SECOND REGULAR SESSION

HOUSE BILL NO. 2061

98TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE GOSEN.

5619H.01I D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 354.415, 375.936, and 376.426, RSMo, and to enact in lieu thereof three new sections relating to health benefit plans.

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

Section A. Sections 354.415, 375.936, and 376.426, RSMo, are repealed and three new sections enacted in lieu thereof, to be known as sections 354.415, 375.936, and 376.426, to read as follows:

354.415. 1. The powers of a health maintenance organization include, but are not limited to, the power to:

(1) Purchase, lease, construct, renovate, operate, and maintain hospitals, medical facilities, or both, and their ancillary equipment, and such property as may reasonably be required for the organization's principal office or for such other purposes as may be necessary in the transaction of the business of the organization;

(2) Make loans to a medical group under contract with it in furtherance of its program, or to make loans to any corporation under its control for the purpose of acquiring or constructing medical facilities and hospitals or in the furtherance of a program providing health care services to enrollees;

(3) Furnish health care services through providers which are under contract with, or employed by, the health maintenance organization;

(4) Contract with any person for the performance, on the organization's behalf, of certain functions such as marketing, enrollment, and administration;

(5) Contract with an insurance company licensed in this state, or with a health services corporation authorized to do business in this state, for the provision of insurance, indemnity, or

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.

reimbursement against the cost of health care services provided by the health maintenance organization;

(6) Offer, in addition to basic health care services:

(a) Additional health care services;

(b) Indemnity benefits covering out-of-area or emergency services; and

(c) Indemnity benefits, in addition to those relating to out-of-area and emergency services, provided through insurers or health services corporations;

(7) Offer as an option one or more health benefit plans which contain deductibles, coinsurance, coinsurance differentials, or variable co-payments. **Co-payments may exceed fifty percent of the total cost of the service except as specifically prohibited under this chapter or chapter 376.** Health benefit plans offered under this section that contain deductibles shall be permitted only **[**when combined with any health savings account or health reimbursement account as described in the Medicare Reform Act, P.L. No. 108-173, Title XII, Section 1201, provided that:

(a) The total out-of-pocket expenses paid for the receipt of basic health services under the plan shall not exceed the annual contribution limits for health savings accounts as determined by the Internal Revenue Service;

(b) The health savings account or health reimbursement account must be funded at a level equal to or greater than the out-of-pocket maximum limits defined for the high deductible health plan; and

(c) A distribution from the health savings account or health reimbursement account to pay a health care provider for a qualified medical expense is made within thirty days of the submission of a claim**] if such deductible does not exceed the cost-sharing annual limits established under 42 U.S.C. Section 18022(c)**.

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

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

375.936. Any of the following practices, if committed in violation of section 375.934, are hereby defined as unfair trade practices in the business of insurance:

(1) "Boycott, coercion, intimidation", entering into any agreement to commit, or by any concerted action committing any act of boycott, coercion or intimidation resulting in or tending to result in an unreasonable restraint of, or monopoly in, the business of insurance;

(2) "Defamation", making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of any insurer, and which is calculated to injure such insurer;

(3) "Failure to maintain complaint handling procedures", failure of any person to maintain a complete record of all the complaints which it has received for a period of not less than three years. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints, and the time it took to process each complaint. For purposes of this subdivision, "complaint" shall mean any written communication primarily expressing a grievance;

(4) "False information and advertising generally", making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any insurer in the conduct of his insurance business, which is untrue, deceptive or misleading;

(5) "False statements and entries:"

(a) Knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating or delivering to any person, or placing before the public, or knowingly causing, directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition or dealings of an insurer;

(b) Knowingly making any false entry of a material fact in any book, report or statement of any insurer or knowingly omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report or statement of such insurer;

(6) "Misrepresentations and false advertising of insurance policies", making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustrations, circular or statement, sales presentation, omission, or comparison which:

(a) Misrepresents the benefits, advantages, conditions, or terms of any policy;

(b) Misrepresents the dividends or share of the surplus to be received on any policy;

(c) Makes any false or misleading statements as to the dividends or share of surplus previously paid on any policy;

(d) Is misleading or is a misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates;

(e) Uses any name or title of any policy or class of policies misrepresenting the true nature thereof;

(f) Is a misrepresentation for the purpose of inducing or tending to induce the purchase, lapse, forfeiture, exchange, conversion, or surrender of any policy, including any intentional misquote of a premium rate;

(g) Is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any policy; or

(h) Misrepresents any policy as being shares of stock;

(7) "Misrepresentation in insurance applications", making false or fraudulent statements or representations on or relative to an application for a policy, for the purpose of obtaining a fee, commission, money, or other benefit from any insurer, agent, agency, broker or other person;

(8) "Prohibited group enrollments", no insurer shall offer more than one group contract of insurance through any person unless such person is licensed pursuant to law; however, this prohibition shall not apply to employer-employee relationships, nor to any such enrollments;

(9) "Rebates":

(a) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract of life insurance, life annuity, accident and health insurance or other insurance, or agreement as to such contract other than as plainly expressed in the insurance contract issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving, or selling, or purchasing or offering or to give, sell, or purchase as inducement to such insurance contract or annuity or in connection therewith, any stocks, bonds or other securities of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract;

(b) Nothing in subdivision (11) or paragraph (a) of this subdivision shall be construed as including within the definition of discrimination or rebates any of the following practices:

a. In the case of any contract of life insurance or life annuity, paying bonuses to nonparticipating policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance; provided that any such bonuses or

abatement of premiums shall be fair and equitable to policyholders and for the best interest of the company and its policyholders;

b. In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses;

c. Readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year;

(10) "Stock operations and advisory board contracts", issuing or delivering or permitting agents, officers or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance;

(11) "Unfair discrimination":

(a) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract;

(b) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever, including any unfair discrimination by not permitting the insured full freedom of choice in the selection of any duly licensed physician, surgeon, optometrist, chiropractor, dentist, psychologist, pharmacist, pharmacy, or podiatrist; except that the terms of this paragraph shall not apply to health maintenance organizations licensed pursuant to chapter 354 **or to health carriers offering health benefit plans described under subdivision (19) of section 376.426**;

(c) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, cancelling or limiting the amount of insurance coverage on a property or casualty risk because of the geographic location of the risk;

(d) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, cancelling or limiting the amount of insurance coverage on a residential property risk, or the personal property contained therein, because of the age of the residential property;

(e) Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual because of the gender or marital status of the individual; however, nothing in this paragraph shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependent benefits;

(f) Refusing to insure solely because another insurer has refused to issue a policy, or has cancelled or has refused to renew an existing policy for which that person was the named insured, nor shall any insurance company or its agent or representative require any applicant or policyholder to divulge in a written application or otherwise whether any insurer has cancelled or refused to renew or issue to the applicant or policyholder a policy of insurance, provided that an insurer may require the name of the prior carrier in order to verify the applicant's previous claims or medical history;

(g) Cancelling or refusing to insure or refusing to continue to insure a policy solely because of race, gender, color, creed, national origin, or ancestry of anyone who is or seeks to become insured;

(h) Terminating, or modifying coverage or refusing to issue or refusing to renew any property or casualty policy or contract of insurance solely because the applicant or insured or any employee of either is mentally or physically impaired; except that this paragraph shall not apply to accident and health insurance sold by a casualty insurer and, in addition, this paragraph shall not be interpreted to modify any other provision of law relating to the termination, modification, issuance or renewal of any insurance policy or contract;

(i) The provisions of paragraphs (c), (d), (e), (f), (g), and (h) of this subdivision shall not apply if:

a. The refusal, cancellation, limitation, termination or modification is for a business purpose which is not a mere pretext for unfair discrimination, or

b. The refusal, cancellation, limitation, termination or modification is required by law or regulatory mandate;

(12) "Unfair financial planning practices", an insurance producer, agent, broker or consultant:

(a) Holding himself out, directly or indirectly, to the public as a financial planner, investment adviser, financial consultant, financial counselor, or any other specialist engaged in the business of giving financial planning or advice relating to investments, insurance, real estate, tax matters, or trust and estate matters when such person is in fact engaged only in the sale of policies; provided, however, an insurance producer, agent, broker or consultant who has passed a professional course of study may use the symbol of the professional designation on his or her business card or stationery;

(b) Engaging in the business of financial planning without disclosing to the client prior to the execution of the agreement provided for in paragraph (c) of this subdivision or solicitation of the sale of a product or service that:

a. He is also an insurance salesperson; and

b. That a commission for the sale of an insurance product will be received in addition to a fee for financial planning, if such is the case. The disclosure requirement under this paragraph may be met by including it in any disclosure required by federal or state securities law;

(c) Charging fees, other than commissions, for financial planning by insurance agents, brokers or consultants, unless such fees are based upon a written agreement, which is signed by the party to be charged in advance of the performance of the services under the agreement. A copy of the agreement shall be provided to the party to be charged at the time the agreement is signed by the party and:

a. The services for which the fee is to be charged must be specifically stated in the agreement;

b. The amount of the fee to be charged or how it will be determined or calculated must be specifically stated in the agreement;

c. The agreement must state that the client is under no obligation to purchase any insurance product through the insurance agent, broker or consultant. The insurance agent, broker or consultant shall retain a copy of the agreement for not less than three years after completion of services, and a copy shall be available to the director upon request;

(13) Any violation of section 375.445.

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**, including a gatekeeper group plan, as that term is defined in section 354.618,** 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 376.1350, and the services described in subsection 4 of section 376.811. Such a provision shall be disclosed in clear, conspicuous, and understandable language in the enrollment application and in the policy form. Whenever a health carrier offers a health benefit plan pursuant to this subdivision to a group contract holder as an exclusive or full replacement health benefit plan the health carrier shall offer at least one additional health benefit plan option that includes an out-of-network benefit. The decision to accept or reject the offer of the option of a health benefit plan that includes an out-of-network benefit shall be made by the enrollee and not the group contract holder;

(20) A provision stating that a health benefit plan issued pursuant to subdivision (19) of this section shall have in place a procedure by which an enrollee may obtain a referral to a nonparticipating provider when the enrollee is diagnosed with a life-threatening condition or disabling degenerative disease. The provisions of subdivisions (19) and (20) of this section shall expire and be null and void at the end of the calendar year following the repeal of 42 U.S.C. Section 300gg by the United States Congress or at the end of the calendar year following a finding by a court of competent jurisdiction that such section is unconstitutional or otherwise infirm.

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