FIRST REGULAR SESSION

SENATE BILL NO. 415

95TH GENERAL ASSEMBLY

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INTRODUCED BY SENATOR DEMPSEY.

Read 1st time February 23, 2009, and ordered printed.

TERRY L. SPIELER, Secretary.

1376S.10I

AN ACT

To repeal sections 354.536, 376.426, 376.428, 376.453, 376.776, 376.966, 376.987, and 379.930, RSMo, and to enact in lieu thereof nineteen new sections relating to health insurance.

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

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Section A. Sections 354.536, 376.426, 376.428, 376.453, 376.776, 376.966, 376.987, and 379.930, RSMo, are repealed and nineteen new sections enacted in lieu thereof, to be known as sections 135.349, 148.372, 354.536, 376.426, 376.428, 376.437, 376.439, 376.443, 376.453, 376.776, 376.966, 376.987, 376.991, 376.1600, 376.1603, 376.1606, 376.1609, 376.1618, and 379.930, to read as follows:

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

(1) "Health savings account" or "account", shall have the same meaning ascribed to it as in 26 U.S.C. Section 223(d), as amended;

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(2) "High deductible health plan", a health savings account eligible plan that meets the criteria established in 26 U.S.C. Section 223(c)(2), as amended, and any regulations promulgated thereunder;

(3) "Qualified health insurance expense", the expenditure of funds for health insurance premiums for high deductible health plans that include, at a minimum, catastrophic health care coverage which are established under the applicable provisions of Section 223 of the Internal Revenue Code;

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

(4) "Qualified health insurance", a high deductible health plan that includes, at a minimum, catastrophic health care coverage which is established under the applicable provisions of Section 223 of the Internal Revenue Code;

(5) "Taxpayer", any person or entity considered to be an employer for purposes of section 143.191, RSMo, or any person or entity who pays compensation to individuals which compensation is reported on Form 1099, who directly employs at least two but not more than fifty persons.

2. For taxable years commencing on or after January 1, 2009, a taxpayer shall be allowed a tax credit against the tax imposed by chapter 143, RSMo, exclusive of the provisions relating to the withholding of tax as provided in sections 143.191 to 143.265, RSMo, for qualified health insurance expenses in an amount of two hundred and fifty dollars for each employee enrolled for twelve consecutive months in a qualified health insurance plan if such qualified health insurance is made available to all of the employees and compensated individuals of the employer pursuant to the applicable provisions of Section 125 of the Internal Revenue Code.

3. In no event shall the total amount of the tax credit under this section for a taxable year exceed the taxpayer's income tax liability. The amount of the tax credit claimed shall not exceed the amount of the taxpayer's state tax liability for the taxable year for which the credit is claimed. However, any tax credit that cannot be claimed in the taxable year the contribution was made may be carried over to the next four succeeding taxable years until the full credit has been claimed.

4. The director of the department of revenue is authorized to promulgate rules and regulations necessary to implement and administer the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are

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subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2009, shall be invalid and void.

148.372. 1. Every insurance company shall be exempt from otherwise applicable premium taxes provided for in section 148.370 on premiums paid by Missouri residents for high deductible health plans sold in Missouri.

2. For all taxable years beginning on or after January 1, 2010, insurance companies shall be exempt from otherwise applicable local premium taxes on premiums paid by Missouri residents for high deductible health plans sold in Missouri.

3. As used in this section, a "high deductible health plan" shall mean a health savings account eligible plan that meets the criteria established in 26 U.S.C. Section 223(c)(2), as amended, and any regulations promulgated thereunder.

4. The director of the department of revenue is authorized to promulgate rules and regulations to implement and administer the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2009, shall be invalid and void.

354.536. 1. If a health maintenance organization plan provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children, such coverage shall continue while the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the enrollee for support and maintenance. Proof of such incapacity and dependency must be furnished to the health maintenance organization by the enrollee **[**at least**]** **within** thirty-one days after the child's attainment of the limiting age. The health maintenance organization may require at reasonable intervals during the two years following the child's attainment of the limiting age subsequent proof of the child's disability

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and dependency. After such two-year period, the health maintenance organization may require subsequent proof not more than once each year.

2. If a health maintenance organization plan provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children, such plan, so long as it remains in force, until the dependent child attains the limiting age, shall remain in force at the option of the enrollee. The enrollee's election for continued coverage under this section shall be furnished to the health maintenance organization within thirty-one days after the child's attainment of the limiting age. As used in this subsection, a dependent child is a person who is:

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

(2) A resident of this state; and

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

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

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

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provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such grace period;

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

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

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

(5) A provision specifying the additional exclusions or limitations, if any, applicable under the policy with respect to a disease or physical condition of a person, not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss, which existed prior to the effective date of the person's coverage under the policy.

Any such exclusion or limitation may only apply to a disease or physical condition for which medical advice or treatment was received by the person during the twelve months prior to the effective date of the person's coverage.

In no event shall such exclusion or limitation apply to loss incurred or disability commencing after the earlier of:

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

physical condition; or

(b) The end of the two-year period commencing on the effective date of the person's coverage;

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

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

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

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

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

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

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

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

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

(15) A provision specifying the conditions under which the policy may be terminated. Such provision shall state that except for nonpayment of the required premium or the failure to meet continued underwriting standards, the insurer may not terminate the policy prior to the first anniversary date of the effective date of the policy as specified therein, and a notice of any intention to terminate the policy by the insurer must be given to the policyholder at least

thirty-one days prior to the effective date of the termination. Any termination by the insurer shall be without prejudice to any expenses originating prior to the effective date of termination. An expense will be considered incurred on the date the medical care or supply is received;

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

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

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

(b) A resident of this state; and

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

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

376.428. 1. A group policy delivered or issued for delivery in this state

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on or after **[**one hundred twenty days following September 28, 1985, by an insurance company, health service corporation or health maintenance organization**]** **January 1, 2010, by a health carrier, as defined in section 376.1350**, which insures employees or members and their eligible dependents for hospital, surgical or major medical insurance on an expense-incurred or service basis, other than for specific diseases or for accidental injuries only, shall provide that employees or members whose coverage under the group policy, which includes coverage for their eligible dependents, would otherwise terminate because of termination of employment or membership shall be entitled to continue their hospital, surgical or major medical coverage, including coverage for their eligible dependents, under that group policy **[**subject to the following terms and conditions:

(1) Continuation shall only be available to an employee or member who has been continuously insured under the group policy, and for similar benefits under any group policy which it replaced, during the entire three-month period ending with such termination. If employment is reinstated during the continuation period, then coverage under the group policy will be reinstated for the employee and any dependents who were covered under continuation;

(2) Continuation shall not be available for any person covered under the group policy who is or could be covered by Medicare, nor any person who is or could be covered by any other insured or uninsured arrangement which provides hospital, surgical or major medical coverage for individuals in a group and under which the person was not covered immediately prior to such termination;

(3) Continuation need not include dental, vision care or prescription drug benefits or any other benefits provided under the group policy in addition to its hospital, surgical or major medical benefits, but continuation must include maternity benefits if those benefits are provided under the group policy;

(4) The employee or member must request such continuation in writing within thirty-one days of the date coverage would otherwise terminate and must pay to the group policyholder, on a monthly basis, the amount of contribution required to continue the coverage. Such premium contribution shall not be more than the group rate of the insurance being continued on the due date of each payment; but, if any benefits are omitted as provided by subdivision (3) of this subsection, such premium contribution shall be reduced accordingly. The employee's or member's written request for continuation, together with the first required premium contribution, must be given to the group policyholder within

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thirty-one days of the date the coverage would otherwise terminate. Employers must notify their employees and members, in writing, of the duties of such employees and members under this subdivision no later than the date on which coverage would otherwise terminate;

(5) Continuation of coverage under the group policy for any covered person shall terminate upon failure to satisfy subdivision (2) of this subsection or, if earlier, at the first to occur of the following:

(a) The date nine months after the date the employee's or member's coverage under the group would have terminated because of termination of employment or membership;

(b) If the employee or member fails to make timely payment of a required premium contribution, the end of the period for which contributions were made;

(c) The date on which the group policy is terminated or, in the case of an employee, the date the employer terminates participation under a group policy. However, if this condition applies and the coverage ceasing by reason of termination is replaced by similar coverage under another group policy, then:

a. The employee or member shall have the right to become covered under that other group policy for the balance of the period that he would have remained covered under the prior group policy in accordance with the conditions of this section;

b. The minimum level of benefits to be provided by the other group policy shall be the applicable level of benefits of the prior group policy reduced by any benefits payable under that prior policy; and

c. The prior group policy shall continue to provide benefits to the extent of its accrued liabilities and extensions of benefits as if the replacement had not occurred**] in the same manner as continuation of coverage is required under the continuation of coverage provisions set forth in the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), as amended**.

2. The spouse of an employee or member whose coverage under the group policy would otherwise terminate due to dissolution of marriage or death of the employee or member shall have the same continuation privilege accorded under sections 376.421 to 376.442, 376.694 to 376.696, and 376.779 to the employee or member upon termination of employment or membership.

3. The right to a converted policy pursuant to sections 376.395 to 376.404 for an employee or member entitled to continuation of coverage under sections 376.421 to 376.442, 376.694 to 376.696, and 376.779 shall commence upon

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termination of the continued coverage provided for in sections 376.421 to 376.442, 376.694 to 376.696, and 376.779.

4. This section shall only apply to those persons who are not subject to the continuation and conversion provisions set forth in Title I, Subtitle B, Part 6 of the Employment Retirement Income Security Act of 1974 or Title XXII of the Public Health Service Act, as said acts were in effect on January 1, 1987.

376.437. 1. Any group policy, contract, or health benefit plan which is issued, delivered, issued for delivery, or renewed in this state on or after January 1, 2010, providing coverage for hospital or medical expenses other than for specific diseases or for accidental injuries only, shall contain a provision that a group member or employee whose insurance coverage under the policy or health benefit plan otherwise terminates after the expiration of the period of continuation of coverage for which the individual is eligible under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), or section 376.428 shall be entitled to continue coverage under that group policy or health benefit plan for himself or herself and his or her eligible dependents if the member or employee was fifty-five years of age or older at the time of the expiration of coverage provided by the federal Consolidated Omnibus Budget Reconciliation Act or section 376.428.

2. In the event and to the extent that this section is applicable, the election by the group member or employee to obtain continuation of coverage as provided under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or under the provisions of section 376.428 shall constitute election of continuation of coverage under this section without further action by the group member or employee. The provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or of section 376.428, whichever is applicable, regarding notice to a group member or an employee of the right to continue coverage shall apply to the continuation of coverage provided under this section.

3. If an eligible group member or employee elects continuation of coverage under the provisions of this section, the monthly premium contribution for the continuation coverage shall not be greater than one hundred two percent of the total of the amount that would be charged if the eligible group member or employee were a current group

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member or employee of the group contract, policy, or health benefit plan plus an amount that the group policyholder would contribute toward the premium if the eligible group member or employee were a current group member or employee.

4. The first premium for the continuation of coverage under this section shall be paid by the eligible group member or employee on the first regular due date following the expiration of the eligible person's benefits under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or under the provisions of section 376.428.

5. Failure of the employee or member to exercise the election in accordance with subsection 2 of this section shall terminate the right to continuation of benefits under subsection 1 of this section.

6. The right to extended continuation coverage under the provisions of this section shall terminate upon the earliest of any of the following:

(1) The failure to pay premiums or required premium contributions, if applicable, when due, including any grace period allowed by the policy;

(2) The date that the group policy or plan is terminated as to all group members or employees except that if a different group policy or plan is made available to group members, the eligible group member or employee shall be eligible for continuation of coverage as if the original policy had not been terminated;

(3) The date on which the eligible member or employee becomes insured under any other group health policy;

(4) The date on which the eligible member or employee becomes eligible for coverage under the federal Medicare Program pursuant to Title XVIII of the federal Social Security Act;

(5) The date on which the member or employee attains his or her sixty-fifth birthday.

7. As used in this section, the term "policy, contract, or plan" shall mean a group insurance policy or health benefit plan providing group health insurance coverage on an expense incurred basis, or a group service or indemnity contract issued by a health carrier as defined in section 376.1350.

8. The director shall promulgate such rules and regulations as may be necessary to implement the provisions of this section. Any rule

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or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2009, shall be invalid and void.

376.439. All group policies delivered, issued for delivery, or renewed in this state on or after January 1, 2010, that provide continuation coverage to individuals and their eligible dependents pursuant to section 376.428, shall have their continuation of coverage experience pooled across all fully insured group business in Missouri. The rating system or methodology in which the premium for all persons covered under a continuation of coverage provision shall be based on the experience of all persons covered by a continuation of coverage provision with any cost of the pool experience spread over all fully insured premiums in Missouri on an equal percentage basis. The health benefit plan under which continuation coverage is provided under section 376.428 shall not have the plan's premium directly affected by those within the group plan who are exercising their continuation rights under section 376.428.

376.443. In addition to the group policy under which an employee or group member may continue coverage under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) or section 376.428, the health carrier shall offer the employee, group member, or any qualifying eligible individual the option of continuation of coverage through a high deductible health plan, or its actuarial equivalent, that is eligible for use with a health savings account under the applicable provisions of Section 223 of the Internal Revenue Code. Such high deductible health plan shall have health insurance premiums that are consistent with the underlying group plan of coverage rated relative to the standard or manual rates for the benefits provided. As used in this section, a "high deductible health plan" shall mean a health savings account eligible plan that meets the criteria

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established in 26 U.S.C. Section 223(c)(2), as amended, and any regulations promulgated thereunder.

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

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

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

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

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

Unofficial Bill Copy

(1) Is a resident of this state;

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

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

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

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

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

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

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

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

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

(3) A trade act eligible individual;

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

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

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

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

(8) Any person currently insured who would have qualified as a federally defined eligible individual or a trade act eligible individual between the effective

Unofficial Bill Copy

date of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and **[**the effective date of this act**]** **January 1, 2008**.

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

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

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

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

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

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

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

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

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

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

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

4. Any person who ceases to meet the eligibility requirements of this

Unofficial Bill Copy

section may be terminated at the end of such person's policy period.

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

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

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

6. Notwithstanding any provision of sections 376.960 to 376.989 to the contrary, eligibility for continuation or conversion of insurance coverage under 29 U.S.C. 1161 to 29 U.S.C. 1168 (COBRA), 42 U.S.C. 300bb-1 to 42 U.S.C. 300bb-8, sections 376.395 to 376.404, or section 376.428 shall not render a person ineligible for coverage under the pool.

376.987. 1. The board shall offer to all eligible persons for pool coverage under section 376.966 the option of receiving health insurance coverage through a high-deductible health plan and the establishment of a health savings account. **The high-deductible health plans shall be offered to all eligible persons on a guaranteed-issue basis.** In order for a qualified individual to obtain a high-deductible health plan through the pool, such individual shall present evidence, in a manner prescribed by regulation, to the board that he or she has established a health savings account in compliance with 26 U.S.C. Section 223, and any amendments and regulations promulgated thereto.

2. As used in this section, the term "health savings account" shall have the same meaning ascribed to it as in 26 U.S.C. Section 223(d), as amended. The term "high-deductible health plan" shall mean a policy or contract of health insurance or health care plan that meets the criteria established in 26 U.S.C. Section 223(c)(2), as amended, and any regulations promulgated thereunder.

3. The board is authorized to promulgate rules and regulations for the administration and implementation of this section. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with

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

376.991. 1. Beginning September 1, 2009, a legislative study committee is hereby established for the purpose of researching new plan designs and alternative coverage options for the high risk pool. The committee shall undertake a study to determine whether including rewards and incentives, or using biometrics, wellness, prevention, early intervention, and other condition management programs and techniques will improve the cost of coverage through the state insurance pool. The legislative study committee shall consist of the following members:

(1) The director of the department of insurance, financial institutions and professional registration;

(2) The board of directors of the pool as set forth in section 376.961;

(3) Two members of the Missouri senate appointed by the president pro tem of the senate with no more than one from any political party; and

(4) Two members of the Missouri house of representatives appointed by the speaker of the house with no more than one member from any political party.

2. The board of directors of the state insurance pool shall provide support personnel or administrative staff in order to complete the study required by this section.

3. No member of the legislative study committee shall receive compensation for the member's services, but shall be entitled to necessary and reasonable expenses incurred in the discharge of the member's duties.

4. The legislative study committee shall submit a report of its findings to each member of the general assembly no later than March 1, 2010.

376.1600. 1. The director of the department of insurance,

Unofficial Bill Copy

financial institutions and professional registration is authorized to allow employees to use funds from one or more employer health reimbursement arrangement only plans to help pay for coverage in the individual health insurance market. This will encourage employer financial support of health insurance or health-related expenses recognized under the rules of the federal Internal Revenue Service. Health reimbursement arrangement only plans shall not be considered insurance under this chapter.

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

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

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

(3) Carries forward any unused portion of the maximum dollar amount at the end of the coverage period to increase the maximum reimbursement amount in subsequent coverage periods.

376.1603. 1. The director shall develop flexible guidelines for coverage and approval of health savings account eligible high deductible health plans which are designed to qualify under federal and state requirements as high deductible health plans for use with health savings accounts which comply with federal requirements under the applicable provisions of the federal Internal Revenue Code.

2. The director is authorized to encourage and promote the marketing of health savings account eligible high deductible plans by health carriers in this state; provided, however, that nothing in this section shall be construed to authorize the interstate sales of insurance.

3. The director shall conduct a national study of health savings account eligible high deductible health plans available in other states and determine if and how these products serve the uninsured and if they should be made available to Missourians.

4. The director shall develop an automatic or fast track approval process for health savings account eligible high deductible plans

Unofficial Bill Copy

already approved under the laws and regulations of this state or other states.

5. The director is authorized to promulgate such rules and regulations as he or she deems necessary and appropriate for the design, promotion, and regulation of health savings account eligible high deductible plans, including rules and regulations for the expedited review of standardized policies, advertisements and solicitations, and other matters deemed relevant by the director. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2009, shall be invalid and void.

376.1606. Notwithstanding any provision of the law to the contrary, a health carrier may offer high deductible health plans with coinsurance percentage thresholds of fifty percent or greater for non-network services. As used in this section, a "high deductible health plan" shall mean a policy or contract of health insurance or health care plan that meets the criteria established in 26 U.S.C. Section 223(c)(2), as amended, and any regulations promulgated thereunder.

376.1609. 1. Notwithstanding any provision of the law to the contrary, health carriers may include wellness and health promotion programs, condition or disease management programs, health risk appraisals programs, and similar provisions in high deductible health plans or policies that comport with federal requirements, provided that such programs are approved by the department of insurance, financial institutions and professional registration.

2. Health carriers that include and operate wellness and health promotion programs, disease and condition management programs, health risk appraisal programs, and similar provisions in high deductible health plans or policies that comport with federal requirements shall not be considered to be engaging in unfair trade

Unofficial Bill Copy

practices under section 375.936 with respect to references to the practices of illegal inducements, unfair discrimination, and rebating.

3. As used in this section, a "high deductible health plan" shall mean a policy or contract of health insurance or health benefit plan, as defined in section 376.1350, that meets the criteria established in 26 U.S.C. Section 223(c)(2), as amended, and any regulations promulgated thereunder.

376.1618. The director shall study and recommend to the general assembly changes to remove any unnecessary application and marketing barriers that limit the entry of new health insurance products into the Missouri market. The director shall examine state statutory and regulatory requirements along with market conditions which create barriers for the entry of new health insurance products and health insurance companies. The director shall also examine proposals adopted in other states that streamline the regulatory environment to make it easier for health insurance companies to market new and existing products. The director shall submit a report of his or her findings and recommendations to each member of the general assembly no later than January 1, 2010.

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

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

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

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

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

or similar coverage;

(4) "Board" means the board of directors of the program established pursuant to sections 379.942 and 379.943;

(5) "Bona fide association", an association which:

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

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

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

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

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

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

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

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

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

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

(10) "Committee", the health benefit plan committee created pursuant to

section 379.944;

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

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

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

a. A group health plan;

b. Health insurance coverage;

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

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

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

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

g. A state health benefits risk pool;

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

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

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

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

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

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

(15) "Eligible employee", an employee who works on a full-time basis and has a normal work week of thirty or more hours. The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if the sole

proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a part-time, temporary or substitute basis. For purposes of sections 379.930 to 379.952, a person, his spouse and his minor children shall constitute only one eligible employee when they are employed by the same small employer;

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

(17) "Excepted benefits":

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

(b) Coverage only for disability income insurance;

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

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

(e) Workers' compensation or similar insurance;

(f) Automobile medical payment insurance;

(g) Credit-only insurance;

(h) Coverage for on-site medical clinics;

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

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

a. Limited scope dental or vision benefits;

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

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

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

a. Coverage only for a specified disease or illness;

b. Hospital indemnity or other fixed indemnity insurance.

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

a. Medicare supplemental coverage (as defined under Section 1882(g)(1)

Unofficial Bill Copy

of the Social Security Act);

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

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

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

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

(20) "Health benefit plan" or "health insurance coverage", benefits consisting of medical care, including items and services paid for as medical care, that are provided directly, through insurance, reimbursement, or otherwise, under a policy, certificate, membership contract, or health services agreement offered by a health insurance issuer, but not including excepted benefits or a policy that is individually underwritten;

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

(a) Health status;

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

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information;

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

(h) Disability;

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

(23) "Late enrollee", an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial

Unofficial Bill Copy

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

(a) The individual meets each of the following:

a. The individual was covered under creditable coverage at the time of the initial enrollment;

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

c. The individual requests enrollment within thirty days after termination of the creditable coverage;

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

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

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

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

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

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

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

(26) "New business premium rate", for each class of business as to a rating period, the lowest premium rate charged or offered, or which could have been charged or offered, by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage;

(27) "Plan of operation", the plan of operation of the program established

Unofficial Bill Copy

pursuant to sections 379.942 and 379.943;

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

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

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

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

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

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

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

Unofficial Bill Copy

employer;

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

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

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