsuring carriers in
247 proportion to the assessments paid by such carriers over the
248 previous two calendar years.

249 (4) If assessments exceed net losses of the program, the
250 excess shall be held at interest and used by the board to offset
251 future losses or to reduce program premiums. As used in this
252 paragraph, "future losses" includes reserves for incurred but not
253 reported claims.

254 (5) Each carrier's proportion of the assessment shall be
255 determined annually by the board based on annual statements and
256 other reports deemed necessary by the board and filed by the

257 carriers with the board.

258 (6) The plan of operation shall provide for the imposition of
259 an interest penalty for late payment of assessments.

260 (7) A carrier may seek from the director a deferment from
261 all or part of an assessment imposed by the board. The director
262 may defer all or part of the assessment of a carrier if the director
263 determines that the payment of the assessment would place the
264 carrier in a financially impaired condition. If all or part of an
265 assessment against a carrier is deferred, the amount deferred shall
266 be assessed against the other participating carriers in a manner
267 consistent with the basis for assessment set forth in this
268 subsection. The carrier receiving such deferment shall remain
269 liable to the program for the amount deferred and the interest
270 penalty provided in subdivision (6) of this subsection and shall be
271 prohibited from reinsuring any groups in the program until such
272 time as it pays such assessments.

273 9. Neither the participation in the program as reinsuring
274 carriers, the establishment of rates, forms or procedures, nor any
275 other joint or collective action required by sections 379.930 to
276 379.952 shall be the basis of any legal action, criminal or civil
277 liability, or penalty against the program or any of its reinsuring
278 carriers either jointly or separately, other than any action by the
279 director to enforce the provisions of sections 379.930 to 379.952.

280 10. The board, as part of the plan of operation, shall
281 develop standards setting forth the manner and levels of
282 compensation to be paid to producers for the sale of basic and
283 standard health benefit plans. In establishing such standards, the
284 board shall take into the consideration: the need to assure the
285 broad availability of coverages; the objectives of the program; the
286 time and effort expended in placing the coverage; the need to
287 provide ongoing service to the small employer; the levels of
288 compensation currently used in the industry; and the overall costs
289 of coverage to small employers selecting these plans.

290 11. The program shall be exempt from any and all taxes.

291 12. The director shall make an initial assessment of one
292 thousand dollars on each insurance company authorized to transact
293 accident or health insurance, each health services corporation, and
294 each health maintenance organization. Initial assessments shall

295 be made during January, 1993, and shall be paid before April 1,
296 1993. Initial assessments shall be deposited into the department
297 of insurance dedicated fund. Within ten days after the effective
298 date of the program's plan of operation, the total amount of the
299 initial assessments shall be transferred at the request of the
300 director to the Missouri small employer health reinsurance
301 program. The program may use such initial assessment in the
302 same manner and for the same purposes as other assessments
303 pursuant to section 379.942 and this section.

304 13. The program, as defined in section 379.930, shall not
305 accept any new risks or renew any existing risk on or after October
306 1, 2005.

307 14. Any program assets or moneys that exceed six hundred
308 thousand dollars on August 28, 2005, shall be delivered on October
309 1, 2005, to the Missouri health insurance pool as established in
310 sections 376.960 to 376.989, RSMo, and shall be accepted by the
311 Missouri health insurance pool and used for the administration and
312 operation of the Missouri health insurance pool.

313 15. Any program assets or moneys that remain on October
314 1, 2006, shall be delivered on October 31, 2006, to the Missouri
315 health insurance pool as established in sections 376.960 to 376.989,
316 RSMo, and shall be accepted by the Missouri health insurance pool
317 and used for the administration and operation of the Missouri
318 health insurance pool.

319 16. The provisions of this section shall expire on December
320 31, 2006.]

[379.944. 1. The director shall appoint a seven-member
2 "Health Benefit Plan Committee". The committee shall be
3 composed of one representative from each of the following
4 categories: an insurance company which is a small employer
5 carrier, a health services corporation which is a small employer
6 carrier, a health maintenance organization which is a small
7 employer carrier, a health care provider, and a small
8 employer. The director shall select two representatives of
9 employees of small employers, including at least one representative
10 of a labor organization.

11 2. The committee shall recommend the form and level of
12 coverages to be made available by small employer carriers

13 pursuant to sections 379.942 and 379.943.

14 3. The committee shall recommend benefit levels, cost
15 sharing levels, exclusions and limitations for the basic health
16 benefit plan and the standard health benefit plan. The committee
17 shall also design a basic health benefit plan and a standard health
18 benefit plan which contain benefit and cost sharing levels that are
19 consistent with the basic method of operation and the benefit plans
20 of health maintenance organizations, including any restrictions
21 imposed by federal law.

22 (1) The plans recommended by the committee shall include
23 cost containment features such as:

24 (a) Utilization review of health care services, including
25 review of medical necessity of hospital and physician services;

26 (b) Case management;

27 (c) Selective contracting with hospitals, physicians and
28 other health care providers;

29 (d) Reasonable benefit differentials applicable to providers
30 that participate or do not participate in arrangements using
31 restricted network provisions; and

32 (e) Other managed care provisions.

33 (2) The committee shall submit the health benefit plans
34 described in this subsection to the director for approval within one
35 hundred eighty days after the appointment of the committee.]

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