SECOND REGULAR SESSION

SENATE BILL NO. 1039

90TH GENERAL ASSEMBLY

INTRODUCED BY SENATOR WESTFALL.

Read 1st time February 22, 2000, and 1,000 copies ordered printed.

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TERRY L. SPIELER, Secretary.

AN ACT

To repeal sections 376.421, 376.424, 376.426, 379.930, 379.932, 379.934, 379.936, 379.938, 379.940 and 379.952, RSMo 1994, relating to group health insurance, and to enact in lieu thereof ten new sections relating to the same subject.

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

Section A. Sections 376.421, 376.424, 376.426, 379.930, 379.932, 379.934, 379.936, 379.938, 379.940 and 379.952, RSMo 1994, are repealed and ten new sections enacted in lieu thereof, to be known as sections 376.421, 376.424, 376.426, 376.429, 379.930, 379.932, 379.936, 379.938, 379.940 and 379.952, to read as follows:

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

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

(a) The employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any class or classes thereof. The policy may provide that the term "employees" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships, if the business of the employer and of such affiliated corporations, proprietorships or partnerships is under common control. The policy may provide that the term "employees" shall include the individual proprietor or partners if the employer is an individual proprietorship or partnership. The policy may provide that the term "employees" shall include

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

retired employees, former employees and directors of a corporate employer. A policy issued to insure the employees of a public body may provide that the term "employees" shall include elected or appointed officials;

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

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

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

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

c. After the expiration of an open enrollment period during which the person could have enrolled for the insurance or could have elected another level of benefits under the policy**] only to the extent authorized by the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), sections 379.930 to 379.952, RSMo, or any state or federal regulations promulgated pursuant to any of these statutes**;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c. After the expiration of an open enrollment period during which the person could have enrolled for the insurance or could have elected another level of benefits under the policy**] only to the extent authorized by the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), sections 379.930 to 379.952, RSMo, or any state or federal regulations promulgated pursuant to any of these statutes**;

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

(a) The persons eligible for insurance shall be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes thereof. The policy may provide that the term "employees" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of such affiliated corporations, proprietorships or partnerships is under common control. The policy may provide that the term "employees" shall include the individual proprietor or partners if the employer is an individual proprietorship or partnership. The policy may provide that the term "employees" shall include retired employees, former employees and directors of a corporate employer. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship;

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

(c) An insurer may exclude or limit the coverage on any person **[**as to whom evidence of individual insurability is not satisfactory to the insurer**] only to the extent authorized by the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), sections 379.930 to 379.952, RSMo, or any state or federal regulations promulgated pursuant to any of these statutes**;

(5) A policy issued to an association or to a trust or to the trustees of a fund established,

created and maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of one hundred persons **or the number required in section 379.930, RSMo, for a bona fide association**; shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least two years **or five years in the case of a bona fide association as defined in section 379.930, RSMo**; shall have a constitution and bylaws which provide that the association or associations shall hold regular meetings not less than annually to further the purposes of the members; shall, except for credit unions, collect dues or solicit contributions from members; and shall provide the members with voting privileges and representation on the governing board and committees. The policy shall be subject to the following requirements:

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

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

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

(d) An insurer may exclude or limit the coverage on any person **[**as to whom evidence of individual insurability is not satisfactory to the insurer**] only to the extent authorized by the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), sections 379.930 to 379.952, RSMo, and any state or federal regulations promulgated pursuant to any of these statutes**;

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

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

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

(c) An insurer may exclude or limit the coverage on any member **[**as to whom evidence of individual insurability is not satisfactory to the insurer**] only to the extent authorized by the federal Health Insurance Portability and Accountability Act of 1996, sections 379.930**

to 379.952, RSMo, and any state or federal regulations promulgated pursuant to any of these statutes;

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

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

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

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

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

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

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

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

(4) An insurer may exclude or limit the coverage on any person **[**as to whom evidence of individual insurability is not satisfactory to the insurer**] only to the extent authorized by the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), sections 379.930 to 379.952, RSMo, and any state or federal regulations promulgated pursuant to any of these statutes**.

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

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

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

376.406 and 376.776 **[**in a policy insuring fewer than ten employees or members and in a policy insuring ten or more employees or members if:

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

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

c. After the expiration of an open enrollment period during which the family member or dependent could have been enrolled for the insurance or could have been enrolled for another level of benefits under the policy**], only to the extent authorized by the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), sections 379.930 to 379.952, RSMo, and any state or federal regulations promulgated pursuant to any of these statutes**.

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

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

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

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

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

(4) A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the individual's coverage**, subject to compliance with the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), sections 379.930 to 379.952, RSMo, and any state or federal regulations promulgated pursuant to any of these statutes**;

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

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

(b) The end of the two-year period commencing on the effective date of the person's coverage**. Notwithstanding the above, a health benefit plan, as defined in section 379.930, may exclude or limit coverage on any person only to the extent authorized by the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), sections 379.930 to 379.952, RSMo, and any state or federal regulations promulgated pursuant to any of these statutes**;

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

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

or dependent's coverage;

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

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

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

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

(12) A provision that benefits for accidental loss of life of a person insured shall be payable to the beneficiary designated by the person insured or, if the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms. In either case, payment of these benefits is subject to the provisions of the policy in the event no such designated or specified beneficiary is living at the death of the person insured. All other benefits of the policy shall be payable to the person insured. The policy may also provide that if any benefit is payable to the estate of a person, or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay such benefit, up to an amount not exceeding two

thousand dollars, to any relative by blood or connection by marriage of such person who is deemed by the insurer to be equitably entitled thereto;

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

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

(15) A provision specifying the conditions under which the policy may be terminated. Such provision shall state that except for nonpayment of the required premium or the failure to meet continued underwriting standards, the insurer may not terminate the policy prior to the first anniversary date of the effective date of the policy as specified therein, and a notice of any intention to terminate the policy by the insurer must be given to the policyholder at least thirty-one days prior to the effective date of the termination. Any termination by the insurer shall be without prejudice to any expenses originating prior to the effective date of termination. An expense will be considered incurred on the date the medical care or supply is received**. Notwithstanding the above, a health benefit plan, as defined by section 379.930, RSMo, may be terminated or nonrenewed only to the extent authorized by the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), sections 379.930 to 379.952, RSMo, and any state or federal regulations promulgated pursuant to any of these statutes**;

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

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

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

(1) "Creditable coverage", "health benefit plan" and "health carrier", the same as provided in section 379.930, RSMo;

(2) "Large employer" and "large group market", the same as provided in the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) and any regulations promulgated pursuant thereto.

2. Premium rates for health benefit plans provided to large employers by health carriers in the large group market shall comply with the requirements of subsection 1 of section 379.936, RSMo.

3. Health carriers providing health benefit plans to large employers in the large group market shall comply with the requirements of subsection 9 of section 379.940, RSMo, regarding certifications of creditable coverage for individuals losing coverage under health benefit plans provided to large employers.

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

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

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

(2) "**Adjusted community rating", a method used to develop a carrier's premium which spreads financial risk in accordance with the requirements in section 375.936:**

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

(4) "Affiliation period", a period of time that must expire before health insurance coverage provided by a health maintenance organization becomes effective, and during which the health maintenance organization is not required to provide benefits;

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

[(4) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business, by the small employer carrier to small employers with similar case characteristics for

health benefit plans with the same or similar coverage;

(5)**] (6)** "Basic health benefit plan" **[**means**],** a lower cost health benefit plan developed pursuant to section 379.944;

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

(8) "Bona fide association", an association which meets all of the following criteria:

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

(b) Has a constitution and by-laws or other analogous governing documents thereto;

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

(d) Is not owned or controlled by a carrier or affiliated with a carrier;

(e) Does not condition membership in the association on any health status-related factor;

(f) Has at least one thousand members if it is a national association; five hundred members if it is a state association; or two hundred members if it is a local association;

(g) All members and dependents of members are eligible for coverage regardless of health status-related factor;

(h) Does not make a health benefit plan offered through the association available other than in connection with a member of the association;

(i) Is governed by a board of directors and sponsors annual meetings of its members; and

(j) Meets any other requirements of state or federal law;

[(7)**] (9)** "Broker" **[**means**],** "broker" as that term is defined in section 375.012, RSMo;

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

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

(10) **[**"Class of business" means all or a separate grouping of small employers established pursuant to section 379.934**]** "**Church plan**", **the same as given such term under section**

3(33) of the Employee Retirement Income Security Act of 1974;

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

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

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

(a) Health benefits or coverage provided under any of the following:

a. A group health plan;

b. A health benefit plan;

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

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

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

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

g. A state health benefits risk pool;

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

i. A public health plan as defined in federal regulations authorized by Public Health Service Act Section 2701(c)(1)(I), as amended by P.L. 104-191; or

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

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

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

[(14)**] (15)** "Director" **[**means**],** the director of the department of insurance of this state;

[(15)**] (16)** "Eligible employee" **[**means**],** an employee who works on a full-time basis and has a normal work week of thirty or more hours **except that at the employer's sole discretion, the term shall also include an employee who works on a full-time basis with a normal work week of anywhere between at least seventeen and one-half and thirty hours, so long as this eligibility criterion is applied uniformly among all of the employer's employees and without regard to health status-related factors**. The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a **[**part-time,**]** temporary or

substitute basis **or who works less than seventeen and one-half hours per week**. **[**For purposes of sections 379.930 to 379.952, a person, his spouse and his minor children shall constitute only one eligible employee when they are employed by the same small employer**]** **Persons covered under a health benefit plan pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 shall not be considered "eligible employees" for purposes of minimum participation requirements pursuant to section 379.940**;

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

(18) "Family composition", includes only:

(a) An enrollee;

(b) An enrollee, spouse and children;

(c) An enrollee and spouse;

(d) An enrollee and children; or

(e) A child only;

(19) "Geographic area", an area established by the director used for adjusting the rates for a health benefit plan;

(20) "Governmental plan", the meaning given such term under section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan:

(21) "Group health plan", an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care as defined in section 379.930 and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise. For purposes of sections 379.930 to 379.952:

(a) Any plan, fund, or program that would not be, but for section 2721(e) of the Public Health Service Act, as added by P.L. 104-191, an employee welfare benefit plan and that is established or maintained by a partnership, to the extent that such plan, fund, or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership, or to their dependents, as defined under the terms of the plan, fund, or program, directly or through insurance, reimbursement, or otherwise, shall be treated, subject to paragraph (b), as an employee welfare benefit plan which is a group health plan;

(b) In the case of a group health plan, the term "employer" also includes the partnership in relation to any partner; and

(c) In the case of a group health plan, the term "participant" also includes an individual who is, or may become, eligible to receive a benefit under the plan, or the individual's beneficiary who is, or may become, eligible to receive a benefit under the

plan, if:

a. In connection with a group health plan maintained by a partnership, an individual who is a partner in relation to the partnership; or

b. In connection with a group health plan maintained by a self-employed individual, under which one or more employees are participants, the self-employed individual;

[(17)**] (22)** "Health benefit plan" **[**means any hospital or medical**], a** policy **[**or**], contract,** certificate**[**, health services corporation contract, or health maintenance organization subscriber contract**] or agreement offered by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services**. Health benefit plan does not include **[**a policy of individual accident and sickness insurance or hospital supplemental policies having a fixed daily benefit, or accident-only, specified disease-only, credit, dental, vision, medicare supplement, long-term care, or disability income insurance, or coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, or automobile medical payment insurance**] coverage for "excepted benefits" as defined in the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191)**;

(23) "Health carrier" or "carrier", any entity subject to the insurance laws and regulations of this state that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a health services corporation, fraternal benefit society, a multiple employer welfare arrangement specifically authorized to operate in the state of Missouri, or any other entity providing a plan of health insurance, health benefits or health services;

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

(a) Health status;

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

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information;

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

(h) Disability;

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

(19)**] (25)** "Late enrollee" **[**means**],** an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period for

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

(a) The individual meets each of the following:

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

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

c. The individual requests enrollment within thirty days after termination of the **[**qualifying previous**] creditable** coverage **or the change in conditions that gave rise to the termination of coverage**;

(b) **Where provided for in contract or where otherwise provided in state law, the individual enrolls during the specified bona fide open enrollment period;**

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

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

(e) The individual changes status from not being an eligible employee to becoming an eligible employee and requests enrollment within thirty days after the change in status;

(f) The individual had coverage under a COBRA continuation provision and the coverage under that provision was exhausted; or

(g) The individual otherwise meets the requirements for special enrollment in section 379.940;

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

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

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

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

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

[(20) "New business premium rate" means, for each class of business as to a rating period,

the lowest premium rate charged or offered, or which could have been charged or offered, by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage;

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

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

(30) "Preexisting condition", a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six months preceding the enrollment date of the coverage. A condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time while the covered person held creditable coverage and that was a covered benefit under the plan shall not be considered a preexisting condition, provided that the creditable coverage was continuous to a date not more than sixty-three days prior to the enrollment date of the new coverage. Genetic information shall not be treated as a condition for which a preexisting condition exclusion may be imposed in the absence of a diagnosis of the condition related to such information;

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

[(23)**]** **(32)** "Producer"**,** includes an insurance agent or broker;

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

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

(a) Medicare or medicaid;

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

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

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

[(27)**]** **(35)** "Restricted network provision" **[**means**],** any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to section 354.400,

RSMo, et seq. to provide health care services to covered individuals;

(36) "Self-employed individual", an individual or sole proprietor who derives a substantial portion of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate Internal Revenue Service Form 1040, Schedule C or F, for the previous taxable year;

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

[(28)**] (38)** "Small employer" **[**means**], in connection with a group health plan with respect to a calendar year and a plan year,** any person, firm, corporation, partnership **[**or**],** association **or political subdivision** that is actively engaged in business that**[**, on at least fifty percent of its working days during the preceding calendar quarter,**]** employed **[**not less than three nor**] an average of at least two but not** more than **[**twenty-five**] fifty** eligible employees**[**, the majority of whom were employed within this state. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer**] on business days during the preceding calendar year and that employs at least two eligible employees on the first day of the plan year. All persons treated as a single employer under subsection (b), (c), (m), or (o) of Section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. Subsequent to the issuance of a health benefit plan to a small employer and for the purpose of determining continued eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of sections 379.930 to 379.952 that apply to a small employer shall continue to apply at least until the plan anniversary following the date the small employer no longer meets the requirements of this definition. In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible employees that it is reasonably expected that the employer will employ on business days in the current calendar year. Any reference in sections 379.930 to 379.952 to an employer shall include a reference to any predecessor of such employer**;

[(29)**] (39)** "Small employer carrier" **[**means**],** a carrier that **issues or** offers **to issue** health benefit plans covering eligible employees of one or more small employers **[**in this state**], regardless of whether coverage is offered through an association or trust or whether the policy or contract is sitused out of state**;

[(30)**] (40)** "Standard health benefit plan" **[**means**],** a health benefit plan developed pursuant to section 379.944**;**

(41) "Waiting period", with respect to a group health plan and an individual who is a potential enrollee in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan. For purposes of calculating periods of creditable coverage pursuant to subdivision (13) of this section, a waiting period shall not be considered a gap in coverage.

379.932. 1. Sections 379.930 to 379.952 shall apply to any health benefit plan that provides coverage to the employees of a small employer in this state if any of the following conditions are met:

(1) Any portion of the premium or benefits is paid by or on behalf of the small employer;

(2) An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium; **[**or**]**

(3) The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of section 162, section 125 or section 106 of the federal Internal Revenue Code**; or**

(4) The health benefit plan is marketed to individual employees through an employer.

2. (1) Except as provided in subdivision (2) of this subsection, for the purposes of sections 379.930 to 379.952, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier and any restrictions or limitations imposed by this act shall apply as if all health benefit plans delivered **or issued for delivery** to small employers in this state by such affiliated carriers were issued by one carrier.

(2) An affiliated carrier that is a health maintenance organization having a certificate of authority under section 354.400, et seq., RSMo, may be considered to be a separate carrier for the purposes of sections 379.930 to 379.952.

(3) Unless otherwise authorized by the director, a small employer carrier shall not enter into one or more ceding arrangements with respect to health benefit plans delivered or issued for delivery to small employers in this state if such arrangements would result in less than fifty percent of the insurance obligation or risk for such health benefit plans being retained by the ceding carrier. **The provisions of sections 375.1280 to 375.1295 shall apply if a small employer carrier cedes or assumes all of the insurance obligation or risk with respect to one or more health benefit plans delivered or issued for delivery to small employers in this state.**

[3. Sections 379.930 to 379.952 shall not apply to any plan or program when the employees pay the total cost of the health benefit plan.**]**

[379.934. 1. A small employer carrier may establish a class of business only to reflect substantial differences in expected claims experience or administrative costs related

to the following reasons:

(1) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers;

(2) The small employer carrier has acquired a class of business from another small employer carrier; or

(3) The small employer carrier provides coverage to one or more association groups that meet the requirements of subdivision (5) of subsection 1 of section 376.421, RSMo.

2. A small employer carrier may establish up to nine separate classes of business under subsection 1 of this section. A small employer carrier which immediately prior to the effective date of sections 379.930 to 379.952 had established more than nine separate classes of business may, on the effective date of sections 379.930 to 379.952*, establish no more than twelve separate classes of business, and shall reduce the number of such classes to eleven within one year after the effective date of sections 379.930 to 379.952; ten within two years after such date; and nine within three years after such date.

3. The director may promulgate rules to provide for a period of transition in order for a small employer carrier to come into compliance with subsection 2 of this section in the instance of acquisition of an additional class of business from another small employer carrier.

4. The director may approve the establishment of additional classes of business upon application to the director and a finding by the director that such action would enhance the efficiency and fairness of the small employer marketplace.**]**

379.936. 1. Premium rates for health benefit plans subject to sections 379.930 to 379.952 shall be subject to the following provisions:

(1) **[**The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent**] The small group carrier shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:**

(a) Geographic area;

(b) Family composition; and

(c) Age;

(2) **[**For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to such employers under the rating system for that class of business shall not vary from the index rate by more than twenty-five percent of the index rate**] The adjustment for age in paragraph (c) above may not use age brackets smaller than five-year increments and these shall begin with age thirty and end with age sixty-five**;

(3) **[**The percentage increase in the premium rate charged to a small employer for a new

rating period may not exceed the sum of the following:

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;

(b) Any adjustment, not to exceed fifteen percent annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business; and

(c) Any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual for the class of business**] Small employer carriers may charge the lowest allowable adult rate for child only coverage**;

(4) **[**Adjustments in rates for claim experience, health status and duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer**] Small employer carriers shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which Medicare is the primary payer and coverage for which Medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection**;

(5) **The adjustments to the rates for a health benefit plan permitted in subdivision (1), paragraph (c) of this subsection shall not result in a rate per enrollee for the health benefit plan of more than two hundred percent of the lowest rate for all adult age groups effective five years after August 28, 2000. During the first two years after August 28, 2000, the permitted rates for any age group shall be no more than four hundred percent of the lowest rate for all adult age groups, and two years after the effective date of this section, the permitted rates for any age group shall be no more than three hundred percent of the lowest rate for all adult age groups;**

(6) Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any assessments paid or payable by small employer carriers pursuant to sections 379.942 and 379.943;

[(6) A small employer carrier may utilize the employer's industry as a case characteristic in establishing premium rates, provided that the rate factor associated with any industry classification shall not vary by more than ten percent from the arithmetic mean of the highest and

lowest rate factors associated with all industry classifications;**]**

(7) **[**In the case of health benefit plans issued prior to July 1, 1993, a premium rate for a rating period may exceed the ranges set forth in subdivisions (1) and (2) of this subsection for a period of three years following July 1, 1993. In such case, the percentage increase in the premium rate charged to a small employer for a new rating period shall not exceed the sum of the following**]** **The premium charged for a health benefit plan may not be adjusted more frequently than annually except that the rates may be changed to reflect**:

(a) **[**The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers**]** **Changes to the enrollment of the small employer**;

(b) **[**Any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the carrier's rate manual for the class of business**]** **Changes to the family composition of the employee; or**

(c) Changes to the health benefit plan requested by the small employer;

(8) **[**(a) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business.**]** Rating factors shall produce premiums for identical groups which differ only by amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans;

[(b) A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period;**]**

(9) For the purposes of this subsection, a health benefit plan that utilizes a restricted provider network shall not be considered similar coverage to a health benefit plan that does not utilize such a network, provided that utilization of the restricted provider network results in substantial differences in claims costs;

(10) **[**A small employer carrier shall not use case characteristics, other than age, sex, industry, geographic area, family composition, and group size without prior approval of the director;

(11)**]** The director may promulgate rules to implement the provisions of this section and to assure that rating practices used by small employer carriers are consistent with the purposes of sections 379.930 to 379.952, including:

(a) Assuring that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design **or coverage**, not including

differences due to the nature of the groups assumed to select particular health benefit plans; and

(b) Prescribing the manner in which **[**case characteristics may be used**]** **geographic territories are designated** by **all** small employer carriers.

2. **[**A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage.

3. The director may suspend for a specified period the application of subdivision (1) of subsection 1 of this section as to the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the director either that the suspension is reasonable in light of the financial condition of the small employer carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

4.**]** In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

(1) **[**The extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or actual or expected variation in health status of the employees of the small employer and their dependents;

(2)**]** The provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and factors, other than claim experience, that affect changes in premium rates;

[(3)**]** **(2)** The provisions relating to renewability of policies and contracts; **[**and

(4)**]** **(3)** The provisions relating to any preexisting condition provision**; and**

(4) A listing of and descriptive information, including benefits and premiums, about all benefit plans for which the small employer is qualified.

[5.**]** **3.** (1) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(2) Each small employer carrier shall file with the director annually on or before March fifteenth an actuarial certification certifying that the carrier is in compliance with sections 379.930 to 379.952 and that the rating methods of the small employer carrier are actuarially sound. Such certification shall be in a form and manner, and shall contain such information, as specified by the director. A copy of the certification shall be retained by the small employer carrier at its principal

place of business.

(3) A small employer carrier shall make the information and documentation described in subdivision (1) of this section available to the director upon request.

4. The requirements of this section shall apply to all small employer health benefit plans issued or renewed on or after August 28, 2000.

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

(1) **[**Nonpayment of the required premiums**] The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health benefit plan or the health carrier has not received timely premium payments**;

(2) **[**Fraud or misrepresentation of the small employer or, with respect to coverage of individual insureds, the insureds or their representatives**] The plan sponsor has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage**;

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

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

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

(6)**] A decision by** the small employer carrier **[**elects**]** to **[**nonrenew**] discontinue offering** all of its health benefit plans delivered or issued for delivery to small employers in this state. In such a case the carrier shall:

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

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

[(7)**] (6)** The director finds that the continuation of the coverage would:

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

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

In such instance the director shall assist affected small employers in finding replacement coverage**;**

(7) The director finds that the product form is obsolete and is being replaced with comparable coverage, and the small employer carrier decides to discontinue offering that particular type of health benefit plan in the state's small employer

market. A type of health benefit plan may be discontinued by the carrier in that market only if the carrier:

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

(b) Provides notice of the decision not to renew coverage to all affected small employers, enrollees and their dependents, and to the insurance supervisory official in each state in which an affected insured individual is known to reside, at least one hundred eighty days prior to the nonrenewal of any health benefit plans by the carrier. Notice to the insurance supervisory official under this paragraph shall be provided at least three working days prior to the notice to the affected small employers and participants and beneficiaries;

(c) Offers to each small employer provided the type of health benefit plan, the option to purchase all other health benefit plans currently being offered by the carrier to small employers in the state; and

(d) In exercising the option to discontinue the particular type of health benefit plan and in offering the option of coverage under paragraph (c) of this subdivision, the carrier acts uniformly without regard to the claims experience of those small employers or any health status-related factor relating to any enrollee or dependent covered or new enrollees or dependents who may become eligible for such coverage;

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

(9) In the case of health benefit plans that are made available in the small group market through a network plan, there is no longer an employee of the small employer living, working or residing within the carrier's established geographic service area and the carrier would deny enrollment in the plan pursuant to section 379.940.

2. A small employer carrier that elects not to **[**renew**] discontinue offering** a health benefit plan under subdivision (6) of subsection 1 of this section shall be prohibited from writing new business in the small employer market in this state for a period of five years from the date of notice to the director. **As determined by the director, however, the small employer carrier may renew its existing business in the small employer market in the state or may be required to nonrenew all of its existing business in the small employer market in the state.**

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

379.940. 1. (1) Every small employer carrier shall, as a condition of transacting business in this state with small employers, actively offer to small employers **all health benefit plans it actively markets to small employers in this state including** at least two health benefit plans. One plan offered by each small employer carrier shall be a basic health benefit plan and one plan shall be a standard health benefit plan. **A small employer carrier shall be considered to be actively marketing a health benefit plan if it offers that plan to a small employer not currently receiving a health benefit plan from that small employer carrier.**

(2) **[**(a)**] Subject to subdivision (1) of this subsection,** a small employer carrier shall issue **[**a basic**] any** health benefit plan **[**or a standard health benefit plan**]** to any eligible small employer that applies for **[**either such**] the** plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with sections 379.930 to 379.952.

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

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

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

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

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

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

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

2. **(1) A small employer carrier shall file with the director, in a format and manner prescribed by the director, the basic health benefit plans and the standard**

health benefit plans to be used by the carrier. A health benefit plan filed pursuant to this paragraph may be used by a small employer or individual carrier beginning thirty days after it is filed unless the director disapproves its use.

(2) The director at any time may, after providing notice and an opportunity for a hearing to the small employer or individual carrier, disapprove the continued use by a small employer or individual carrier of a basic or standard health benefit plan on the grounds that the plan does not meet the requirements of sections 379.930 to 379.952.

3. Health benefit plans covering small employers shall comply with the following provisions:

(1) A health benefit plan shall not deny, exclude or limit benefits for a covered individual for losses incurred more than twelve months following the effective date of the individual's coverage due to a preexisting condition**, or the first date of the waiting period for such enrollment if that date is earlier than the effective date**. A health benefit plan shall not define a preexisting condition more restrictively than**[**:

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

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

(c) A pregnancy existing on the effective date of coverage**] as defined in section 379.930**.

(2) **[**A health benefit plan shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to such services, provided that the qualifying previous coverage was continuous to a date not less than thirty days prior to the effective date of the new coverage.**] The period of any preexisting condition exclusion must be reduced by the aggregate of the period of creditable coverage, pursuant to section 2701(c)(3) of the Public Health Service Act as amended by P.L. 104-191, provided that the creditable coverage was continuous to a date not more than sixty-three days prior to the effective date of new coverage. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage applied by the employer or the carrier, or an affiliation period, or for the normal application and enrollment process following employment or other triggering event for eligibility.** This subdivision does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan**, provided that any carrier-imposed waiting period shall be no longer than sixty days. A health maintenance organization that does not use preexisting condition limitations in any of its health benefit plans may impose an affiliation period that:**

(a) Does not exceed sixty days for new entrants and does not exceed ninety days

for late enrollees;

(b) During which the health maintenance organization charges no premiums and the coverage issued is not effective; and

(c) Is applied uniformly, without regard to any health status-related factor.

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

(4) **A small employer carrier is prohibited from imposing any preexisting condition exclusion in the following cases:**

(a) A small employer carrier shall not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition;

(b) Subject to paragraph (e) of this subdivision, a small employer carrier shall not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage;

(c) Subject to paragraph (e) of this subdivision, a small employer carrier shall not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-day period beginning on the date of adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of adoption or placement for adoption;

(d) A small employer carrier shall not impose any preexisting condition exclusion in the case of a condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time while the covered person held creditable coverage, and the medical advice, diagnosis, care or treatment was a covered benefit under the plan, provided that the creditable coverage was continuous to a date not more than sixty-three days prior to the effective date of the new coverage;

(e) Paragraphs (b) and (c) of this subdivision shall no longer apply to an individual after the end of the first sixty-three-day period during all of which the individual was not covered under any creditable coverage.

(5) (a) A small employer carrier shall permit an employee or a dependent of the employee, who is eligible, but not enrolled, to enroll for coverage under the terms of the group health plan of the small employer during a special enrollment period if:

a. The employee or dependent was covered under a group health plan or had coverage under a health benefit plan at the time coverage was previously offered to the

employee or dependent;

b. The employee stated in writing at the time coverage was previously offered that coverage under a group health plan or other health benefit plan was the reason for declining enrollment, but only if the plan sponsor or carrier, if applicable, required such a statement at the time coverage was previously offered and provided notice to the employee of the requirement and the consequences of the requirement at that time;

c. The employee's or dependent's coverage described under subparagraph a:

(i) Was under a COBRA continuation provision and the coverage under this provision has been exhausted; or

(ii) Was not under a COBRA continuation provision and that other coverage has been terminated as a result of loss of eligibility for coverage, including as a result of a legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment or employer contributions towards that other coverage have been terminated; and

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

(b) If an employee requests enrollment pursuant to subparagraph d. of this subdivision, the enrollment is effective not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.

(6) (a) A small employer carrier that makes coverage available under a group health plan with respect to a dependent of an individual shall provide for a dependent special enrollment period described in paragraph (b) of this subdivision during which the person or, if not otherwise enrolled, the individual may be enrolled under the group health plan as a dependent of the individual and, in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if the spouse is otherwise eligible for coverage if:

a. The individual is a participant under the health benefit plan or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan, but for a failure to enroll during a previous enrollment period; and

b. A person becomes a dependent of the individual through marriage, birth or adoption or placement for adoption.

(b) The special enrollment period for individuals that meet the provisions of paragraph (a) of this subdivision shall be a period of not less than thirty days and begins on the later of:

a. The date dependent coverage is made available; or

b. The date of the marriage, birth or adoption or placement for adoption described in subparagraph b. of paragraph (a) of this subdivision.

(c) If an individual seeks to enroll a dependent during the first thirty days of the dependent special enrollment period described under paragraph (b) of this subdivision, the coverage of the dependent shall be effective:

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

b. In the case of a dependent's birth, as of the date of birth; and

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

(7) (a) Except as provided in paragraph (d) of this subdivision, requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier.

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

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

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

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

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

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

[(5)**] (8)** (a) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals **or dependents** in a small employer group or to only part of the group, except in the case of late enrollees as provided in subdivision (3) of this subsection.

(b) A **small employer carrier shall not place any restriction in regard to any**

health status-related factor on an eligible employee or dependent with respect to enrollment or plan participation.

(c) Except as permitted under subdivisions (1) and (3) of this subsection, a small employer carrier shall not modify a **[**basic or standard**]** health benefit plan with respect to a small employer or any eligible employee or dependent through riders, endorsements or otherwise, to restrict or exclude coverage for certain diseases **[**or**],** medical conditions **or services** otherwise covered by the health benefit plan.

[3.**] 4.** (1) A small employer carrier shall not be required to offer coverage or accept applications pursuant to subsection 1 of this section in the case of the following:

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

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

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

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

[4.**] 5. (1)** A small employer carrier shall not be required to provide coverage to small employers pursuant to subsection 1 of this section for any period of time for which the director determines that **[**requiring the acceptance of small employers in accordance with the provisions of subsection 1 of this section would place the small employer carrier in a financially impaired condition.**]:**

(a) The small employer carrier does not have the financial reserves necessary to underwrite additional coverage; and

(b) The small employer carrier is applying this subsection uniformly to all small employers in the small group market in this state consistent with state law and without regard to the claims experience of a small employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents.

(2) A small employer carrier that denies coverage in accordance with subdivision (1) of this subsection may not offer coverage in the small group market for the later of:

(a) A period of one hundred eighty days after the date the coverage is denied; or

(b) Until the small employer carrier has demonstrated to the director that it has sufficient financial reserves to underwrite additional coverage.

6. A small employer carrier shall not be required to provide coverage to small employers pursuant to subsections 1 and 2 of this section if the small employer carrier elects not to offer new coverage to small employers in this state. However, a small employer carrier that elects not to offer new coverage to small employers under this subsection may be allowed, as determined by the director, to maintain its existing policies in the state.

7. A small employer carrier that elects not to offer new coverage to small employers under subsection 6 of this section shall provide notice to the director and shall be prohibited from writing new business in the small employer market in this state for a period of five years from the date of notice to the director.

8. This section shall not apply to health benefit plans offered by a small employer carrier if the carrier makes the health benefit plans available in the small employer market only through one or more bona fide associations as defined in section 379.930.

9. (1) Small employer carriers shall provide written certification of creditable coverage to individuals:

(a) At the time an individual ceases to be covered under the health benefit plan or otherwise becomes covered under a COBRA continuation provision;

(b) In the case of an individual who becomes covered under a COBRA continuation provision, at the time the individual ceases to be covered under that provision; and

(c) At the time a request is made on behalf of an individual if the request is made not later than twenty-four months after the date of cessation of coverage described in paragraph (a) or (b) of this subdivision, whichever is later.

(2) Small employer carriers may provide the certification of creditable coverage required under paragraph (a) of subdivision (1) of this subsection at a time consistent with notices required under any applicable COBRA continuation provision.

(3) The certificate of creditable coverage required to be provided pursuant to subdivision (1) of this subsection shall contain:

(a) Written certification of the period of creditable coverage of the individual under the health benefit plan and the coverage, if any, under the applicable COBRA continuation provision; and

(b) The waiting period, if any, and, if applicable, affiliation period imposed with respect to the individual for any coverage under the health benefit plan.

[5. Sections 379.930 to 379.938 and sections 379.942 to 379.950 shall become effective July 1, 1993, this section and section 379.952 shall become effective July 1, 1994.**]**

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

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

(a) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of **[**the health status, claims experience**] any health status-related factor**, industry, occupation or geographic location of the small employer;

(b) Encouraging or directing small employers to seek coverage from another carrier because of **[**the health status, claims experience**] any health status-related factor**, industry, occupation or geographic location of the small employer.

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

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

(2) Subdivision (1) of this subsection shall not apply with respect to a compensation arrangement that provides compensation to an agent or broker on the basis of percentage of premium, provided that the percentage shall not vary because of **[**the health status, claims experience**] any initial or renewal health status-related factor**, industry, occupation or geographic area of the small employer.

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

5. No small employer carrier shall terminate, fail to renew or limit its contract or agreement of representation with an agent or broker for any reason related to **[**the health status, claims experience**] any initial or renewal health status-related factor**, occupation, or

geographic location of the small employers placed by the agent or broker with the small employer carrier.

6. No small employer carrier or producer shall induce or otherwise encourage a small employer to separate or otherwise exclude an employee **or dependent** from health coverage or benefits provided in connection with the employee's employment.

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

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

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

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

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