SECOND REGULAR SESSION

SENATE BILL NO. 1238

93RD GENERAL ASSEMBLY

INTRODUCED BY SENATOR CALLAHAN.

Read 1st time March 1, 2006, and ordered printed.

TERRY L. SPIELER, Secretary.

5480S.01I

AN ACT

To amend chapter 376, RSMo, by adding thereto eleven new sections relating to the small business health fairness act of 2006.

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

Section A. Chapter 376, RSMo, is amended by adding thereto eleven new sections, to be known as sections 376.1500, 376.1503, 376.1506, 376.1509, 376.1512, 376.1515, 376.1518, 376.1521, 376.1524, 376.1527, and 376.1530, to read as follows:

376.1500. 1. Sections 376.1500 to 376.1530 shall be known and may be cited as the "Small Business Health Fairness Act of 2006".

2. For purposes of sections 376.1500 to 376.1530, the following terms shall mean:

(1) "Affiliated member", in connection with a sponsor:

(a) A person who is otherwise eligible to be a member of the sponsor but who elects an affiliated status with the sponsor;

(b) In the case of a sponsor with members which consist of associations, a person who is a member of any such association and elects an affiliated status with the sponsor; or

(c) In the case of an association health plan in existence on the effective date of the small business health fairness act of 2006, a person eligible to be a member of the sponsor or one of its member associations;

(2) "Association health plan", a group health plan whose sponsor:

(a) Is or is deemed to be organized and maintained in good faith as a bona fide trade association with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis; a bona fide industry association, including a

rural electric cooperative association or a rural telephone cooperative association; a bona fide professional association; or a bona fide chamber of commerce or similar bona fide business association, including a corporation or similar organization that operates on a cooperative basis, for substantial purposes other than that of obtaining or providing medical care;

(b) Is or is deemed to be established as a permanent entity which receives the active support of its members and requires for membership payment on a periodic basis of dues or payments necessary to maintain eligibility for membership in the sponsor; and

(c) Does not condition membership, such dues or payments, or coverage under the plan on the basis of health status-related factors with respect to the employees of its members or affiliated members, or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation.

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (a) to (c) of this subdivision shall be deemed to be a sponsor described in this subsection;

(3) "Director", the director of the Missouri department of insurance;

(4) "Employee", any individual employed by an employer;

(5) "Employer", any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan. Employer includes a group or association of employers acting for an employer in such capacity;

(6) "Group health plan", has the meaning provided in Section 733(a)(1) of the federal Employee Retirement Income Security Act of 1974, after applying subsection 3 of this section;

(7) "Health insurance coverage" has the meaning provided in Section 733(b)(l) of the federal Employee Retirement Income Security Act of 1974;

(8) "Health insurance issuer", has the meaning provided in Section 733(b)(2) of the federal Employee Retirement Income Security Act of 1974;

(9) "Health status-related factor", has the meaning provided in Section 733(d)(2) of the federal Employee Retirement Income Security Act of 1974;

(10) "Individual market", the market for health insurance coverage offered to individuals other than in connection with a group health plan. Individual market includes coverage offered in connection with a group health plan that has fewer than two participants as current employees or participants described in Section 732(d)(3) of the federal Employee Retirement Income Security Act of 1974 on the first day of the plan year;

(11) "Large employer", in connection with a group health plan with respect to a plan year, an employer who employed an average of at least fifty-one employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year;

(12) "Medical care", has the meaning provided in Section 733(a)(2) of the federal Employee Retirement Income Security Act of 1974;

(13) "Participating employer", in connection with an association health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan;

(14) "Qualified actuary", an individual who is a member of the American Academy of Actuaries or meets such reasonable standards and qualifications as the director may prescribe by rule;

(15) "Small employer", in connection with a group health plan with respect to a plan year, an employer who is not a large employer.

3. For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is an association health plan, and for purposes of applying sections 376.1500 to 376.1530 in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan:

(1) In the case of a partnership, employer includes the partnership in relation to the partners, and employee includes any partner in relation to the partnership; and

(2) In the case of a self-employed individual, employer and employee shall include such individual.

4. In the case of any plan, fund, or program which was

established or is maintained for the purpose of providing medical care, through the purchase of insurance or otherwise, for employees or their dependents covered thereunder and which demonstrates to the director that all requirements for certification under sections 376.1500 to 376.1530 would be met with respect to such plan, fund, or program if such plan, fund, or program were a group health plan, such plan, fund, or program shall be treated for purposes of sections 376.1500 to 376.1530 as an employee welfare benefit plan on and after the date of such demonstration.

376.1503. 1. The department of insurance shall establish by rule a procedure under which, subject to subsection 2 of this section, the department shall certify association health plans which apply for certification under sections 376.1500 to 376.1530.

2. Under the procedure established in subsection 1 of this section, in the case of an association health plan that provides at least one benefit option which does not consist of health insurance coverage, the department shall certify such plan as meeting the requirements of sections 376.1500 to 376.1530 only if the department is satisfied that the applicable requirements of sections 376.1500 to 376.1530 are met or, upon the date on which the plan is to commence operations, will be met with respect to the plan.

3. An association health plan with respect to which certification under this section is in effect shall meet the applicable requirements of this section effective on the date of certification or, if later, on the date on which the plan is to commence operations.

4. The department may by rule provide for continued certification of association health plans under this section.

5. The department shall establish a class certification procedure for association health plans under which all benefits consist of health insurance coverage. Under such procedure, the department shall provide for the granting of certification under this section to the plans in each class of such association health plans upon appropriate filing under such procedure in connection with plans in such class and payment of the required fee under subsection 1 of section 376.1518.

6. An association health plan which offers one or more benefit options which do not consist of health insurance coverage may be certified under this section only if such plan consists of any of the

following:

(1) A plan which offered such coverage on the effective date of sections 376.1500 to 376.1530;

(2) A plan under which the sponsor does not restrict membership to one or more trades and businesses or industries and whose eligible participating employers represent a broad cross-section of trades and businesses and industries; or

(3) A plan whose eligible participating employers represent one or more trades or businesses, or one or more industries, consisting of any of the following: agriculture; equipment and automobile dealerships; barbering and cosmetology; certified public accounting practices; child care; construction; dance, theatrical, and orchestra productions; disinfecting and pest control; financial services; fishing; food service establishments; hospitals; labor organizations; logging; manufacturing of metals; mining; medical and dental practices; medical laboratories; professional consulting services; sanitary services; local and freight transportation; warehousing; wholesaling/distributing; or any other trade or business or industry which has been indicated as having average or above average risk or health claims experience by reason of state rate filings, denials of coverage, proposed premium rate levels, or other means of demonstrating by such plan in accordance with rules promulgated by the department.

376.1506. 1. The requirements of this section are met with respect to an association health plan if the sponsor has met or is deemed under sections 376.1500 to 376.1530 to have met the requirements of subdivision (1) of subsection 2 of section 376.1500 for a continuous period of not less than three years ending with the date of the application for certification under sections 376.1500 to 376.1530.

2. The requirements of this section are met with respect to an association health plan if the following requirements are met:

(1) The plan is operated pursuant to a trust agreement by a board of trustees which has complete fiscal control over the plan and which is responsible for all operations of the plan;

(2) The board of trustees has in effect rules of operation and financial controls, based on a three-year plan of operation, adequate to carry out the terms of the plan and to meet all requirements of sections 376.1500 to 376.1530 applicable to the plan;

(3) (a) Except as provided in paragraphs (b) and (c) of this subdivision, the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

(b) a. Except as provided in subparagraphs b. and c. of this paragraph, no such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the plan.

b. Officers or employees of a sponsor which is a service provider, other than a contract administrator, to the plan may be members of the board if they constitute not more than twenty-five percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

c. If a sponsor is an association whose membership consists primarily of providers of medical care, subparagraph a. of this paragraph shall not apply if provider described in paragraph (a) of this subdivision is a provider of medical care under the plan.

(c) Paragraph (a) of this subdivision shall not apply to an association health plan which is in existence on the effective date of the small business health fairness act of 2006.

(d) The board has sole authority under the plan to approve applications for participation in the plan and to contract with a service provider to administer the day-to-day affairs of the plan.

3. If a group health plan is established and maintained by a franchiser for a franchise network consisting of its franchisees:

(1) The requirements of subsection 1 of this section and subdivision (1) of subsection 2 of section 376.1500 shall be deemed met if such requirements would otherwise be met if the franchiser is deemed to be the sponsor referred to in subdivision (1) of subsection 2 of section 376.1500, such network is deemed to be an association described in subdivision (1) of subsection 2 of section 376.1500, and each franchisee is deemed to be a member of the association and the sponsor referred to in subdivision (1) of subsection 2 of section 376.1500; and

(2) The requirements of subdivision (1) of subsection 1 of section 376.1509 shall be deemed met.

The director by rule may define for purposes of this subsection the terms "franchiser", "franchise network", and "franchisee".

4. (1) For a group health plan described in subdivision (1) of subsection 3 of this section:

(a) The requirements of subsection 1 of this section and subdivision (1) of subsection 2 of section 376.1500 shall be deemed met;

(b) The joint board of trustees shall be deemed a board of trustees with respect to which the requirements of subsection 2 of this section are met; and

(c) The requirements of section 376.1509 shall be deemed met;

(2) A group health plan is described in this subdivision if:

(a) The plan is a multiemployer plan; or

(b) The plan is in existence on the effective date of sections 376.1500 to 376.1530, and would be described in 29 U.S.C. Section 1002(40)(A)(I) but solely for the failure to meet the requirements of 29 U.S.C. Section 1002(40)(C)(ii).

(3) A group health plan described in subdivision (2) of this subsection shall only be treated as an association health plan under sections 376.1500 to 376.1530 if the sponsor of the plan applies for and obtains certification of the plan as an association health plan under sections 376.1500 to 376.1530.

376.1509. 1. The requirements of this section are met with respect to an association health plan if, under the terms of the plan:

(1) Each participating employer is a member of the sponsor, the sponsor, or an affiliated member of the sponsor with respect to which the requirements of subsection 2 of this section are met; except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or such an affiliated member of the sponsor, participating employers may also include such employer; and

(2) All individuals commencing coverage under the plan after certification under sections 376.1500 to 376.1530 shall be:

(a) Active or retired owners including self-employed individuals, officers, directors, or employees of, or partners in, participating employers; or

(b) The beneficiaries of individuals described in paragraph (a) of this subdivision.

2. In the case of an association health plan in existence on the effective date of the small business health fairness act of 2006, an affiliated member of the sponsor of the plan may be offered coverage under the plan as a participating employer only if:

(1) The affiliated member was an affiliated member on the date of certification under sections 376.1500 to 376.1530; or

(2) During the twelve-month period preceding the date of the offering of such coverage, the affiliated member has not maintained or contributed to a group health plan with respect to any of its employees who would otherwise be eligible to participate in such association health plan.

3. The requirements of this section are met with respect to an association health plan if, under the terms of the plan, no participating employer may provide health insurance coverage in the individual market for any employee not covered under the plan which is similar to the coverage contemporaneously provided to employees of the employer under the plan, if such exclusion of the employee from coverage under the plan is based on a health status-related factor with respect to the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the plan.

4. The requirements of this section are met with respect to an association health plan if:

(1) Under the terms of the plan, all employers meeting the preceding requirements of this section are eligible to qualify as participating employers for all geographically available coverage options, unless, in the case of any such employer, participation or contribution requirements of the type referred to in Section 2711 of the federal Public Health Service Act are not met;

(2) Upon request, any employer eligible to participate is furnished information regarding all coverage options available under the plan; and

(3) The applicable requirements of Sections 701, 702, and 703 of the federal Employee Retirement Income Security Act of 1974 are met with respect to the plan.

376.1512. 1. The requirements of this section are met with

respect to an association health plan if the following requirements are met:

(1) The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under Section 402(a)(1) of the federal Employee Retirement Income Security Act of 1974, which:

(a) Provides that the board of trustees serves as the named fiduciary required for plans under Section 402(a)(1) of the federal Employee Retirement Income Security Act of 1974 and serves in the capacity of a plan administrator, referred to in 29 U.S.C. Section 1002(16)(A);

(b) Provides that the sponsor of the plan is to serve as plan sponsor, referred to in 29 U.S.C. Section 1002(l6)(B); and

(c) Incorporates the requirements of section 376.1515;

(2) (a) The contribution rates for any participating small employer do not vary on the basis of any health status-related factor in relation to employees of such employer or their beneficiaries and do not vary on the basis of the type of business or industry in which such employer is engaged;

(b) Nothing in sections 376.1500 to 376.1530 or any other provision of state law shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from:

a. Setting contribution rates based on the claims experience of the plan; or

b. Varying contribution rates for small employers in this state to the extent that such rates could vary using the same methodology employed in this state for regulating premium rates in the small group market with respect to health insurance coverage offered in connection with bona fide associations within the meaning of Section 2791(d)(3) of the federal Public Health Service Act, subject to the requirements of Section 702(b) of the federal Employee Retirement Income Security Act of 1974 relating to contribution rates;

(3) If any benefit option under the plan does not consist of health insurance coverage, the plan has as of the beginning of the plan year not fewer than one thousand participants and beneficiaries;

(4) (a) If a benefit option which consists of health insurance

coverage is offered under the plan, state-licensed insurance agents shall be used to distribute to small employers coverage which does not consist of health insurance coverage in a manner comparable to the manner in which such agents are used to distribute health insurance coverage.

(b) For purposes of paragraph (a) of this subdivision, "state-licensed insurance agents" means one or more agents who are licensed in this state and are subject to the laws of this state relating to licensure, qualification, testing, examination, and continuing education of persons authorized to offer, sell, or solicit health insurance coverage in this state;

(5) Such other requirements as the director determines are necessary to carry out the purposes of sections 376.1500 to 376.1530, which shall be prescribed by the director by rule.

2. Subject to Section 514(d) of the federal Employee Retirement Income Security Act of 1974, nothing in sections 376.1500 to 376.1530 or any provision of state law shall be construed to preclude an association health plan or a health insurance issuer offering health insurance coverage in connection with an association health plan from exercising its sole discretion in selecting the specific items and services consisting of medical care to be included as benefits under such plan or coverage, except in the case of any law to the extent that it:

(1) Prohibits an exclusion of a specific disease from such coverage; or

(2) Is not preempted under Section 731(a)(1) of the federal Employee Retirement Income Security Act of 1974 with respect to matters governed by Section 711 or 712 of the federal Employee Retirement Income Security Act of 1974.

376.1515. 1. The requirements of this section are met with respect to an association health plan if:

(1) The benefits under the plan consist solely of health insurance coverage; or

(2) If the plan provides any additional benefit options which do not consist of health insurance coverage, the plan:

(a) Establishes and maintains reserves with respect to such additional benefit options, in amounts recommended by the qualified actuary, consisting of:

a. A reserve sufficient for unearned contributions;

b. A reserve sufficient for benefit liabilities which have been incurred, which have not been satisfied, and for which risk of loss has not yet been transferred, and for expected administrative costs with respect to such benefit liabilities;

c. A reserve sufficient for any other obligations of the plan; and

d. A reserve sufficient for a margin of error and other fluctuations, taking into account the specific circumstances of the plan; and

(b) Establishes and maintains aggregate and specific excess/stop loss insurance and solvency indemnification, with respect to such additional benefit options for which risk of loss has not yet been transferred, as follows:

a. The plan shall secure aggregate excess/stop loss insurance for the plan with an attachment point which is not greater than one hundred twenty-five percent of expected gross annual claims. The director may by rule provide for upward adjustments in the amount of such percentage in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under paragraph (a) of this subdivision.

b. The plan shall secure specific excess/stop loss insurance for the plan with an attachment point which is at least equal to an amount recommended by the plan's qualified actuary. The director may by rule provide for adjustments in the amount of such insurance in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under paragraph (a) of this subdivision.

c. The plan shall secure indemnification insurance for any claims which the plan is unable to satisfy by reason of a plan termination.

Any rules promulgated by the director pursuant to subparagraphs a. or b. of paragraph (b) of this subdivision may allow for such adjustments in the required levels of excess/stop loss insurance as the qualified actuary may recommend, taking into account the specific circumstances of the plan.

2. In the case of any association health plan described in subdivision (2) of subsection 1 of this section, the requirements of this section are met if the plan establishes and maintains surplus in an

amount at least equal to:

(1) Five hundred thousand dollars; or

(2) Such greater amount, but not greater than two million dollars, as may be set forth in rules promulgated by the department based on the level of aggregate and specific excess/stop loss insurance provided with respect to such plan.

3. In the case of any association health plan described in subdivision (2) of subsection 1 of this section, the department may provide such additional requirements relating to reserves and excess/stop loss insurance as the department considers appropriate. Such requirements may be provided by rule with respect to any such plan or any class of such plans.

4. The department may provide for adjustments to the levels of reserves otherwise required under subsections 1 and 2 of this section with respect to any plan or class of plans to take into account excess/stop loss insurance provided with respect to such plan or plans.

5. The director may permit an association health plan described in subdivision (2) of subsection 1 of this section to substitute, for all or part of the requirements of this section (except subparagraph c. of paragraph (b) of subdivision (2) of subsection 1 of this section), such security, guarantee, hold-harmless arrangement, or other financial arrangement as the director determines to be adequate to enable the plan to fully meet all its financial obligations on a timely basis and is otherwise no less protective of the interests of participants and beneficiaries than the requirements for which it is substituted. For purposes of this subsection, the department may take into account evidence provided by the plan or sponsor which demonstrates an assumption of liability with respect to the plan. Such evidence may be in the form of a contract of indemnification, lien, bonding, insurance, letter of credit, recourse under applicable terms of the plan in the form of assessments of participating employers, security, or other financial arrangement.

6. (1) (a) In the case of an association health plan described in subdivision (2) of subsection 1 of this section, the requirements of this subsection are met if the plan makes payments into the association health plan fund under this subdivision when they are due. Such payments shall consist of annual payments in the amount of five

thousand dollars and, in addition to such annual payments, such supplemental payments as the director may determine to be necessary under subdivision (2) of subsection 1 of this section. Payments under this subdivision are payable to the fund at the time determined by the director. Initial payments are due in advance of certification under sections 376.1500 to 376.1530. Payments shall continue to accrue until a plan's assets are distributed pursuant to a termination procedure.

(b) If any payment is not made by a plan when it is due, a late payment charge of not more than one hundred percent of the payment which was not timely paid shall be payable by the plan to the fund.

(c) The director shall not cease to carry out the provisions of subdivision (2) of this section on account of the failure of a plan to pay any payment when due.

(2) In any case in which the director determines that there is, or that there is reason to believe that there will be:

(a) A failure to take necessary corrective actions under subsection 1 of section 376.1524 with respect to an association health plan described in this section; or

(b) A termination of such a plan under subsection 2 of section 376.1524 or subdivision (8) of subsection 2 of section 376.1527, the director shall determine the amounts necessary to make payments to an insurer, designated by the director, to maintain in force excess/stop loss insurance coverage or indemnification insurance coverage for such plan if the director determines that there is a reasonable expectation that without such payments claims would not be satisfied by reason of termination of such coverage. The director shall, subject to appropriations, pay such amounts so determined to the insurer designated by the director.

(3) (a) There is hereby established in the state treasury a fund to be known as the "Association Health Plan Fund". The fund shall be available for making payments pursuant to subdivision (2) of this subsection. The fund shall be credited with payments received pursuant to paragraph (a) of subdivision (l) of this subsection, penalties received pursuant to paragraph (b) of subdivision (1) of this subsection, and earnings on investments of amounts of the fund under paragraph (b) of this subdivision.

(b) If the director determines that moneys in the fund are in

excess of current needs, the director may request the investment by the state treasurer of such amounts as the director determines advisable.

7. (1) The term "aggregate excess/stop loss insurance" means, in connection with an association health plan, a contract:

(a) Under which an insurer, meeting such minimum standards, as the director may prescribe by rule, provides for payment to the plan with respect to aggregate claims under the plan in excess of an amount or amounts specified in such contract;

(b) Which is guaranteed renewable; and

(c) Which allows for payment of premiums by any third party on behalf of the insured plan.

(2) The term "specific excess/stop loss insurance" means, in connection with an association health plan, a contract:

(a) Under which an insurer, meeting such minimum standards, as the director may prescribe by rule, provides for payment to the plan with respect to claims under the plan in connection with a covered individual in excess of an amount or amounts specified in such contract in connection with such covered individual;

(b) Which is guaranteed renewable; and

(c) Which allows for payment of premiums by any third party on behalf of the insured plan.

8. For purposes of this section, the term "indemnification insurance" means, in connection with an association health plan, a contract:

(1) Under which an insurer, meeting such minimum standards as the director may prescribe by rule, provides for payment to the plan with respect to claims under the plan which the plan is unable to satisfy by reason of a termination pursuant to subsection 2 of section 376.1524 relating to mandatory termination;

(2) Which is guaranteed renewable and noncancellable for any reason, except as the director may prescribe by rule; and

(3) Which allows for payment of premiums by any third party on behalf of the insured plan.

9. For purposes of this section, the term "reserves" means, in connection with an association health plan, plan assets which meet the fiduciary standards and such additional requirements regarding liquidity as the director may prescribe by rule.

10. (1) Within ninety days after the effective date of the small business health fairness act of 2005, the director shall establish a "Solvency Standards Working Group". In promulgating the initial rules under this section, the director shall take into account the recommendations of such working group.

(2) The working group shall consist of not more than fifteen members appointed by the director. The director shall include among persons invited to membership on the working group at least one of each of the following:

(a) A representative of the National Association of Insurance Commissioners;

(b) A representative of the American Academy of Actuaries;

(c) A representative of state government, or its interests;

(d) A representative of existing self-insured arrangements, or their interests;

(e) A representative of associations of the type referred to in subdivision (1) of subsection 2 of section 376.1500, or their interests; and

(f) A representative of multiemployer plans that are group health plans, or their interests.

376.1518. 1. Under the procedure established in subsection 1 of section 376.1503, an association health plan shall pay to the director at the time of filing an application for certification under sections 376.1500 to 376.1530 a filing fee in the amount of five thousand dollars, which shall be available to the director, subject to appropriations, for the sole purpose of administering the certification procedures applicable with respect to association health plans.

2. An application for certification under sections 376.1500 to 376.1530 meets the requirements of this section only if it includes, in a manner and form prescribed by rule by the director with at least the following information:

(1) The names and addresses of the sponsor and the members of the board of trustees of the plan;

(2) The expected number of participants and beneficiaries under the plan;

(3) Evidence provided by the board of trustees that the bonding requirements of Section 412 of the federal Employee Retirement Income

Security Act of 1974 will be met as of the date of the application or, if later, commencement of operations;

(4) A copy of the documents governing the plan, including any bylaws and trust agreements, the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan;

(5) A copy of any agreements between the plan and contract administrators and other service providers;

(6) In the case of association health plans providing benefits options in addition to health insurance coverage, a report setting forth information with respect to such additional benefit options determined as of a date within the one hundred twenty-day period ending with the date of the application, including the following:

(a) A statement, certified by the board of trustees of the plan, and a statement of actuarial opinion, signed by a qualified actuary, that all applicable requirements of section 376.1515 are or will be met in accordance with prescribed rules of the director;

(b) A statement of actuarial opinion, signed by a qualified actuary, which sets forth a description of the extent to which contribution rates are adequate to provide for the payment of all obligations and the maintenance of required reserves under the plan for the twelve-month period beginning with such date within such one hundred twenty-day period, taking into account the expected coverage and experience of the plan. If the contribution rates are not fully adequate, the statement of actuarial opinion shall indicate the extent to which the rates are inadequate and the changes needed to ensure adequacy;

(c) A statement of actuarial opinion signed by a qualified actuary, which sets forth the current value of the assets and liabilities accumulated under the plan and a projection of the assets, liabilities, income, and expenses of the plan for the twelve-month period referred to in paragraph (b) of this subdivision. The income statement shall identify separately the plan's administrative expenses and claims;

(d) A statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves, and other expenses associated with the operation of the plan;

(e) Any other information as may be determined by the director

by rule as necessary to carry out the purposes of sections 376.1500 to 376.1530.

3. A certification granted under sections 376.1500 to 376.1530 to an association health plan shall not be effective unless at least twenty-five percent of the participants and beneficiaries under the plan are located in Missouri. For purposes of this subsection, an individual shall be considered to be located in Missouri if a known address of such individual is located in Missouri or if such individual is employed in Missouri.

4. In the case of any association health plan certified under sections 376.1500 to 376.1530, descriptions of material changes in any information which was required to be submitted with the application for the certification under sections 376.1500 to 376.1530 shall be filed in such form and manner as shall be prescribed by the director by rule. The director may by rule require prior notice of material changes with respect to specified matters which may serve as the basis for suspension or revocation of the certification.

5. An association health plan certified under sections 376.1500 to 376.1530 which provides benefit options in addition to health insurance coverage for such plan year shall meet the requirements of Section 503B of the federal Employee Retirement Income Security Act of 1974 by filing an annual report under such Section 503B of the federal Employee Retirement Income Security Act of 1974 which shall include information described in subdivision (6) of subsection 2 of this section with respect to the plan year and, notwithstanding Section 503C(a)(1)(A) of the federal Employee Retirement Income Security Act of 1974, shall be filed with the director not later than ninety days after the close of the plan year, or on such later date as may be prescribed by the director by rule. The director may by rule require such interim reports as it considers appropriate.

6. The board of trustees of each association health plan which provides benefits options in addition to health insurance coverage and which is applying for certification under sections 376.1500 to 376.1530 or is certified under sections 376.1500 to 376.1530 shall engage, on behalf of all participants and beneficiaries, a qualified actuary who shall be responsible for the preparation of the materials comprising information necessary to be submitted by a qualified actuary under

sections 376.1500 to 376.1530. The qualified actuary shall utilize such assumptions and techniques as are necessary to enable such actuary to form an opinion as to whether the contents of the matters reported under sections 376.1500 to 376.1530:

(1) Are in the aggregate reasonably related to the experience of the plan and to reasonable expectations; and

(2) Represent such actuary's best estimate of anticipated experience under the plan.

The opinion by the qualified actuary shall be made with respect to, and shall be made a part of, the annual report.

376.1521. Except as provided in subsection 2 of section 376.1524, an association health plan which is or has been certified under sections 376.1500 to 376.1530 may terminate upon or at any time after cessation of accruals in benefit liabilities only if the board of trustees:

(1) Not less than sixty days before the proposed termination date, provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date;

(2) Develops a plan for winding up the affairs of the plan in connection with such termination in a manner which will result in timely payment of all benefits for which the plan is obligated; and

(3) Submits such plan in writing to the director.

Actions required under this section shall be taken in such form and manner as may be prescribed by the director by rule.

376.1524. 1. An association health plan which is certified under sections 376.1500 to 376.1530 and which provides benefits other than health insurance coverage shall continue to meet the requirements of section 376.1515, irrespective of whether such certification continues in effect. The board of trustees of such plan shall determine quarterly whether the requirements of section 376.1515 are met. In any case in which the board determines that there is reason to believe that there is or will be a failure to meet such requirements, or the director makes such a determination and so notifies the board, the board shall immediately notify the qualified actuary engaged by the plan, and such actuary shall, not later than the end of the next following month, make such recommendations to the board for corrective action as the actuary determines necessary to ensure compliance with section 376.1515. Not

later than thirty days after receiving from the actuary recommendations for corrective actions, the board shall notify the director, in such form and manner as the director may prescribe by rule, of such recommendations of the actuary for corrective action, together with a description of the actions, if any, that the board has taken or plans to take in response to such recommendations. The board shall thereafter report to the director, in such form and frequency as the director may specify to the board, regarding corrective action taken by the board until the requirements of section 376.1515 are met.

2. In any case in which:

(1) The director has been notified under subsection 1 of this section of a failure of an association health plan which is or has been certified under sections 376.1500 to 376.1530 and is described in subdivision (2) of subsection 1 of section 376.1515 to meet the requirements of section 376.1515 and has not been notified by the board of trustees of the plan that corrective action has restored compliance with such requirements; and

(2) The director determines that there is a reasonable expectation that the plan will continue to fail to meet the requirements of section 376.1515, the board of trustees of the plan shall, at the direction of the director, terminate the plan and, in the course of the termination, take such actions as the director may require, including satisfying any claims referred to in subparagraph c. of paragraph (b) of subdivision (2) of subsection 1 of section 376.1515 and recovering for the plan any liability under subparagraph c. of paragraph (b) of subdivision (2) of subsection 1 of section 376.1515 or subsection 5 of section 376.1515, as necessary to ensure that the affairs of the plan will be, to the maximum extent possible, wound up in a manner which will result in timely provision of all benefits for which the plan is obligated.

376.1527. 1. Whenever the director determines that an association health plan which is or has been certified under sections 376.1500 to 376.1530 and which is described in subdivision (2) of subsection 1 of section 376.1515 will be unable to provide benefits when due or is otherwise in a financially hazardous condition, as shall be defined by the director by rule, the director shall, upon notice to the plan, apply to the appropriate court for appointment of the director as trustee to administer the plan for the duration of the insolvency. The

plan may appear as a party and other interested persons may intervene in the proceedings at the discretion of the court. The court shall appoint the director trustee if the court determines that the trusteeship is necessary to protect the interests of the participants and beneficiaries or providers of medical care or to avoid any unreasonable deterioration of the financial condition of the plan. The trusteeship of the director shall continue until the conditions described in the first sentence of this subsection are remedied or the plan is terminated.

2. The director, upon appointment as trustee under subsection 1 of this section, shall have the power:

(1) To do any act authorized by the plan, sections 376.1500 to 376.1530, or other applicable provisions of state law to be done by the plan administrator or any trustee of the plan;

(2) To require the transfer of all or any part of the assets and records of the plan to the director as trustee;

(3) To invest any assets of the plan which the director holds in accordance with the provisions of the plan, rules prescribed by the director, and applicable provisions of state law;

(4) To require the sponsor, the plan administrator, any participating employer, and any employee organization representing plan participants to furnish any information with respect to the plan which the director as trustee may reasonably need in order to administer the plan;

(5) To collect for the plan any amounts due the plan and to recover reasonable expenses of the trusteeship;

(6) To commence, prosecute, or defend on behalf of the plan any suit or proceeding involving the plan;

(7) To issue, publish, or file such notices, statements, and reports as may be required by the director by rule or required by any order of the court;

(8) To terminate the plan, or provide for its termination in accordance with subsection 2 of section 376.1524, and liquidate the plan assets, to restore the plan to the responsibility of the sponsor, or to continue the trusteeship;

(9) To provide for the enrollment of plan participants and beneficiaries under appropriate coverage options; and

(10) To do such other acts as may be necessary to comply with

sections 376.1500 to 376.1530 or any order of the court and to protect the interests of plan participants and beneficiaries and providers of medical care.

3. As soon as practicable after the director's appointment as trustee, the director shall give notice of such appointment to:

(1) The sponsor and plan administrator;

(2) Each participant;

(3) Each participating employer; and

(4) If applicable, each employee organization which, for purposes of collective bargaining, represents plan participants.

4. Except to the extent inconsistent with the provisions of sections 376.1500 to 376.1530, or as may be otherwise ordered by the court, the director, upon appointment as trustee under this section, shall be subject to the same duties as those of a trustee under Section 704 of Title 11, United States Code, and shall have the duties of a fiduciary for purposes of sections 376.1500 to 376.1530.

5. An application by the director under this subsection may be filed notwithstanding the pendency in the same or any other court of any bankruptcy, mortgage foreclosure, or equity receivership proceeding, or any proceeding to reorganize, conserve, or liquidate such plan or its property, or any proceeding to enforce a lien against property of the plan.

(1) Upon the filing of an application for the appointment as trustee or the issuance of a decree under this section, the court to which the application is made shall have exclusive jurisdiction of the plan involved and its property wherever located with the powers, to the extent consistent with the purposes of this section, of a court of the United States having jurisdiction over cases under Chapter 11 of Title 11, United States Code. Pending an adjudication under this section such court shall stay, and upon appointment by it of the director as trustee, such court shall continue the stay of, any pending mortgage foreclosure, equity receivership, or other proceeding to reorganize, conserve, or liquidate the plan, the sponsor, or property of such plan or sponsor, and any other suit against any receiver, conservator, or trustee of the plan, the sponsor, or property of the plan or sponsor. Pending such adjudication and upon the appointment by it of the director as trustee, the court may stay any proceeding to enforce

a lien against property of the plan or the sponsor or any other suit against the plan or the sponsor.

(2) An action under this section may be brought in the judicial circuit where the sponsor or the plan administrator resides or does business or where any asset of the plan is situated. A court in which such action is brought may issue process with respect to such action in any other judicial circuit.

6. In accordance with rules prescribed by the director, the director shall appoint, retain, and compensate accountants, actuaries, and other professional service personnel as may be necessary in connection with the director's service as trustee under this section.

376.1530. 1. The provisions of sections 376.1500 to 376.1530 shall supersede any and all state laws insofar as they may now or hereafter preclude, or have the effect of precluding, a health insurance issuer from offering health insurance coverage in connection with an association health plan which is certified under sections 376.1500 to 376.1530.

2. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in sections 376.1500 to 376.1530 shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. Sections 376.1500 to 376.1530 and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, 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, 2006, shall be invalid and void.

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