SECOND REGULAR SESSION

[TRULY AGREED TO AND FINALLY PASSED**]**

CONFERENCE COMMITTEE SUBSTITUTE FOR

HOUSE COMMITTEE SUBSTITUTE FOR

SENATE SUBSTITUTE FOR

SENATE COMMITTEE SUBSTITUTE FOR

SENATE BILLS NOS. 865 & 866

98TH GENERAL ASSEMBLY

2016

5458S.07T

AN ACT

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

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Section A. Sections 338.270, 338.347, 374.185, 376.1237, 379.934, 379.936, 379.938, and 379.940, RSMo, are repealed and sixteen new sections enacted in lieu thereof, to be known as sections 191.1075, 191.1080, 191.1085, 338.075, 338.202, 338.270, 338.347, 374.185, 376.379, 376.388, 376.465, 376.1237, 379.934, 379.936, 379.938, and 379.940, to read as follows:

191.1075. As used in sections 191.1075 to 191.1085, the following terms shall mean:

(1) "Department", the department of health and senior services;

(2) "Health care professional", a physician or other health care practitioner licensed, accredited, or certified by the state of Missouri to perform specified health services;

(3) "Hospital":

(a) A place devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment, or care of not less than twenty-four consecutive hours in any week of three or more nonrelated individuals suffering from illness, disease, injury, deformity, or other

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

abnormal physical conditions; or

(b) A place devoted primarily to provide for not less than twenty-four consecutive hours in any week medical or nursing care for three or more unrelated individuals. "Hospital" does not include convalescent, nursing, shelter, or boarding homes as defined in chapter 198.

191.1080. 1. There is hereby created within the department the "Missouri Palliative Care and Quality of Life Interdisciplinary Council", which shall be a palliative care consumer and professional information and education program to improve quality and delivery of patient-centered and family-focused care in this state.

2. On or before December 1, 2016, the following members shall be appointed to the council:

(1) Two members of the senate, appointed by the president pro tempore of the senate;

(2) Two members of the house of representatives, appointed by the speaker of the house of representatives;

(3) Two board-certified hospice and palliative medicine physicians licensed in this state, appointed by the governor with the advice and consent of the senate;

(4) Two certified hospice and palliative nurses licensed in this state, appointed by the governor with the advice and consent of the senate;

(5) A certified hospice and palliative social worker, appointed by the governor with the advice and consent of the senate;

(6) A patient and family caregiver advocate representative, appointed by the governor with the advice and consent of the senate; and

(7) A spiritual professional with experience in palliative care and health care, appointed by the governor with the advice and consent of the senate.

3. Council members shall serve for a term of three years. The members of the council shall elect a chair and vice chair whose duties shall be established by the council. The department shall determine a time and place for regular meetings of the council, which shall meet at least biannually.

4. Members of the council shall serve without compensation, but

shall, subject to appropriations, be reimbursed for their actual and necessary expenses incurred in the performance of their duties as members of the council.

5. The council shall consult with and advise the department on matters related to the establishment, maintenance, operation, and outcomes evaluation of palliative care initiatives in this state, including the palliative care consumer and professional information and education program established in section 191.1085.

6. The council shall submit an annual report to the general assembly, which includes an assessment of the availability of palliative care in this state for patients at early stages of serious disease and an analysis of barriers to greater access to palliative care.

7. The council authorized under this section shall automatically expire August 28, 2022.

191.1085. 1. There is hereby established the "Palliative Care Consumer and Professional Information and Education Program" within the department.

2. The purpose of the program is to maximize the effectiveness of palliative care in this state by ensuring that comprehensive and accurate information and education about palliative care is available to the public, health care providers, and health care facilities.

3. The department shall publish on its website information and resources, including links to external resources, about palliative care for the public, health care providers, and health care facilities including, but not limited to:

(1) Continuing education opportunities for health care providers;

(2) Information about palliative care delivery in the home, primary, secondary, and tertiary environments; and

(3) Consumer educational materials and referral information for palliative care, including hospice.

4. Each hospital in this state is encouraged to have a palliative care presence on its intranet or internet website which provides links to one or more of the following organizations: the Institute of Medicine, the Center to Advance Palliative Care, the Supportive Care Coalition, the National Hospice and Palliative Care Organization, the American Academy of Hospice and Palliative Medicine, and the National Institute on Aging.

5. Each hospital in this state is encouraged to have patient education information about palliative care available for distribution to patients.

6. The department shall consult with the palliative care and quality of life interdisciplinary council established in section 191.1080 in implementing the section.

7. The department may promulgate rules to implement the provisions of sections 191.1075 to 191.1085. 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 191.1075 to 191.1085 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 191.1075 to 191.1085 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, 2016, shall be invalid and void.

8. Notwithstanding the provisions of section 23.253 to the contrary, the program authorized under this section shall automatically expire on August 28, 2022.

338.075. 1. All licensees, registrants, and permit holders of the board of pharmacy shall report to the board of pharmacy:

(1) Any final adverse action taken by another licensing state, jurisdiction, or government agency against any license, permit, or authorization held by the person or entity to practice or operate as a pharmacist, intern pharmacist, pharmacy technician, pharmacy, drug distributor, drug manufacturer, or drug outsourcing facility. For purposes of this section, "adverse action" shall include, but is not limited to, revocation, suspension, censure, probation, disciplinary reprimand, or disciplinary restriction of a license, permit, or other authorization or a voluntary surrender of such license, permit, or other authorization in lieu of discipline or adverse action;

(2) Any surrender of a license or authorization to practice or operate as a pharmacist, intern pharmacist, pharmacy technician, pharmacy, drug distributor, drug manufacturer, or drug outsourcing facility while under disciplinary investigation by another licensing

state, jurisdiction, or governmental agency; and

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

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

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

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

2. For purposes of this section, "maintenance medication" means a medication prescribed for chronic, long-term conditions that is taken on a regular, recurring basis; 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 on or before the first day of the month in which the permit expires and, if application for renewal of permit is not made before the first day of the

following month, the existing permit, 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 a nonresident pharmacy license if the renewal applicant does not hold a current pharmacy license or its equivalent in the state 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:

(1) Establishing or employing one or more designees as a central electronic depository for licensing and rate and form filings with the director and for records required or allowed to be maintained;

(2) Encouraging insurance companies and producers to implement electronic filing through a central electronic depository;

(3) Developing and maintaining uniform forms;

(4) Conducting joint market conduct examinations and other investigations through collaboration and cooperation with other insurance regulators;

(5) Holding joint administrative hearings;

(6) Instituting and prosecuting joint civil or administrative enforcement proceedings;

(7) Sharing and exchanging personnel;

(8) Coordinating licensing under section 375.014;

(9) Formulating rules, statements of policy, guidelines, forms, no action determinations, and bulletins; and

(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:

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

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

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

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

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

(6) "Pharmacy benefits manager", an entity that contracts with pharmacies on behalf of health carriers or any health plan sponsored

by the state or a political subdivision of the state.

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

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

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

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

4. A pharmacy benefits manager shall not place a drug on a maximum allowable cost list unless there are at least two therapeutically equivalent multi-source generic drugs, or at least one generic drug available from at least one manufacturer, generally available for purchase by network pharmacies from national or regional wholesalers.

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

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

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

6. For appeals that are denied, the pharmacy benefits manager

shall provide the reason for the denial and identify the national drug code of a drug product that may be purchased by contracted pharmacies at a price at or below the maximum allowable cost and, when applicable, may be substituted lawfully.

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

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

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

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

8. Appeals shall be upheld if:

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

(2) The drug subject to the maximum allowable cost pricing in question does not 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 Insurance Rate Transparency Act".

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

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

(1) "Director", the director of the department of insurance, financial institutions and professional registration, or his or her designee;

(2) "Excepted health benefit plan", a health benefit plan providing the following coverage or any combination thereof:

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

(b) Coverage only for disability income insurance;

(c) Credit-only insurance;

(d) Short-term medical insurance of less than twelve months'

duration; or

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

a. Dental or vision benefits;

b. Coverage only for a specified disease or illness; or

c. Hospital indemnity or other fixed indemnity insurance;

(3) "Grandfathered health benefit plan", a health benefit plan in the small group market that was issued, or a health benefit plan in the individual market that was purchased, on or before March 23, 2010;

(4) "Health benefit plan", the same meaning given to such term under section 376.1350; however, for purposes of this section, the term shall exclude plans sold in the large group market, as that term is defined under section 376.450, and shall exclude long-term care and Medicare supplement plans;

(5) "Health carrier", the same meaning given to such term under section 376.1350;

(6) "Individual market", the market for health insurance coverage offered directly to individuals and their dependents and not in connection with a group health benefit plan;

(7) "Small group market", the health insurance market under which individuals obtain health insurance coverage, directly or through an arrangement on behalf of themselves and their dependents, through a group health plan maintained by a small employer, as defined under section 379.930.

4. No health carrier shall deliver, issue for delivery, continue, or renew any health benefit plan until rates have been filed with the director.

5. For excepted health benefit plans, such rates shall be filed, thirty days prior to use, for informational purposes only. Rates shall not be excessive, inadequate, or unfairly discriminatory.

6. For grandfathered health benefit plans, such rates shall be filed, thirty days prior to use, for informational purposes only.

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

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

(b) The date the health carrier notifies the director of its intent

to use rates that the director has deemed unreasonable; or

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

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

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

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

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

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

(2) Review proposed rates and rate filing documentation;

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

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

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

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

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

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

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

15. The director may promulgate rules to promote health insurance rate transparency including, but not limited to, prescribing the form and content of the information required to be submitted and of the standards of review that are consistent with 45 CFR 154. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable, and if any of the powers vested with the general assembly under 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, 2016, shall be invalid and void.

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

consistent with 45 CFR 154.

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

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

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

4. The provisions of 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, short-term major medical policies of six months' or less duration, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

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

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

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

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

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

2. A small employer carrier may establish up to nine separate classes of business under subsection 1 of this section. A small employer carrier which

immediately prior to the effective date of sections 379.930 to 379.952 had established more than nine separate classes of business may, on the effective date of sections 379.930 to 379.952, establish no more than twelve separate classes of business, and shall reduce the number of such classes to eleven within one year after the effective date of sections 379.930 to 379.952; ten within two years after such date; and nine within three years after such date.

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

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

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

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

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

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

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

(b) Any adjustment, not to exceed fifteen percent annually and adjusted pro rata for rating periods of less than one year, due to the claim experience,

health status or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business; and

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

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

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

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

(7) In the case of health benefit plans issued prior to July 1, 1993, a premium rate for a rating period may exceed the ranges set forth in subdivisions (1) and (2) of this subsection for a period of three years following July 1, 1993. In such case, the percentage increase in the premium rate charged to a small employer for a new rating period shall not exceed the sum of the following:

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

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

(8) (a) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of

business. Rating factors shall produce premiums for identical groups which differ only by amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans;

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

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

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

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

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

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

2. A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage.

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

4. In connection with the offering for sale of any health benefit plan to a

small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

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

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

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

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

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

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

(3) A small employer carrier shall make the information and documentation described 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 renewable with respect to all eligible employees and dependents, at the option of the small employer, except in any of the following cases:

(1) The plan sponsor fails to pay a premium or contribution in accordance with the terms of a health benefit plan or the health carrier has not received a timely premium payment;

(2) The plan sponsor performs an act or practice that constitutes fraud, or makes an intentional misrepresentation of material fact under the terms of the coverage;

(3) Noncompliance with the carrier's minimum participation requirements;

(4) Noncompliance with the carrier's employer contribution requirements;

(5) In the case of a small employer carrier that offers coverage through a network plan, there is no longer any enrollee under the health benefit plan who lives, resides or works in the service area of the health insurance issuer and the small employer carrier would deny enrollment with respect to such plan under subsection 4 of this section;

(6) The small employer carrier elects to discontinue offering a **[**particular type of health benefit plan**] product, as defined in 45 CFR 144.103,** in the state's small group market. A type of **[**health benefit plan**] product** may be discontinued by a small employer carrier in such market only if such carrier:

(a) Issues a notice to each plan sponsor provided coverage of such type in the small group market (and participants and beneficiaries covered under such coverage) of the discontinuation at least ninety days prior to the date of discontinuation of the coverage;

(b) Offers to each plan sponsor provided coverage of such type the option to purchase all other health benefit plans currently being offered by the small employer carrier in the state's small group market; and

(c) Acts uniformly without regard to the claims experience of those plan sponsors or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage;

(7) A small employer carrier elects to discontinue offering all health insurance coverage in the small group market in this state. A small employer carrier shall not discontinue offering all health insurance coverage in the small employer market unless:

(a) The carrier provides notice of discontinuation to the director and to each plan sponsor (and participants and beneficiaries covered under such coverage) at least one hundred eighty days prior to the date of the discontinuation of coverage; and

(b) All health insurance issued or delivered for issuance in Missouri in the small employer market is discontinued and coverage under such health insurance is not renewed;

(8) In the case of health insurance coverage that is made available in the small group market only through one or more bona fide associations, the membership of an employer in the association (on the basis of which the coverage

is provided) ceases but only if such coverage is terminated under this subdivision uniformly without regard to any health status-related factor relating to any covered individual;

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

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

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

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

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

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

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

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

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

(2) (a) A small employer carrier shall issue a health benefit plan to any eligible small employer that applies for either such plan and agrees to make the

required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with sections 379.930 to 379.952.

(b) **For health benefit plans purchased on or before March 23, 2010,** in the case of a small employer carrier that establishes more than one class of business pursuant to section 379.934, the small employer carrier shall maintain and issue to eligible small employers all health benefit plans in each class of business so established. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business, provided that:

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

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

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

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

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

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

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

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

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

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

(c) In applying minimum participation requirements with respect to a

small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether the applicable percentage of participation is met.

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

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

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

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

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

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

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

(c) Within an area where the small employer carrier reasonably anticipates, and demonstrates to the satisfaction of the director, that it will not

have the capacity within its established geographic service area to deliver service adequately to the members of such groups because of its obligations to existing group policyholders and enrollees.

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

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

4. A small employer carrier shall not be required to provide coverage to small employers pursuant to subsection 1 of this section for any period of time for which the director determines that requiring the acceptance of small employers in accordance with the provisions of subsection 1 of this section would place the small employer carrier in a financially impaired condition, and the small employer is applying this subsection uniformly to all small employers in the small group market in this state consistent with applicable state law and without regard to the claims experience of a small employer and its employees and their dependents or any health status-related factor relating to such employees and their dependents.

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