SECOND REGULAR SESSION

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

HOUSE COMMITTEE SUBSTITUTE FOR

SENATE COMMITTEE SUBSTITUTE FOR

SENATE BILLS NOS. 567 & 792

93RD GENERAL ASSEMBLY

2006

3385L.05T

AN ACT

To repeal sections 290.145, 376.421, 376.429, and 379.952, RSMo, and to enact in lieu thereof five new sections relating to health insurance coverage.

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

Section A. Sections 290.145, 376.421, 376.429, and 379.952, RSMo, are repealed and five new sections enacted in lieu thereof, to be known as sections 290.145, 376.392, 376.421, 376.429, and 379.952, to read as follows:

290.145. It shall be an improper employment practice for an employer to refuse to hire, or to discharge, any individual, or to otherwise disadvantage any individual, with respect to compensation, terms or conditions of employment because the individual uses lawful alcohol or tobacco products off the premises of the employer during hours such individual is not working for the employer, unless such use interferes with the duties and performance of the employee, the employee's coworkers, or the overall operation of the employer's business; except that, nothing in this section shall prohibit an employer from providing or contracting for health insurance benefits at a reduced premium rate **or at a reduced deductible level** for employees who do not smoke or use tobacco products. Religious organizations and church-operated institutions, and not-for-profit organizations whose principal business is health care promotion shall be exempt from the provisions of this section. The provisions of this section shall not be deemed to create a cause of action for injunctive relief, damages or other relief.

376.392. For any health carrier or health benefit plan, as defined

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

in section 376.1350, that provides prescription drug coverage, if a prescription drug covered by a health carrier or health benefit plan is prescribed in a single dosage amount for which the particular prescription drug is not manufactured in such single dosage amount and requires dispensing the particular prescription drug in a combination of different manufactured dosage amounts, the health carrier or health benefit plan shall only impose one co-payment for the dispensing of the combination of manufactured dosages that equal the prescribed dosage for such prescription drug. Such co-payment requirement shall not apply to prescriptions in excess of a one-month supply. If technology does not permit such adjudication, the health carrier or health benefit plan shall provide reimbursement forms for the patient.

376.421. 1. Except as provided in subsection 2 of this section, no policy of group health insurance shall be delivered in this state unless it conforms to one of the following descriptions:

(1) A policy issued to an employer, or to the trustees of a fund established by an employer, which employer or trustees shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

(a) The employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any class or classes thereof. The policy may provide that the term "employees" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships, if the business of the employer and of such affiliated corporations, proprietorships or partnerships is under common control. The policy may provide that the term "employees" shall include the individual proprietor or partners if the employer is an individual proprietorship or partnership. The policy may provide that the term "employees" shall include retired employees, former employees and directors of a corporate employer. A policy issued to insure the employees of a public body may provide that the term "employees" shall include elected or appointed officials;

(b) The premium for the policy shall be paid either from the employer's funds or from funds contributed by the insured employees, or from both. Except as provided in paragraph (c) of this subdivision, a policy on which no part of the premium is to be derived from funds contributed by the insured employees must

insure all eligible employees, except those who reject such coverage in writing; and

(c) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer in a policy insuring fewer than ten employees and in a policy insuring ten or more employees if:

a. Application is not made within thirty-one days after the date of eligibility for insurance; or

b. The person voluntarily terminated the insurance while continuing to be eligible for insurance under the policy; or

c. After the expiration of an open enrollment period during which the person could have enrolled for the insurance or could have elected another level of benefits under the policy;

(2) A policy issued to a creditor or its parent holding company or to a trustee or trustees or agent designated by two or more creditors, which creditor, holding company, affiliate, trustee, trustees or agent shall be deemed the policyholder, to insure debtors of the creditor or creditors with respect to their indebtedness subject to the following requirements:

(a) The debtors eligible for insurance under the policy shall be all of the debtors of the creditor or creditors, or all of any class or classes thereof. The policy may provide that the term "debtors" shall include:

a. Borrowers of money or purchasers or lessees of goods, services, or property for which payment is arranged through a credit transaction;

b. The debtors of one or more subsidiary corporations; and

c. The debtors of one or more affiliated corporations, proprietorships or partnerships if the business of the policyholder and of such affiliated corporations, proprietorships or partnerships is under common control;

(b) The premium for the policy shall be paid either from the creditor's funds or from charges collected from the insured debtors, or from both. Except as provided in paragraph (c) of this subdivision, a policy on which no part of the premium is to be derived from funds contributed by insured debtors specifically for their insurance must insure all eligible debtors;

(c) An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer in a policy insuring fewer than ten debtors and in a policy insuring ten or more debtors if:

a. Application is not made within thirty-one days after the date of

eligibility for insurance; or

b. The person voluntarily terminated the insurance while continuing to be eligible for insurance under the policy; or

c. After the expiration of an open enrollment period during which the person could have enrolled for the insurance or could have elected another level of benefits under the policy;

(d) The total amount of insurance payable with respect to an indebtedness shall not exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor. The insurer may exclude any payments which are delinquent on the date the debtor becomes disabled as defined in the policy;

(e) The insurance may be payable to the creditor or to any successor to the right, title, and interest of the creditor. Such payment or payments shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of each such payment and any excess of insurance shall be payable to the insured or the estate of the insured;

(f) Notwithstanding the preceding provisions of this subdivision, insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment, and insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan;

(3) A policy issued to a labor union or similar employee organization, which shall be deemed to be the policyholder, to insure members of such union or organization for the benefit of persons other than the union or organization or any of its officials, representatives, or agents, subject to the following requirements:

(a) The members eligible for insurance under the policy shall be all of the members of the union or organization, or all of any class or classes thereof;

(b) The premium for the policy shall be paid either from funds of the union or organization or from funds contributed by the insured members specifically for their insurance, or from both. Except as provided in paragraph (c) of this subdivision, a policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members, except those who reject such coverage in writing;

(c) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer in a

policy insuring fewer than ten members and in a policy insuring ten or more members if:

a. Application is not made within thirty-one days after the date of eligibility for insurance; or

b. The person voluntarily terminated the insurance while continuing to be eligible for insurance under the policy; or

c. After the expiration of an open enrollment period during which the person could have enrolled for the insurance or could have elected another level of benefits under the policy;

(4) A policy issued to a trust, or to the trustee of a fund, established or adopted by two or more employers, or by one or more labor unions or similar employee organizations, or by one or more employers and one or more labor unions or similar employee organizations, which trust or trustee shall be deemed the policyholder, to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations, subject to the following requirements:

(a) The persons eligible for insurance shall be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes thereof. The policy may provide that the term "employees" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of such affiliated corporations, proprietorships or partnerships is under common control. The policy may provide that the term "employees" shall include the individual proprietor or partners if the employer is an individual proprietorship or partnership. The policy may provide that the term "employees" shall include retired employees, former employees and directors of a corporate employer. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship;

(b) The premium for the policy shall be paid from funds contributed by the employer or employers of the insured persons or by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and the employer or union or similar employee organization. Except as provided in paragraph (c) of this subdivision, a policy on which no part of the premium is to be derived from funds contributed

by the insured persons specifically for their insurance, must insure all eligible persons except those who reject such coverage in writing;

(c) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer;

(5) A policy issued to an association or to a trust or to the trustees of a fund established, created and maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of one hundred persons; shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least two years; shall have a constitution and bylaws which provide that the association or associations shall hold regular meetings not less than annually to further the purposes of the members; shall, except for credit unions, collect dues or solicit contributions from members; and shall provide the members with voting privileges and representation on the governing board and committees. The policy shall be subject to the following requirements:

(a) The policy may insure members of such association or associations, employees thereof, or employees of members, or one or more of the preceding, or all of any class or classes thereof for the benefit of persons other than the employee's employer;

(b) The premium for the policy shall be paid from funds contributed by the association or associations or by employer members, or by both, or from funds contributed by the covered persons or from both the covered persons and the association, associations, or employer members;

(c) Except as provided in paragraph (d) of this subdivision, a policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for their insurance must insure all eligible persons, except those who reject such coverage in writing;

(d) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer;

(6) A policy issued to a credit union or to a trustee or trustees or agent designated by two or more credit unions, which credit union, trustee, trustees or agent shall be deemed the policyholder, to insure members of such credit union or credit unions for the benefit of persons other than the credit union or credit unions, trustee or trustees, or agent or any of their officials, subject to the following requirements:

(a) The members eligible for insurance shall be all of the members of the

credit union or credit unions, or all of any class or classes thereof;

(b) The premium for the policy shall be paid by the policyholder from the credit union's funds and, except as provided in paragraph (c) of this subdivision, must insure all eligible members;

(c) An insurer may exclude or limit the coverage on any member as to whom evidence of individual insurability is not satisfactory to the insurer;

(7) A policy issued to cover persons in a group where that group is specifically described by a law of this state as one which may be covered for group life insurance. The provisions of such law relating to eligibility and evidence of insurability shall apply.

2. Group health insurance offered to a resident of this state under a group health insurance policy issued to a group other than one described in subsection 1 of this section shall be subject to the following requirements:

(1) No such group health insurance policy shall be delivered in this state unless the director finds that:

(a) The issuance of such group policy is not contrary to the best interest of the public;

(b) The issuance of the group policy would result in economies of acquisition or administration; and

(c) The benefits are reasonable in relation to the premiums charged;

(2) No such group health insurance coverage may be offered in this state by an insurer under a policy issued in another state unless this state or another state having requirements substantially similar to those contained in subdivision (1) of this subsection has made a determination that such requirements have been met;

(3) The premium for the policy shall be paid either from the policyholder's funds, or from funds contributed by the covered persons, or from both;

(4) An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

3. As used in this section, "insurer" shall have the same meaning as the definition of "health carrier" under section 376.1350, and "class" means a predefined group of persons eligible for coverage under a group insurance policy where members of a class represent the same or essentially the same hazard; except that, an insurer may offer a policy to an employer that charges a reduced premium rate or deductible for employees who do not smoke or use tobacco products as

authorized under section 290.145, RSMo, and such insurer shall not be considered to be in violation of any unfair trade practice, as defined in section 379.936, RSMo, even if only some employers elect to purchase such a policy and other employers do not.

376.429. 1. All health benefit plans, as defined in section 376.1350, that are delivered, issued for delivery, continued or renewed on or after August 28, **[**2002**] 2006**, and providing coverage to any resident of this state shall provide coverage for routine patient care costs as defined in subsection 6 of this section incurred as the result of phase **II,** III**,** or IV of a clinical trial that is approved by an entity listed in subsection 4 of this section and is undertaken for the purposes of the prevention, early detection, or treatment of cancer. **Health benefit plans may limit coverage for the routine patient care costs of patients in phase II of a clinical trial to those treating facilities within the health benefit plans' provider network; except that, this provision shall not be construed as relieving a health benefit plan of the sufficiency of network requirements under state statute.**

2. In the case of treatment under a clinical trial, the treating facility and personnel must have the expertise and training to provide the treatment and treat a sufficient volume of patients. There must be equal to or superior, noninvestigational treatment alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the noninvestigational alternatives.

3. Coverage required by this section shall include coverage for routine patient care costs incurred for drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, including coverage for reasonable and medically necessary services needed to administer the drug or use the device under evaluation in the clinical trial.

4. Subsections 1 and 2 of this section requiring coverage for routine patient care costs shall apply to **phase III or IV of** clinical trials that are approved or funded by one of the following entities:

(1) One of the National Institutes of Health (NIH);

(2) An NIH cooperative group or center as defined in subsection 6 of this section;

(3) The FDA in the form of an investigational new drug application;

(4) The federal Departments of Veterans' Affairs or Defense;

(5) An institutional review board in this state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects (45 CFR 46); or

(6) A qualified research entity that meets the criteria for NIH Center support grant eligibility.

5. **Subsections 1 and 2 of this section requiring coverage for routine patient care costs shall apply to phase II of clinical trials if:**

(1) Phase II of a clinical trial is sanctioned by the National Institutes of Health (NIH) or National Cancer Institute (NCI) and conducted at academic or National Cancer Institute Center; and

(2) The person covered under this section is enrolled in the clinical trial. This section shall not apply to persons who are only following the protocol of phase II of a clinical trial, but not actually enrolled.

6. An entity seeking coverage for treatment, prevention, or early detection in a clinical trial approved by an institutional review board under subdivision (5) of subsection 4 of this section shall maintain and post electronically a list of the clinical trials meeting the requirements of subsections 2 and 3 of this section. This list shall include: the phase for which the clinical trial is approved; the entity approving the trial; the particular disease; and the number of participants in the trial. If the electronic posting is not practical, the entity seeking coverage shall periodically provide payers and providers in the state with a written list of trials providing the information required in this section.

[6.**]** **7.** As used in this section, the following terms shall mean:

(1) "Cooperative group", a formal network of facilities that collaborate on research projects and have an established NIH-approved Peer Review Program operating within the group, including the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program;

(2) "Multiple project assurance contract", a contract between an institution and the federal Department of Health and Human Services (DHHS) that defines the relationship of the institution to the DHHS and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects;

(3) "Routine patient care costs" shall include coverage for reasonable and medically necessary services needed to administer the drug or device under

evaluation in the clinical trial. Routine patient care costs include all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except:

(a) The investigational item or service itself;

(b) Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and

(c) Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

[7.**]** **8.** For the purpose of this section, providers participating in clinical trials shall obtain a patient's informed consent for participation on the clinical trial in a manner that is consistent with current legal and ethical standards. Such documents shall be made available to the health insurer upon request.

[8.**]** **9.** The provisions of this section shall not apply to a policy, plan or contract paid under Title XVIII or Title XIX of the Social Security Act.

[9.**]** **10.** Nothing in this section shall apply to any accident-only policy, specified disease policy, hospital indemnity policy, Medicare supplement policy, long-term care policy, short-term major medical policy of six months or less duration, or other limited benefit health insurance policies.

11. The provisions of this section regarding phase II of a clinical trial shall not apply automatically to an individually underwritten health benefit plan, but shall be an option to any such plan.

379.952. 1. Each small employer carrier shall actively market health benefit plan coverage, including the basic and standard health benefit plans, to eligible small employers in the state. If a small employer carrier denies coverage to a small employer on the basis of the health status or claims experience of the small employer or its employees or dependents, the small employer carrier shall offer the small employer the opportunity to purchase a basic health benefit plan or a standard health benefit plan.

2. (1) Except as provided in subdivision (2) of this subsection, no small employer carrier or agent or broker shall, directly or indirectly, engage in the following activities:

(a) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation or geographic location of the small

employer;

(b) Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer.

(2) The provisions of subdivision (1) of this subsection shall not apply with respect to information provided by a small employer carrier or agent or broker to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

3. (1) Except as provided in subdivision (2) of this subsection, no small employer carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with an agent or broker that provides for or results in the compensation paid to an agent or broker for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation or geographic location of the small employer.

(2) Subdivision (1) of this subsection shall not apply with respect to a compensation arrangement that provides compensation to an agent or broker on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation or geographic area of the small employer.

4. A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to an agent or broker, if any, for the sale of a basic or standard health benefit plan.

5. No small employer carrier shall terminate, fail to renew or limit its contract or agreement of representation with an agent or broker for any reason related to the health status, claims experience, occupation, or geographic location of the small employers placed by the agent or broker with the small employer carrier.

6. No small employer carrier or producer shall induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment**; except that, a carrier may offer a policy to a small employer that charges a reduced premium rate or deductible for employees who do not smoke or use tobacco products, and such carrier shall not be considered in violation of sections 379.930 to 379.952 or any unfair trade practice, as defined in section 379.936, even if only some small employers elect to purchase such a policy and other small employers do**

not.

7. Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial with specificity.

8. The director may promulgate rules setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

9. (1) A violation of this section by a small employer carrier or a producer shall be an unfair trade practice under sections 375.930 to 375.949, RSMo.

(2) If a small employer carrier enters into a contract, agreement or other arrangement with a third-party administrator to provide administrative marketing or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this section as if it were a small employer carrier.

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