

SECOND REGULAR SESSION  
[CORRECTED]  
HOUSE COMMITTEE SUBSTITUTE FOR  
SENATE SUBSTITUTE FOR  
SENATE COMMITTEE SUBSTITUTE FOR  
**SENATE BILL NOS. 865 & 866**  
**98TH GENERAL ASSEMBLY**

5458H.05C

D. ADAM CRUMBLISS, Chief Clerk

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**AN ACT**

To repeal sections 338.270, 338.347, 374.185, 376.1237, 376.1900, 379.934, 379.936, 379.938, and 379.940, RSMo, and to enact in lieu thereof fourteen new sections relating to health care.

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

Section A. Sections 338.270, 338.347, 374.185, 376.1237, 376.1900, 379.934, 379.936,  
2 379.938, and 379.940, RSMo, are repealed and fourteen new sections enacted in lieu thereof, to  
3 be known as sections 338.075, 338.202, 338.270, 338.347, 374.185, 376.379, 376.388, 376.465,  
4 376.1237, 376.1900, 379.934, 379.936, 379.938, and 379.940, to read as follows:

**338.075. 1. All licensees, registrants, and permit holders of the board of pharmacy  
2 shall report to the board of pharmacy:**  
3       **(1) Any final adverse action taken by another licensing state, jurisdiction, or  
4 government agency against any license, permit, or authorization held by the person or  
5 entity to practice or operate as a pharmacist, intern pharmacist, pharmacy technician,  
6 pharmacy, drug distributor, drug manufacturer, or drug outsourcing facility. For  
7 purposes of this section, "adverse action" shall include, but is not limited to, revocation,  
8 suspension, censure, probation, disciplinary reprimand, or disciplinary restriction of a  
9 license, permit, or other authorization or a voluntary surrender of such license, permit, or  
10 other authorization in lieu of discipline or adverse action;**

EXPLANATION — Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

11           **(2) Any surrender of a license or authorization to practice or operate as a**  
12 **pharmacist, intern pharmacist, pharmacy technician, pharmacy, drug distributor, drug**  
13 **manufacturer, or drug outsourcing facility while under disciplinary investigation by**  
14 **another licensing state, jurisdiction, or governmental agency; and**

15           **(3) Any exclusion to participate in any state or federally funded health care**  
16 **program such as Medicare, Medicaid, or MO HealthNet for fraud, abuse, or submission**  
17 **of any false or fraudulent claim, payment, or reimbursement request.**

18           **2. Reports shall be submitted as provided by the board of pharmacy by rule.**

19           **3. The board of pharmacy shall promulgate rules to implement the provisions of**  
20 **this section. Any rule or portion of a rule, as that term is defined in section 536.010, that**  
21 **is created under the authority delegated in this section shall become effective only if it**  
22 **complies with and is subject to all of the provisions of chapter 536 and, if applicable,**  
23 **section 536.028. This section and chapter 536 are nonseverable, and if any of the powers**  
24 **vested with the general assembly pursuant to chapter 536 to review, to delay the effective**  
25 **date, or to disapprove and annul a rule are subsequently held unconstitutional, then the**  
26 **grant of rulemaking authority and any rule proposed or adopted after August 28, 2016,**  
27 **shall be invalid and void.**

**338.202. 1. Notwithstanding any other provision of law, unless the prescriber has**  
2 **specified on the prescription that dispensing a prescription for a maintenance medication**  
3 **in an initial amount followed by periodic refills is medically necessary, a pharmacist may**  
4 **exercise his or her professional judgment to dispense varying quantities of maintenance**  
5 **medication per fill up to the total number of dosage units as authorized by the prescriber**  
6 **on the original prescription, including any refills. Dispensing of the maintenance**  
7 **medication based on refills authorized by the physician on the prescription shall be limited**  
8 **to no more than a ninety-day supply of the medication, and the maintenance medication**  
9 **shall have been previously prescribed to the patient for at least a three-month period.**

10           **2. For purposes of this section, "maintenance medication" means a medication**  
11 **prescribed for chronic, long-term conditions that is taken on a regular, recurring basis;**  
12 **except that, it shall not include controlled substances, as defined under section 195.010.**

**338.270. 1. Application blanks for renewal permits shall be mailed to each permittee**  
2 **on or before the first day of the month in which the permit expires and, if application for renewal**  
3 **of permit is not made before the first day of the following month, the existing permit, or renewal**  
4 **thereof, shall lapse and become null and void upon the last day of that month.**

5           **2. The board of pharmacy shall not renew a nonresident pharmacy license if the**  
6 **renewal applicant does not hold a current pharmacy license or its equivalent in the state**  
7 **in which the nonresident pharmacy is located.**

338.347. 1. Application blanks for renewal of license shall be mailed to each licensee on or before the first day of the month in which the license expires and, if application for renewal of license with required fee is not made before the first day of the following month, the existing license, or renewal thereof, shall lapse and become null and void upon the last day of that month.

2. **The board of pharmacy shall not renew an out-of-state wholesale drug distributor, out-of-state pharmacy distributor, or drug distributor license or registration if the renewal applicant does not hold a current distributor license or its equivalent in the state or jurisdiction in which the distribution facility is located or, if a drug distributor registrant, the entity is not authorized and in good standing to operate as a drug manufacturer with the Food and Drug Administration or within the state or jurisdiction where the facility is located.**

374.185. 1. The director may cooperate, coordinate, and consult with other members of the National Association of Insurance Commissioners, the commissioner of securities, state securities regulators, the division of finance, the division of credit unions, the attorney general, federal banking and securities regulators, the National Association of Securities Dealers (NASD), the United States Department of Justice, the Commodity Futures Trading Commission, [and] the Federal Trade Commission, **and the United States Department of Health and Human Services** to effectuate greater uniformity in insurance and financial services regulation among state and federal governments, and self-regulatory organizations. The director may share records with any aforesaid entity, except that any record that is confidential, privileged, or otherwise protected from disclosure by law shall not be disclosed unless such entity agrees in writing prior to receiving such record to provide it the same protection. No waiver of any applicable privilege or claim of confidentiality regarding any record shall occur as the result of any disclosure.

2. In cooperating, coordinating, consulting, and sharing records and information under this section and in acting by rule, order, or waiver under the laws relating to insurance, the director shall, at the discretion of the director, take into consideration in carrying out the public interest the following general policies:

- (1) Maximizing effectiveness of regulation for the protection of insurance consumers;
- (2) Maximizing uniformity in regulatory standards; and
- (3) Minimizing burdens on the business of insurance, without adversely affecting essentials of consumer protection.

3. The cooperation, coordination, consultation, and sharing of records and information authorized by this section includes:

- 24 (1) Establishing or employing one or more designees as a central electronic depository
- 25 for licensing and rate and form filings with the director and for records required or allowed to
- 26 be maintained;
- 27 (2) Encouraging insurance companies and producers to implement electronic filing
- 28 through a central electronic depository;
- 29 (3) Developing and maintaining uniform forms;
- 30 (4) Conducting joint market conduct examinations and other investigations through
- 31 collaboration and cooperation with other insurance regulators;
- 32 (5) Holding joint administrative hearings;
- 33 (6) Instituting and prosecuting joint civil or administrative enforcement proceedings;
- 34 (7) Sharing and exchanging personnel;
- 35 (8) Coordinating licensing under section 375.014;
- 36 (9) Formulating rules, statements of policy, guidelines, forms, no action determinations,
- 37 and bulletins; and
- 38 (10) Formulating common systems and procedures.

**376.379. 1. A health carrier or managed care plan offering a health benefit plan in this state that provides prescription drug coverage shall offer, as part of the plan, medication synchronization services developed by the health carrier or managed care plan that allow for the alignment of refill dates for an enrollee's prescription drugs that are covered benefits.**

**2. Under its medication synchronization services, a health carrier or managed care plan shall:**

**(1) Not charge an amount in excess of the otherwise applicable co-payment amount under the health benefit plan for dispensing a prescription drug in a quantity that is less than the prescribed amount if:**

**(a) The pharmacy dispenses the prescription drug in accordance with the medication synchronization services offered under the health benefit plan; and**

**(b) A participating provider dispenses the prescription drug; and**

**(2) Provide a full dispensing fee to the pharmacy that dispenses the prescription drug to the covered person.**

**3. For purposes of this section, the terms "health carrier", "managed care plan", "health benefit plan", "enrollee", and "participating provider" shall have the same meanings given to such terms under section 376.1350.**

**376.388. 1. As used in this section, unless the context requires otherwise, the following terms shall mean:**

3           (1) "Contracted pharmacy" or "pharmacy", a pharmacy located in Missouri  
4 participating in the network of a pharmacy benefits manager through a direct or indirect  
5 contract;

6           (2) "Health carrier", an entity subject to the insurance laws and regulations of this  
7 state that contracts or offers to contract to provide, deliver, arrange for, pay for, or  
8 reimburse any of the costs of health care services, including a sickness and accident  
9 insurance company, a health maintenance organization, a nonprofit hospital and health  
10 service corporation, or any other entity providing a plan of health insurance, health  
11 benefits, or health services, except that such plan shall not include any coverage pursuant  
12 to a liability insurance policy, workers' compensation insurance policy, or medical  
13 payments insurance issued as a supplement to a liability policy;

14           (3) "Maximum allowable cost", the per unit amount that a pharmacy benefits  
15 manager reimburses a pharmacist for a prescription drug, excluding a dispensing or  
16 professional fee;

17           (4) "Maximum allowable cost list" or "MAC list", a listing of drug products that  
18 meet the standard described in this section;

19           (5) "Pharmacy", as such term is defined in chapter 338;

20           (6) "Pharmacy benefits manager", an entity that contracts with pharmacies on  
21 behalf of health carriers or any health plan sponsored by the state or a political subdivision  
22 of the state.

23           2. Upon each contract execution or renewal between a pharmacy benefits manager  
24 and a pharmacy or between a pharmacy benefits manager and a pharmacy's contracting  
25 representative or agent, such as a pharmacy services administrative organization, a  
26 pharmacy benefits manager shall, with respect to such contract or renewal:

27           (1) Include in such contract or renewal the sources utilized to determine maximum  
28 allowable cost and update such pricing information at least every seven days; and

29           (2) Maintain a procedure to eliminate products from the maximum allowable cost  
30 list of drugs subject to such pricing or modify maximum allowable cost pricing at least  
31 every seven days, if such drugs do not meet the standards and requirements of this section,  
32 in order to remain consistent with pricing changes in the marketplace.

33           3. A pharmacy benefits manager shall reimburse pharmacies for drugs subject to  
34 maximum allowable cost pricing that has been updated to reflect market pricing at least  
35 every seven days as set forth under subdivision (1) of subsection 2 of this section.

36           4. A pharmacy benefits manager shall not place a drug on a maximum allowable  
37 cost list unless there are at least two therapeutically equivalent multi-source generic drugs,

38 or at least one generic drug available from at least one manufacturer, generally available  
39 for purchase by network pharmacies from national or regional wholesalers.

40 **5. All contracts between a pharmacy benefits manager and a contracted pharmacy**  
41 **or between a pharmacy benefits manager and a pharmacy's contracting representative or**  
42 **agent, such as a pharmacy services administrative organization, shall include a process to**  
43 **internally appeal, investigate, and resolve disputes regarding maximum allowable cost**  
44 **pricing. The process shall include the following:**

45 **(1) The right to appeal shall be limited to fourteen calendar days following the**  
46 **reimbursement of the initial claim; and**

47 **(2) A requirement that the pharmacy benefits manager shall respond to an appeal**  
48 **described in this subsection no later than fourteen calendar days after the date the appeal**  
49 **was received by such pharmacy benefits manager.**

50 **6. For appeals that are denied, the pharmacy benefits manager shall provide the**  
51 **reason for the denial and identify the national drug code of a drug product that may be**  
52 **purchased by contracted pharmacies at a price at or below the maximum allowable cost**  
53 **and, when applicable, may be substituted lawfully.**

54 **7. If the appeal is successful, the pharmacy benefits manager shall:**

55 **(1) Adjust the maximum allowable cost price that is the subject of the appeal**  
56 **effective on the day after the date the appeal is decided;**

57 **(2) Apply the adjusted maximum allowable cost price to all similarly situated**  
58 **pharmacies as determined by the pharmacy benefits manager; and**

59 **(3) Allow the pharmacy that succeeded in the appeal to reverse and rebill the**  
60 **pharmacy benefits claim giving rise to the appeal.**

61 **8. Appeals shall be upheld if:**

62 **(1) The pharmacy being reimbursed for the drug subject to the maximum allowable**  
63 **cost pricing in question was not reimbursed as required under subsection 3 of this section;**  
64 **or**

65 **(2) The drug subject to the maximum allowable cost pricing in question does not**  
66 **meet the requirements set forth under subsection 4 of this section.**

**376.465. 1. This section shall be known and may be cited as the "Missouri Health**  
2 **Insurance Rate Transparency Act".**

3 **2. It is the intent of the Missouri general assembly that the review of health**  
4 **insurance rates as specified in this section is consistent with the general powers of the**  
5 **department as outlined under section 374.010.**

6 **3. As used in this section, the following terms mean:**

- 7           (1) "Director", the director of the department of insurance, financial institutions  
8 and professional registration, or his or her designee;
- 9           (2) "Excepted health benefit plan", a health benefit plan providing the following  
10 coverage or any combination thereof:
- 11           (a) Coverage only for accident insurance, including accidental death and  
12 dismemberment insurance;
- 13           (b) Coverage only for disability income insurance;
- 14           (c) Credit-only insurance;
- 15           (d) Short-term medical insurance of less than twelve months' duration; or
- 16           (e) If provided under a separate policy, certificate, or contract of insurance, any of  
17 the following:
- 18           a. Dental or vision benefits;
- 19           b. Coverage only for a specified disease or illness; or
- 20           c. Hospital indemnity or other fixed indemnity insurance;
- 21           (3) "Grandfathered health benefit plan", a health benefit plan in the small group  
22 market that was issued, or a health benefit plan in the individual market that was  
23 purchased, on or before March 23, 2010;
- 24           (4) "Health benefit plan", the same meaning given to such term under section  
25 376.1350; however, for purposes of this section, the term shall exclude plans sold in the  
26 large group market, as that term is defined under section 376.450, and shall exclude long-  
27 term care and Medicare supplement plans;
- 28           (5) "Health carrier", the same meaning given to such term under section 376.1350;
- 29           (6) "Individual market", the market for health insurance coverage offered directly  
30 to individuals and their dependents and not in connection with a group health benefit plan;
- 31           (7) "Small group market", the health insurance market under which individuals  
32 obtain health insurance coverage, directly or through an arrangement on behalf of  
33 themselves and their dependents, through a group health plan maintained by a small  
34 employer, as defined under section 379.930.
- 35           4. No health carrier shall deliver, issue for delivery, continue, or renew any health  
36 benefit plan until rates have been filed with the director.
- 37           5. For excepted health benefit plans, such rates shall be filed, thirty days prior to  
38 use, for informational purposes only. Rates shall not be excessive, inadequate, or unfairly  
39 discriminatory.
- 40           6. For grandfathered health benefit plans, such rates shall be filed, thirty days prior  
41 to use, for informational purposes only.

42           **7. (1) For health benefit plans that are not grandfathered health benefit plans or**  
43 **excepted health benefit plans, a health carrier may use rates on the earliest of:**

44           **(a) The date the director determines the rates are reasonable;**

45           **(b) The date the health carrier notifies the director of its intent to use rates that the**  
46 **director has deemed unreasonable; or**

47           **(c) Sixty days after the date of filing rates with the director.**

48           **(2) The director may notify the health carrier within sixty days of the date of filing**  
49 **rates with the director that the health carrier has failed to provide sufficient rate filing**  
50 **documentation to review the proposed rates. The health carrier may, as described in this**  
51 **section, provide additional information to support the rate filing.**

52           **8. For health benefit plans described under subsection 7 of this section, all proposed**  
53 **rates and rate filing documentation shall be submitted in the form and content prescribed**  
54 **by rule, which is consistent with the requirements of 45 CFR 154, and shall include review**  
55 **standards and criteria consistent with 45 CFR 154.**

56           **9. The director shall determine by rule when rates filed under this section shall be**  
57 **made publicly available. Rate filing documentation and other supporting information that**  
58 **is a trade secret or of a proprietary nature, and has been designated as such by the health**  
59 **carrier, shall not be considered a public record.**

60           **10. For rates filed for health benefit plans described under subsection 7 of this**  
61 **section, the director shall:**

62           **(1) Provide a means by which the public can submit written comments concerning**  
63 **proposed rate increases;**

64           **(2) Review proposed rates and rate filing documentation;**

65           **(3) Determine that a proposed rate is an unreasonable rate if the increase is an**  
66 **excessive rate, an inadequate rate, an unfairly discriminatory rate, or an unjustified rate,**  
67 **consistent with 45 CFR 154; and**

68           **(4) Within sixty days after submission, provide a written notice to the health carrier**  
69 **detailing whether the proposed rates are reasonable or unreasonable. For proposed rates**  
70 **deemed unreasonable, the written notice shall specify deficiencies and provide detailed**  
71 **reasons for the director's decision that the proposed rate is excessive, inadequate,**  
72 **unjustified, or unfairly discriminatory.**

73           **11. Within thirty days after receiving written notice of the director's determination**  
74 **that the proposed rates are unreasonable, as described under subsection 10 of this section,**  
75 **a health carrier may amend its rates, request reconsideration based upon additional**  
76 **information, or implement the proposed rates. The health carrier shall notify the director**



77 of its intention no later than thirty days after its receipt of the written notice of the  
78 determination of unreasonable rates.

79 **12. If a health carrier implements a rate that the director has determined is**  
80 **unreasonable under subsection 10 of this section, the department shall make such**  
81 **determination public, in a form and manner determined by rule.**

82 **13. For health benefit plans described under subsection 7 of this section, the**  
83 **director shall publish final rates on the department's website no earlier than thirty days**  
84 **prior to the first day of the annual open enrollment period in the individual market for the**  
85 **applicable calendar year. The final rate is the rate that will be implemented by the health**  
86 **carrier on a specified date.**

87 **14. Time frames described under this section may be extended upon mutual**  
88 **agreement between the director and the health carrier.**

89 **15. The director may promulgate rules to promote health insurance rate**  
90 **transparency including, but not limited to, prescribing the form and content of the**  
91 **information required to be submitted and of the standards of review that are consistent**  
92 **with 45 CFR 154. Any rule or portion of a rule, as that term is defined in section 536.010,**  
93 **that is created under the authority delegated in this section shall become effective only if**  
94 **it complies with and is subject to all of the provisions of chapter 536 and, if applicable,**  
95 **section 536.028. This section and chapter 536 are nonseverable, and if any of the powers**  
96 **vested with the general assembly under chapter 536 to review, to delay the effective date,**  
97 **or to disapprove and annul a rule are subsequently held unconstitutional, then the grant**  
98 **of rulemaking authority and any rule proposed or adopted after August 28, 2016, shall be**  
99 **invalid and void.**

100 **16. This section shall apply to health benefit plans that are delivered, issued for**  
101 **delivery, continued, or renewed on or after January 1, 2018. In order to ensure that health**  
102 **benefit plans comply with the provisions of this section, the director shall promulgate rules**  
103 **regarding the initial implementation of the provisions of this section. Such rules shall be**  
104 **effective no later than March 1, 2017, and, for health benefit plans described under**  
105 **subsection 7 of this section, shall include, but not be limited to, the form and content of the**  
106 **information required to be submitted and of the standards of review, consistent with 45**  
107 **CFR 154.**

376.1237. 1. Each health carrier or health benefit plan that offers or issues health benefit  
2 plans which are delivered, issued for delivery, continued, or renewed in this state on or after  
3 January 1, 2014, and that provides coverage for prescription eye drops shall provide coverage  
4 for the refilling of an eye drop prescription prior to the last day of the prescribed dosage period  
5 without regard to a coverage restriction for early refill of prescription renewals as long as the

6 prescribing health care provider authorizes such early refill, and the health carrier or the health  
7 benefit plan is notified.

8 2. For the purposes of this section, health carrier and health benefit plan shall have the  
9 same meaning as defined in section 376.1350.

10 3. The coverage required by this section shall not be subject to any greater deductible or  
11 co-payment than other similar health care services provided by the health benefit plan.

12 4. The provisions of this section shall not apply to a supplemental insurance policy,  
13 including a life care contract, accident-only policy, specified disease policy, hospital policy  
14 providing a fixed daily benefit only, Medicare supplement policy, long-term care policy,  
15 short-term major medical policies of six months' or less duration, or any other supplemental  
16 policy as determined by the director of the department of insurance, financial institutions and  
17 professional registration.

18 5. The provisions of this section shall terminate on January 1, [2017] **2020**.

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

2 (1) **"Distant site", a site at which a health care provider is located while providing**  
3 **health care services by means of telehealth or telemedicine;**

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

10 [(2)] (3) "Health benefit plan" shall have the same meaning ascribed to it in section  
11 376.1350;

12 [(3)] (4) "Health care provider" shall have the same meaning ascribed to it in section  
13 376.1350;

14 [(4)] (5) "Health care service", a service for the diagnosis, prevention, treatment, cure  
15 or relief of a physical or mental health condition, illness, injury or disease;

16 [(5)] (6) "Health carrier" shall have the same meaning ascribed to it in section 376.1350;

17 (7) **"Originating site", a site at which a patient is located at the time health care**  
18 **services are provided to him or her by means of telemedicine;**

19 [(6)] (8) "Telehealth" [shall have the same meaning ascribed to it in section 208.670] or  
20 **"telemedicine", the delivery of health care services by means of information and**  
21 **communication technologies that facilitate the assessment, diagnosis, consultation,**  
22 **treatment, education, care management, and self-management of a patient's health care**  
23 **while such patient is at the originating site and the health care provider is at the distant**

24 **site. The provision of a telehealth or telemedicine service shall not include telephone**  
25 **conversations, electronic mail messages, or facsimile transmissions between a practitioner**  
26 **and a recipient.**

27 2. Each health carrier or health benefit plan that offers or issues health benefit plans  
28 which are delivered, issued for delivery, continued, or renewed in this state on or after January  
29 1, 2014, shall not deny coverage for a health care service on the basis that the health care service  
30 is provided through telehealth if the same service would be covered if provided through face-to-  
31 face diagnosis, consultation, or treatment.

32 3. A health carrier may not exclude an otherwise covered health care service from  
33 coverage solely because the service is provided through telehealth rather than face-to-face  
34 consultation or contact between a health care provider and a patient.

35 4. A health carrier shall not be required to reimburse a telehealth provider or a consulting  
36 provider for site origination fees or costs for the provision of telehealth services; however,  
37 subject to correct coding, a health carrier shall reimburse a health care provider for the diagnosis,  
38 consultation, or treatment of an insured or enrollee when the health care service is delivered  
39 through telehealth on the same basis that the health carrier covers the service when it is delivered  
40 in person.

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

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

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

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

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

59 10. The provisions of this section shall not apply to a supplemental insurance policy,  
60 including a life care contract, accident-only policy, specified disease policy, hospital policy  
61 providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-  
62 term major medical policies of six months' or less duration, or any other supplemental policy as  
63 determined by the director of the department of insurance, financial institutions and professional  
64 registration.

65 **11. A health carrier may reimburse a health care provider for telehealth services**  
66 **that utilize asynchronous store-and-forward technologies. As used in this section, the term**  
67 **"asynchronous store-and-forward technology" means cameras or other recording devices**  
68 **that store images that may be forwarded via telecommunications devices at a later time.**

379.934. 1. **For health benefit plans purchased on or before March 23, 2010**, a small  
2 employer carrier may establish a class of business only to reflect substantial differences in  
3 expected claims experience or administrative costs related to the following reasons:

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

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

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

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

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

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

379.936. 1. Premium rates for health benefit plans **purchased on or before March 23,**  
2 **2010, and that are** subject to sections 379.930 to 379.952, shall be subject to the following  
3 provisions:

4 (1) The index rate for a rating period for any class of business shall not exceed the index  
5 rate for any other class of business by more than twenty percent;

6 (2) For a class of business, the premium rates charged during a rating period to small  
7 employers with similar case characteristics for the same or similar coverage, or the rates that  
8 could be charged to such employers under the rating system for that class of business shall not  
9 vary from the index rate by more than thirty-five percent of the index rate;

10 (3) The percentage increase in the premium rate charged to a small employer for a new  
11 rating period may not exceed the sum of the following:

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

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

23 (c) Any adjustment due to change in coverage or change in the case characteristics of the  
24 small employer, as determined from the small employer carrier's rate manual for the class of  
25 business;

26 (4) Adjustments in rates for claim experience, health status and duration of coverage  
27 shall not be charged to individual employees or dependents. Any such adjustment shall be  
28 applied uniformly to the rates charged for all employees and dependents of the small employer;

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

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

36 (7) In the case of health benefit plans issued prior to July 1, 1993, a premium rate for a  
37 rating period may exceed the ranges set forth in subdivisions (1) and (2) of this subsection for  
38 a period of three years following July 1, 1993. In such case, the percentage increase in the

39 premium rate charged to a small employer for a new rating period shall not exceed the sum of  
40 the following:

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

48 (b) Any adjustment due to change in coverage or change in the case characteristics of  
49 the small employer, as determined from the carrier's rate manual for the class of business;

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

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

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

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

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

67 (a) Assuring that differences in rates charged for health benefit plans by small employer  
68 carriers are reasonable and reflect objective differences in plan design, not including differences  
69 due to the nature of the groups assumed to select particular health benefit plans; and

70 (b) Prescribing the manner in which case characteristics may be used by small employer  
71 carriers.

72 2. A small employer carrier shall not transfer a small employer involuntarily into or out  
73 of a class of business. A small employer carrier shall not offer to transfer a small employer into  
74 or out of a class of business unless such offer is made to transfer all small employers in the class

75 of business without regard to case characteristics, claim experience, health status or duration of  
76 coverage.

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

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

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

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

93 (3) The provisions relating to renewability of policies and contracts; and

94 (4) The provisions relating to any preexisting condition provision.

95 5. (1) Each small employer carrier shall maintain at its principal place of business a  
96 complete and detailed description of its rating practices and renewal underwriting practices,  
97 including information and documentation that demonstrate that its rating methods and practices  
98 are based upon commonly accepted actuarial assumptions and are in accordance with sound  
99 actuarial principles.

100 (2) Each small employer carrier shall file with the director annually on or before March  
101 fifteenth an actuarial certification certifying that the carrier is in compliance with sections  
102 379.930 to 379.952 and that the rating methods of the small employer carrier are actuarially  
103 sound. Such certification shall be in a form and manner, and shall contain such information, as  
104 specified by the director. A copy of the certification shall be retained by the small employer  
105 carrier at its principal place of business.

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

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

- 4 (1) The plan sponsor fails to pay a premium or contribution in accordance with the terms  
5 of a health benefit plan or the health carrier has not received a timely premium payment;
- 6 (2) The plan sponsor performs an act or practice that constitutes fraud, or makes an  
7 intentional misrepresentation of material fact under the terms of the coverage;
- 8 (3) Noncompliance with the carrier's minimum participation requirements;
- 9 (4) Noncompliance with the carrier's employer contribution requirements;
- 10 (5) In the case of a small employer carrier that offers coverage through a network plan,  
11 there is no longer any enrollee under the health benefit plan who lives, resides or works in the  
12 service area of the health insurance issuer and the small employer carrier would deny enrollment  
13 with respect to such plan under subsection 4 of this section;
- 14 (6) The small employer carrier elects to discontinue offering a [particular type of health  
15 benefit plan] **product, as defined in 45 CFR 144.103**, in the state's small group market. A type  
16 of [health benefit plan] **product** may be discontinued by a small employer carrier in such market  
17 only if such carrier:
- 18 (a) Issues a notice to each plan sponsor provided coverage of such type in the small  
19 group market (and participants and beneficiaries covered under such coverage) of the  
20 discontinuation at least ninety days prior to the date of discontinuation of the coverage;
- 21 (b) Offers to each plan sponsor provided coverage of such type the option to purchase  
22 all other health benefit plans currently being offered by the small employer carrier in the state's  
23 small group market; and
- 24 (c) Acts uniformly without regard to the claims experience of those plan sponsors or any  
25 health status-related factor relating to any participants or beneficiaries covered or new  
26 participants or beneficiaries who may become eligible for such coverage;
- 27 (7) A small employer carrier elects to discontinue offering all health insurance coverage  
28 in the small group market in this state. A small employer carrier shall not discontinue offering  
29 all health insurance coverage in the small employer market unless:
- 30 (a) The carrier provides notice of discontinuation to the director and to each plan sponsor  
31 (and participants and beneficiaries covered under such coverage) at least one hundred eighty days  
32 prior to the date of the discontinuation of coverage; and
- 33 (b) All health insurance issued or delivered for issuance in Missouri in the small  
34 employer market is discontinued and coverage under such health insurance is not renewed;
- 35 (8) In the case of health insurance coverage that is made available in the small group  
36 market only through one or more bona fide associations, the membership of an employer in the  
37 association (on the basis of which the coverage is provided) ceases but only if such coverage is  
38 terminated under this subdivision uniformly without regard to any health status-related factor  
39 relating to any covered individual;



40 (9) The director finds that the continuation of the coverage would:

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

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

43

44 In such instance the director shall assist affected small employers in finding replacement  
45 coverage.

46 2. A small employer carrier that elects not to renew a health benefit plan under  
47 subdivision (7) of subsection 1 of this section shall be prohibited from writing new business in  
48 the small employer market in this state for a period of five years from the date of notice to the  
49 director.

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

53 4. At the time of coverage renewal, a health insurance issuer may modify the health  
54 insurance coverage for a product offered to a group health plan in the small group market if, for  
55 coverage that is available in such market other than only through one or more bona fide  
56 associations, such modification is consistent with state law and effective on a uniform basis  
57 among group health plans with that product. For purposes of this subsection, renewal shall be  
58 deemed to occur not more often than annually on the anniversary of the effective date of the  
59 group health plan's health insurance coverage unless a longer term is specified in the policy or  
60 contract.

61 5. In the case of health insurance coverage that is made available by a small employer  
62 carrier only through one or more bona fide associations, references to plan sponsor in this section  
63 is deemed, with respect to coverage provided to a small employer member of the association, to  
64 include a reference to such employer.

379.940. 1. (1) Every small employer carrier shall, as a condition of transacting  
2 business in this state with small employers, actively offer to small employers all health benefit  
3 plans it actively markets to small employers in this state, except for plans developed for health  
4 benefit trust funds.

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

9 (b) **For health benefit plans purchased on or before March 23, 2010**, in the case of  
10 a small employer carrier that establishes more than one class of business pursuant to section  
11 379.934, the small employer carrier shall maintain and issue to eligible small employers all

12 health benefit plans in each class of business so established. A small employer carrier may apply  
13 reasonable criteria in determining whether to accept a small employer into a class of business,  
14 provided that:

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

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

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

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

24 2. Health benefit plans **purchased on or before March 23, 2010** covering small  
25 employers shall comply with the following provisions:

26 (1) A health benefit plan shall comply with the provisions of sections 376.450 and  
27 376.451.

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

33 (b) A small employer carrier shall not require a minimum participation level greater than:

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

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

38 (c) In applying minimum participation requirements with respect to a small employer,  
39 a small employer carrier shall not consider employees or dependents who have qualifying  
40 existing coverage in determining whether the applicable percentage of participation is met.

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

44 (3) (a) If a small employer carrier offers coverage to a small employer, the small  
45 employer carrier shall offer coverage to all of the eligible employees of a small employer and  
46 their dependents who apply for enrollment during the period in which the employee first  
47 becomes eligible to enroll under the terms of the plan. A small employer carrier shall not offer

48 coverage to only certain individuals or dependents in a small employer group or to only part of  
49 the group.

50 (b) A small employer carrier shall not modify a health benefit plan with respect to a  
51 small employer or any eligible employee or dependent through riders, endorsements or  
52 otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise  
53 covered by the health benefit plan.

54 (c) An eligible employee may choose to retain their individually underwritten health  
55 benefit plan at the time such eligible employee is entitled to enroll in a small employer health  
56 benefit plan. If the eligible employee retains their individually underwritten health benefit plan,  
57 a small employer may provide a defined contribution through the establishment of a cafeteria 125  
58 plan under section 379.953. Small employers shall establish an equal amount of defined  
59 contribution for all plans. If an eligible employee retains their individually underwritten health  
60 benefit plan under this subdivision, the provisions of sections 379.930 to 379.952 shall not apply  
61 to the individually underwritten health benefit plan.

62 3. (1) Subject to subdivision (3) of this subsection, a small employer carrier shall not  
63 be required to offer coverage or accept applications pursuant to subsection 1 of this section in  
64 the case of the following:

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

67 (b) To an employee, when the employee does not live, work or reside within the carrier's  
68 established geographic service area; or

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

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

78 (3) A small employer carrier shall apply the provisions of this subsection uniformly to  
79 all small employers without regard to the claims experience of a small employer and its  
80 employees and their dependents or any health status-related factor relating to such employees and  
81 their dependents.

82 4. A small employer carrier shall not be required to provide coverage to small employers  
83 pursuant to subsection 1 of this section for any period of time for which the director determines

84 that requiring the acceptance of small employers in accordance with the provisions of subsection  
85 1 of this section would place the small employer carrier in a financially impaired condition, and  
86 the small employer is applying this subsection uniformly to all small employers in the small  
87 group market in this state consistent with applicable state law and without regard to the claims  
88 experience of a small employer and its employees and their dependents or any health status-  
89 related factor relating to such employees and their dependents.

✓