FIRST REGULAR SESSION

SENATE COMMITTEE SUBSTITUTE FOR

SENATE BILL NO. 403

97TH GENERAL ASSEMBLY

Reported from the Committee on Small Business, Insurance and Industry, April 11, 2013, with recommendation that the Senate Committee Substitute do pass.

TERRY L. SPIELER, Secretary.

1801S.02C

AN ACT

To repeal sections 354.410, 354.430, 354.603, 376.405, 376.426, 376.446, 376.777, and 376.1363, RSMo, and to enact in lieu thereof sixteen new sections relating to health insurance, with penalty provisions.

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

Section A. Sections 354.410, 354.430, 354.603, 376.405, 376.426, 376.446, 376.777, and 376.1363, RSMo, are repealed and sixteen new sections enacted in lieu thereof, to be known as sections 354.410, 354.430, 354.603, 376.405, 376.426, 376.446, 376.777, 376.1363, 376.2000, 376.2002, 376.2004, 376.2006, 376.2008, 376.2010, 376.2012, and 376.2014, to read as follows:

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

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

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;

(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 model, or three hundred thousand dollars for an individual practice association. At the beginning of each succeeding year, unless not applicable, the organization shall deposit with the director, or organization or trustee, cash, securities, or any combination of these or other measures acceptable to the director, in an amount equal to four percent of its estimated annual uncovered expenditures for that year.

(2) Unless not applicable, an organization that is in operation on September 28, 1983, shall make a deposit equal to the larger of: (a) one percent of the preceding twelve months' uncovered expenditures, or (b) one hundred fifty thousand dollars for a medical group/staff model, or three hundred thousand dollars for an individual practice association on the first day of the first calendar year beginning six months or more after September 28, 1983. In the second calendar year, if applicable, the amount of the additional deposit shall be equal to two percent of its estimated annual uncovered expenditures. In the third calendar year, if applicable, the additional deposit shall be equal to three percent of its estimated annual uncovered expenditures for that year, and in the fourth calendar year and subsequent years, if applicable, the additional deposit shall be equal to four percent of its estimated annual uncovered expenditures for each year. Each year's estimate, after the first year of operation, shall reasonably reflect the prior years' operating experience and delivery arrangements. The director may waive any of the deposit requirements set forth in subdivisions (1) and (2) above, whenever satisfied that the organization has sufficient net worth and an adequate history of generating net income to assure its financial viability for the next year, or its performance and obligations are guaranteed by an organization with sufficient net worth and an adequate history of generating net income, or the assets of the organization or its contracts with insurers, hospital or medical service corporations, governments, or other organizations are sufficient to reasonably assure the performance of its obligations.

3. When an organization has achieved a net worth not including land, buildings, and equipment, of at least one million dollars or has achieved a net worth including organization-related land, buildings, and equipment of at least five million dollars, the annual deposit requirements shall not apply. The annual deposit requirement shall not apply to an organization if the total amount of the

deposit is equal to twenty-five percent of its estimated annual uncovered expenditures for the next calendar year, or the capital and surplus requirements for the formation or admittance of an accident and health insurer in this state, whichever is less. If the organization has a guaranteeing organization which has been in operation for at least five years and has a net worth not including land, buildings, and equipment of at least one million dollars or which has been in operation for at least ten years and has a net worth including organization-related land, buildings, and equipment of at least five million dollars, the annual deposit requirement shall not apply; provided, however, that if the guaranteeing organization is sponsoring more than one organization, the net worth requirement shall be increased by a multiple equal to the number of such organizations. This requirement to maintain a deposit in excess of the deposit required of an accident and health insurer shall not apply during any time that the guaranteeing organization maintains a net worth at least equal to the capital and surplus requirements for an accident and health insurer for each organization it sponsors.

4. All income from deposits shall belong to the depositing organization and shall be paid to it as it becomes available. A health maintenance organization that has made a securities deposit may withdraw the securities deposit or any part thereof, first having deposited, in lieu thereof, a deposit of cash, securities, or any combination of these or other measures of equal amount and value to that withdrawn. Any securities shall be approved by the director before being substituted.

5. In any year in which an annual deposit is not required of an organization, at its request the director shall reduce the required deposit by one hundred thousand dollars for each two hundred fifty thousand dollars of net worth in excess of the amount that allows it not to make an annual deposit. If the amount of net worth no longer supports a reduction of its required deposit, the organization shall immediately redeposit one hundred thousand dollars for each two hundred fifty thousand dollars of reduction in net worth, provided that its total deposit shall not exceed the maximum required under this section. Notwithstanding any provisions of sections 354.400 to 354.636, the deposit held by the director shall in no case be less than one hundred fifty thousand dollars for a group staff/model or three hundred thousand dollars for an individual practice association model.

6. Each health maintenance organization that obtains a certificate of

authority after September 28, 1983, shall have and maintain a capital account of at least one hundred fifty thousand dollars for a medical group/staff model, or three hundred thousand dollars for an individual practice association in addition to any deposit requirements under this section. The capital account shall be net of any accrued liabilities and be in the form of cash, securities or any combination of these or other measures acceptable to the director.

7. A certificate of authority shall be denied only after compliance with the requirements of section 354.490.

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 nongroup 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 made in a separate document issued to the enrollee.

5. A copy of the form of the evidence of coverage to be used in this state, and any amendment thereto, shall be subject to the filing of subsection 2 of this section unless it is subject to the jurisdiction of the director under the laws governing health insurance or health services corporations, in which event the filing provisions of those laws shall apply.

354.603. 1. A health carrier shall maintain a network that is sufficient in number and types of providers to assure that all services to enrollees shall be accessible without unreasonable delay. In the case of emergency services, enrollees shall have access twenty-four hours per day, seven days per week. The health carrier's medical director shall be responsible for the sufficiency and supervision of the health carrier's network. Sufficiency shall be determined by the director in accordance with the requirements of this section and by reference to any reasonable criteria, including but not limited to provider-enrollee ratios by specialty, primary care provider-enrollee ratios, geographic accessibility, reasonable distance accessibility criteria for pharmacy and other services, waiting times for appointments with participating providers, hours of operation, and the volume of technological and specialty services available to serve the needs of enrollees requiring technologically advanced or specialty care.

(1) In any case where the health carrier has an insufficient number or type of participating providers to provide a covered benefit, the health carrier shall ensure that the enrollee obtains the covered benefit at no greater cost than if the benefit was obtained from a participating provider, or shall make other arrangements acceptable to the director.

(2) The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers, including local pharmacists, to the business or personal residence of enrollees. In determining whether a health carrier has complied with this provision, the director shall give due consideration to the relative availability of health care providers in the service area under, especially rural areas, consideration.

(3) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, and legal authority of its providers to furnish all contracted benefits to

enrollees. The provisions of this subdivision shall not be construed to require any health care provider to submit copies of such health care provider's income tax returns to a health carrier. A health carrier may require a health care provider to obtain audited financial statements if such health care provider received ten percent or more of the total medical expenditures made by the health carrier.

(4) A health carrier shall make its entire network available to all enrollees unless a contract holder has agreed in writing to a different or reduced network.

2. A health carrier shall file with the director, in a manner and form defined by rule of the department of insurance, financial institutions and professional registration, an access plan meeting the requirements of sections 354.600 to 354.636 for each of the managed care plans that the health carrier offers in this state. The health carrier may request the director to deem sections of the access plan as proprietary or competitive information that shall not be made public. For the purposes of this section, information is proprietary or competitive if revealing the information will cause the health carrier's competitors to obtain valuable business information. The health carrier shall provide such plans, absent any information deemed by the director to be proprietary, to any interested party upon request. The health carrier shall prepare an access plan prior to offering a new managed care plan, and shall update an existing access plan whenever it makes any change as defined by the director to an existing managed care plan. The director shall approve or disapprove the access plan, or any subsequent alterations to the access plan, within sixty days of filing. The access plan shall describe or contain at a minimum the following:

(1) The health carrier's network;

(2) The health carrier's procedures for making referrals within and outside its network;

(3) The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of enrollees of the managed care plan;

(4) The health carrier's methods for assessing the health care needs of enrollees and their satisfaction with services;

(5) The health carrier's method of informing enrollees of the plan's services and features, including but not limited to the plan's grievance procedures, its process for choosing and changing providers, and its procedures

for providing and approving emergency and specialty care;

(6) The health carrier's system for ensuring the coordination and continuity of care for enrollees referred to specialty physicians, for enrollees using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(7) The health carrier's process for enabling enrollees to change primary care professionals;

(8) The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, in the event of a reduction in service area or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how enrollees shall be notified of the contract termination, reduction in service area or the health carrier's insolvency or other modification or cessation of operations, and transferred to other health care professionals in a timely manner; and

(9) Any other information required by the director to determine compliance with the provisions of sections 354.600 to 354.636.

3. In reviewing an access plan filed pursuant to subsection 2 of this section, the director shall deem a managed care plan's network to be adequate if it meets one or more of the following criteria:

(1) The managed care plan is a Medicare **[**+ Choice**]** **Advantage** coordinated care plan offered by the health carrier pursuant to a contract with the federal Centers for Medicare and Medicaid Services;

(2) The managed care plan is being offered by a health carrier that has been accredited by the National Committee for Quality Assurance at a level of "accredited" or better, and such accreditation is in effect at the time the access plan is filed;

(3) The managed care plan's network has been accredited by the Joint Commission on the Accreditation of Health Organizations for Network Adequacy, and such accreditation is in effect at the time the access plan is filed. If the accreditation applies to only a portion of the managed care plan's network, only the accredited portion will be deemed adequate; or

(4) The managed care plan is being offered by a health carrier that has been accredited by the Utilization Review Accreditation Commission at a level of "accredited" or better, and such accreditation is in effect at the time the access plan is filed.

4. Notwithstanding any other provision of law to the contrary, a health carrier, as defined in section 354.600, may offer a health benefit plan that is a managed care plan that requires all health care services to be delivered by a participating provider in the health carrier's network, except for emergency services, as defined in section 354.600, and the services described in subsection 4 of section 376.811. Such a provision shall be disclosed in the policy form.

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

2. The director of the department of insurance, financial institutions and professional registration shall have authority to make such reasonable rules and regulations concerning the filing and submission of **[**such policy forms**]** **policies** as are necessary, proper or advisable. Such rules and regulations shall provide, among other things, that if a policy form is disapproved, **[**the reasons therefor**]** **all specific reasons for noncompliance** shall be stated in writing **within forty-five days from the date of filing**; that a hearing shall be granted upon such disapproval, if so requested; and that the failure of the director of the department of insurance, financial institutions and professional registration to take action approving or disapproving a submitted policy form within **[**a stipulated time, not to exceed sixty**]** **forty-five** days from the date of filing, shall be deemed an approval thereof **[**until such time as the director of the department of insurance, financial institutions and professional registration shall notify the submitting company, in writing, of his disapproval thereof**]**. **If at any time after a policy form is approved or deemed approved, the director determines that any provision of the filing is contrary to state law, the director shall notify the health carrier of the specific provision that is contrary to state law and request that the health carrier file an amendment form that modifies the provision to conform to state law. The failure of the director of the department of insurance, financial institutions and professional registration to take action approving or disapproving a submitted amendment form within forty-five days from the date of**

filing shall be deemed an approval thereof. In the event that a policy form is approved or deemed approved and is subsequently amended for state law compliance upon the department's request as provided herein, the department shall not retroactively enforce the amended policy form.

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

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

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

(1) A provision that the policyholder is entitled to a grace period of thirty-one days for the payment of any premium due except the first, during

which grace period the policy shall continue in force, unless the policyholder shall have given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such grace period;

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

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

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

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

(a) The end of a continuous period of twelve months commencing on or

after the effective date of the person's coverage during all of which the person has received no medical advice or treatment in connection with such disease or physical condition; or

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

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

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

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

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

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

the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required;

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

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

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

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

(15) A provision specifying the conditions under which the policy may be terminated. Such provision shall state that except for nonpayment of the required premium or the failure to meet continued underwriting standards, the insurer may not terminate the policy prior to the first anniversary date of the

effective date of the policy as specified therein, and a notice of any intention to terminate the policy by the insurer must be given to the policyholder at least thirty-one days prior to the effective date of the termination. Any termination by the insurer shall be without prejudice to any expenses originating prior to the effective date of termination. An expense will be considered incurred on the date the medical care or supply is received;

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

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

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

(b) A resident of this state; and

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

(18) In the case of a policy insuring debtors, a provision that the insurer shall furnish to the policyholder for delivery to each debtor insured under the policy a certificate of insurance describing the coverage and specifying that the

benefits payable shall first be applied to reduce or extinguish the indebtedness.

(19) Notwithstanding any other provision of law to the contrary, a health carrier, as defined in section 376.1350, may offer a health benefit plan that is a managed care plan that requires all health care services to be delivered by a participating provider in the health carrier's network, except for emergency services, as defined in section 354.600, and the services described in subsection 4 of section 376.811. Such a provision shall be disclosed in the policy form.

376.446. 1. **Notwithstanding any other law or regulation to the contrary, any health carrier, as defined in section 376.1350, may offer as an option one or more health benefit plans which contain deductibles, coinsurance, coinsurance differentials, or variable copayments. Health benefit plans which contain deductibles may be combined with any health savings accounts (HSA) as described in the Medicare Reform Act, P.L. No. 108-173, Title XII, Section 1201.**

2. Health carriers shall permit individuals to learn the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's health benefit plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, such information shall be made available to such individual through an internet website and such other means for individuals without access to the internet. As used in this section, the terms "health carrier" and "health benefit plans" shall have the same meanings assigned to them in section 376.1350.

[2.**]** **3.** This section 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, hospitalization-surgical care policy, short-term major medical policy of six months or less duration, or any other supplemental policy.

4. Notwithstanding any other law or regulation to the contrary, no combination of deductibles and copayments paid for the receipt of basic health care services may exceed the annual maximum out-of-pocket expenses of a high deductible health plan as defined in 26 U.S.C. 223. Deductibles and copayments applicable to supplemental health care services, catastrophic-only plans as defined under the Affordable

Care Act, or pre-existing conditions are not subject to the annual limitations described in this section.

[3.**]** **5.** The provisions of subsections **[**1 and**]** 2 **and 3** shall become effective on January 1, 2014.

376.777. 1. Required provisions. Except as provided in subsection 3 of this section each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this subsection in the words in which the same appear in this section; provided, however, that the insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the director of the department of insurance, financial institutions and professional registration which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the director of the department of insurance, financial institutions and professional registration may approve.

(1) A provision as follows:

"ENTIRE CONTRACT; CHANGES:

This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions".

(When under the provisions of subdivision (2) of subsection 1 of section 376.775 the effective and termination dates are stated in the premium receipt, the insurer shall insert in the first sentence of the foregoing policy provision immediately following the comma after the word "any", the following words: "and the insurer's official premium receipt when executed").

(2) A provision as follows:

"TIME LIMIT ON CERTAIN DEFENSES:

(a) After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two-year period".

(The foregoing policy provision shall not be so construed as to affect any

legal requirements for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of subdivisions (1), (2), (3), (4) and (5) of subsection 2 of this section in the event of misstatement with 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 refuse any renewal shall have, at the beginning of the above provision, "Unless not less than five days prior to the premium due date the insurer has delivered to the insured or has mailed to his last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted").

(4) A provision as follows:

"REINSTATEMENT:

If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent

duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer, or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement".

(The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (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.)

(5) A provision as follows:

"NOTICE OF CLAIM:

Written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insured at ..... (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer".

(In a policy providing a loss-of-time benefit which may be payable for at least two years, an insurer may at its option insert the following between the first and second sentences of the above provision: "Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, he shall, at least once in every six months after having given notice of claim, give to the insurer notice of

continuance of said disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given").

(6) A provision as follows:

"CLAIM FORMS:

The insurer upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made".

(7) A provision as follows:

"PROOFS OF LOSS:

Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required".

(8) A provision as follows:

"TIME OF PAYMENT OF CLAIMS:

Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid ..... (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof".

(9) A provision as follows:

"PAYMENT OF CLAIMS:

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured".

(The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer:

"If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $..... (insert an amount which shall not exceed one thousand dollars), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment. Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person").

(10) A provision as follows:

"PHYSICAL EXAMINATIONS AND AUTOPSY:

The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law".

(11) A provision as follows:

"LEGAL ACTIONS:

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be

brought after the expiration of three years after the time written proof of loss is required to be furnished".

(12) A provision as follows:

"CHANGE OF BENEFICIARY:

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

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

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

(1) A provision as follows:

"CHANGE OF OCCUPATION:

If the insured be injured or contract sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the

policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation".

(2) A provision as follows:

"MISSTATEMENT OF AGE:

If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age".

(3) A provision as follows:

"OTHER INSURANCE IN THIS INSURER:

If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for ..... (insert type of coverage or coverages) in excess of $..... (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate, or in lieu thereof.

Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies".

(4) A provision as follows:

"INSURANCE WITH OTHER INSURERS:

If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this

insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage".

(If the foregoing policy provision is included in a policy which also contains the next following policy provision there shall be added to the caption of the foregoing provision the phrase "EXPENSE INCURRED BENEFITS". The insurer may, at its option, include in this provision a definition of "other valid coverage", approved as to form by the director of the department of insurance, financial institutions and professional registration, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the director of the department of insurance, financial institutions and professional registration. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employees benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage").

(5) A provision as follows:

"INSURANCE WITH OTHER INSURERS:

If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the

indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined".

(If the foregoing policy provision is included in a policy which also contains the next preceding policy provision there shall be added to the caption of the foregoing provision the phrase "OTHER BENEFITS". The insurer may, at its option, include in this provision a definition of "other valid coverage", approved as to form by the director of the department of insurance, financial institutions and professional registration which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the director of the department of insurance, financial institutions and professional registration. In the absence of such definition such term shall not include group insurance, or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute) whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage", of which the insurer has had notice. In applying the foregoing policy provision no third party liability coverage shall be included as "other valid coverage").

(6) A provision as follows:

"RELATION OF EARNINGS TO INSURANCE:

If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two years as shall exceed the pro rata amount of the premiums for

the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of two hundred dollars or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time".

(The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (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 this date of issue. The insurer may, at its option, include in this provision a definition of "valid loss of time coverage", approved as to form by the director of the department of insurance, financial institutions and professional registration, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the director of the department of insurance, financial institutions and professional registration or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations).

(7) A provision as follows:

"UNPAID PREMIUM:

Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom".

(8) A provision as follows:

"CANCELLATION:

The insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to his last address as shown by the records of the insurer, stating when, not less than five days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. If the insured cancels, the earned

premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation".

(9) A provision as follows:

"CONFORMITY WITH STATE STATUTES:

Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes".

(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, abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued.

5. Third party ownership. The word "insured" as used in sections 376.770 to 376.800, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits and rights provided therein.

6. Requirements of other jurisdictions.

(1) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of sections 376.770 to 376.800 and which is prescribed or required by the law of the state under which the insurer is organized.

(2) Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

7. Approval of policies.

(1) No policy subject to sections 376.770 to 376.800 shall be delivered or issued for delivery to any person in this state unless such policy, including any rider, endorsement or other provisions, supplementary thereto, shall have been approved by the director of the department of insurance, financial institutions and professional registration.

(2) The director of the department of insurance, financial institutions and professional registration shall have authority to make such reasonable rules and regulations concerning the filing and submission of policies as are necessary, proper or advisable. Such rules and regulations shall provide, among other things, that if a policy form is disapproved, **[**the reasons therefor**]** **all specific reasons for noncompliance** shall be stated in writing **within forty-five days from the date of filing**; that a hearing shall be granted upon such disapproval, if so requested; and that the failure of the director of the department of insurance, financial institutions and professional registration to take action approving or disapproving a submitted policy form within **[**a stipulated time, not to exceed sixty**]** **forty-five** days from the date of filing, shall be deemed an approval thereof **[**until such time as the director of the department of insurance, financial institutions and professional registration shall notify the submitting company, in writing, of his disapproval thereof**]**. **If at any time after a policy form is approved or deemed approved, the director determines that any provision of the filing is contrary to state law, the director shall notify**

the health carrier of the specific provision that is contrary to state law and request that the health carrier file an amendment form that modifies the provision to conform to state law. The failure of the director of the department of insurance, financial institutions and professional registration to take action approving or disapproving a submitted amendment form within forty-five days from the date of filing shall be deemed an approval thereof. In the event that a policy form is approved or deemed approved and is subsequently amended for state law compliance upon the department's request as provided herein, the department shall not retroactively enforce the amended policy form.

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

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

(5) Notwithstanding any other provision of law to the contrary, a health carrier, as defined in section 376.1350, may offer a health benefit plan that is a managed care plan that requires all health care services to be delivered by a participating provider in the health carrier's network, except for emergency services, as defined in section 354.600, and the services described in subsection 4 of section 376.811. Such a provision shall be disclosed in the policy form.

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 all necessary information:

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

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

4. For retrospective review determinations, a health carrier shall make

the determination within thirty working days of receiving all necessary information. A carrier shall provide notice in writing of the carrier's determination to an enrollee within ten working days of making the determination.

5. A written notification of an adverse determination shall include the principal reason or reasons for the determination, the instructions for initiating an appeal or reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination. A health carrier shall provide the clinical rationale in writing for an adverse determination, including the clinical review criteria used to make that determination, to any party who received notice of the adverse determination and who requests such information.

6. A health carrier shall have written procedures to address the failure or inability of a provider or an enrollee to provide all necessary information for review. In cases where the provider or an enrollee will not release necessary information, the health carrier may deny certification of an admission, procedure or service.

376.2000. 1. Sections 376.2000 to 376.2014 shall be known and may be cited as the "Health Insurance Marketplace Innovation Act of 2013".

2. As used in sections 376.2000 to 376.2014, the following terms mean:

(1) "Department", the department of insurance, financial institutions and professional registration;

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

(3) "Exchange", any health benefit exchange established or operating in this state, including any exchange established or operated by the United States Department of Health and Human Services.

(4) "Navigator", a person selected to perform the activities and duties identified in 42 U.S.C. 18031(i) in this state, any person who receives grant funds from 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), and any person performing any such defined or related duties irrespective of whether such person is identified as a navigator, certified application counselor, in-person assister, or other

title.

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 shall not:

(1) Engage in any activities that would require an insurance producer license;

(2) Provide advice concerning the benefits, terms, and features of a particular health plan or offer advice about which health plan is better or worse for a particular individual or employer;

(3) Recommend or endorse a particular health plan or advise consumers about which health plan to choose; or

(4) Provide any information or services related to health benefit plans or other products not offered in the exchange.

3. Only a person licensed as an insurance producer in this state may:

(1) Sell, solicit, or negotiate health insurance;

(2) Provide advice concerning the benefits, terms, and features of a particular health plan or offer advice about which health plan is better or worse for a particular individual or employer; or

(3) Recommend a particular health plan or advise consumers about which health plan to choose.

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. An entity applying for an entity navigator license shall make application on a form containing the information prescribed by the director.

3. The director may require any documents deemed necessary to verify the information contained in an application submitted in accordance with subsections 1 and 2 of this section.

4. Entities licensed as navigators shall, in a manner prescribed by the director, provide a list of all individual navigators that are employed by or in any manner affiliated with the navigator entity and shall report any changes in employment or affiliation within twenty days of such change.

5. The director shall require that each navigator obtain a surety bond in an amount acceptable to the director or otherwise demonstrate a level of financial responsibility capable of protecting all persons against the wrongful acts, misrepresentations, errors, omissions, or negligence of the navigator. The director may ask for a copy of the bond or other evidence of financial responsibility at any time.

6. Prior to any exchange becoming operational in this state, the director shall prescribe initial training, continuing education, and written examination standards and requirements for navigators.

376.2006. 1. A navigator license shall be valid for two years.

2. A navigator may file an application for renewal of a license and pay the renewal fee as prescribed by the director. Any navigator who fails to timely file for license renewal shall be charged a late fee in an amount prescribed by the director.

3. Prior to the filing date for an application for renewal of a license, an individual licensee shall comply with any ongoing training

and continuing education requirements established by the director. Such navigator shall file with the director, by a method prescribed by the director, proof of satisfactory certification of completion of the continuing 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 refer the person back to that insurance producer for information, assistance, and any other services.

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

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.

✓