CONFERENCE COMMITTEE SUBSTITUTE

FOR

HOUSE COMMITTEE SUBSTITUTE

FOR

SENATE SUBSTITUTE

FOR

SENATE BILL NO. 262

AN ACT

To repeal sections 354.410, 354.415, 354.430, 376.405, 376.426, 376.777, 376.961, 376.962, 376.964, 376.966, 376.968, 376.970, 376.973, and 376.1363, RSMo, and to enact in lieu thereof thirty new sections relating to health insurance, with penalty provisions, an effective date for certain sections and an emergency clause for certain sections.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF MISSOURI, AS FOLLOWS:

1 Section A. Sections 354.410, 354.415, 354.430, 376.405,
2 376.426, 376.777, 376.961, 376.962, 376.964, 376.966, 376.968,
3 376.970, 376.973, and 376.1363, RSMo, are repealed and thirty new
4 sections enacted in lieu thereof, to be known as sections
5 338.321, 354.410, 354.415, 354.430, 376.325, 376.405, 376.426,
6 376.777, 376.961, 376.962, 376.964, 376.966, 376.968, 376.970,
7 376.973, 376.1192, 376.1363, 376.1575, 376.1578, 376.1900,
8 376.2000, 376.2002, 376.2004, 376.2006, 376.2008, 376.2010,
9 376.2011, 376.2012, 376.2014, and 1, to read as follows:
10 338.321. 1. The "Missouri Oral Chemotherapy Parity Interim
11 Committee" is hereby created to study the disparity in patient
12 co-payments between orally and intravenously administered

1 chemotherapies, the reasons for the disparity, and the patient
2 benefits in establishing co-payment parity between oral and
3 infused chemotherapy agents. The committee shall consider
4 information on the costs or actuarial analysis associated with
5 the delivery of patient oncology treatments.
6 2. The Missouri oral chemotherapy parity interim committee
7 shall consist of the following members:
8 (1) Two members of the senate, appointed by the president
9 pro tempore of the senate;
10 (2) Two members of the house of representatives, appointed
11 by the speaker of the house of representatives;
12 (3) One member who is an oncologist or physician with
13 expertise in the practice of oncology licensed in this state
14 under chapter 334;
15 (4) One member who is an oncology nurse licensed in this
16 state under chapter 335;
17 (5) One member who is a representative of a Missouri
18 pharmacy benefit management company;
19 (6) One member from an organization representing licensed
20 pharmacists in this state;
21 (7) One member from the business community representing
22 businesses on health insurance issues;
23 (8) One member from an organization representing the
24 leading research-based pharmaceutical and biotechnology
25 companies;
26 (9) One patient advocate;
27 (10) One member from the organization representing a
28 majority of hospitals in this state;

(11) One member from a health carrier as such term is defined under section 376.1350;

(12) One member from the organization representing a majority of health carriers in this state, as such term is defined under section 376.1350;

(13) One member from the American Cancer Society; and

(14) One member from an organization representing generic pharmaceutical drug manufacturers.

3. All members, except for the members from the general assembly, shall be appointed by the governor no later than September 1, 2013. The department of insurance, financial institutions and professional registration shall provide assistance to the committee.

4. No later than January 1, 2014, the committee shall submit a report to the governor, the speaker of the house of representatives, the president pro tempore of the senate, and the appropriate legislative committee of the general assembly regarding the results of the study and any legislative recommendations.

354.410. 1. The director shall issue or deny a certificate of authority to any person filing an application pursuant to section 354.405. Issuance of a certificate of authority may then be granted upon payment of the application fee prescribed in section 354.500 if the director is satisfied that the following conditions are met:

(1) The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy, and possess good reputations;

(2) The health care organization constitutes an appropriate mechanism whereby the health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis through insurance or otherwise, except to the extent of **[**reasonable**]** requirements for co-payments, coinsurance or deductibles;

(3) The health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the director may consider:

(a) The financial soundness of the arrangements for health care services and the schedule of charges used in connection therewith;

(b) The adequacy of working capital;

(c) Any agreement with an insurer, a government, or any other organization for insuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the health maintenance organization;

(d) Any agreement with providers for the provision of health care services; and

(e) Any deposit of cash or securities submitted in accordance with subsection 2;

(4) The health maintenance organization's arrangements for health care services and the schedule of charges used in connection therewith are financially sound;

(5) The working capital be adequate;

(6) Any agreement with an insurer, a health service

corporation, a government, or any other organization for insuring the payment of the cost of health care services contain a provision for the automatic applicability of alternative coverage in the event of discontinuance of the health maintenance organization;

(7) There be an agreement with providers for the provision of health care services;

(8) The enrollees shall be afforded an opportunity to participate in matters of policy and operation pursuant to section 354.420;

(9) Nothing in the proposed method of operation, as shown by the information submitted pursuant to section 354.405 or by independent investigation, is contrary to the public interest; and

(10) The health maintenance organization is able to provide its enrollees with adequate access to health care providers.

2. Unless otherwise provided below, each health maintenance organization shall deposit with the director, or with any organization or trustee acceptable to the director through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that is acceptable to the director in the amount set forth in this subsection:

(1) The amount for an organization that is beginning operation shall be the greater of: (a) five percent of its estimated expenditures for health care services for its first year of operation, (b) twice its estimated average monthly uncovered expenditures for its first year of operation, or (c) one hundred fifty thousand dollars for a medical group/staff

1 model, or three hundred thousand dollars for an individual
2 practice association. At the beginning of each succeeding year,
3 unless not applicable, the organization shall deposit with the
4 director, or organization or trustee, cash, securities, or any
5 combination of these or other measures acceptable to the
6 director, in an amount equal to four percent of its estimated
7 annual uncovered expenditures for that year.
8 (2) Unless not applicable, an organization that is in
9 operation on September 28, 1983, shall make a deposit equal to
10 the larger of: (a) one percent of the preceding twelve months'
11 uncovered expenditures, or (b) one hundred fifty thousand dollars
12 for a medical group/staff model, or three hundred thousand
13 dollars for an individual practice association on the first day
14 of the first calendar year beginning six months or more after
15 September 28, 1983. In the second calendar year, if applicable,
16 the amount of the additional deposit shall be equal to two
17 percent of its estimated annual uncovered expenditures. In the
18 third calendar year, if applicable, the additional deposit shall
19 be equal to three percent of its estimated annual uncovered
20 expenditures for that year, and in the fourth calendar year and
21 subsequent years, if applicable, the additional deposit shall be
22 equal to four percent of its estimated annual uncovered
23 expenditures for each year. Each year's estimate, after the
24 first year of operation, shall reasonably reflect the prior
25 years' operating experience and delivery arrangements. The
26 director may waive any of the deposit requirements set forth in
27 subdivisions (1) and (2) above, whenever satisfied that the
28 organization has sufficient net worth and an adequate history of

1 generating net income to assure its financial viability for the
2 next year, or its performance and obligations are guaranteed by
3 an organization with sufficient net worth and an adequate history
4 of generating net income, or the assets of the organization or
5 its contracts with insurers, hospital or medical service
6 corporations, governments, or other organizations are sufficient
7 to reasonably assure the performance of its obligations.
8 3. When an organization has achieved a net worth not
9 including land, buildings, and equipment, of at least one million
10 dollars or has achieved a net worth including
11 organization-related land, buildings, and equipment of at least
12 five million dollars, the annual deposit requirements shall not
13 apply. The annual deposit requirement shall not apply to an
14 organization if the total amount of the deposit is equal to
15 twenty-five percent of its estimated annual uncovered
16 expenditures for the next calendar year, or the capital and
17 surplus requirements for the formation or admittance of an
18 accident and health insurer in this state, whichever is less. If
19 the organization has a guaranteeing organization which has been
20 in operation for at least five years and has a net worth not
21 including land, buildings, and equipment of at least one million
22 dollars or which has been in operation for at least ten years and
23 has a net worth including organization-related land, buildings,
24 and equipment of at least five million dollars, the annual
25 deposit requirement shall not apply; provided, however, that if
26 the guaranteeing organization is sponsoring more than one
27 organization, the net worth requirement shall be increased by a
28 multiple equal to the number of such organizations. This

1 requirement to maintain a deposit in excess of the deposit
2 required of an accident and health insurer shall not apply during
3 any time that the guaranteeing organization maintains a net worth
4 at least equal to the capital and surplus requirements for an
5 accident and health insurer for each organization it sponsors.
6 4. All income from deposits shall belong to the depositing
7 organization and shall be paid to it as it becomes available. A
8 health maintenance organization that has made a securities
9 deposit may withdraw the securities deposit or any part thereof,
10 first having deposited, in lieu thereof, a deposit of cash,
11 securities, or any combination of these or other measures of
12 equal amount and value to that withdrawn. Any securities shall
13 be approved by the director before being substituted.
14 5. In any year in which an annual deposit is not required
15 of an organization, at its request the director shall reduce the
16 required deposit by one hundred thousand dollars for each two
17 hundred fifty thousand dollars of net worth in excess of the
18 amount that allows it not to make an annual deposit. If the
19 amount of net worth no longer supports a reduction of its
20 required deposit, the organization shall immediately redeposit
21 one hundred thousand dollars for each two hundred fifty thousand
22 dollars of reduction in net worth, provided that its total
23 deposit shall not exceed the maximum required under this section.
24 Notwithstanding any provisions of sections 354.400 to 354.636,
25 the deposit held by the director shall in no case be less than
26 one hundred fifty thousand dollars for a group staff/model or
27 three hundred thousand dollars for an individual practice
28 association model.

1 6. Each health maintenance organization that obtains a
2 certificate of authority after September 28, 1983, shall have and
3 maintain a capital account of at least one hundred fifty thousand
4 dollars for a medical group/staff model, or three hundred
5 thousand dollars for an individual practice association in
6 addition to any deposit requirements under this section. The
7 capital account shall be net of any accrued liabilities and be in
8 the form of cash, securities or any combination of these or other
9 measures acceptable to the director.
10 7. A certificate of authority shall be denied only after
11 compliance with the requirements of section 354.490.
12 354.415. 1. The powers of a health maintenance
13 organization include, but are not limited to, the power to:
14 (1) Purchase, lease, construct, renovate, operate, and
15 maintain hospitals, medical facilities, or both, and their
16 ancillary equipment, and such property as may reasonably be
17 required for the organization's principal office or for such
18 other purposes as may be necessary in the transaction of the
19 business of the organization;
20 (2) Make loans to a medical group under contract with it in
21 furtherance of its program, or to make loans to any corporation
22 under its control for the purpose of acquiring or constructing
23 medical facilities and hospitals or in the furtherance of a
24 program providing health care services to enrollees;
25 (3) Furnish health care services through providers which
26 are under contract with, or employed by, the health maintenance
27 organization;
28 (4) Contract with any person for the performance, on the

1 organization's behalf, of certain functions such as marketing,
2 enrollment, and administration;
3 (5) Contract with an insurance company licensed in this
4 state, or with a health services corporation authorized to do
5 business in this state, for the provision of insurance,
6 indemnity, or reimbursement against the cost of health care
7 services provided by the health maintenance organization;
8 (6) Offer, in addition to basic health care services:
9 (a) Additional health care services;
10 (b) Indemnity benefits covering out-of-area or emergency
11 services; and
12 (c) Indemnity benefits, in addition to those relating to
13 out-of-area and emergency services, provided through insurers or
14 health services corporations;
15 (7) Offer as an option one or more health benefit plans
16 which contain deductibles, coinsurance, coinsurance
17 differentials, or variable co-payments. Health benefit plans
18 offered under this section that contain deductibles shall be
19 permitted only when combined with any health savings account or
20 health reimbursement account as described in the Medicare Reform
21 Act, P.L. No. 108-173, Title XII, Section 1201, provided that:
22 (a) The total out-of-pocket expenses paid for the receipt
23 of basic health services under the plan shall not exceed the
24 annual contribution limits for health savings accounts as
25 determined by the Internal Revenue Service;
26 (b) The health savings account or health reimbursement
27 account must be funded at a level equal to or greater than the
28 out-of-pocket maximum limits defined for the high deductible

health plan; and

(c) A distribution from the health savings account or health reimbursement account to pay a health care provider for a qualified medical expense is made within thirty days of the submission of a claim.

2. Prior to the exercise of any power granted in subdivision (1) or (2) of subsection 1 of this section, involving an amount in excess of five hundred thousand dollars, a health maintenance organization shall file notice, with adequate supporting information, with the director. The director shall disapprove such exercise of power if, in his opinion, it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. If the director does not disapprove such exercise of power within sixty days of the filing, it shall be deemed approved.

3. The director may exempt from the filing requirement of subsection 2 of this section those activities having minimal effect.

354.430. 1. Every enrollee residing in this state is entitled to evidence of coverage. If the enrollee obtains coverage through an insurance policy or a contract issued by a health services corporation, whether by option or otherwise, the insurer or the health services corporation shall issue the evidence of coverage. Otherwise the health maintenance organization shall issue the evidence of coverage.

2. No evidence of coverage, or amendment thereto, shall be issued or delivered to any person in this state until a copy of

the form of the evidence of coverage, or amendment thereto, has been filed with the director.

3. An evidence of coverage shall contain:

(1) No provisions or statements which are unjust, unfair, inequitable, misleading, or deceptive, or which encourage misrepresentation, or which are untrue, misleading, or deceptive as defined in subsection 1 of section 354.460; and

(2) A clear and complete statement, if a contract, or a reasonably complete summary, if a certificate, of:

(a) The health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(b) Any limitations on the services, kind of services, benefits or kinds of benefits to be provided, including any deductible or co-payment, coinsurance, or other cost-sharing feature as requested by the group contract holder or, in the case of non-group coverage, the individual certificate holder;

(c) Where and in what manner information is available as to how services may be obtained;

(d) The total amount of payment for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts; and

(e) A clear and understandable description of the health maintenance organization's method for resolving enrollee complaints, including the health maintenance organization's toll-free customer service number and the department of insurance, financial institutions and professional registration's consumer complaint hot line number.

4. Any subsequent change in an evidence of coverage may be

1 made in a separate document issued to the enrollee.
2 5. A copy of the form of the evidence of coverage to be
3 used in this state, and any amendment thereto, shall be subject
4 to the filing of subsection 2 of this section unless it is
5 subject to the jurisdiction of the director under the laws
6 governing health insurance or health services corporations, in
7 which event the filing provisions of those laws shall apply.
8 376.325. 1. To the extent a health carrier has developed a
9 closed or exclusive provider network as provided in subdivision
10 (19) of section 376.426 through contractual arrangements with
11 selected providers, such health carrier shall accept into such
12 closed or exclusive network any willing licensed physician who
13 agrees to accept a fee schedule, payment, or reimbursement rate
14 that is fifteen percent less than the health carrier's standard
15 prevailing or market fee schedule, payment, or reimbursement rate
16 for such network in the specific geography of the licensed
17 physician's practice.
18 2. This section shall not apply to any licensed physician
19 who does not meet the health carrier's selection standards and
20 credentialing criteria or who has not entered into the health
21 carrier's standard participating provider agreement.
22 3. As used in this section, the term "health carrier" shall
23 have the same meaning ascribed to it in section 376.1350. The
24 term "physician" shall mean a physician licensed to practice in
25 Missouri under the provisions of chapter 334. As used in this
26 section, a "closed or exclusive provider network" is a network
27 for a health benefit plan that requires all health care services
28 to be delivered by a participating provider in the health

1 carrier's network, except for emergency services, as defined in
2 section 376.1350, and the services described in subsection 4 of
3 section 376.811.

4 376.405. 1. No insurance company licensed to transact
5 business in this state shall deliver or issue for delivery in
6 this state any policy of group accident or group health
7 insurance, or group accident and health insurance, including
8 insurance against hospital, medical or surgical expenses,
9 covering a group in this state, unless such policy form shall
10 have been approved by the director of the department of
11 insurance, financial institutions and professional registration
12 of the state of Missouri.

13 2. The director of the department of insurance, financial
14 institutions and professional registration shall have authority
15 to make such reasonable rules and regulations concerning the
16 filing and submission of such policy forms as are necessary,
17 proper or advisable. Such rules and regulations shall provide,
18 among other things, that if a policy form is disapproved, **[**the
19 reasons therefor**]** all specific reasons for nonconformance shall
20 be stated in writing within forty-five days from the date of
21 filing; that a hearing shall be granted upon such disapproval, if
22 so requested; and that the failure of the director of the
23 department of insurance, financial institutions and professional
24 registration, to take action approving or disapproving a
25 submitted policy form within **[**a stipulated time, not to exceed
26 sixty**]** forty-five days from the date of filing, shall be deemed
27 an approval thereof **[**until such time as the director of the
28 department of insurance, financial institutions and professional

1 registration shall notify the submitting company, in writing, of
2 his disapproval thereof]. If at any time after a policy form is
3 approved or deemed approved, the director determines that any
4 provision of the filing is contrary to state law, the director
5 shall notify the health carrier of the specific provisions that
6 are contrary to state law and any specific statute or regulation
7 to which the provision is contrary, and request that the health
8 carrier file, within thirty days of the notification, an
9 amendment form that modifies the provision to conform to state
10 law. Upon approval of the amendment form by the director, the
11 health carrier shall issue a copy of the amendment to each
12 individual and entity to which the filing has been issued. Such
13 amendment shall have the force and effect as if the amendment was
14 in the original filing or policy.
15 3. The director of the department of insurance, financial
16 institutions and professional registration shall approve only
17 those policy forms which are in compliance with the insurance
18 laws of this state and which contain such words, phraseology,
19 conditions and provisions which are specific, certain and
20 unambiguous and reasonably adequate to meet needed requirements
21 for the protection of those insured. The disapproval of any
22 policy form shall be based upon the requirements of the laws of
23 this state or of any regulation lawfully promulgated thereunder.
24 4. The director of the department of insurance, financial
25 institutions and professional registration may, by order or
26 bulletin, exempt from the approval requirements of this section
27 for so long as he deems proper any insurance policy, document, or
28 form or type thereof, as specified in such order or bulletin, to

1 which, in his opinion, this section may not practicably be
2 applied, or the approval of which is, in his opinion, not
3 desirable or necessary for the protection of the public.
4 376.426. No policy of group health insurance shall be
5 delivered in this state unless it contains in substance the
6 following provisions, or provisions which in the opinion of the
7 director of the department of insurance, financial institutions
8 and professional registration are more favorable to the persons
9 insured or at least as favorable to the persons insured and more
10 favorable to the policyholder; except that: provisions in
11 subdivisions (5), (7), (12), (15), and (16) of this section shall
12 not apply to policies insuring debtors; standard provisions
13 required for individual health insurance policies shall not apply
14 to group health insurance policies; and if any provision of this
15 section is in whole or in part inapplicable to or inconsistent
16 with the coverage provided by a particular form of policy, the
17 insurer, with the approval of the director, shall omit from such
18 policy any inapplicable provision or part of a provision, and
19 shall modify any inconsistent provision or part of the provision
20 in such manner as to make the provision as contained in the
21 policy consistent with the coverage provided by the policy:
22 (1) A provision that the policyholder is entitled to a
23 grace period of thirty-one days for the payment of any premium
24 due except the first, during which grace period the policy shall
25 continue in force, unless the policyholder shall have given the
26 insurer written notice of discontinuance in advance of the date
27 of discontinuance and in accordance with the terms of the policy.
28 The policy may provide that the policyholder shall be liable to

1 the insurer for the payment of a pro rata premium for the time
2 the policy was in force during such grace period;
3 (2) A provision that the validity of the policy shall not
4 be contested, except for nonpayment of premiums, after it has
5 been in force for two years from its date of issue, and that no
6 statement made by any person covered under the policy relating to
7 insurability shall be used in contesting the validity of the
8 insurance with respect to which such statement was made after
9 such insurance has been in force prior to the contest for a
10 period of two years during such person's lifetime nor unless it
11 is contained in a written instrument signed by the person making
12 such statement; except that, no such provision shall preclude the
13 assertion at any time of defenses based upon the person's
14 ineligibility for coverage under the policy or upon other
15 provisions in the policy;
16 (3) A provision that a copy of the application, if any, of
17 the policyholder shall be attached to the policy when issued,
18 that all statements made by the policyholder or by the persons
19 insured shall be deemed representations and not warranties and
20 that no statement made by any person insured shall be used in any
21 contest unless a copy of the instrument containing the statement
22 is or has been furnished to such person or, in the event of the
23 death or incapacity of the insured person, to the individual's
24 beneficiary or personal representative;
25 (4) A provision setting forth the conditions, if any, under
26 which the insurer reserves the right to require a person eligible
27 for insurance to furnish evidence of individual insurability
28 satisfactory to the insurer as a condition to part or all of the

1 individual's coverage;
2 (5) A provision specifying the additional exclusions or
3 limitations, if any, applicable under the policy with respect to
4 a disease or physical condition of a person, not otherwise
5 excluded from the person's coverage by name or specific
6 description effective on the date of the person's loss, which
7 existed prior to the effective date of the person's coverage
8 under the policy. Any such exclusion or limitation may only
9 apply to a disease or physical condition for which medical advice
10 or treatment was received by the person during the twelve months
11 prior to the effective date of the person's coverage. In no
12 event shall such exclusion or limitation apply to loss incurred
13 or disability commencing after the earlier of:
14 (a) The end of a continuous period of twelve months
15 commencing on or after the effective date of the person's
16 coverage during all of which the person has received no medical
17 advice or treatment in connection with such disease or physical
18 condition; or
19 (b) The end of the two-year period commencing on the
20 effective date of the person's coverage;
21 (6) If the premiums or benefits vary by age, there shall be
22 a provision specifying an equitable adjustment of premiums or of
23 benefits, or both, to be made in the event the age of the covered
24 person has been misstated, such provision to contain a clear
25 statement of the method of adjustment to be used;
26 (7) A provision that the insurer shall issue to the
27 policyholder, for delivery to each person insured, a certificate
28 setting forth a statement as to the insurance protection to which

1 that person is entitled, to whom the insurance benefits are
2 payable, and a statement as to any family member's or dependent's
3 coverage;

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

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

22 (10) A provision that in the case of claim for loss of time
23 for disability, written proof of such loss must be furnished to
24 the insurer within ninety days after the commencement of the
25 period for which the insurer is liable, and that subsequent
26 written proofs of the continuance of such disability must be
27 furnished to the insurer at such intervals as the insurer may
28 reasonably require, and that in the case of claim for any other

1 loss, written proof of such loss must be furnished to the insurer
2 within ninety days after the date of such loss. Failure to
3 furnish such proof within such time shall not invalidate nor
4 reduce any claim if it was not reasonably possible to furnish
5 such proof within such time, provided such proof is furnished as
6 soon as reasonably possible and in no event, except in the
7 absence of legal capacity of the claimant, later than one year
8 from the time proof is otherwise required;
9 (11) A provision that all benefits payable under the policy
10 other than benefits for loss of time shall be payable not more
11 than thirty days after receipt of proof and that, subject to due
12 proof of loss, all accrued benefits payable under the policy for
13 loss of time shall be paid not less frequently than monthly
14 during the continuance of the period for which the insurer is
15 liable, and that any balance remaining unpaid at the termination
16 of such period shall be paid as soon as possible after receipt of
17 such proof;
18 (12) A provision that benefits for accidental loss of life
19 of a person insured shall be payable to the beneficiary
20 designated by the person insured or, if the policy contains
21 conditions pertaining to family status, the beneficiary may be
22 the family member specified by the policy terms. In either case,
23 payment of these benefits is subject to the provisions of the
24 policy in the event no such designated or specified beneficiary
25 is living at the death of the person insured. All other benefits
26 of the policy shall be payable to the person insured. The policy
27 may also provide that if any benefit is payable to the estate of
28 a person, or to a person who is a minor or otherwise not

1 competent to give a valid release, the insurer may pay such
2 benefit, up to an amount not exceeding two thousand dollars, to
3 any relative by blood or connection by marriage of such person
4 who is deemed by the insurer to be equitably entitled thereto;
5 (13) A provision that the insurer shall have the right and
6 opportunity, at the insurer's own expense, to examine the person
7 of the individual for whom claim is made when and so often as it
8 may reasonably require during the pendency of the claim under the
9 policy and also the right and opportunity, at the insurer's own
10 expense, to make an autopsy in case of death where it is not
11 prohibited by law;
12 (14) A provision that no action at law or in equity shall
13 be brought to recover on the policy prior to the expiration of
14 sixty days after proof of loss has been filed in accordance with
15 the requirements of the policy and that no such action shall be
16 brought at all unless brought within three years from the
17 expiration of the time within which proof of loss is required by
18 the policy;
19 (15) A provision specifying the conditions under which the
20 policy may be terminated. Such provision shall state that except
21 for nonpayment of the required premium or the failure to meet
22 continued underwriting standards, the insurer may not terminate
23 the policy prior to the first anniversary date of the effective
24 date of the policy as specified therein, and a notice of any
25 intention to terminate the policy by the insurer must be given to
26 the policyholder at least thirty-one days prior to the effective
27 date of the termination. Any termination by the insurer shall be
28 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 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

1 be established where the dependent child is:

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

4 (b) A resident of this state; and

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

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

15 (19) Notwithstanding any other provision of law to the
16 contrary, a health carrier, as defined in section 376.1350, may
17 offer a health benefit plan that is a managed care plan that
18 requires all health care services to be delivered by a
19 participating provider in the health carrier's network, except
20 for emergency services, as defined in section 376.1350, and the
21 services described in subsection 4 of section 376.811. Such a
22 provision shall be disclosed in clear, conspicuous, and
23 understandable language in the enrollment application and in the
24 policy form. Whenever a health carrier offers a health benefit
25 plan pursuant to this subdivision to a group contract holder as
26 an exclusive or full replacement health benefit plan the health
27 carrier shall offer at least one additional health benefit plan
28 option that includes an out-of-network benefit. The decision to

1 accept or reject the offer of the option of a health benefit plan
2 that includes an out-of-network benefit shall be made by the
3 enrollee and not the group contract holder;
4 (20) A provision stating that a health benefit plan issued
5 pursuant to subdivision (19) of this section shall have in place
6 a procedure by which an enrollee may obtain a referral to a
7 nonparticipating provider when the enrollee is diagnosed with a
8 life-threatening condition or disabling degenerative disease.
9 The provisions of subdivisions (19) and (20) of this section
10 shall expire and be null and void at the end of the calendar year
11 following the repeal of 42 U.S.C. Section 300gg by the United
12 States Congress or at the end of the calendar year following a
13 finding by a court of competent jurisdiction that such section is
14 unconstitutional or otherwise infirm.
15 376.777. 1. Required provisions. Except as provided in
16 subsection 3 of this section each such policy delivered or issued
17 for delivery to any person in this state shall contain the
18 provisions specified in this subsection in the words in which the
19 same appear in this section; provided, however, that the insurer
20 may, at its option, substitute for one or more of such provisions
21 corresponding provisions of different wording approved by the
22 director of the department of insurance, financial institutions
23 and professional registration which are in each instance not less
24 favorable in any respect to the insured or the beneficiary. Such
25 provisions shall be preceded individually by the caption
26 appearing in this subsection or, at the option of the insurer, by
27 such appropriate individual or group captions or subcaptions as
28 the director of the department of insurance, financial

1 institutions and professional registration may approve.
2 (1) A provision as follows: "ENTIRE CONTRACT; CHANGES: This
3 policy, including the endorsements and the attached papers, if
4 any, constitutes the entire contract of insurance. No change in
5 this policy shall be valid until approved by an executive officer
6 of the insurer and unless such approval be endorsed hereon or
7 attached hereto. No agent has authority to change this policy or
8 to waive any of its provisions".
9 (When under the provisions of subdivision (2) of subsection
10 1 of section 376.775 the effective and termination dates are
11 stated in the premium receipt, the insurer shall insert in the
12 first sentence of the foregoing policy provision immediately
13 following the comma after the word "any", the following words:
14 "and the insurer's official premium receipt when executed").
15 (2) A provision as follows: "TIME LIMIT ON CERTAIN
16 DEFENSES:
17 (a) After two years from the date of issue of this policy
18 no misstatements, except fraudulent misstatements, made by the
19 applicant in the application for such policy shall be used to
20 void the policy or to deny a claim for loss incurred or
21 disability (as defined in the policy) commencing after the
22 expiration of such two-year period".
23 (The foregoing policy provision shall not be so construed as
24 to affect any legal requirements for avoidance of a policy or
25 denial of a claim during such initial two-year period, nor to
26 limit the application of subdivisions (1), (2), (3), (4) and (5)
27 of subsection 2 of this section in the event of misstatement with
28 respect to age or occupation or other insurance.)

(A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age fifty or, (2) in the case of a policy issued after age forty-four, for at least five years from its date of issue, may contain in lieu of the foregoing the following provision (from which the clause in parentheses may be omitted at the insurer's option) under the caption "UNCONTESTABLE": "After this policy has been in force for a period of three years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become uncontestable as to the statements contained in the application). (b) No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy."

(3) A provision as follows: "GRACE PERIOD:

A grace period of . . . (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force."

(A policy which contains a cancellation provision may add, at the end of the above provision, subject to the right of the insurer to cancel in accordance with the cancellation provision hereof. A policy in which the insurer reserves the right to

1 refuse any renewal shall have, at the beginning of the above
2 provision, "Unless not less than five days prior to the premium
3 due date the insurer has delivered to the insured or has mailed
4 to his last address as shown by the records of the insurer
5 written notice of its intention not to renew this policy beyond
6 the period for which the premium has been accepted").
7 (4) A provision as follows: "REINSTATEMENT:
8 If any renewal premium be not paid within the time granted
9 the insured for payment, a subsequent acceptance of premium by
10 the insurer or by any agent duly authorized by the insurer to
11 accept such premium, without requiring in connection therewith an
12 application for reinstatement, shall reinstate the policy;
13 provided, however, that if the insurer or such agent requires an
14 application for reinstatement and issues a conditional receipt
15 for the premium tendered, the policy will be reinstated upon
16 approval of such application by the insurer, or, lacking such
17 approval, upon the forty-fifth day following the date of such
18 conditional receipt unless the insurer has previously notified
19 the insured in writing of its disapproval of such application.
20 The reinstated policy shall cover only loss resulting from such
21 accidental injury as may be sustained after the date of
22 reinstatement and loss due to such sickness as may begin more
23 than ten days after such date. In all other respects the insured
24 and insurer shall have the same rights thereunder as they had
25 under the policy immediately before the due date of the defaulted
26 premium, subject to any provisions endorsed hereon or attached
27 hereto in connection with the reinstatement. Any premium
28 accepted in connection with a reinstatement shall be applied to a

1 period for which premium has not been previously paid, but not to
2 any period more than sixty days prior to the date of
3 reinstatement".
4 (The last sentence of the above provision may be omitted
5 from any policy which the insured has the right to continue in
6 force subject to its terms by the timely payment of premiums (1)
7 until at least age fifty or, (2) in the case of a policy issued
8 after age forty-four, for at least five years from its date of
9 issue.)
10 (5) A provision as follows: "NOTICE OF CLAIM:
11 Written notice of claim must be given to the insurer within
12 twenty days after the occurrence or commencement of any loss
13 covered by the policy, or as soon thereafter as is reasonably
14 possible. Notice given by or on behalf of the insured or the
15 beneficiary to the insured at .... (insert the location of
16 such office as the insurer may designate for the purpose), or to
17 any authorized agent of the insurer, with information sufficient
18 to identify the insured, shall be deemed notice to the insurer".
19 (In a policy providing a loss-of-time benefit which may be
20 payable for at least two years, an insurer may at its option
21 insert the following between the first and second sentences of
22 the above provision: "Subject to the qualifications set forth
23 below, if the insured suffers loss of time on account of
24 disability for which indemnity may be payable for at least two
25 years, he shall, at least once in every six months after having
26 given notice of claim, give to the insurer notice of continuance
27 of said disability, except in the event of legal incapacity. The
28 period of six months following any filing of proof by the insured

1 or any payment by the insurer on account of such claim or any
2 denial of liability in whole or in part by the insurer shall be
3 excluded in applying this provision. Delay in the giving of such
4 notice shall not impair the insured's right to any indemnity
5 which would otherwise have accrued during the period of six
6 months preceding the date on which such notice is actually
7 given").
8 (6) A provision as follows: "CLAIM FORMS:
9 The insurer upon receipt of a notice of claim, will furnish
10 to the claimant such forms as are usually furnished by it for
11 filing proofs of loss.
12
13 If such forms are not furnished within fifteen days after the
14 giving of such notice the claimant shall be deemed to have
15 complied with the requirements of this policy as to proof of loss
16 upon submitting, within the time fixed in the policy for filing
17 proofs of loss, written proof covering the occurrence, the
18 character and the extent of the loss for which claim is made".
19 (7) A provision as follows: "PROOFS OF LOSS:
20 Written proof of loss must be furnished to the insurer at
21 its said office in case of claim for loss for which this policy
22 provides any periodic payment contingent upon continuing loss
23 within ninety days after the termination of the period for which
24 the insurer is liable and in case of claim for any other loss
25 within ninety days after the date of such loss. Failure to
26 furnish such proof within the time required shall not invalidate
27 nor reduce any claim if it was not reasonably possible to give
28 proof within such time, provided such proof is furnished as soon

1 as reasonably possible and in no event, except in the absence of
2 legal capacity, later than one year from the time proof is
3 otherwise required".

4 (8) A provision as follows: "TIME OF PAYMENT OF CLAIMS:
5 Indemnities payable under this policy for any loss other
6 than loss for which this policy provides any periodic payment
7 will be paid immediately upon receipt of due written proof of
8 such loss. Subject to due written proof of loss, all accrued
9 indemnities for loss for which this policy provides periodic
10 payment will be paid .... (insert period for payment which
11 must not be less frequently than monthly) and any balance
12 remaining unpaid upon the termination of liability will be paid
13 immediately upon receipt of due written proof".

14 (9) A provision as follows: "PAYMENT OF CLAIMS:
15 Indemnity for loss of life will be payable in accordance
16 with the beneficiary designation and the provisions respecting
17 such payment which may be prescribed herein and effective at the
18 time of payment. If no such designation or provision is then
19 effective, such indemnity shall be payable to the estate of the
20 insured. Any other accrued indemnities unpaid at the insured's
21 death may, at the option of the insurer, be paid either to such
22 beneficiary or to such estate. All other indemnities will be
23 payable to the insured".

24 (The following provisions, or either of them, may be
25 included with the foregoing provision at the option of the
26 insurer: "If any indemnity of this policy shall be payable to the
27 estate of the insured, or to an insured or beneficiary who is a
28 minor or otherwise not competent to give a valid release, the

1 insurer may pay such indemnity, up to an amount not exceeding
2 $...... (insert an amount which shall not exceed one thousand
3 dollars), to any relative by blood or connection by marriage of
4 the insured or beneficiary who is deemed by the insurer to be
5 equitably entitled thereto. Any payment made by the insurer in
6 good faith pursuant to this provision shall fully discharge the
7 insurer to the extent of such payment. Subject to any written
8 direction of the insured in the application or otherwise all or a
9 portion of any indemnities provided by this policy on account of
10 hospital, nursing, medical, or surgical services may, at the
11 insurer's option and unless the insured requests otherwise in
12 writing not later than the time of filing proofs of such loss, be
13 paid directly to the hospital or person rendering such services;
14 but it is not required that the service be rendered by a
15 particular hospital or person").
16 (10) A provision as follows: "PHYSICAL EXAMINATIONS AND
17 AUTOPSY:
18 The insurer at its own expense shall have the right and
19 opportunity to examine the person of the insured when and as
20 often as it may reasonably require during the pendency of a claim
21 hereunder and to make an autopsy in case of death where it is not
22 forbidden by law".
23 (11) A provision as follows: "LEGAL ACTIONS:
24 No action at law or in equity shall be brought to recover on
25 this policy prior to the expiration of sixty days after written
26 proof of loss has been furnished in accordance with the
27 requirements of this policy. No such action shall be brought
28 after the expiration of three years after the time written proof

1 of loss is required to be furnished".

2 (12) A provision as follows: "CHANGE OF BENEFICIARY:

3 Unless the insured makes an irrevocable designation of
4 beneficiary, the right to change of beneficiary is reserved to
5 the insured and the consent of the beneficiary or beneficiaries
6 shall not be requisite to surrender or assignment of this policy
7 or to change of beneficiary or beneficiaries, or to any other
8 changes in this policy".

9 (The first clause of this provision, relating to the
10 irrevocable designation of beneficiary, may be omitted at the
11 insurer's option).

12 2. Other provisions. Except as provided in subsection 3 of
13 this section, no such policy delivered or issued for delivery to
14 any person in this state shall contain provisions respecting the
15 matters set forth below unless such provisions are in the words
16 in which the same appear in this section; provided, however, that
17 the insurer may, at its option, use in lieu of any such provision
18 a corresponding provision of different wording approved by the
19 director of the department of insurance, financial institutions
20 and professional registration which is not less favorable in any
21 respect to the insured or the beneficiary. Any such provision
22 contained in the policy shall be preceded individually by the
23 appropriate caption appearing in this subsection or, at the
24 option of the insurer, by such appropriate individual or group
25 captions or subcaptions as the director of the department of
26 insurance, financial institutions and professional registration
27 may approve.

28 (1) A provision as follows: "CHANGE OF OCCUPATION:

1 If the insured be injured or contract sickness after having
2 changed his occupation to one classified by the insurer as more
3 hazardous than that stated in this policy or while doing for
4 compensation anything pertaining to an occupation so classified,
5 the insurer will pay only such portion of the indemnities
6 provided in this policy as the premium paid would have purchased
7 at the rates and within the limits fixed by the insurer for such
8 more hazardous occupation. If the insured changes his occupation
9 to one classified by the insurer as less hazardous than that
10 stated in this policy, the insurer, upon receipt of proof of such
11 change of occupation, will reduce the premium rate accordingly,
12 and will return the excess pro rata unearned premium from the
13 date of change of occupation or from the policy anniversary date
14 immediately preceding receipt of such proof, whichever is the
15 more recent. In applying this provision, the classification of
16 occupational risk and the premium rates shall be such as have
17 been last filed by the insurer prior to the occurrence of the
18 loss for which the insurer is liable or prior to date of proof of
19 change in occupation with the state official having supervision
20 of insurance in the state where the insured resided at the time
21 this policy was issued; but if such filing was not required, then
22 the classification of occupational risk and the premium rates
23 shall be those last made effective by the insurer in such state
24 prior to the occurrence of the loss or prior to the date of proof
25 of change in occupation".
26 (2) A provision as follows: "MISSTATEMENT OF AGE:
27 If the age of the insured has been misstated, all amounts
28 payable under this policy shall be such as the premium paid would

1 have purchased at the correct age".

2 (3) A provision as follows: "OTHER INSURANCE IN THIS
3 INSURER:

4 If an accident or sickness or accident and sickness policy
5 or policies previously issued by the insurer to the insured be in
6 force concurrently herewith, making the aggregate indemnity for
7 .... (insert type of coverage or coverages) in excess of
8 $...... (insert maximum limit of indemnity or indemnities) the
9 excess insurance shall be void and all premiums paid for such
10 excess shall be returned to the insured or to his estate, or in
11 lieu thereof. Insurance effective at any one time on the insured
12 under a like policy or policies in this insurer is limited to the
13 one such policy elected by the insured, his beneficiary or his
14 estate, as the case may be, and the insurer will return all
15 premiums paid for all other such policies".

16 (4) A provision as follows: "INSURANCE WITH OTHER INSURERS:

17 If there be other valid coverage, not with this insurer,
18 providing benefits for the same loss on a provision of service
19 basis or on an expense incurred basis and of which this insurer
20 has not been given written notice prior to the occurrence or
21 commencement of loss, the only liability under any expense
22 incurred coverage of this policy shall be for such proportion of
23 the loss as the amount which would otherwise have been payable
24 hereunder plus the total of the like amounts under all such other
25 valid coverages for the same loss of which this insurer had
26 notice bears to the total like amounts under all valid coverages
27 for such loss, and for the return of such portion of the premiums
28 paid as shall exceed the pro rata portion for the amount so

1 determined. For the purpose of applying this provision when
2 other coverage is on a provision of service basis, the "like
3 amount" of such other coverage shall be taken as the amount
4 which the services rendered would have cost in the absence of
5 such coverage".
6 (If the foregoing policy provision is included in a policy
7 which also contains the next following policy provision there
8 shall be added to the caption of the foregoing provision the
9 phrase "EXPENSE INCURRED BENEFITS". The insurer may, at its
10 option, include in this provision a definition of "other valid
11 coverage", approved as to form by the director of the department
12 of insurance, financial institutions and professional
13 registration, which definition shall be limited in subject matter
14 to coverage provided by organizations subject to regulation by
15 insurance law or by insurance authorities of this or any other
16 state of the United States or any province of Canada, and by
17 hospital or medical service organizations, and to any other
18 coverage the inclusion of which may be approved by the director
19 of the department of insurance, financial institutions and
20 professional registration. In the absence of such definition
21 such term shall not include group insurance, automobile medical
22 payments insurance, or coverage provided by hospital or medical
23 service organizations or by union welfare plans or employer or
24 employees benefit organizations. For the purpose of applying the
25 foregoing policy provision with respect to any insured, any
26 amount of benefit provided for such insured pursuant to any
27 compulsory benefit statute (including any workers' compensation
28 or employer's liability statute whether provided by a

1 governmental agency or otherwise shall in all cases be deemed to
2 be "other valid coverage" of which the insurer has had notice.
3 In applying the foregoing policy provision no third party
4 liability coverage shall be included as "other valid coverage").
5 (5) A provision as follows: "INSURANCE WITH OTHER INSURERS:
6 If there be other valid coverage, not with this insurer,
7 providing benefits for the same loss on other than an expense
8 incurred basis and of which this insurer has not been given
9 written notice prior to the occurrence or commencement of loss,
10 the only liability for such benefits under this policy shall be
11 for such proportion of the indemnities otherwise provided
12 hereunder for such loss as the like indemnities of which the
13 insurer had notice (including the indemnities under this policy)
14 bear to the total amount of all like indemnities for such loss,
15 and for the return of such portion of the premium paid as shall
16 exceed the pro rata portion for the indemnities thus determined".
17 (If the foregoing policy provision is included in a policy
18 which also contains the next preceding policy provision there
19 shall be added to the caption of the foregoing provision the
20 phrase "OTHER BENEFITS". The insurer may, at its option, include
21 in this provision a definition of "other valid coverage",
22 approved as to form by the director of the department of
23 insurance, financial institutions and professional registration
24 which definition shall be limited in subject matter to coverage
25 provided by organizations subject to regulation by insurance law
26 or by insurance authorities of this or any other state of the
27 United States or any province of Canada, and to any other
28 coverage the inclusion of which may be approved by the director

1 of the department of insurance, financial institutions and
2 professional registration. In the absence of such definition
3 such term shall not include group insurance, or benefits provided
4 by union welfare plans or by employer or employee benefit
5 organizations. For the purpose of applying the foregoing policy
6 provision with respect to any insured, any amount of benefit
7 provided for such insured pursuant to any compulsory benefit
8 statute (including any workers' compensation or employer's
9 liability statute) whether provided by a governmental agency or
10 otherwise shall in all cases be deemed to be "other valid
11 coverage", of which the insurer has had notice. In applying the
12 foregoing policy provision no third party liability coverage
13 shall be included as "other valid coverage").
14 (6) A provision as follows: "RELATION OF EARNINGS TO
15 INSURANCE:
16 If the total monthly amount of loss of time benefits
17 promised for the same loss under all valid loss of time coverage
18 upon the insured, whether payable on a weekly or monthly basis,
19 shall exceed the monthly earnings of the insured at the time
20 disability commenced or his average monthly earnings for the
21 period of two years immediately preceding a disability for which
22 claim is made, whichever is the greater, the insurer will be
23 liable only for such proportionate amount of such benefits under
24 this policy as the amount of such monthly earnings or such
25 average monthly earnings of the insured bears to the total amount
26 of monthly benefits for the same loss under all such coverage
27 upon the insured at the time such disability commences and for
28 the return of such part of the premiums paid during such two

1 years as shall exceed the pro rata amount of the premiums for the
2 benefits actually paid hereunder; but this shall not operate to
3 reduce the total monthly amount of benefits payable under all
4 such coverage upon the insured below the sum of two hundred
5 dollars or the sum of the monthly benefits specified in such
6 coverages, whichever is the lesser, nor shall it operate to
7 reduce benefits other than those payable for loss of time".
8 (The foregoing policy provision may be inserted only in a
9 policy which the insured has the right to continue in force
10 subject to its terms by the timely payment of premiums (1) until
11 at least age fifty or, (2) in the case of a policy issued after
12 age forty-four, for at least five years from this date of issue.
13 The insurer may, at its option, include in this provision a
14 definition of "valid loss of time coverage", approved as to form
15 by the director of the department of insurance, financial
16 institutions and professional registration, which definition
17 shall be limited in subject matter to coverage provided by
18 governmental agencies or by organizations subject to regulation
19 by insurance law or by insurance authorities of this or any other
20 state of the United States or any province of Canada, or to any
21 other coverage the inclusion of which may be approved by the
22 director of the department of insurance, financial institutions
23 and professional registration or any combination of such
24 coverages. In the absence of such definition such term shall not
25 include any coverage provided for such insured pursuant to any
26 compulsory benefit statute (including any workers' compensation
27 or employer's liability statute), or benefits provided by union
28 welfare plans or by employer or employee benefit organizations).

1 (7) A provision as follows: "UNPAID PREMIUM:
2 Upon the payment of a claim under this policy, any premium
3 then due and unpaid or covered by any note or written order may
4 be deducted therefrom".
5 (8) A provision as follows: "CANCELLATION:
6 The insurer may cancel this policy at any time by written
7 notice delivered to the insured, or mailed to his last address as
8 shown by the records of the insurer, stating when, not less than
9 five days thereafter, such cancellation shall be effective; and
10 after the policy has been continued beyond its original term the
11 insured may cancel this policy at any time by written notice
12 delivered or mailed to the insurer, effective upon receipt or on
13 such later date as may be specified in such notice. In the event
14 of cancellation, the insurer will return promptly the unearned
15 portion of any premium paid. If the insured cancels, the earned
16 premium shall be computed by the use of the short-rate table last
17 filed with the state official having supervision of insurance in
18 the state where the insured resided when the policy was issued.
19 If the insurer cancels, the earned premium shall be computed pro
20 rata. Cancellation shall be without prejudice to any claim
21 originating prior to the effective date of cancellation".
22 (9) A provision as follows: "CONFORMITY WITH STATE
23 STATUTES:
24 Any provision of this policy which, on its effective date,
25 is in conflict with the statutes of the state in which the
26 insured resides on such date is hereby amended to conform to the
27 minimum requirements of such statutes".
28 (10) A provision as follows: "ILLEGAL OCCUPATION:

The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation".

(11) A provision as follows: "INTOXICANTS AND NARCOTICS:

The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician".

3. Inapplicable or inconsistent provisions. 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 of the department of insurance, financial institutions and professional registration, shall omit from such policy an 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.

4. Order of certain policy provisions. The provisions which are the subject of subsections 1 and 2 of this section, or any corresponding provisions which are used in lieu thereof in accordance with such subsections, shall be printed in the consecutive order of the provisions in such subsections or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous,

1 abstruse, or likely to mislead a person to whom the policy is
2 offered, delivered or issued.
3 5. Third party ownership. The word "insured" as used in
4 sections 376.770 to 376.800, shall not be construed as preventing
5 a person other than the insured with a proper insurable interest
6 from making application for and owning a policy covering the
7 insured or from being entitled under such a policy to any
8 indemnities, benefits and rights provided therein.
9 6. Requirements of other jurisdictions.
10 (1) Any policy of a foreign or alien insurer, when
11 delivered or issued for delivery to any person in this state, may
12 contain any provision which is not less favorable to the insured
13 or the beneficiary than the provisions of sections 376.770 to
14 376.800 and which is prescribed or required by the law of the
15 state under which the insurer is organized.
16 (2) Any policy of a domestic insurer may, when issued for
17 delivery in any other state or country, contain any provision
18 permitted or required by the laws of such other state or country.
19 7. Approval of policies.
20 (1) No policy subject to sections 376.770 to 376.800 shall
21 be delivered or issued for delivery to any person in this state
22 unless such policy, including any rider, endorsement or other
23 provisions, supplementary thereto, shall have been approved by
24 the director of the department of insurance, financial
25 institutions and professional registration.
26 (2) The director of the department of insurance, financial
27 institutions and professional registration shall have authority
28 to make such reasonable rules and regulations concerning the

1 filing and submission of policies as are necessary, proper or
2 advisable. Such rules and regulations shall provide, among other
3 things, that if a policy form is disapproved, **[**the reasons
4 therefor**]** all specific reasons for nonconformance shall be stated
5 in writing within forty-five days from the date of filing; that a
6 hearing shall be granted upon such disapproval, if so requested;
7 and that the failure of the director of the department of
8 insurance, financial institutions and professional registration,
9 to take action approving or disapproving a submitted policy form
10 within **[**a stipulated time, not to exceed sixty**]** forty-five days
11 from the date of filing, shall be deemed an approval thereof
12 **[**until such time as the director of the department of insurance,
13 financial institutions and professional registration shall notify
14 the submitting company, in writing, of his disapproval thereof**]**.
15 If at any time after a policy form is approved or deemed
16 approved, the director determines that any provision of the
17 filing is contrary to state law, the director shall notify the
18 health carrier of the specific provisions that are contrary to
19 state law and any specific statute or regulation to which the
20 provision is contrary, and request that the health carrier file,
21 within thirty days of the notification an amendment form that
22 modifies the provision to conform to state law. Upon approval of
23 the amendment form by the director, the health carrier shall
24 issue a copy of the amendment to each individual and entity to
25 which the filing has been issued. Such amendment shall have the
26 force and effect as if the amendment was in the original filing
27 or policy.
28 (3) The director of the department of insurance, financial

1 institutions and professional registration shall approve only
2 those policies which are in compliance with the insurance laws of
3 this state and which contain such words, phraseology, conditions
4 and provisions which are specific, certain and unambiguous and
5 reasonably adequate to meet needed requirements for the
6 protection of those insured. The disapproval of any policy form
7 shall be based upon the requirements of the laws of this state or
8 of any regulation lawfully promulgated thereunder.

9 (4) The director of the department of insurance, financial
10 institutions and professional registration may, by order or
11 bulletin, exempt from the approval requirements of this section
12 for so long as he deems proper any insurance policy, document, or
13 form or type thereof, as specified in such order or bulletin, to
14 which, in his opinion, this section may not practicably be
15 applied, or the approval of which is, in his opinion, not
16 desirable or necessary for the protection of the public.

17 (5) Notwithstanding any other provision of law to the
18 contrary, a health carrier, as defined in section 376.1350, may
19 offer a health benefit plan that is a managed care plan that
20 requires all health care services to be delivered by a
21 participating provider in the health carrier's network, except
22 for emergency services, as defined in section 376.1350, and the
23 services described in subsection 4 of section 376.811. Such a
24 provision shall be disclosed in the policy form.

25 376.961. 1. There is hereby created a nonprofit entity to
26 be known as the "Missouri Health Insurance Pool". All insurers
27 issuing health insurance in this state and insurance arrangements
28 providing health plan benefits in this state shall be members of

1 the pool.

2 2. Beginning January 1, 2007, the board of directors shall
3 consist of the director of the department of insurance, financial
4 institutions and professional registration or the director's
5 designee, and eight members appointed by the director. Of the
6 initial eight members appointed, three shall serve a three-year
7 term, three shall serve a two-year term, and two shall serve a
8 one-year term. All subsequent appointments to the board shall be
9 for three-year terms. Members of the board shall have a
10 background and experience in health insurance plans or health
11 maintenance organization plans, in health care finance, or as a
12 health care provider or a member of the general public; except
13 that, the director shall not be required to appoint members from
14 each of the categories listed. The director may reappoint
15 members of the board. The director shall fill vacancies on the
16 board in the same manner as appointments are made at the
17 expiration of a member's term and may remove any member of the
18 board for neglect of duty, misfeasance, malfeasance, or
19 nonfeasance in office.

20 3. Beginning August 28, 2007, the board of directors shall
21 consist of fourteen members. The board shall consist of the
22 director and the eight members described in subsection 2 of this
23 section and shall consist of the following additional five
24 members:

25 (1) One member from a hospital located in Missouri,
26 appointed by the governor, with the advice and consent of the
27 senate;

28 (2) Two members of the senate, with one member from the

majority party appointed by the president pro tem of the senate and one member of the minority party appointed by the president pro tem of the senate with the concurrence of the minority floor leader of the senate; and

(3) Two members of the house of representatives, with one member from the majority party appointed by the speaker of the house of representatives and one member of the minority party appointed by the speaker of the house of representatives with the concurrence of the minority floor leader of the house of representatives.

4. The members appointed under subsection 3 of this section shall serve in an ex officio capacity. The terms of the members of the board of directors appointed under subsection 3 of this section shall expire on December 31, 2009. On such date, the membership of the board shall revert back to nine members as provided for in subsection 2 of this section.

5. Beginning on August 28, 2013, the board of directors, on behalf of the pool, the executive director, and any other employees of the pool, shall have the authority to provide assistance or resources to any department, agency, public official, employee, or agent of the federal government for the specific purpose of transitioning individuals enrolled in the pool to coverage outside of the pool beginning on or before January 1, 2014. Such authority does not extend to authorizing the pool to implement, establish, create, administer, or otherwise operate a state-based exchange.

376.962. 1. The board of directors on behalf of the pool shall submit to the director a plan of operation for the pool and

1 any amendments thereto necessary or suitable to assure the fair,
2 reasonable and equitable administration of the pool. After
3 notice and hearing, the director shall approve the plan of
4 operation, provided it is determined to be suitable to assure the
5 fair, reasonable and equitable administration of the pool, and it
6 provides for the sharing of pool gains or losses on an equitable
7 proportionate basis. The plan of operation shall become
8 effective upon approval in writing by the director consistent
9 with the date on which the coverage under sections 376.960 to
10 376.989 becomes available. If the pool fails to submit a
11 suitable plan of operation within one hundred eighty days after
12 the appointment of the board of directors, or at any time
13 thereafter fails to submit suitable amendments to the plan, the
14 director shall, after notice and hearing, adopt and promulgate
15 such reasonable rules as are necessary or advisable to effectuate
16 the provisions of this section. Such rules shall continue in
17 force until modified by the director or superseded by a plan
18 submitted by the pool and approved by the director.
19 2. In its plan, the board of directors of the pool shall:
20 (1) Establish procedures for the handling and accounting of
21 assets and moneys of the pool;
22 (2) Select an administering insurer <u>or third-party</u>
23 <u>administrator</u> in accordance with section 376.968;
24 (3) Establish procedures for filling vacancies on the board
25 of directors; <u>and</u>
26 (4) Establish procedures for the collection of assessments
27 from all members to provide for claims paid under the plan and
28 for administrative expenses incurred or estimated to be incurred

during the period for which the assessment is made. The level of payments shall be established by the board pursuant to the provisions of section 376.973. Assessment shall occur at the end of each calendar year and shall be due and payable within thirty days of receipt of the assessment notice**[**;

(5) Develop and implement a program to publicize the existence of the plan, the eligibility requirements, and procedures for enrollment, and to maintain public awareness of the plan**]**.

3. On or before September 1, 2013, the board shall submit the amendments to the plan of operation as are necessary or suitable to ensure a reasonable transition period to allow for the termination of issuance of policies by the pool.

4. The amendments to the plan of operation submitted by the board shall include all of the requirements outlined in subsection 2 of this section and shall address the transition of individuals covered under the pool to alternative health insurance coverage as it is available after January 1, 2014. The plan of operation shall also address procedures for finalizing the financial matters of the pool, including assessments, claims expenses, and other matters identified in subsection 2 of this section.

5. The director shall review the plan of operation submitted under subsection 3 of this section and shall promulgate rules to effectuate the transitional plan of operation. Such rules shall be effective no later than October 1, 2013. Any rule or portion of a rule, as that term is defined in section 536.010, 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 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 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, 2013, shall be invalid and void.

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

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of sections 376.960 to 376.989, including the authority, with the approval of the director, to enter into contracts with similar pools of other states for the joint performance of common administrative 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 for recovery of any assessments for, on behalf of, or against pool members;

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

(4) Establish appropriate rates, rate schedules, rate

1 adjustments, expense allowances, agents' referral fees, claim
2 reserve formulas and any other actuarial function appropriate to
3 the operation of the pool. Rates shall not be unreasonable in
4 relation to the coverage provided, the risk experience and
5 expenses of providing the coverage. Rates and rate schedules may
6 be adjusted for appropriate risk factors such as age and area
7 variation in claim costs and shall take into consideration
8 appropriate risk factors in accordance with established actuarial
9 and underwriting practices;
10 (5) Assess members of the pool in accordance with the
11 provisions of this section, and to make advance interim
12 assessments as may be reasonable and necessary for the
13 organizational and interim operating expenses. Any such interim
14 assessments are to be credited as offsets against any regular
15 assessments due following the close of the fiscal year;
16 (6) Prior to January 1, 2014, issue policies of insurance
17 in accordance with the requirements of sections 376.960 to
18 376.989. In no event shall new policies of insurance be issued
19 on or after January 1, 2014;
20 (7) Appoint, from among members, appropriate legal,
21 actuarial and other committees as necessary to provide technical
22 assistance in the operation of the pool, policy or other contract
23 design, and any other function within the authority of the pool;
24 (8) Establish rules, conditions and procedures for
25 reinsuring risks of pool members desiring to issue pool plan
26 coverages in their own name. Such reinsurance facility shall not
27 subject the pool to any of the capital or surplus requirements,
28 if any, otherwise applicable to reinsurers;

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

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

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. Prior to January 1, 2014, 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;

1 (5) Any person, regardless of age, that can be claimed as a
2 dependent of a trade act eligible individual on such trade act
3 eligible individual's tax filing;
4 (6) Any person whose health insurance coverage is
5 involuntarily terminated for any reason other than nonpayment of
6 premium or fraud, and who is not otherwise ineligible under
7 subdivision (4) of subsection 3 of this section. If application
8 for pool coverage is made not later than sixty-three days after
9 the involuntary termination, the effective date of the coverage
10 shall be the date of termination of the previous coverage;
11 (7) Any person whose premiums for health insurance coverage
12 have increased above the rate established by the board under
13 paragraph (a) of subdivision (1) of subsection 3 of this section;
14 (8) Any person currently insured who would have qualified
15 as a federally defined eligible individual or a trade act
16 eligible individual between the effective date of the federal
17 Health Insurance Portability and Accountability Act of 1996,
18 Public Law 104-191 and the effective date of this act.
19 3. The following individual persons shall not be eligible
20 for coverage under the pool:
21 (1) Persons who have, on the date of issue of coverage by
22 the pool, or obtain coverage under health insurance or an
23 insurance arrangement substantially similar to or more
24 comprehensive than a plan policy, or would be eligible to have
25 coverage if the person elected to obtain it, except that:
26 (a) This exclusion shall not apply to a person who has such
27 coverage but whose premiums have increased to one hundred fifty
28 percent to two hundred percent of rates established by the board

1 as applicable for individual standard risks;
2 (b) A person may maintain other coverage for the period of
3 time the person is satisfying any preexisting condition waiting
4 period under a pool policy; and
5 (c) A person may maintain plan coverage for the period of
6 time the person is satisfying a preexisting condition waiting
7 period under another health insurance policy intended to replace
8 the pool policy;
9 (2) Any person who is at the time of pool application
10 receiving health care benefits under section 208.151;
11 (3) Any person having terminated coverage in the pool
12 unless twelve months have elapsed since such termination, unless
13 such person is a federally defined eligible individual;
14 (4) Any person on whose behalf the pool has paid out one
15 million dollars in benefits;
16 (5) Inmates or residents of public institutions, unless
17 such person is a federally defined eligible individual, and
18 persons eligible for public programs;
19 (6) Any person whose medical condition which precludes
20 other insurance coverage is directly due to alcohol or drug abuse
21 or self-inflicted injury, unless such person is a federally
22 defined eligible individual or a trade act eligible individual;
23 (7) Any person who is eligible for Medicare coverage.
24 4. Any person who ceases to meet the eligibility
25 requirements of this section may be terminated at the end of such
26 person's policy period.
27 5. If an insurer issues one or more of the following or
28 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. Coverage under the pool shall expire on January 1, 2014.

376.968. The board shall select an insurer **[**or**]**, insurers, or third-party administrators through a competitive bidding process to administer the pool. The board shall evaluate bids submitted based on criteria established by the board which shall include:

(1) The insurer's proven ability to handle individual accident and health insurance;

(2) The efficiency of the insurer's claim-paying procedures;

(3) An estimate of total charges for administering the plan;

(4) The insurer's ability to administer the pool in a cost-efficient manner.

376.970. 1. The administering insurer shall serve for a period of three years subject to removal for cause. At least one year prior to the expiration of each three-year period of service by an administering insurer, the board shall invite all insurers,

including the current administering insurer, to submit bids to serve as the administering insurer for the succeeding three-year period. Selection of the administering insurer for the succeeding period shall be made at least six months prior to the end of the current three-year period.

2. The administering insurer shall:

(1) Perform all eligibility and administrative claim-payment functions relating to the pool;

(2) Establish a premium billing procedure for collection of premium from insured persons. Billings shall be made on a period basis as determined by the board;

(3) Perform all necessary functions to assure timely payment of benefits to covered persons under the pool including:

(a) Making available information relating to the proper manner of submitting a claim for benefits to the pool and distributing forms upon which submission shall be made;

(b) Evaluating the eligibility of each claim for payment by the pool;

(4) Submit regular reports to the board regarding the operation of the pool. The frequency, content and form of the report shall be determined by the board;

(5) Following the close of each calendar year, determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the board and the department on a form prescribed by the director;

(6) Be paid as provided in the plan of operation for its expenses incurred in the performance of its services.

1 3. On or before September 1, 2013, the board shall invite
2 all insurers and third-party administrators, including the
3 current administering insurer, to submit bids to serve as the
4 administering insurer or third-party administrator for the pool.
5 Selection of the administering insurer or third-party
6 administrator shall be made prior to January 1, 2014.
7 4. Beginning January 1, 2014, the administering insurer or
8 third-party administrator shall:
9 (1) Submit to the board and director a detailed plan
10 outlining the winding down of operations of the pool. The plan
11 shall be submitted no later than January 31, 2014, and shall be
12 updated quarterly thereafter;
13 (2) Perform all administrative claim-payment functions
14 relating to the pool;
15 (3) Perform all necessary functions to assure timely
16 payment of benefits to covered persons under the pool including:
17 (a) Making available information relating to the proper
18 manner of submitting a claim for benefits to the pool and
19 distributing forms upon which submission shall be made;
20 (b) Evaluating the eligibility of each claim for payment by
21 the pool;
22 (4) Submit regular reports to the board regarding the
23 operation of the pool. The frequency, content and form of the
24 report shall be determined by the board;
25 (5) Following the close of each calendar year, determine
26 the expense of administration, and the paid and incurred losses
27 for the year, and report such information to the board and
28 department on a form prescribed by the director;

1 <u>(6) Be paid as provided in the plan of operation for its</u>
2 <u>expenses incurred in the performance of its services.</u>
3 376.973. 1. Following the close of each fiscal year, the
4 pool administrator shall determine the net premiums (premiums
5 less administrative expense allowances), the pool expenses of
6 administration and the incurred losses for the year, taking into
7 account investment income and other appropriate gains and losses.
8 Health insurance premiums and benefits paid by an insurance
9 arrangement that are less than an amount determined by the board
10 to justify the cost of collection shall not be considered for
11 purposes of determining assessments. The total cost of pool
12 operation shall be the amount by which all program expenses,
13 including pool expenses of administration, incurred losses for
14 the year, and other appropriate losses exceeds all program
15 revenues, including net premiums, investment income, and other
16 appropriate gains.
17 2. Each insurer's assessment shall be determined by
18 multiplying the total cost of pool operation by a fraction, the
19 numerator of which equals that insurer's premium and subscriber
20 contract charges for health insurance written in the state during
21 the preceding calendar year and the denominator of which equals
22 the total of all premiums, subscriber contract charges written in
23 the state and one hundred ten percent of all claims paid by
24 insurance arrangements in the state during the preceding calendar
25 year; provided, however, that the assessment for each health
26 maintenance organization shall be determined through the
27 application of an equitable formula based upon the value of
28 services provided in the preceding calendar year.

3. Each insurance arrangement's assessment shall be determined by multiplying the total cost of pool operation calculated under subsection 1 of this section by a fraction, the numerator of which equals one hundred ten percent of the benefits paid by that insurance arrangement on behalf of insureds in this state during the preceding calendar year and the denominator of which equals the total of all premiums, subscriber contract charges and one hundred ten percent of all benefits paid by insurance arrangements made on behalf of insureds in this state during the preceding calendar year. Insurance arrangements shall report to the board claims payments made in this state on an annual basis on a form prescribed by the director.

4. If assessments exceed actual losses and administrative expenses of the pool, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" include reserves for incurred but not paid claims.

5. Assessments shall continue until such a time as the executive director of the pool provides notice to the board and director that all claims have been paid.

6. Any assessment funds remaining at the time the executive director provides notice that all claims have been paid shall be deposited in the state general revenue fund.

376.1192. 1. As used in this section, "health benefit plan" and "health carrier" shall have the same meaning as such terms are defined in section 376.1350.

2. Beginning September 1, 2013, the oversight division of the joint committee on legislative research shall perform an

1 actuarial analysis of the cost impact to health carriers,
2 insureds with a health benefit plan, and other private and public
3 payers if state mandates were enacted to provide health benefit
4 plan coverage for the following:
5 (1) Orally administered anticancer medication that is used
6 to kill or slow the growth of cancerous cells charged at the same
7 co-payment, deductible, or coinsurance amount as intravenously
8 administered or injected cancer medication that is provided,
9 regardless of formulation or benefit category determination by
10 the health carrier administering the health benefit plan;
11 (2) Diagnosis and treatment of eating disorders that
12 include anorexia nervosa, bulimia, binge eating, eating disorders
13 nonspecified, and any other severe eating disorders contained in
14 the most recent version of the Diagnostic and Statistical Manual
15 of Mental Disorders published by the American Psychiatric
16 Association. The actuarial analysis shall assume the following
17 are included in health benefit plan coverage:
18 (a) Residential treatment for eating disorders, if such
19 treatment is medically necessary in accordance with the Practice
20 Guidelines for the Treatment of Patients with Eating Disorders,
21 as most recently published by the American Psychiatric
22 Association; and
23 (b) Access to medical treatment that provides coverage for
24 integrated care and treatment as recommended by medical and
25 mental health care professionals, including but not limited to
26 psychological services, nutrition counseling, physical therapy,
27 dietician services, medical monitoring, and psychiatric
28 monitoring.

3. By December 31, 2013, the director of the oversight division of the joint committee on legislative research shall submit a report of the actuarial findings prescribed by this section to the speaker of the house of representatives, the president pro tempore of the senate, and the chairpersons of the house of representatives committee on health insurance and the senate small business, insurance and industry committee, or the committees having jurisdiction over health insurance issues if the preceding committees no longer exist.

4. For the purposes of this section, the actuarial analysis of health benefit plan coverage shall assume that such coverage:

(1) Shall not be subject to any greater deductible or co-payment than other health care services provided by the health benefit plan; and

(2) Shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policies of six months' or less duration, or any other supplemental policy.

5. The cost for each actuarial analysis shall not exceed thirty thousand dollars and the oversight division of the joint committee on legislative research may utilize any actuary contracted to perform services for the Missouri consolidated health care plan to perform the analysis required under this section.

6. The provisions of this section shall expire on December 31, 2013.

376.1363. 1. A health carrier shall maintain written procedures for making utilization review decisions and for notifying enrollees and providers acting on behalf of enrollees of its decisions. For purposes of this section, "enrollee" includes the representative of an enrollee.

2. For initial determinations, a health carrier shall make the determination within two working days of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required:

(1) In the case of a determination to certify an admission, procedure or service, the carrier shall notify the provider rendering the service by telephone or electronically within twenty-four hours of making the initial certification, and provide written or electronic confirmation of **[**the**]** a telephone or electronic notification to the enrollee and the provider within two working days of making the initial certification;

(2) In the case of an adverse determination, the carrier shall notify the provider rendering the service by telephone or electronically within twenty-four hours of making the adverse determination; and shall provide written or electronic confirmation of **[**the**]** a telephone or electronic notification to the enrollee and the provider within one working day of making the adverse determination.

3. For concurrent review determinations, a health carrier shall make the determination within one working day of obtaining

1 all necessary information:

2 (1) In the case of a determination to certify an extended
3 stay or additional services, the carrier shall notify by
4 telephone or electronically the provider rendering the service
5 within one working day of making the certification, and provide
6 written or electronic confirmation to the enrollee and the
7 provider within one working day after **[**the**]** telephone or
8 electronic notification. The written notification shall include
9 the number of extended days or next review date, the new total
10 number of days or services approved, and the date of admission or
11 initiation of services;

12 (2) In the case of an adverse determination, the carrier
13 shall notify by telephone or electronically the provider
14 rendering the service within twenty-four hours of making the
15 adverse determination, and provide written or electronic
16 notification to the enrollee and the provider within one working
17 day of **[**the**]** a telephone or electronic notification. The service
18 shall be continued without liability to the enrollee until the
19 enrollee has been notified of the determination.

20 4. For retrospective review determinations, a health
21 carrier shall make the determination within thirty working days
22 of receiving all necessary information. A carrier shall provide
23 notice in writing of the carrier's determination to an enrollee
24 within ten working days of making the determination.

25 5. A written notification of an adverse determination shall
26 include the principal reason or reasons for the determination,
27 the instructions for initiating an appeal or reconsideration of
28 the determination, and the instructions for requesting a written

1 statement of the clinical rationale, including the clinical
2 review criteria used to make the determination. A health carrier
3 shall provide the clinical rationale in writing for an adverse
4 determination, including the clinical review criteria used to
5 make that determination, to any party who received notice of the
6 adverse determination and who requests such information.
7 6. A health carrier shall have written procedures to
8 address the failure or inability of a provider or an enrollee to
9 provide all necessary information for review. In cases where the
10 provider or an enrollee will not release necessary information,
11 the health carrier may deny certification of an admission,
12 procedure or service.
13 376.1575. As used in sections 376.1575 to 376.1580, the
14 following terms shall mean:
15 (1) "Completed application", a practitioner's application
16 to a health carrier that seeks the health carrier's authorization
17 for the practitioner to provide patient care services as a member
18 of the health carrier's network and does not omit any information
19 which is clearly required by the application form and the
20 accompanying instructions;
21 (2) "Credentialing", a health carrier's process of
22 assessing and validating the qualifications of a practitioner to
23 provide patient care services and act as a member of the health
24 carrier's provider network;
25 (3) "Health carrier", the same meaning as such term is
26 defined in section 376.1350;
27 (4) "Practitioner":
28 (a) A physician or physician assistant eligible to provide

treatment services under chapter 334;

(b) A pharmacist eligible to provide services under chapter 338;

(c) A dentist eligible to provide services under chapter 332;

(d) A chiropractor eligible to provide services under chapter 331;

(e) An optometrist eligible to provide services under chapter 336;

(f) A podiatrist eligible to provide services under chapter 330;

(g) A psychologist or licensed clinical social worker eligible to provide services under chapter 337; or

(h) An advanced practice nurse eligible to provide services under chapter 335.

376.1578. 1. Within two working days after receipt of a faxed or mailed completed application, the health carrier shall send a notice of receipt to the practitioner. A health carrier shall provide access to a provider web portal that allows the practitioner to receive notice of the status of an electronically submitted application.

2. A health carrier shall assess a health care practitioner's credentialing information and make a decision as to whether to approve or deny the practitioner's credentialing application within sixty business days of the date of receipt of the completed application. The sixty-day deadline established in this section shall not apply if the application or subsequent verification of information indicates that the practitioner has:

(1) A history of behavioral disorders or other impairments affecting the practitioner's ability to practice, including but not limited to substance abuse;

(2) Licensure disciplinary actions against the practitioner's license to practice imposed by any state or territory or foreign jurisdiction;

(3) Had the practitioner's hospital admitting or surgical privileges or other organizational credentials or authority to practice revoked, restricted, or suspended based on the practitioner's clinical performance; or

(4) A judgment or judicial award against the practitioner arising from a medical malpractice liability lawsuit.

3. The department of insurance, financial institutions and professional registration shall establish a mechanism for reporting alleged violations of this section to the department.

376.1900. 1. As used in this section, the following terms shall mean:

(1) "Electronic visit", or "e-Visit", an online electronic medical evaluation and management service completed using a secured web-based or similar electronic-based communications network for a single patient encounter. An electronic visit shall be initiated by a patient or by the guardian of a patient with the health care provider, be completed using a federal Health Insurance Portability and Accountability Act (HIPAA) compliant online connection, and include a permanent record of the electronic visit;

(2) "Health benefit plan" shall have the same meaning ascribed to it in section 376.1350;

1 (3) "Health care provider" shall have the same meaning
2 ascribed to it in section 376.1350;
3 (4) "Health care service", a service for the diagnosis,
4 prevention, treatment, cure or relief of a physical or mental
5 health condition, illness, injury or disease;
6 (5) "Health carrier" shall have the same meaning ascribed
7 to it in section 376.1350;
8 (6) "Telehealth" shall have the same meaning ascribed to it
9 in section 208.670.
10 2. Each health carrier or health benefit plan that offers
11 or issues health benefit plans which are delivered, issued for
12 delivery, continued, or renewed in this state on or after January
13 1, 2014, shall not deny coverage for a health care service on the
14 basis that the health care service is provided through telehealth
15 if the same service would be covered if provided through face-to-
16 face diagnosis, consultation, or treatment.
17 3. A health carrier may not exclude an otherwise covered
18 health care service from coverage solely because the service is
19 provided through telehealth rather than face-to-face consultation
20 or contact between a health care provider and a patient.
21 4. A health carrier shall not be required to reimburse a
22 telehealth provider or a consulting provider for site origination
23 fees or costs for the provision of telehealth services; however,
24 subject to correct coding, a health carrier shall reimburse a
25 health care provider for the diagnosis, consultation, or
26 treatment of an insured or enrollee when the health care service
27 is delivered through telehealth on the same basis that the health
28 carrier covers the service when it is delivered in person.

5. A health care service provided through telehealth shall not be subject to any greater deductible, copayment, or coinsurance amount than would be applicable if the same health care service was provided through face-to-face diagnosis, consultation, or treatment.

6. A health carrier shall not impose upon any person receiving benefits under this section any copayment, coinsurance, or deductible amount, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the policy, contract, or health benefit plan.

7. Nothing in this section shall preclude a health carrier from undertaking utilization review to determine the appropriateness of telehealth as a means of delivering a health care service, provided that the determinations shall be made in the same manner as those regarding the same service when it is delivered in person.

8. A health carrier or health benefit plan may limit coverage for health care services that are provided through telehealth to health care providers that are in a network approved by the plan or the health carrier.

9. Nothing in this section shall be construed to require a health care provider to be physically present with a patient where the patient is located unless the health care provider who is providing health care services by means of telehealth determines that the presence of a health care provider is necessary.

1 10. The provisions of this section shall not apply to a
2 supplemental insurance policy, including a life care contract,
3 accident-only policy, specified disease policy, hospital policy
4 providing a fixed daily benefit only, Medicare supplement policy,
5 long-term care policy, short-term major medical policies of six
6 months' or less duration, or any other supplemental policy as
7 determined by the director of the department of insurance,
8 financial institutions and professional registration.
9 376.2000. 1. Sections 376.2000 to 376.2014 shall be known
10 and may be cited as the "Health Insurance Marketplace Innovation
11 Act of 2013".
12 2. As used in sections 376.2000 to 376.2014, the following
13 terms mean:
14 (1) "Department", the department of insurance, financial
15 institutions and professional registration;
16 (2) "Director", the director of the department of
17 insurance, financial institutions and professional registration;
18 (3) "Exchange", any health benefit exchange established or
19 operating in this state, including any exchange established or
20 operated by the United States Department of Health and Human
21 Services.
22 (4) "Navigator", a person that, for compensation, provides
23 information or services in connection with eligibility,
24 enrollment, or program specifications of any health benefit
25 exchange operating in this state, including any person that is
26 selected to perform the activities and duties identified in 42
27 U.S.C. 18031(i) in this state, any person who receives funds from
28 the United States Department of Health and Human Services to

perform any of the activities and duties identified in 42 U.S.C. 18031(i), or any other person certified by the United States Department of Health and Human Services, or a health benefit exchange operating in this state, to perform such defined or related duties irrespective of whether such person is identified as a navigator, certified application counselor, in-person assister, or other title. A "navigator" does not include any not-for-profit entity disseminating to a general audience public health information.

376.2002. 1. No individual or entity shall perform, offer to perform, or advertise any service as a navigator in this state, or receive navigator funding from the state or an exchange unless licensed as a navigator by the department under sections 376.2000 to 376.2014.

2. A navigator may:

(1) Provide fair and impartial information and services in connection with eligibility, enrollment, and program specifications of any health benefit exchange operating in this state, including information about the costs of coverage, advance payments of premium tax credits, and cost sharing reductions;

(2) Facilitate the selection of a qualified health plan;

(3) Initiate the enrollment process;

(4) Provide referrals to any applicable office of health insurance consumer assistance, ombudsman, or other agency for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or determination under the plan; and

(5) Use culturally and linguistically appropriate language to communicate the information authorized in this subsection.

1 3. Unless also properly licensed as an insurance producer
2 in this state with authority for health under section 375.014, a
3 navigator shall not:
4 (1) Sell, solicit, or negotiate health insurance;
5 (2) Engage in any activity that would require an insurance
6 producer license;
7 (3) Provide advice concerning the benefits, terms, and
8 features of a particular health plan or offer advice about which
9 exchange health plan is better or worse for a particular
10 individual or employer;
11 (4) Recommend or endorse a particular health plan or advise
12 consumers about which health plan to choose; or
13 (5) Provide any information or services related to health
14 benefit plans or other products not offered in the exchange.
15 4. The following entities or persons are exempt from the
16 requirement to be licensed as a navigator:
17 (1) An entity or person licensed as an insurance producer
18 in this state with authority for health under section 375.014;
19 (2) A law firm or licensed attorney in this state; and
20 (3) A "health care provider" as defined in section 376.1350
21 provided that:
22 (a) The health care provider does not receive any funds
23 from the United States Department of Health and Human Services or
24 a health exchange operating in this state to act as a navigator;
25 and
26 (b) The activities or functions performed are related to
27 advising, assisting, or counseling patients regarding private or
28 public coverage or financial matters related to medical

treatments or government assistance programs.
However, nothing in this section shall prohibit a health care provider from voluntarily becoming licensed as a navigator.

376.2004. 1. An individual applying for a navigator license shall make application to the department on a form developed by the director and declare under penalty of refusal, suspension, or revocation of the license that the statements made in the application are true, correct, and complete to the best of the individual's knowledge and belief. Before approving the application, the director shall find that the individual:

(1) Is eighteen years of age or older;

(2) Resides in this state or maintains his or her principal place of business in the state;

(3) Is not disqualified for having committed any act that would be grounds for refusal to issue, renew, suspend, or revoke an insurance producer license under section 375.141;

(4) Has successfully passed the written examination prescribed by the director;

(5) When applicable, has the written consent of the director under 18 U.S.C. 1033 or any successor statute regulating crimes by or affecting persons engaged in the business of insurance whose activities affect interstate commerce;

(6) Has identified the entity with which he or she is affiliated and supervised; and

(7) Has paid the fees prescribed by the director.

2. An entity that acts as a navigator, supervises the activities of individual navigators, or receives funding to perform such activities shall obtain a navigator entity license.

1 An entity applying for an entity navigator license shall make
2 application on a form containing the information prescribed by
3 the director.
4 3. The director may require any documents deemed necessary
5 to verify the information contained in an application submitted
6 in accordance with subsections 1 and 2 of this section.
7 4. Entities licensed as navigators shall, in a manner
8 prescribed by the director, provide a list of all individual
9 navigators that are employed by or in any manner affiliated with
10 the navigator entity and shall report any changes in employment
11 or affiliation within twenty days of such change.
12 5. Prior to any exchange becoming operational in this
13 state, the director shall prescribe initial training, continuing
14 education, and written examination standards and requirements for
15 navigators.
16 376.2006. 1. A navigator license shall be valid for two
17 years.
18 2. A navigator may file an application for renewal of a
19 license and pay the renewal fee as prescribed by the director.
20 Any navigator who fails to timely file for license renewal shall
21 be charged a late fee in an amount prescribed by the director.
22 3. Prior to the filing date for an application for renewal
23 of a license, an individual licensee shall comply with any
24 ongoing training and continuing education requirements
25 established by the director. Such navigator shall file with the
26 director, by a method prescribed by the director, proof of
27 satisfactory certification of completion of the continuing
28 education requirements. Any failure to fulfill the ongoing

training and continuing education requirements shall result in the expiration of the license.

376.2008. Upon contact with a person who acknowledges having existing health insurance coverage obtained through an insurance producer, a navigator shall advise the person to consult with a licensed insurance producer regarding coverage in the private market.

376.2010. 1. The director may place on probation, suspend, revoke, or refuse to issue, renew, or reinstate a navigator license or may levy a fine not to exceed one thousand dollars for each violation, or any combination of actions, for any one or more of the causes listed in section 375.141, 375.936 or for other good cause. In the event that the action by the director is not to renew or to deny an application for a license, the director shall notify the applicant or licensee in writing and shall advise the applicant or licensee of the reason for the denial or nonrenewal. Appeal of the nonrenewal or denial of the application for a navigator license shall be made under the provisions of chapter 621.

2. In addition to imposing the penalties authorized by subsection 1 of this section, the director may require that restitution be made to any person who has suffered financial injury because of a violation of this section.

3. The director shall have the power to examine and investigate the business affairs and records of any navigator to determine whether the individual or entity has engaged or is engaging in any violation of this section.

4. The navigator license held by an entity may be suspended

1 or revoked, renewal or reinstatement thereof may be refused, or a
2 fine may be levied, with or without a suspension, revocation, or
3 refusal to renew a license, if the director finds that an
4 individual licensee's violation was known or should have been
5 known by the employing or supervising entity and the violation
6 was not reported to the director and no corrective action was
7 undertaken on a timely basis.

8 376.2011. 1. If the director determines that a person has
9 engaged, is engaging, or has taken a substantial step toward
10 engaging in an act, practice, omission, or course of business
11 constituting a violation of sections 376.2000 to 376.2014 or a
12 rule adopted or order issued pursuant thereto, or a person has
13 materially aided or is materially aiding an act, practice,
14 omission, or course of business constituting a violation in
15 sections 376.2000 to 376.2014 or a rule adopted or order issued
16 pursuant thereto, the director may issue such administrative
17 orders as authorized under section 374.046.

18 2. If the director believes that a person has engaged, is
19 engaging, or has taken a substantial step toward engaging in an
20 act, practice, omission, or course of business constituting a
21 violation of sections 376.2000 to 376.2014 or a rule adopted or
22 order issued pursuant thereto, or that a person has materially
23 aided or is materially aiding an act, practice, omission, or
24 course of business constituting a violation in sections 376.2000
25 to 376.2014 or a rule adopted or order issued pursuant thereto,
26 the director may maintain a civil action for relief authorized
27 under section 374.048.

28 3. A violation of sections 376.2000 to 376.2014 is a level

two violation under section 374.049.

376.2012. 1. Each licensed navigator shall report to the director within thirty calendar days of the final disposition of the matter of any administrative action taken against him or her in another jurisdiction or by another governmental agency in this state. This report shall include a copy of the order, consent to order, or other relevant legal documents.

2. Within thirty days of the initial pretrial hearing date, a navigator shall report to the director any criminal prosecution of the navigator in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing, and any other relevant legal documents.

3. An entity that acts as a navigator that terminates the employment, engagement, affiliation, or other relationship with an individual navigator shall notify the director within twenty days following the effective date of the termination, using a format prescribed by the director if the reason for termination is one of the reasons set forth in section 375.141 or 375.936 or if the entity has knowledge that the navigator was found by a court or governmental body to have engaged in any such activities. Upon the written request of the director, the entity shall provide additional information, documents, records, or other data pertaining to the termination or activity of the individual.

376.2014. 1. The requirements of sections 379.930 to 379.952 and chapters 375, 376, 407 and any related rules shall apply to navigators. The activities and duties of a navigator shall be deemed to constitute transacting the business of

insurance.

2. If any provision of sections 376.2000 to 376.2014 or its application to any person or circumstance is held invalid by a court of competent jurisdiction or by federal law, the invalidity does not affect other provisions or applications of sections 376.2000 to 376.2014 that can be given effect without the invalid provision or application. The provisions of sections 376.2000 to 376.2014 are severable, and the valid provisions or applications shall remain in full force and effect.

3. The director may promulgate rules and regulations to implement and administer the provisions of sections 376.2000 to 376.2014. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in sections 376.2000 to 376.2014 shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. Sections 376.2000 to 376.2014 and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 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, 2013, shall be invalid and void.

Section 1. Notwithstanding any other provision of law to the contrary, the department of insurance, financial institutions and professional registration shall exercise its authority and responsibility over health insurance product form filings, consumer complaints, and investigations into compliance with

1 state law, regardless as to how a health insurance product may be
2 sold or marketed in this state or to residents of this state.
3 Section B. The enactment of sections 376.1575, 376.1578,
4 and 376.1900 of this act shall become effective January 1, 2014.
5 Section C. Because of the need to ensure that navigators
6 are adequately trained to provide essential health insurance
7 information to the public and because of the need to ensure that
8 the Department of Insurance, Financial Institutions and
9 Professional Registration has the regulatory authority to oversee
10 the marketing of health insurance products in this state, the
11 enactment of sections 376.2000, 376.2002, 376.2004, 376.2006,
12 376.2008, 376.2010, 376.2011, 376.2012, 376.2014, and section 1
13 of this act are deemed necessary for the immediate preservation
14 of the public health, welfare, peace and safety, and are hereby
15 declared to be an emergency act within the meaning of the
16 constitution, and the enactment of sections 376.2000, 376.2002,
17 376.2004, 376.2006, 376.2008, 376.2010, 376.2011, 376.2012,
18 376.2014, and section 1 of this act shall be in full force and
19 effect upon its passage and approval.
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26 ____________________________ _____________________________
27 Shalonn "Kiki" Curls Chris Molendorp