SECOND REGULAR SESSION

SENATE BILL NO. 820

90TH GENERAL ASSEMBLY

INTRODUCED BY SENATORS MAXWELL, CLAY, WIGGINS, DePASCO AND BLAND.

Read 1st time January 12, 2000, and 1,000 copies ordered printed.

TERRY L. SPIELER, Secretary.

3379S.03I

AN ACT

To repeal sections 376.421, 376.424, 376.773, 376.775, 376.960, 376.961, 376.966, 376.986, 379.930, 379.938, 379.940, 379.943 and 379.952, RSMo 1994, relating to health insurance, and to enact in lieu thereof nineteen new sections relating to the same subject, with an effective date for certain sections.

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

Section A. Sections 376.421, 376.424, 376.773, 376.775, 376.960, 376.961, 376.966, 376.986, 379.930, 379.938, 379.940, 379.943 and 379.952, RSMo 1994, are repealed and nineteen new sections enacted in lieu thereof, to be known as sections 374.283, 376.421, 376.424, 376.765, 376.771, 376.772, 376.773, 376.774, 376.775, 376.960, 376.961, 376.966, 376.986, 379.930, 379.938, 379.940, 379.943, 379.952 and 1, to read as follows:

374.283. 1. There is hereby established the "Advisory Commission on Health Insurance Mandates" to be composed of the director of the department of insurance, the chairperson of the committee of jurisdiction handling health insurance matters of the house of representatives, one member of the minority party of the house of representatives appointed by the minority leader subject to the final approval of the speaker, the chairperson of the committee of jurisdiction handling health insurance matters of the senate and one member of the minority party of the senate appointed by the minority leader subject to the final approval of the president pro tem of the senate.

2. The commission may hold one or more public hearings to receive comments and suggestions, and shall conduct a mandated health benefit analysis and make a report to the governor, the speaker of the house of representatives and the president pro tem of the senate on or before January 1, 2001, concerning:

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

(1) The benefits and costs of each health insurance benefit and each offer of a health insurance benefit mandated by the laws of this state;

(2) The appropriate method or methods of determining the benefits and costs of possible future mandated health insurance benefits and mandated offers of health insurance benefits; and

(3) Such other matters as the commission may deem necessary or proper to analyze the benefits and costs of mandated health insurance benefits and mandated offers of health insurance benefits.

3. The commission shall, every two years, conduct additional mandated health benefit analyses of each health insurance benefit and each offer of a health insurance benefit mandated by the laws of this state. A report of such analysis shall be made to the governor, the speaker of the house of representatives and the president pro tem of the senate.

4. The members of the commission shall serve without compensation in addition to their official compensation, but shall be reimbursed for actual and necessary expenses incurred in the performance of their official duties. Reimbursement for actual and necessary expenses incurred in the performance of the commission's official duties, including any actuarial assistance deemed necessary by the commission, shall be provided by the director of the department of insurance from funds appropriated for such purpose.

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

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

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

(b) The premium for the policy shall be paid either from the employer's funds or from funds contributed by the insured employees, or from both. Except as provided in paragraph (c)

of this subdivision, a policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees, except those who reject such coverage in writing; and

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

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

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

c. After the expiration of an open enrollment period during which the person could have enrolled for the insurance or could have elected another level of benefits under the policy**] only to the extent authorized by the federal Health Insurance Portability and Accountability Act of 1996 (P.L. 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 (P.L. 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 (P.L. 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 professional 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 professional**

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 (P.L. 104-191), sections 379.930 to 379.952, RSMo, or 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 (P.L. 104-191), sections 379.930 to 379.952, RSMo, or 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 (P.L. 104-191), sections 379.930 to 379.952, RSMo, or any state or federal regulations promulgated pursuant to any of these statutes**.

3. (1) A carrier offering a group health plan shall provide the certification required in subdivision (2) of this subsection:

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

(b) In the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision; and

(c) On the request on behalf of an individual made not later than twenty-four months after the date of cessation of the coverage described in paragraphs (a) or (b) of this subdivision, whichever is later. The certification under paragraph (a) of this subdivision may be provided, to the extent practicable, at a time consistent with notices required under any applicable federal COBRA continuation provision.

(2) The certification described in this subdivision is a written certification of:

(a) The period of creditable coverage of the individual under such plan and the coverage if any under such federal COBRA continuation provision; and

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

(3) To the extent that medical care under a group health plan consists of group

health insurance coverage, the plan is deemed to have satisfied the certification requirement under this subsection if the health insurer offering the coverage provides for such certification in accordance with this subsection.

(4) The terms "carrier", "creditable coverage", and "group health plan" as used in subsections 3 and 4 of this section shall have the same meanings as provided for such terms in section 379.930, RSMo.

4. A carrier issuing either an individual or a group health plan may require any person applying for coverage based on such person's prior creditable coverage to first exhaust any continuation of coverage permitted or required by section 376.428 before such carrier waives any otherwise applicable medical underwriting requirements or preexisting conditions restrictions of limitations.

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 (P.L. 104-191), sections 379.930 to 379.952, RSMo, or any state or federal regulations promulgated pursuant to any of these statutes**.

376.765. 1. No insurance company may require an insured, applicant for

insurance, or prospective insured, directly or indirectly to purchase life insurance or annuities as a condition of being allowed to purchase health insurance.

2. As used in this section:

(1) "Health insurance", any policy, contract, certificate or agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of, health care services;

(2) "Insurance company" includes any insurance company, health services corporation, health maintenance organization, and any person or entity required by the laws of this state to obtain a certificate of authority or license from the director of the department of insurance.

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

(1) "Age bracket", ages of an individual in increments of no more than five years beginning at age nineteen;

(2) "Allowed rating characteristics" includes only family composition, geographic area, age bracket and regular use of tobacco;

(3) "Block of business", a particular form of individual policy of accident and sickness insurance issued by an insurer to one or more individuals which includes distinct benefits, services and terms;

(4) "Enrollee", the individual who is covered by a policy of accident and sickness insurance, has paid premiums for all persons covered by such policy and is responsible for continued premium payments under such policy;

(5) "Family composition", includes only:

(a) An enrollee;

(b) The enrollee, and the enrollee's spouse and children;

(c) The enrollee and the enrollee's spouse;

(d) The enrollee and the enrollee's children; or

(e) The enrollee's children only;

(6) "Geographic area", an area within this state established by the director, by rule, to be used for adjusting the rates for a policy of accident and sickness insurance.

2. An insurer may refuse to issue an individual policy of accident and sickness insurance based on the insurer's underwriting standards; provided, however, that an insurer shall not refuse to issue such a policy if the applicant had prior creditable coverage which was terminated, so long as:

(1) Application for coverage is made not later than sixty-three days following such termination; and

(2) The aggregate period of such individual's creditable coverage is not less than twelve months; and

(3) The individual has exhausted coverage under any COBRA continuation or coverage under any state continuation pursuant to section 376.428 to which the

individual is entitled.

3. No insurer shall be required to issue further individual policies of accident and sickness insurance pursuant to this section, if the individual policies of accident and sickness insurance issued to individuals without medical underwriting constitutes two percent or more of such carrier's earned premium on an annual basis from individual policies of accident and sickness insurance. Every insurer who meets the two percent earned premium threshold shall report to the director in a format prescribed by the director. If the director determines that all insurers in the individual market have met the two percent threshold, the threshold shall, upon order of the director, be expanded an additional two percent.

4. (1) An individual policy of accident and sickness insurance shall be renewable with respect to an enrollee or dependents at the option of the enrollee, except in any of the following cases:

(a) Nonpayment of the required premiums;

(b) Fraud or misrepresentation by the enrollees or their representatives;

(c) Attainment of eligibility for Medicare due to age. In the case of eligibility for Medicare prior to the qualifying age, the existing individual health plan shall be renewable and shall be subject to the rate limitations set forth in subsections 5 and 6 of this section, except that the existing individual health benefit plan may be modified so that benefits which would otherwise be payable may be reduced by an amount no more than that paid by Medicare;

(d) The insurer elects to nonrenew all of its individual policies of accident and sickness insurance delivered or issued for delivery in the state. In that case, the insurer shall:

a. Provide advance notice of its decision to the director in each state in which it is licensed to sell policies of accident and sickness insurance;

b. Provide notice of the decision not to renew coverage to all enrollees and to the director in each state in which an enrollee is known to reside at least ninety days prior to the nonrenewal of the policy of accident and sickness insurance by the carrier. Notice to the director pursuant to this paragraph shall be provided at least three working days prior to the notice to the enrollees;

(e) The director finds that the continuation of the coverage would not be in the best interests of the enrollees or would impair the carrier's ability to meet its contractual obligations. In that instance, the director shall assist enrollees in finding replacement coverage; or

(2) An individual insurer that elects not to renew a policy of accident and sickness insurance pursuant to paragraph (d) of subdivision (1) of this subsection shall be prohibited from writing new business in the individual market in this state for a

period of five years from the date of notice to the director;

(3) In the case of an individual insurer doing business in one established geographic service area of the state, the requirements set forth in this subsection shall apply only to the insurer's operations in that service area.

5. The premium rates for any individual policy of accident and sickness insurance shall be subject to the following provisions:

(1) The insurer shall develop its rates based on allowed rating characteristics. A block of business shall have a single uniform rate that is adjusted for individuals within the block only by factors based on allowed rating characteristics. Rating characteristics shall not include durational or tier rating, or changes in health status or claim experience after issue. After adjustment for allowed rating characteristics and benefit design, and recognition of differences in rating factors across blocks of business, the rate for any block of business of individual policies of accident and sickness insurance business after July 1, 2001, sections 376.771, 376.772, 376.773 and 376.775 by an insurer subject to sections 376.771, 376.772, 376.773 and 376.775 shall not exceed the rate for any other block of individual policies of accident and sickness insurance by more than:

(a) One hundred percent beginning July 1, 2001;

(b) Eighty-four percent beginning July 1, 2002;

(c) Sixty-eight percent beginning July 1, 2003;

(d) Fifty-two percent beginning July 1, 2004; and

(e) Thirty-five percent beginning July 1, 2005;

(2) After adjustment for allowed rating characteristics and benefit design, the insurer may not charge an individual enrolled without use of underwriting standards pursuant to subsection 2 of this section a rate that exceeds the rate charged to other individuals by more than thirty-five percent, except that after such individual has maintained continuous coverage for five years, then the rate charged to such individual shall be developed based on subdivision (1) of this subsection; and

(3) Individual insurers may charge no more than the lowest allowable adult rate for child-only coverage.

6. The annualized amount of rate change applied to a single block of business shall not exceed the annualized amount of rate change applied to any other block of business by more than fifteen percent due to the claim experience or health status of such block of business after adjustment for allowed rating characteristics and benefit design.

7. (1) An insurer offering a policy of accident and sickness insurance shall provide the certification required in subdivision (2) of this subsection:

(a) At the time an individual ceases to be covered under the policy; and

(b) On the request on behalf of an individual made not later than twenty-four months after the date of cessation of the coverage described in paragraph (a) of this subdivision.

(2) The certification described in this subdivision is a written certification of:

(a) The period of creditable coverage of the individual under such policy; and

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

8. An insurer issuing either an individual or a group health plan may require any person applying for coverage based on such person's prior creditable coverage to first exhaust any continuation of coverage permitted or required by section 376.428 before such insurer waives any otherwise applicable medical underwriting requirements or preexisting conditions restrictions or limitations.

9. Any difference in commissions or other compensation arrangements for sale, enrollment, delivery or issuance of individual policies of accident and sickness insurance between such policies issued to individuals without medical underwriting and to other individuals, shall be deemed an unfair act or practice constituting "unfair discrimination" within the meaning of section 375.936, RSMo.

376.772. 1. A nonprofit corporation shall be established to be known as the "Missouri Individual Health Benefit Reinsurance Association". All persons that provide health benefit plans in this state, including insurers providing accident and sickness insurance pursuant to this chapter, health maintenance organizations and all other entities providing health insurance or health benefits subject to state insurance regulation, shall be members of the association provided, however, that persons that provide no health benefit plans other than health benefit plans to individuals pursuant to the Medicaid program shall be exempt from membership in the association. The association shall:

(1) Be incorporated;

(2) Operate under an established and approved plan of operation; and

(3) Exercise its powers through a board of directors established pursuant to this section.

2. The initial board of directors of the association shall consist of seven members appointed by the governor as follows:

(1) Four members shall be representatives of the four largest carriers of individual comprehensive medical expense health insurance in the state as of the calendar year ending December 31, 1999;

(2) Three members shall be representatives of the three largest carriers of health insurance in the state, excluding Medicare supplement coverage premiums, which are not otherwise represented.

Members of the board may be reimbursed from the funds of the association for expenses incurred by them as members, but shall not otherwise be compensated by the association for their services.

3. The association shall submit to the director of the department of insurance a plan of operation for the association and any amendments to the association's articles of incorporation necessary and appropriate to assure the fair, reasonable and equitable administration of the association. The plan shall provide for the sharing of losses related to those individuals enrolled without use of underwriting standards pursuant to subsection 2 of section 376.771, if any, on an equitable and proportional basis among the members of the association. If the association fails to submit a suitable plan of operation within one hundred-eighty days after the appointment of the board of directors, the director of the department of insurance shall adopt rules necessary to implement this section. The rules shall continue in force until modified by the director or superseded by a plan submitted by the association and approved by the director. In addition to other requirements, the plan of operation shall provide for all of the following:

(1) The handling and accounting of assets and funds of the association;

(2) The amount of and method for reimbursing the expenses of board members;

(3) Regular times and places for meetings of the board of directors;

(4) Records to be kept relating to all financial transactions and annual fiscal reporting to the director of the department of insurance; and

(5) Any additional provisions necessary or proper for the execution of the powers and duties of the association.

4. The plan of operation may provide that the powers and duties of the association may be delegated to a person who will perform functions similar to those of the association. A delegation pursuant to this section shall take effect only upon the approval of the board of directors.

5. The association shall have the general powers and authority enumerated by this section and executed in accordance with the plan of operation approved by the director of the department of insurance pursuant to subsection 3 of this section. In addition, the association may do any of the following:

(1) Enter into contracts as necessary or proper to administer this chapter;

(2) Sue or be sued, including taking any legal action necessary or proper for recovery of any assessments for, on behalf of, or against members of the association or other participating persons;

(3) Appoint from among members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the association, including the hiring of independent consultants as necessary;

(4) Perform any other functions within the authority of the association.

6. Following the close of each calendar year, the association, in conjunction with the director, shall require each carrier to report the amount of earned premiums and the associated paid losses by the carrier for individuals enrolled without use of underwriting standards pursuant to subsection 2 of section 376.771. The reporting of such amounts shall be certified by an officer of the carrier.

7. The board shall develop procedures and make reinsurance premium assessments and distributions as required to equalize the individual carrier gains and losses so that each carrier receives the same ratio of paid claims to eight-six percent of earned premiums as the aggregate of all carriers for those individuals enrolled without use of underwriting standards pursuant to subsection 2 of section 376.771. Reinsurance premium assessments and distributions pursuant to this subsection are distinct from assessable loss assessments and are not subject to the provisions of subsections 8, 9 and 10 of this section.

8. If the statewide aggregate ratio of paid claims to eighty-six percent of earned premiums is greater than one, the dollar difference between eighty-six percent of earned premiums and the paid claims shall represent an assessable loss.

9. (1) The assessable loss plus necessary operating expenses for the association, plus any additional expenses as provided by law, shall be assessed by the association to all members in proportion to their respective shares of total health insurance premiums and payments for subscriber contracts received in Missouri during the second preceding calendar year, or with paid losses in the year, coinciding with or ending during the calendar year. Members of the association with individual enrollment representing at least two percent of the member's total commercial health insurance premiums and payments for subscriber contracts received in Missouri during the preceding calendar year and who continue to enroll individuals after July 1, 2001, shall be assessed at a level that is one-half of the assessment level established for members of the association without individual enrollment representing at least two percent of the respective member's total commercial health insurance premiums and payments for subscriber contracts received in Missouri during the preceding calendar year. Notwithstanding the foregoing, there shall be an amount subtracted from both the member's and the total health insurance premiums and payments for subscriber contracts. The amount subtracted shall equal the premiums and subscriber payments received on account of individuals enrolled without use of underwriting standards pursuant to subsection 2 of section 376.771, if, and only if, the member's premiums and subscriber payments received on account of individuals enrolled without use of underwriting standards pursuant to subsection 2 of section 376.771 exceeds the threshold established in this subdivision. The threshold shall be:

(a) One-tenth of one percent of the member's premiums and subscriber payments received on account of all individual policies of accident and sickness insurance; or

(b) Inapplicable to any member which commenced issuing individual policies of accident and sickness insurance less than two years prior to the end of the year for which the assessment is made, provided that such member has not ceased issuing new individual policies of accident and sickness insurance prior to the date on which the board decides to make the assessment.

(2) In sharing assessable losses, the association may abate or defer any part of the assessment of a member if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. The association may also provide for an initial or interim assessment against the members of the association to meet the operating expenses of the association until the next calendar year is completed.

10. The board shall develop procedures for distributing the assessable loss assessments to each carrier in proportion to the carrier's respective share of premium for those individuals enrolled without use of underwriting standards pursuant to subsection 2 of section 376.771 to the statewide total premium for all individuals enrolled without use of underwriting standards pursuant to subsection 2 of section 376.771.

11. The board shall ensure that procedures for collecting and distributing assessments are as efficient as possible for carriers. The board may establish procedures which combine or offset the assessment from, and the distribution due to, a carrier.

12. A carrier may petition the association board to seek remedy from writing a significantly disproportionate share of individuals enrolled without use of underwriting standards in relation to total premiums written in this state for health benefit plans. Upon a finding that a carrier has written a disproportionate share, the board may agree to compensate the carrier either by paying to the carrier an additional fee not to exceed two percent of earned premiums from individuals enrolled without use of underwriting standards for that carrier or by petitioning the director of insurance or director of the board, as appropriate, for remedy.

13. Upon a finding that the acceptance of the offer of coverage to those individuals enrolled without use of underwriting standards pursuant to subsection 2 of section 376.771 would place the carrier in a financially impaired condition, the director of the department of insurance shall not require the carrier to offer coverage or accept applications for any period of time the financial impairment is deemed to exist.

14. (1) No member of the board of directors of the Missouri individual health

benefit reinsurance association shall be civilly liable, either jointly or separately, as a result of any act, omission or decision in performance of his duties as specifically required by this section. Such immunity shall not attach for any intentional or reckless act affecting the property or rights of any person.

(2) Neither the participation in the Missouri individual health benefit reinsurance association as members, the establishment of rates, forms or procedures, nor any other joint or collective action required or permitted by the provisions of this section shall be the basis of any legal action, criminal or civil liability or penalty against the association or any of its members.

376.773. 1. The word "insurer" as used in sections 376.770 to 376.800 shall mean any insurance company issuing or writing any policy of accident and sickness insurance which is subject to the provisions of sections 376.770 to 376.800. **For purposes of sections 376.771, 376.772 and 376.774, subsection 2 of this section and subsection 3 of section 376.775 only, the word "insurer" includes any other entity subject to the insurance laws of this state or the jurisdiction of the director of insurance 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, health maintenance organization, health services corporation, or any other entity providing a plan of health insurance, health benefits or health services except that the word "insurer" shall not include any insurance company issuing or writing accident-only, credit, dental, vision, specified disease, fixed indemnity, Medicare supplement, long-term care or disability income insurance, coverage issued as a supplement to liability insurance, workers' compensation insurance or similar insurance or automobile medical payments insurance.**

2. The term "policy of accident and sickness insurance" as used in sections 376.770 to 376.800 includes any policy or contract of insurance against loss resulting from sickness or from bodily injury or death by accident, or both, issued or written by any insurance company authorized **[**under**]** **pursuant to** the laws of the state of Missouri to transact such insurance in this state or issued by any insurance company to a resident of the state of Missouri. **For purposes of sections 376.771, 376.772 and 376.774 and subsection 3 of section 376.775 only, the term "policy of accident and sickness insurance" includes a policy, contract, certificate or agreement offered by an insurer to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services. "Policy of accident and sickness insurance" does not include accident-only, credit, dental, vision, specified disease, fixed indemnity, Medicare supplement, long-term care or disability income insurance, coverage issued as a supplement to liability insurance, workers' compensation insurance or similar insurance or automobile medical payments insurance.**

3. The term "director of insurance" as used in sections 376.770 to 376.800 shall mean the

director of the department of insurance.

376.774. 1. This section shall apply to individual policies of accident and sickness insurance.

2. As used in this section, the following words and phrases shall mean:

(1) "Block of business", a particular form of individual policy of accident and sickness insurance issued by an insurer to one or more individuals which includes distinct benefits, services and terms; and

(2) "Closed block of business", a block of business which an insurer ceases to actively offer or sell to new applicants.

3. No block of business shall be closed by an insurer unless:

(1) The insurer permits existing contract holders to purchase a contract from any block of business that is not closed and which provides comparable benefits, services and terms, with no additional underwriting requirement or waiting period;

(2) The insurer pools the experience of the closed block of business with all appropriate blocks of business that are not closed for the purpose of determining the premium rate of any contract within the closed block, with no rate penalty or surcharge beyond that which reflects the experience of the combined pool; and

(3) If an insurer does not offer or sell any block of business which provides comparable benefits, services and terms comparable to the closed block of business, subdivisions (1) and (2) of this subsection shall not apply. If a block of business providing benefits, services and terms comparable to the closed block of business becomes available within twenty-four months of the notice to the director, such block shall be open to any contract holder in accordance with the provisions of subdivisions (1) and (2) of this subsection. The insurer shall provide notice to the director in writing within thirty days of its decision to close a block of business or, in the absence of an actual decision to close a block of business, within thirty days of its determination that a block of business is within one of the presumptions set forth in subsection 4 of this section.

4. Unless an insurer presents evidence satisfactory to the director that such a presumption is or would be incorrect, a block of business shall be presumed closed if either of the following circumstances exist:

(1) There has been an overall reduction in that block of twelve percent in the number of in-force contracts for a period of twelve months; or

(2) That block has less than five hundred in-force contracts in this state.

The presumption that applies in the circumstances of subdivision (2) of subsection 4 of this section shall not apply to a block of business initiated within the previous twenty-four months, but notification of that block of business shall be provided to the director pursuant to subsection 5 of this section. The fact that a block of business does not meet

one of the presumptions set fourth in this subsection shall not preclude a determination that it is closed as defined in subdivision (2) of subsection 2 of this section.

5. An insurer shall notify the director in writing within thirty days of its decision to close a block of business or, in the absence of an actual decision to close a block of business, within thirty days of its determination that a block of business is within one of the presumptions set forth in subsection 4 of this section. When the insurer decides to close a block of business, the written notice to the director shall fully disclose all information required for compliance with subsection 3 of this section. When the insurer determines that a block of business is within a presumption of subsection 4 of this section, the written notice to the director shall fully disclose all information required for compliance with a presumption of subsection 3 of this section. In the case of either notice, the insurer shall provide additional information within fifteen business days after a request by the director. This subsection shall not apply to an insurer which does not have available a block of business which provides comparable benefits, services and terms comparable to the closed block of business and which has complied with the notice requirements pursuant to subdivision (3) of subsection 3 of this section.

6. An insurer shall preserve for a period of not less than five years in an identified location which is readily accessible for review by the director, all books and records relating to any action taken by an insurer pursuant to subsection 3 of this section.

7. No insurer shall offer or sell any contract, or provide misleading information about the active or closed status of a block of business, for the purpose of evading this section.

376.775. 1. No policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless:

(1) The entire money and other considerations therefor are expressed therein; and

(2) The time at which the insurance takes effect and terminates is expressed therein, except that if the policy is delivered subject to the condition that it shall take effect when the first premium is accepted by the insurer, the time at which the insurance takes effect and terminates may be expressed in the insurer's executed premium receipt which shall by reference be made a part of the policy; and

(3) It purports to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who shall be deemed to be the policyholder, any two or more eligible members of that family, including husband, wife, dependent children or any children under a specified age which shall not exceed nineteen years and any other person dependent upon the policyholder; and

(4) The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any

endorsements or attached papers is plainly printed in lightfaced type of a style in general use, the size of which shall be uniform and not less than ten-point with a lowercase unspaced alphabet length not less than one hundred and twenty-point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions); and

(5) The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in section 376.777, are printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "EXCEPTIONS", or "EXCEPTIONS AND REDUCTIONS", provided that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies; and

(6) Each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof; and

(7) It contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the director of insurance.

2. If any policy is issued by an insurer domiciled in this state for delivery to a person residing in another state, and if the official having responsibility for the administration of the insurance laws of such other state shall have advised the director of insurance that any such policy is not subject to approval or disapproval by such official, the director of insurance may by ruling require that such policy meet the standards set forth in subsection 1 of this section and in section 376.777.

3. A policy of accident and sickness insurance may include a preexisting condition exclusion that excludes charges or expenses incurred for no more than the first twelve months following the effective date of coverage. A policy of accident and sickness insurance 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 creditable coverage; provided that the creditable coverage is continuous to a date not less than sixty-three days prior to the date of application for the new coverage and the aggregate period of such individual's creditable coverage is not less than twelve months. 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. As used in this subsection and in section 376.771:

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

(a) Coverage of the individual pursuant to any of the following:

a. A group health plan;

b. Health insurance coverage;

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

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

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

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

g. A state health benefits risk pool;

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

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

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

k. Short-term major medical coverage;

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

(2) "Preexisting condition exclusion", with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date.

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

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

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

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

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

(a) Coverage of the individual pursuant to any of the following:

a. A group health plan;

b. Health insurance coverage;

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

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

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

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

organization;

g. A state health benefits risk pool;

h. A health plan offered pursuant to Chapter 89 of Title 5, United States code;

i. A public health plan;

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

k. Short-term major medical coverage;

(b) A period of creditable coverage shall not be counted, with respect to enrollment of an individual 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;

(5) "Director", the director of the Missouri department of insurance;

[(4)**]** **(6)** "Department", the Missouri department of insurance;

[(5)**]** **(7)** "**Government health plan**", **a plan as defined in Section 3(32) of the Employee Retirement Income Security Act of 1974, and any plan established or maintained for its employees by the government of the United States, or by any agency or instrumentality of such government;**

(8) "**Group health plan**", **an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Security Act of 1974 to the extent that the plan provides medical care to employees or their dependents, as defined under the terms of the plan;**

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

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

[(7)**]** **(11)** "Hospital", a place devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment or care for not less than twenty-four hours in any week of three or more nonrelated individuals suffering from illness, disease, injury, deformity or other abnormal physical condition; or a place devoted primarily to provide medical or nursing care for three or more nonrelated individuals for not less than twenty-four hours in any week. The term

"hospital" does not include convalescent, nursing, shelter or boarding homes, as defined in chapter 198, RSMo;

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

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

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

[(11)**] (15)** "**Medical care**", **amounts paid for:**

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

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

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

(16) "Medicare", coverage **[**under**] pursuant to** both part A and part B of Title XVIII of the Social Security Act, 42 USC 1395 et seq., as amended;

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

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

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

[(15)**] (20)** "Pool", the state health insurance pool created in sections 376.961, 376.962 and 376.964.

376.961. 1. There is hereby created a nonprofit entity to be known as the "Missouri Health Insurance Pool". All insurers issuing health insurance in this state and insurance arrangements providing health plan benefits in this state on and after January 1, 1991, shall be members of the pool.

2. **The pool shall operate subject to the supervision and control of the board. The board shall consist of the director or the director's designated representative, who shall serve as an ex officio member of the board and shall be its chairperson, and eight members appointed by the governor. At least two board members shall be individuals, or the parent, spouse or child of individuals reasonably**

expected to qualify for coverage by the pool. At least two board members shall be representatives of insurers. A majority of the board shall be composed of individuals who are not representatives of insurers or health care providers. The director shall give notice to all insurers and insurance arrangements of the time and place for the initial organizational meetings. **[**The board of directors shall be selected by the pool participants, and shall consist of seven members: one member each from the three largest domestic insurance companies participating in the pool, based on premium income in Missouri; one member each from the two largest domestic health services corporations participating in the pool, based on premium income in Missouri; one member from an independent domestic health maintenance organization participating in the pool; and one member from the general public who is not an insurer, or any officer, director, or employee of an insurer.**] At least** two members of the board of directors shall be of minority groups and at least one such member shall be an African-American. The board shall appoint one or more insurers to serve as administrator. **[**Both the selection of the board of directors and the administering insurer shall be subject to approval by the director.**] Notwithstanding the terms of the board members serving on the effective date of sections 376.960, 376.961, 376.966 and 376.986, the governor shall appoint members of the board who will succeed to all the rights, privileges, duties and obligations of the board as follows: three members of the board to serve a term of two years, three members to serve a term of four years and two of the members to serve a term of six years. Subsequent board members shall serve for a term of three years. A board member's term shall continue until his or her successor is appointed.**

3. **[**If, within sixty days of the organizational meeting, the board of directors is not selected or the administering insurer is not appointed, the director shall appoint the initial board and appoint an administering insurer.**] Board members shall not be compensated in their capacity as board members but shall be reimbursed for reasonable expenses incurred in the necessary performance of their duties.**

376.966. 1. **An individual person shall be eligible for benefit plan coverage if the individual is and continues to be a resident of this state and the applicant provides evidence of the following:**

(1) A notice of rejection or refusal to issue substantially similar insurance for health reasons by one insurer; or

(2) A refusal by an insurer to issue insurance except at a rate exceeding one hundred thirty-five percent of the standard risk rate calculated pursuant to subsection 4 of section 376.986, RSMo; or

(3) As of the date on which the individual seeks coverage pursuant to this section, the aggregate period of such individual's creditable coverage is not less than twelve months.

2. No employee shall involuntarily lose his **or her** group coverage by decision of his **or her**

employer on the grounds that such employee may subsequently enroll in the pool. The department of insurance shall have authority to promulgate rules and regulations to enforce this subsection.

[2.**]** **3.** Any individual who is a resident of this state **and not otherwise eligible pursuant to subsection 1 of this section** shall be eligible for pool coverage, except the following:

(1) Persons who have, on the date of issue of coverage by the pool, coverage under health insurance or an insurance arrangement except that this exclusion shall not apply to a person who has such coverage but whose premiums have increased to three hundred percent or more of rates established by the board as applicable for individual standard risks;

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

(3) **[**Any person having terminated coverage in the pool unless twelve months have elapsed since such termination;

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

(5)**]** Inmates of public institutions and persons eligible for public programs;

[(6)**]** **(4)** Any person whose medical condition which precludes other insurance coverage is directly due to alcohol or drug abuse or **intentionally** self-inflicted injury;

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

[(8)**]** **(6)** Any person who is eligible for Medicare coverage.

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

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

376.986. 1. The pool shall offer major medical expense coverage to every person eligible for coverage **[**under**]** **pursuant to** section 376.966. The coverage to be issued by the pool and its schedule of benefits, exclusions and other limitations, shall be established by the board with the

advice and recommendations of the pool members, and such plan of pool coverage shall be submitted to the director for approval. The pool shall also offer coverage for drugs and supplies requiring a medical prescription and coverage for patient education services, to be provided at the direction of a physician, encompassing the provision of information, therapy, programs, or other services on an inpatient or outpatient basis, designed to restrict, control, or otherwise cause remission of the covered condition, illness or defect.

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

3. Premiums charged for pool coverage may not be unreasonable in relation to the benefits provided, the risk experience and the reasonable expenses of providing the coverage. Separate schedules of premium rates based on age, sex and geographical location may apply for individual risks.

4. The pool shall determine the standard risk rate by calculating the average individual standard rate charged by the five insurers with the largest number of individual contracts in force. In the event five insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. **[**Initial rates for pool coverage shall not be less than one hundred fifty percent of rates established as applicable for individual standard risks. Subsequent rates shall be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein. In no event shall pool rates exceed two hundred percent of rates applicable to individual standard risks. All rates and rate schedules shall be submitted to the director for approval.**] Rates for pool coverage shall be:**

(1) One hundred thirty-five percent of the standard risk rate for any covered individual who, as of the effective date of pool coverage, was previously covered by creditable coverage; provided that:

(a) The creditable coverage was continuous to a date not less than sixty-three days prior to the effective date of the new coverage; and

(b) The aggregate period of such individual's creditable coverage is not less than twelve months;

(2) One hundred thirty-five percent of the standard risk rate for any covered individual who enrolled for pool coverage during the plan's open enrollment period between October first and October thirty-first of each year;

(3) Two hundred percent of the standard risk rate for any covered individual to

whom neither subdivision (1) nor (2) of this subsection apply.

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

6. Pool coverage shall exclude charges or expenses incurred during the first twelve months following the effective date of coverage as to any condition which, during the six-month period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment or for which medical advice, care or treatment was recommended or received as to such condition. Such preexisting condition exclusions shall be waived**:**

(1) To the extent to which similar exclusions, if any, have been satisfied under any prior **[**health insurance**] creditable** coverage which was **[**involuntarily**]** terminated, if that application for pool coverage is made not later than **[**sixty**] sixty-three** days following such **[**involuntary**]** termination and, in such case, coverage in the pool shall be effective from the date on which such prior coverage was terminated**; and**

(2) The aggregate period of such individual's creditable coverage is not less than twelve months.

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

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

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) "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;

(3) "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) **[**"Basic health benefit plan" means a lower cost health benefit plan developed pursuant to section 379.944;

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

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

[(8)**] (7)** "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)**] (8)** "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)**] (9)** "Class of business" **[**means**],** all or a separate grouping of small employers established pursuant to section 379.934;

(10) "Church plan", the meaning given such term in 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) Coverage of the individual pursuant to any of the following:

a. A group health plan;

b. Health insurance coverage;

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

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

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

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

g. A state health benefits risk pool;

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

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

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

k. Short-term major medical coverage;

(b) A period of creditable coverage shall not be counted, with respect to enrollment of an individual 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. The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a part-time, temporary or substitute basis**[**. For purposes of sections 379.930 to 379.952, a person, his spouse and his minor children shall constitute only one eligible employee when they are employed by the same small employer**]**;

[(16)**] (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;

[(17)**] (18) "Government plan", the meaning given such term pursuant to Section 3(32) of the Employee Retirement Income Security Act of 1974 or any federal government plan;**

(19) "Group health plan", an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care, as defined in this section, and including any item or service paid for as medical care to an employee or the employee's dependent, as defined under the terms of the plan, directly or through insurance, reimbursement or otherwise. For purposes of sections 379.930 to 379.952:

(a) Any plan, fund or program which would not be, but for this subdivision, an employee welfare benefit plan and which is established or maintained by a partnership to the extent that such plan, fund or program provides medical care, including any item or service paid for as medical care to a present or former partner in such partnership, or to the partner's 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) of this subdivision, 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 a partnership in relation to any partner; and

(c) In the case of a group health plan, the term "participant" also includes:

a. In connection with a group health plan maintained by a partnership, an individual who is a partner in relation to a 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, if such individual is or may become eligible to receive a benefit under the plan or such individual's beneficiary may be eligible to receive any such benefit;

(20) "Health benefit plan" **[**means**],** any hospital or medical policy or certificate, health services corporation contract, or health maintenance organization subscriber contract. 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;

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

(a) Health status;

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

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information;

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

(h) Disability;

[(18)**] (22)** "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)**] (23)** "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, death of a spouse **[**or divorce;**], dissolution or legal separation; and**

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

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

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

[(20)**] (24)** "**Medical care**", **an amount paid for:**

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

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

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

(25) "**Network plan**", **a health benefit plan that requires an enrollee to use or creates incentives, including financial incentives, for an enrollee to use, health care providers managed, owned, under contract with or employed by the health carrier;**

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

[(22)**] (28)** "**Plan sponsor**", **the meaning given such term pursuant to Section 3(16)(B) of the Employee Retirement Income Security Act of 1974;**

(29) "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)**] (30)** "Producer" includes an insurance agent or broker;

[(24)**] (31)** "**Professional association**", **an association which meets all of the following:**

(a) Serves a single profession, if such profession requires a significant amount of education, training or experience, or a license or certificate from a state authority to practice such profession;

(b) Has been actively in existence for five years;

(c) Has a constitution or bylaws, or any other analogous governing document;

(d) Has been formed and maintained in good faith for a purpose other than obtaining insurance;

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

(f) Does not condition membership in the association on health status or claims experience;

(g) 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;

(h) Any member or dependent of a member is eligible for coverage regardless of health status or claims experience;

(i) Does not offer a health benefit plan to an individual through the association other than in connection with a member of the association;

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

(k) Producers may only market an association membership, accept an application for membership, or sign up a member in the professional association if such individual is actively engaged in, or directly related to, the profession represented by the professional association;

(32) "**Professional association plan**", **a health benefit plan offered through a professional association that covers members of a professional association and their dependents in this state regardless of the situs of delivery of the policy or contract and meets the following:**

(a) Conforms with the provisions of section 379.936 concerning the premium rates as they apply to an individual carrier and individual health benefit plan;

(b) Provides renewability of coverage for the members and dependents of members of a professional association which meets the requirements set forth in subsection 2 of section 379.938 as applied to an individual health benefit plan;

(c) Provides availability of coverage for the members and dependents of members of the professional association in conformance with the provisions of subdivisions (1), (2) and (3) of subsection 2 of section 379.940 as applied to an individual health benefit plan and individual carrier;

(d) Is offered by a carrier that offers health benefit plan coverage to any professional association seeking health benefit plan coverage from such carrier; and

(e) Conforms with the preexisting condition provisions of subsection 2 of section 379.940 as applied to an individual health benefit plan;

(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.**] sections 354.400 to 354.550, RSMo,** to provide health care services to covered individuals;

[(28)**] (36)** "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**] employed an average of at least two but no** 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 employees on the first day of the plan year. All persons treated as a single employer pursuant to subsection (b), (c), (m) or (o) of Section 414 of the Internal Revenue Code**

of 1986 shall be treated as one employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining continued eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, the provisions of sections 379.930 to 379.952 that apply to a small employer shall continue to apply at least until the plan anniversary following the date the small employer no longer meets the requirements of this definition. In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of employees that it is reasonably expected that the employer will employ on business days in the current calendar year. Any reference in sections 379.930 to 379.952 to an employer shall include a reference to any predecessor of such employer;

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

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

379.938. 1. A 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 fails to pay a premium or contribution in accordance with the terms of a health benefit plan or the health carrier has not received a timely premium payment**;

(2) **[**Fraud or misrepresentation of the small employer or, with respect to coverage of individual insureds, the insureds or their representatives**] The plan sponsor performs an act or practice that constitutes fraud, or makes 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**] A decision by a small employer carrier to discontinue offering a particular type of group health benefit plan in the state's small employer market. A type of health benefit plan may be discontinued by the carrier in such market only if such carrier:**

(a) Provides advance notice to the insurance supervisory official in each state in which the carrier is licensed;

(b) Provides notice of a decision not to renew coverage to all affected small employers, participants and beneficiaries, 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 plan by the

carrier. Notice to such official pursuant to this paragraph shall be provided at least three working days prior to the notice to such small employers, participants and beneficiaries;

(c) Offers to each plan sponsor providing such plan, the option to purchase any other health benefit plan currently offered by such carrier to employers in the state; and

(d) In exercising an option to discontinue a particular type of group health benefit plan and offering the option of coverage pursuant to paragraph (c) of this subdivision, the carrier acts uniformly without regard to any claims experience of such sponsor or any health status-related factor relating to any participant or beneficiary covered, or new participant or beneficiary who may become eligible for such coverage;

(6) **A decision by** the small employer carrier **[**elects**]** to **discontinue or** nonrenew 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**] pursuant to** 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**, participants and beneficiaries,** 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**] pursuant to** this paragraph shall be provided at least three working days prior to the notice to the affected small employers**[**;**], participants and beneficiaries; and**

(c) Discontinue all health insurance issued or delivered for issuance in the state's small employer market and shall not renew coverage under any health benefit plan issued to a small employer;

(7) In the case of a health benefit plan that is available in the small employer market only through one or more professional associations, the membership of an employer in such association, on the basis of which the coverage is provided, ceases, but only if the coverage is terminated pursuant to this subdivision uniformly without regard to any health status-related factor relating to any covered individual;

[(7)**] (8)** 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.

2. A small employer carrier that elects not to renew a health benefit plan **[**under**] pursuant to** 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.

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.

4. A small employer carrier offering coverage through a network plan shall not be required to offer coverage or accept applications pursuant to subsection 1 or 2 of this section:

(1) To an eligible person who no longer resides, lives or works in the service area or in an area for which the carrier is authorized to do business, but only if coverage is terminated pursuant to this subdivision uniformly without regard to any health status-related factor of any covered individual; or

(2) To a small employer that no longer has an enrollee in such plan who lives, resides or works in the service area of the carrier or the area for which the carrier is authorized to do business.

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 **[**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**] all health benefit plans it actively markets to small employers in this state**.

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

(b) In the case of a small employer carrier that establishes more than one class of business pursuant to section 379.934, the small employer carrier shall maintain and issue to eligible small employers **[**at least one basic health benefit plan and at least one standard**] all** health benefit **[**plan**] plans** 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) 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. 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. 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)**] provided, however, that** a pregnancy existing on the effective date of coverage **shall not be considered a preexisting condition**.

(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**] creditable** coverage **[**that provided benefits with respect to such services, provided that the qualifying previous**]:**

(a) The creditable coverage was continuous to a date not less than **[**thirty**] sixty-three** days prior to the **[**effective**]** date of **application for** the new coverage**[**. This subdivision does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan**]; and**

(b) The aggregate period of such individual's creditable coverage is not less than twelve months.

(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.

(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 enrollment 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.

[(4)**] (5)** (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 minimum participation requirements only by the size of the small employer group.

(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 any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

[(5)**]** **(6)** (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 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) **In accordance with the federal Health Insurance Portability and Accountability Act of 1996,** 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 otherwise covered by the health benefit plan.

3. (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, when the employee does not 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 eligible employee**]** 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. 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.

[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.**]**

379.943. 1. Within one hundred eighty days after the appointment of the initial board, the board shall submit to the director a plan of operation and thereafter any amendments thereto

necessary or suitable, to assure the fair, reasonable and equitable administration of the program. The director may, after notice and hearing, approve the plan of operation if the director determines it to be suitable to assure the fair, reasonable and equitable administration of the program, and provides for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of sections 379.942 and 379.943. The plan of operation shall become effective upon approval in writing by the director.

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

3. The plan of operation shall:

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

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

(3) Establish procedures for reinsuring risks in accordance with the provisions of sections 379.942 and 379.943;

(4) Establish procedures for collecting assessments from reinsuring carriers to fund claims and administrative expenses incurred or estimated to be incurred by the program; and

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

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

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

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

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

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

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

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

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

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

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

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

(1) With respect to a **[**basic health benefit plan or a standard**]** health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a basic or standard health benefit plan.

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

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

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

(4) A small employer carrier may terminate reinsurance for a small employer on any plan anniversary.

6. (1) The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to sections 379.942 and 379.943. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall also include a system for classification of small employer carriers that reflects the degree to which the small employer carrier uses the cost containment features adopted by the health benefit plan committee **[**under**] pursuant to** section 379.944. The methodology shall provide for the development of base reinsurance premium rates, which shall be multiplied by the factors set forth in subdivision (2) of this subsection to determine the premium rates for the program. The base reinsurance premium rates, shall be established by the board, subject to the approval of the director, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard health benefit plan.

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

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

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

8. (1) Prior to March first of each year, the board shall determine and report to the director the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

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

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

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

b. Each reinsuring carrier's share of the program net loss described in this subsection shall be its proportionate share, determined by premiums earned in the preceding calendar year from

all health benefit plans delivered or issued for delivery to small employers in this state by all reinsuring carriers, times one-half of the total program net loss. An assessment levied or paid by a reinsuring carrier pursuant to subparagraph a of this paragraph shall not be credited or offset against any assessment levied pursuant to this subparagraph.

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

(c) The director by rule and after a hearing thereon, may change the assessment formula established pursuant to paragraph (a) of this subdivision from time to time as appropriate. The director may provide for the shares of the assessment base attributable to premiums from all health benefit plans and to premiums from health benefit plans ceded to the program to vary during a transition period.

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

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

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

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

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

(d) a. If assessments in each of two consecutive calendar years exceed the amount specified in paragraph (c) of subdivision (3) of this subsection, the program shall be eligible to receive additional financing as provided in subparagraph b of this paragraph.

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

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

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

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

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

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

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

(7) A carrier may seek from the director a deferment from all or part of an assessment imposed by the board. The director may defer all or part of the assessment of a carrier if the director determines that the payment of the assessment would place the carrier in a financially impaired condition. If all or part of an assessment against a carrier is deferred, the amount deferred shall be assessed against the other participating carriers in a manner consistent with the

basis for assessment set forth in this subsection. The carrier receiving such deferment shall remain liable to the program for the amount deferred and the interest penalty provided in subdivision (6) of this subsection and shall be prohibited from reinsuring any groups in the program until such time as it pays such assessments.

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

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

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

12. The director shall make an initial assessment of one thousand dollars on each insurance company authorized to transact accident or health insurance, each health services corporation, and each health maintenance organization. Initial assessments shall be made during January, 1993, and shall be paid before April 1, 1993. Initial assessments shall be deposited into the department of insurance dedicated fund. Within ten days after the effective date of the program's plan of operation, the total amount of the initial assessments shall be transferred at the request of the director to the Missouri small employer health reinsurance program. The program may use such initial assessment in the same manner and for the same purposes as other assessments pursuant to sections 379.942 and 379.943.

379.952. 1. Each small employer carrier shall actively market health benefit plan coverage, including the basic and standard health benefit plans, 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, industry, occupation or geographic location of the small employer;

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

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

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

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

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

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

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

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**]** **pursuant to** 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.

10. For purposes of health benefit plans sold to employers of exactly two eligible

employees and health benefit plans sold to employers with more than twenty-five eligible employees but not more than fifty eligible employees, sections 379.934 and 379.936 shall become effective July 1, 2001.

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

(1) "Health insurance" includes accident and sickness insurance on an indemnity basis and health maintenance organization plans;

(2) "Health insurance purchasing cooperative", an organization that purchases, coordinates and administers health benefits plans on behalf of employers and individuals by combining their purchasing power to negotiate prices with competing health plans.

2. The director of the department of insurance shall administer a grant program within this state for the establishment and maintenance of health insurance purchasing cooperatives. Such grants shall be paid from general revenue up to an aggregate of four hundred thousand dollars. The director may provide financial assistance in the form of grants of up to twenty-five thousand dollars from funds appropriated for such purpose to any not for profit corporation for the planning, establishment and maintenance of a health insurance purchasing cooperative.

3. Grants for the purpose of planning, or establishing and maintaining a health insurance purchasing cooperative shall be made from general revenue. In making grants, the director shall:

(1) Consider whether the applicant for the grant has prior successful experience in the purchase of health insurance on a group basis;

(2) Give priority to applicants with continuous existence for the past five years and clear title to cash or marketable securities in the amount of the funds matching the grant;

4. The grant moneys shall be administered by the director and, when appropriated, shall be used as matching funds on a fifty percent state grant and fifty percent grantee basis.

5. There is hereby established the "Advisory Joint Committee on Health Insurance Purchasing Cooperatives" to be composed of five members of the house of representatives appointed by the speaker of the house of representatives and five members of the senate appointed by the president pro tem of the senate. Members of the committee shall serve without compensation, but shall be reimbursed for actual and necessary expenses incurred in the performance of their official duties. Reimbursement for actual and necessary expenses incurred in the performance of the committee's official duties shall be provided by the director of the department of insurance from funds appropriated for that purpose. The director shall regularly inform the members of the committee as to the progress of the administration of the

program for the establishment and maintenance of health insurance purchasing cooperatives.

Section B. Sections 376.771, 376.772, 376.773, 376.774 and 376.775 shall become effective July 1, 2001.

✓