354.010. Definitions. — As used in sections 354.010 to 354.380, unless the context clearly indicates otherwise, the following terms mean:

(1) "**Corporation**", a domestic health services corporation subject to the provisions of sections 354.010 to 354.380;

(2) "**Director**", the director of the department of commerce and insurance of the state of Missouri;

(3) "**Health services**", the health care and services provided by hospitals, or other health care institutions, organizations, associations or groups, and by doctors of medicine, osteopathy, dentistry, chiropractic, optometry and podiatry, nursing services, medical appliances, equipment and supplies, drugs, medicines, ambulance services, and other therapeutic services and supplies;

(4) "**Health services corporation**", any not-for-profit corporation heretofore or hereafter organized or operating for the purposes of establishing and operating a nonprofit plan or plans under which prepaid hospital care, medical-surgical care and other health care and services, or reimbursement therefor, may be furnished to a member or beneficiary;

(5) "**Member**" or "**beneficiary**", a natural person who is entitled to receive health services, or reimbursement therefor, pursuant to a contract made by a health services corporation with or for the benefit of such person;

(6) "**Membership contract**", any agreement, contract or certificate by which a health services corporation describes the health services or benefits to be provided thereunder to its members or beneficiaries;

(7) "**Not-for-profit corporation**", a nonprofit domestic corporation organized under or accepting the provisions of chapter 355 or incorporated under chapter 352.

(L. 1973 S.B. 3 § 1, A.L. 1983 H.B. 127)

---------- 354.010 8/28/1983 ----------

354.015. Health services corporations, laws applicable to — exceptions. — All health services corporations heretofore or hereafter organized shall be subject to the provisions of sections 354.010 to 354.380, to the provisions of the other laws of this state which are specifically designated in sections 354.010 to 354.380, and to the provisions of any other laws of this state relating to insurance which specifically state they shall apply to health services corporations. The provisions of this act* shall not apply to any labor organization's health plan providing services established and maintained solely for its

members and their dependents, and facilities of not-for-profit corporations in existence on October 1, 1980, subject either to the provisions and regulations of section 302 of the Labor-Management Relations Act, 29 U.S.C. 186 or the Labor-Management Reporting and Disclosure Act, 29 U.S.C. 401-538.

(L. 1973 S.B. 3 § 2, A.L. 1981 S.B. 185, A.L. 1983 H.B. 127)

*"This act" (H.B. 127, 1983) contained numerous sections. Consult Disposition of Sections table for a definitive listing.

---------- 354.015 8/28/1983 ----------

354.020. Preexisting health services corporation to amend articles, effect of. — 1. Any health services corporation heretofore organized under the provisions of either chapter 352 or chapter 355 shall amend its articles of incorporation to comply with the provisions of sections 354.010 to 354.380 for organization, and for issuance of a certificate of incorporation and of a certificate for authority to do business.

2. After completion of the actions provided in subsection 1 and the issuance of the required certificates, the corporation shall be a corporation organized under sections 354.010 to 354.380 and shall be entitled to all the rights, privileges and benefits and shall be subject to all the obligations, duties and liabilities provided in sections 354.010 to 354.380.

(L. 1973 S.B. 3 § 3, A.L. 1983 H.B. 127)

---------- 354.020 8/28/1983 ----------

354.025. Corporate purposes and authority. — A health services corporation may be organized for the purposes of establishing and operating a voluntary, nonprofit plan or plans under which hospital care, medical-surgical care, and other health care and services, or reimbursement therefor, may be furnished to persons who become members or beneficiaries; of acting as agent or intermediary for other health services corporations, for any governmental body or agency, or for other corporations, associations, partnerships or individuals in the field of health care and services; and of research, education or related activity to further objects within the purview of sections 354.010 to 354.380.

(L. 1973 S.B. 3 § 4, A.L. 1983 H.B. 127)

---------- 354.025 8/28/1983 ----------

354.027. Discrimination in coverage or reimbursement for covered service by licensed persons, prohibited. — A health services corporation which provides its members or beneficiaries with coverage for certain services, or reimbursement therefor, shall provide such coverage or reimbursement in all situations in which the covered

service is performed by a person duly licensed to perform such service. No health services corporation may discriminate in its coverage or reimbursement amounts for covered services among persons duly licensed to provide such covered services. The provisions of this section shall not apply to any federally qualified health maintenance organization. This section shall apply to all contracts issued or renewed on or after January 1, 1984. This section shall apply only to persons duly licensed as physicians, surgeons, optometrists, chiropractors, dentists, psychologists, pharmacists, pharmacies, or podiatrists, as defined by and in accordance with the statutes of the state of Missouri.

(L. 1983 H.B. 127, A.L. 1993 H.B. 709)

---------- 354.027 8/28/1993 ----------

354.030. For-profit corporations excluded from act. — No group, association or organization created for or engaged in business or activity for profit, provision for the incorporation of which is made by any of the corporation laws of this state, shall be organized or operate, directly or indirectly, as a health services corporation under sections 354.010 to 354.380.

(L. 1973 S.B. 3 § 5, A.L. 1983 H.B. 127)

---------- 354.030 8/28/1983 ----------

354.035. Procedure for organization of corporation. — A health services corporation may be organized in the manner provided for the organization of a general not-for-profit corporation in chapter 355 by filing articles of incorporation in triplicate in the office of the secretary of state. One copy of the articles of incorporation shall be forwarded by the secretary of state to the director. If the secretary of state finds that the purposes stated in the articles of incorporation are within the purview of, and limited to the purposes authorized by, section 354.025, and that such articles otherwise conform to law, he shall, when all fees and charges have been paid, file one of such triplicate originals in his office and issue a certificate of incorporation to which he shall affix the other triplicate original. The certificate of incorporation and copy of articles of incorporation shall be delivered by the secretary of state to the incorporators.

(L. 1973 S.B. 3 § 6, A.L. 1983 H.B. 127)

---------- 354.035 8/28/1983 ----------

354.040. Articles of incorporation, required information and contents. — In addition to the contents required or permitted by chapter 355, the articles of incorporation of a health services corporation shall comply with the following:

(1) The name of the corporation shall not include the words "insurance", "casualty", "surety", "mutual", or any other words descriptive of the insurance, casualty or surety business;

(2) The corporate name of any corporation to be formed under sections 354.010 to 354.380 shall not be the same as, or deceptively similar to, the name of any other corporation authorized to do business in this state;

(3) The statement of purposes shall be in conformity with the provisions of sections 354.010 to 354.380;

(4) Any such corporation organized prior to September 28, 1973, whose existing articles of incorporation shall not be in substantial conformity with sections 354.010 to 354.380, shall adopt and file, as provided in sections 354.010 to 354.380, such amendments to its articles as are necessary to effect substantial compliance with sections 354.010 to 354.380.

(L. 1973 S.B. 3 § 7, A.L. 1983 H.B. 127)

---------- 354.040 8/28/1983 ----------

354.045. Issuance of certificate, effect of. — Upon the issuance of the certificate of incorporation by the secretary of state, the corporate existence shall begin, and such certificate of incorporation shall be conclusive evidence, except against the state, that all conditions precedent required to be performed by the incorporators have been complied with and that the corporation has been incorporated under sections 354.010 to 354.380.

(L. 1973 S.B. 3 § 8, A.L. 1983 H.B. 127)

---------- 354.045 8/28/1983 ----------

354.050. General powers of corporation. — The corporation shall have all the powers, rights and privileges of a corporation organized under chapter 355, except insofar as such provisions are inconsistent with the provisions of sections 354.010 to 354.380, but it shall not commence its business or operations until it receives authority to do so from the director of the department of commerce and insurance, as provided in section 354.055.

(L. 1973 S.B. 3 § 9, A.L. 1983 H.B. 127)

---------- 354.050 8/28/1983 ----------

354.055. Certificate of authority required — expiration of, extended how. — No corporation subject to the provisions of this chapter shall commence operations or transact any business in this state unless it shall first procure from the director of the department of commerce and insurance a certificate of authority stating that the requirements of the laws of this state have been complied with and authorizing it to do

business. The certificate of authority shall expire on the last day of June in each year, but shall be extended automatically pending formal renewal by the director, if the corporation has continued to comply with the provisions of sections 354.010 to 354.380 and of the laws of this state.

(L. 1973 S.B. 3 § 10, A.L. 1983 H.B. 127)

---------- 354.055 8/28/1983 ----------

354.060. Director to issue certificate, when. — 1. The director of the department of commerce and insurance shall determine that all the requirements of sections 354.010 to 354.380 for commencement of business have been complied with, and upon such determination shall issue to the corporation a certificate of authority to do business as a health services corporation under sections 354.010 to 354.380.

2. The director shall not issue or renew his certificate of authority to any corporation operating or proposing to operate under the provisions of sections 354.010 to 354.380, unless such corporation shall be in compliance with all the requirements of sections 354.010 to 354.380.

(L. 1973 S.B. 3 § 11, A.L. 1983 H.B. 127)

---------- 354.060 8/28/1983 ----------

354.065. Articles of incorporation, how amended — copy to director, when. — A corporation may amend its articles of incorporation from time to time in the manner provided in chapter 355 and shall file a duly certified copy of its certificate of amendment with the director of the department of commerce and insurance within twenty days after the issuance of the certificate of amendment by the secretary of state. Upon the issuance of the certificate of amendment by the secretary of state, the amendment shall become effective and the articles of incorporation shall be deemed to be amended accordingly.

(L. 1973 S.B. 3 § 12, A.L. 1998 S.B. 680, A.L. 1999 S.B. 1, et al., A.L. 2000 S.B. 896, A.L. 2007 S.B. 613 Revision)

---------- 354.065 8/28/2007 ----------

354.070. Certificate of authority automatically extended, when. — When the annual statement of a corporation subject to the provisions of sections 354.010 to 354.380 is filed and all fees due from the corporation are tendered, the corporation's certificate of authority to do business in this state shall automatically be extended pending formal renewal by the director, or until such time as he should refuse to renew the certificate.

(L. 1973 S.B. 3 § 13, A.L. 1983 H.B. 127)

---------- 354.070 8/28/1983 ----------

354.075. Capital required to do business. — No corporation subject to the provisions of sections 354.010 to 354.380 shall be permitted to do business in this state unless it shall have a paid-in capital or guaranty fund of not less than one hundred and fifty thousand dollars, in addition to the reserves required in sections 354.010 to 354.380. The surplus and guaranty fund shall be placed and held on joint deposit with the director for the protection of all subscribers, members and beneficiaries.

(L. 1973 S.B. 3 § 14, A.L. 1983 H.B. 127)

---------- 354.075 8/28/1983 ----------

354.080. Reserves required, how computed. — The corporation shall maintain at all times reserves adequate to provide the hospital, medical-surgical and other health services made available to its members and beneficiaries and to meet all its costs and expenses. The reserves shall not be less than an amount equal to two months of benefit payments and administrative expenses, based on an average of the preceding twelve months, or if the reserves are not equal to such average, they must have been increased during the preceding twelve months by an amount equal to one percent of the gross dues income during such period. The determination of minimum reserves hereunder shall be subject, as to amounts payable to participating providers of the health services, to any right of the corporation to prorate the amounts under the terms of its health service contracts with providers. The director may decrease or suspend the requirements of this section if he finds that such action would be in the best interest of the members of the corporation.

(L. 1973 S.B. 3 § 15)

---------- 354.080 8/28/1973 ----------

354.085. Membership contract forms, approval by director, when — time for filing — time for disapproval. — No corporation subject to the provisions of sections 354.010 to 354.380 shall deliver or issue for delivery in this state a form of membership contract, or any endorsement or rider thereto, until a copy of the form shall have been approved by the director. The director shall not approve any policy forms which are not in compliance with the provisions of sections 354.010 to 354.380 of this state, or which contain any provision which is deceptive, ambiguous or misleading, or which do not contain such words, phraseology, conditions and provisions which are specific, certain and reasonably adequate to meet needed requirements for the protection of those insured. If a policy form is disapproved, the reasons therefor shall be stated in writing; a hearing shall be granted upon such disapproval, if so requested; provided, however, that such hearing shall be held no sooner than fifteen days following the request. The failure of the director

of the department of commerce and insurance to take action approving or disapproving a submitted policy form within forty-five days from the date of filing shall be deemed an approval thereof. The director shall not disapprove any deemed policy form for a period of twelve months thereafter. If at any time during that twelve-month period the director determines that any provision of the deemed policy form is contrary to state law, the director shall notify the health services corporation of the specific provision that is contrary to state law, and any specific statute to which the provision is contrary to, and request that the health services corporation file, within thirty days of receipt of the request, an amendment form that modifies the provision to conform to state law. Upon approval of the amendment form by the director, the health services corporation shall issue a copy of the amendment to each individual and entity to which the deemed policy form was previously issued and shall attach a copy of the amendment to the deemed policy form when it is subsequently issued. Such amendment shall have the force and effect as if the amendment was in the original filing or policy. The director of the department of commerce and insurance shall have authority to make such reasonable rules and regulations concerning the filing and submission of such policy forms as are necessary, proper or advisable.

(L. 1973 S.B. 3 § 16, A.L. 1983 H.B. 127, A.L. 2003 H.B. 121)

---------- 354.085 8/28/2003 ----------

354.090. Health services corporation contracts, purposes, parties to. — 1. A corporation subject to the provisions of sections 354.010 to 354.380 may enter into contracts for the rendering of hospital services, medical-surgical services and other health services on behalf of its members or beneficiaries with hospitals maintained by any governmental body or agency, or maintained by a nonprofit corporation organized for hospital purposes, or with other corporations, organizations, associations, partnerships or individuals furnishing hospital services, medical-surgical services, or other health services. Any health services corporation may enter into agreements or contracts with other organizations or corporations licensed to do business in this state or in any other state for the transfer of members or beneficiaries, for the reciprocal joint provisions of benefits to the members or beneficiaries of the corporation and of such other organizations or corporations, or for such other joint undertakings as the corporation's board of directors may approve.

2. In lieu of direct payment from an insured for goods or services furnished, a pharmacist may take an assignment of such insured's right to reimbursement for those goods or services provided to a member of a health services corporation. No health services corporation may refuse to pay the pharmacist any payment due the insured under the terms of the policy or contract.

(L. 1973 S.B. 3 § 17, A.L. 1983 H.B. 127)

---------- 354.090 8/28/1983 ----------

354.095. Limitation of membership and benefits — certain benefits to be provided, when. — 1. A corporation subject to the provisions of sections 354.010 to 354.380 may, in the discretion of its board of directors, limit or define the classes of persons who shall be eligible to become members or beneficiaries, limit and define the benefits which it will furnish, and may define such benefits as it undertakes to furnish into classes or kinds. It may make available to its members or beneficiaries such health services, or reimbursement therefor, as the board of directors of any such corporation may approve; if maternity benefits are provided to any members of any plan, then maternity benefits shall be provided to any member of such plan without discrimination as to whether the member is married or unmarried, and if maternity benefits are provided to a beneficiary of any plan, then maternity benefits shall be provided to such beneficiary of such plan without discrimination as to whether the beneficiary is married or unmarried.

2. If an ambulatory surgical facility as defined by subdivision (2)* of section 197.200, has received a certificate of need as provided in chapter 197, a health services corporation shall provide benefits to the facility on the same basis as it does to all other health care facilities, whether contracting members or noncontracting members. A health services corporation shall use the same standards that are applied to any other health care facility within the same health services area in defining the benefits that the corporation will furnish to the ambulatory surgical facility, the classes to which such benefits will be furnished, and the amount of reimbursement.

(L. 1973 S.B. 3 § 18, A.L. 1981 S.B. 185, A.L. 1983 H.B. 127)

*In 2017 statutory reference to subdivision "(1)" changed to "(2)" in accordance with section 3.060.

---------- 354.095 8/28/1983 ----------

354.105. Annual report required, contents of. — All corporations subject to the provisions of sections 354.010 to 354.380 shall make and file annually with the director on or before the first day of March of each year a report under oath upon a form to be prescribed by the director setting forth:

(1) The name of the corporation;

(2) The address of its registered office in this state and the name of its registered agent at such address;

(3) The names and addresses of its directors and officers;

(4) A brief statement of the character of the affairs which the corporation is actually conducting;

(5) The amount of all dues or fees collected in this state or from residents thereof with respect to members or beneficiaries in the last calendar year, the amounts actually paid during such year for health services for the members or beneficiaries, and the amounts placed in reserves;

(6) A financial report for the most recent fiscal year of the corporation, prepared by an officer of the corporation or by a certified public accountant;

(7) A statement of any other facts or information concerning the affairs of the health services corporation which may be required reasonably by the director.

(L. 1973 S.B. 3 § 20, A.L. 1983 H.B. 127)

---------- 354.105 8/28/1983 ----------

354.115. Member's grievance, how and where filed — director may investigate, court action not barred. — Any individual member of a corporation subject to the provisions of sections 354.010 to 354.380 who believes himself to be aggrieved by any act or omission of such corporation or its officers, directors, or employees may file a statement in writing of his grievance in the office of the director, and the director may make such investigation of such grievance as he deems appropriate. No such investigation by the director shall act as a bar to any suit in a court of competent jurisdiction instituted by any such member, or as a bar to any defense thereto by the corporation involved.

(L. 1973 S.B. 3 § 22, A.L. 1983 H.B. 127)

---------- 354.115 8/28/1983 ----------

354.120. Rules and regulations by director authorized — procedure, review. — The director may promulgate such reasonable rules and regulations not inconsistent with the provisions of sections 354.010 to 354.380 as he shall deem necessary for its proper administration, pursuant to the provisions of this section and chapter 536. No rule or portion of a rule promulgated under the authority of this chapter shall become effective unless it has been promulgated pursuant to the provisions of section 536.024.

(L. 1973 S.B. 3 § 23, A.L. 1983 H.B. 127, A.L. 1993 S.B. 52, A.L. 1995 S.B. 3)

---------- 354.120 8/28/1995 ----------

354.125. Corporation not liable for injuries resulting from medical services rendered members. — A health services corporation shall not be liable for injuries resulting from neglect, misfeasance, malfeasance or malpractice on the part of any person, organization,

agency or corporation rendering health services to the health services corporation's members and beneficiaries.

(L. 1973 S.B. 3 § 24)

---------- 354.125 8/28/1973 ----------

354.130. Exemption from certain taxes, exceptions. — Every health services corporation shall be exempt from all taxes with respect to its membership dues or fees and other income, and shall be exempt from all franchise taxes and license fees except as otherwise specified in sections 354.010 to 354.380.

(L. 1973 S.B. 3 § 25, A.L. 1983 H.B. 127)

---------- 354.130 8/28/1983 ----------

354.140. Dissolution, liquidation or rehabilitation of corporation, procedure for. — Any dissolution, liquidation, or rehabilitation of a corporation subject to the provisions of sections 354.010 to 354.380 shall be instituted and carried out pursuant to the provisions of chapter 355 to the extent that the same are not inconsistent with the provisions of sections 354.010 to 354.380.

(L. 1973 S.B. 3 § 27, A.L. 1983 H.B. 127)

---------- 354.140 8/28/1983 ----------

354.145. Appeal from director's actions or decisions, how taken. — Every final administrative action or decision of the director under sections 354.010 to 354.380 shall be subject to judicial review under and in accordance with the administrative procedure and review law of this state, chapter 536.

(L. 1973 S.B. 3 § 28, A.L. 1983 H.B. 127)

---------- 354.145 8/28/1983 ----------

354.150. Fees — waiver, when. — 1. Every health services corporation subject to the provisions of sections 354.010 to 354.380 shall pay to the director the fees specified in section 374.230.

2. Fees mandated in subdivision (1) of section 374.230 shall be waived if a majority shareholder, officer, or director of the organizing corporation is a member of the Missouri National Guard or any other active duty military, resides in the state of Missouri, and provides proof of such service to the secretary of state.

(L. 1973 S.B. 3 § 29, A.L. 1983 H.B. 127, A.L. 1993 H.B. 709, A.L. 2007 S.B. 66, A.L. 2014 S.B. 600, A.L. 2018 S.B. 982)

Effective 1-01-19

---------- 354.150 1/1/2019 ----------

354.152. Premiums, dues or fees subject to restrictions — violation, hearing — order prohibiting. — Premiums, dues or fees made by each corporation shall be subject to the following provisions:

(1) Premiums, dues or fees shall not be excessive or inadequate, as herein defined, nor shall they be unfairly discriminatory;

(2) No premiums, dues or fees shall be held to be excessive unless such premiums, dues or fees are unreasonably high relative to the corporation's loss experience under policies, plans or contracts with respect to the territory or classification to which such premiums, dues or fees are applicable;

(3) No premiums, dues or fees shall be held to be inadequate unless such premiums, dues or fees are unreasonably low for the coverage provided and the continued use of such premiums, dues or fees endangers the solvency of the corporation using the same;

(4) If the director of the department of commerce and insurance has reason to believe that any premiums, dues or fees do not meet the standards of this section, he shall hold a public hearing in connection therewith, provided* that within a reasonable period of time, which shall be not less than ten days before the date of such hearing, he shall mail written notice specifying the matters to be considered at such hearing to any corporation believed by him not to be in compliance with the provisions of this section;

(5) If the director, after such hearings, for good cause finds that such premiums, dues or fees do not meet the provisions of this section, he shall issue an order specifying in what respects any such premiums, dues or fees fails to meet the provisions of this section and stating when, within a reasonable period of time thereafter, the further use of such premiums, dues or fees by the corporation which is the subject of the examination shall be prohibited and a copy of such order shall be sent to such corporation.

(L. 1979 S.B. 93)

*Word "providing" appears in original rolls.

---------- 354.152 8/28/1979 ----------

354.155. Disclaimer as to nonhealth services corporations. — Nothing contained in sections 354.010 to 354.380 shall affect the right to organize a corporation under chapter 352 or chapter 355 or the powers or rights of corporations organized pursuant thereto which are not health services corporations.

(L. 1973 S.B. 3 § 30, A.L. 1983 H.B. 127)

354.165. Certain organizations exempt. — The provisions of sections 354.010 to 354.380 or of any law relating to insurance shall not apply to any labor organization's health plan providing services established and maintained solely for its members and their immediate families, or to any health plan or services established and maintained by a trust in which a labor organization is interested as that term is defined in, and which trust is subject to the provisions and regulations of, the Federal Labor-Management Reporting and Disclosure Act, 29 U.S.C. 401-531. The administrator of any other plan or program to provide health service or benefits, or to pay or indemnify for the payment of their cost, which is maintained by any employer or jointly by any employer and employees and/or labor organizations exclusively for employees and their families, hereinafter referred to as "**plan or program**", shall make and file annually with the director on or before the first day of March of each year a report under oath, upon a form to be prescribed by the director, setting out the income and expenses of the plan or program for the preceding year and its financial condition as of the end of that year. In lieu of filing such prescribed form the administrator of any such plan or program may file with the director a duplicate set of documents, records, reports, booklets and other instruments as may have been filed by it within the preceding twelve months pursuant to the Federal Welfare and Pension Plans Disclosure Act, 29 U.S.C. 301-309, the Federal Labor-Management Reporting and Disclosure Act, 29 U.S.C. 151-168, 401-531 or the Labor Management Relations Act, 29 U.S.C. 186. Any labor organization member or any employee claiming to be aggrieved under the terms of any such plan or program may file a complaint with respect thereto with the director. The authority of the director under the insurance laws of this state and sections 354.010 to 354.380 to prohibit or regulate such a plan or program shall be limited to the following:

(1) Compelling the filing of the annual reports referred to above;

(2) Investigating the complaints of members or employees;

(3) Examining the financial conditions, affairs and management of the plan or program;

(4) Instituting judicial proceedings to enjoin the continuation of any act or practices which he believes to be unfair and deceptive with respect to such members.

This section shall not be construed as exempting from regulation by the department of commerce and insurance any insurance contract or health services contract which provides for the payment of benefits or the supplying of health services under the labor organization, union-employer-employee or employer-employee plans referred to in this section which are purchased from insurance companies or health-services corporations subject to regulation by the department of commerce and insurance.

(L. 1973 S.B. 3 § 32, A.L. 1983 H.B. 127)

---------- 354.165 8/28/1983 ----------

354.175. Wage continuation plans by employer exempt. — Provisions of sections 354.010 to 354.380 or of any law relating to insurance shall not apply to any employer's plan to insure the continued payment of wages or like compensation to employees during periods of sickness or disability.

(L. 1973 S.B. 3 § 34, A.L. 1983 H.B. 127)

---------- 354.175 8/28/1983 ----------

354.180. Administrative order, director to issue, when. — 1. If the director determines that a person has engaged, is engaging in, or has taken a substantial step toward engaging in an act, practice or course of business constituting a violation of sections 354.010 to 354.380 or a rule adopted or order issued pursuant thereto, or a person has materially aided or is materially aiding an act, practice, omission, or course of business constituting a violation of sections 354.010 to 354.380 or a rule adopted or order issued pursuant thereto, the director may issue such administrative orders as authorized under section 374.046. A violation of these sections is a level two violation under section 374.049, except for any violation of sections 354.320 and 354.350, which is a level three violation.

2. If the director believes that a person has engaged, is engaging in, or has taken a substantial step toward engaging in an act, practice or course of business constituting a violation of sections 354.010 to 354.380 or a rule adopted or order issued pursuant thereto, or that a person has materially aided or is materially aiding an act, practice, omission, or course of business constituting a violation of sections 354.010 to 354.380 or a rule adopted or order issued pursuant thereto, the director may maintain a civil action for relief authorized under section 374.048. A violation of these sections is a level two violation under section 374.049, except for any violation of sections 354.320 and 354.350, which is a level three violation.

(L. 1983 H.B. 127, A.L. 2007 S.B. 66)

---------- 354.180 8/28/2007 ----------

354.190. Examinations, procedures. — 1. The director shall examine and inquire into all violations of the laws of the state applicable to corporations subject to the provisions of sections 354.010 to 354.380, and examine the financial condition, affairs and management of any corporation subject to the provisions of sections 354.010 to 354.380 incorporated by or doing business in this state, and inquire into and investigate the business transacted in

this state by any corporation subject to the provisions of sections 354.010 to 354.380 or such corporation's enrollment representatives.

2. He or any of his duly appointed agents may compel the attendance before him, and may examine, under oath, the directors, officers, employees, enrollment representatives, attorneys or any other person, in reference to the condition, affairs, management of the business, or any matters relating thereto. He may administer oaths or affirmations, and shall have power to summon and compel the attendance of witnesses, and to require and compel the production of records, books, papers, contracts or other documents, if necessary.

3. The director may make and conduct the examination in person, or he may appoint one or more persons to make and conduct the same for him. If made by one other than the director in person, the person duly appointed by the director shall have the same powers as above granted to the director. A certificate of appointment, under the official seal of the director, shall be sufficient authority and evidence thereof for the person or persons to act. For the purpose of making the examinations, or having the same made, the director may employ the necessary clerical, actuarial and other assistance.

4. The director may accept, in lieu of an examination by himself, or by his authority, a certificate of an examination, accompanied by a statement of all the facts in the case made by the insurance commissioner or superintendent of another state, of a health services corporation organized under the laws of such state.

(L. 1983 H.B. 127)

---------- 354.190 8/28/1983 ----------

354.195. Records of examination, duty to keep. — Said director shall keep and preserve in a permanent form a full record of his proceedings, including a concise statement of the condition of every corporation subject to the provisions of sections 354.010 to 354.380 whose affairs he shall have examined.

(L. 1983 H.B. 127)

---------- 354.195 8/28/1983 ----------

354.200. Examinations, false testimony, penalty. — 1. Any person testifying falsely in reference to any matter material to the investigation, examination or inquiry shall, upon conviction thereof, be deemed guilty of a class A misdemeanor, punishable as provided by law.

2. Any person who shall refuse to give such director full and truthful information, and answer in writing to any inquiry or question made in writing by the director, in regard to

the business * relating to any corporation subject to the provisions of sections 354.010 to 354.380 carried on by such person, or to appear and testify under oath before the director in regard to the same, shall, upon conviction thereof, be deemed guilty of a class B misdemeanor, punishable as provided by law.

3. Any director, officer, manager, enrollment representative, or employee of any corporation subject to the provisions of sections 354.010 to 354.380, or any other person, who shall make any false certificate or entry or memorandum upon any of the books or papers of any such corporation, or upon any statement or exhibit offered, filed or offered to be filed in the department of commerce and insurance, or used in the course of any examination, inquiry or investigation, with intent to deceive the director or any person employed or appointed by him to make any examination, inquiry or investigation, shall, upon conviction thereof, be guilty of a class A misdemeanor, punishable as provided by law.

(L. 1983 H.B. 127)

*Word "of" appears here in original rolls.

---------- 354.200 8/28/1983 ----------

354.205. Examinations — costs, how paid. — 1. The expenses of any proceedings concerning, or examinations of, a corporation subject to the provisions of sections 354.010 to 354.380, conducted by the department of commerce and insurance shall be assessed by the director upon the corporation proceeded against or examined, or whose policies have been valued, and shall be in the first instance paid by such corporation, on the order of the director, directly to the person or persons rendering the service.

2. If the corporation subject to the provisions of sections 354.010 to 354.380 has been or shall be adjudged insolvent, or shall neglect, fail or refuse to pay the director may approve the payment of the expenses, in whole or in part, which shall be paid in like manner as other expenses of the department of commerce and insurance; and the amount so paid, together with cost, charges and fees for collecting the same, shall be a first lien upon all the assets and property of such corporation, and may be recovered by the director of revenue in any court of competent jurisdiction; or if such corporation be in liquidation, or process of being wound up, the cost and expenses of settling its affairs shall be allowed and taxed as costs against said corporation, and shall be a first lien upon and payable out of its assets. The director of revenue shall deposit such sums in the state treasury to reimburse the insurance fund.

3. Before any costs of any examination or valuation shall be paid, vouchers for the same shall be submitted to and approved by the commissioner of administration.

4. When any examination or valuation is made by the director in person or by any salaried employee of the department of commerce and insurance, the cost of making the same shall be certified to the director of revenue for collection.

(L. 1983 H.B. 127)

---------- 354.205 8/28/1983 ----------

354.207. Second medical opinion to be allowed by health services corporations, procedure, costs. — 1. A health services corporation shall allow enrollees to seek a second medical opinion or consultation from a willing second physician at no additional cost to the enrollee beyond what the enrollee would otherwise pay for an initial medical opinion or consultation from that second physician.

2. If an enrollee chooses to seek a second medical opinion, and if the health services corporation does not employ or contract with another physician with the expertise necessary to provide a second medical opinion, then the health services corporation shall arrange for a referral to another physician with the necessary expertise to provide a second opinion or consultation and ensure that the enrollee obtains the covered benefit at no greater cost to the enrollee than if the benefit were obtained from participating physicians.

3. The second opinions required in this section and section 354.546 shall be covered only in the event that the original diagnosis requires major surgery or other treatment necessitating general anesthesia or other serious illness involving loss of bodily part or function or other debilitating disease.

(L. 1998 S.B. 754 § 354.207, § 1)

---------- 354.207 8/28/1998 ----------

354.210. Director may seek relief, when. — If the director has reason to believe that any health services corporation is in such financial condition that the assumption of additional obligations would be hazardous to its members or the general public, the director may issue orders or seek relief to protect the public under the provisions of section 354.180.

(L. 1983 H.B. 127, A.L. 2007 S.B. 66)

---------- 354.210 8/28/2007 ----------

354.215. Examiner's sick leave to apply to health services corporations. — The provisions of sections 374.261 to 374.269, which relate to the insurance examiner's sick leave fund, shall apply to health services corporations certified to operate in this state in the same manner as these sections now apply to those domestic insurers which pay a

premium tax and are engaged in the business of insurance within this state. The provisions of sections 374.261 to 374.269 shall also apply to examiners of the department of commerce and insurance conducting examinations under section 354.190 in the same manner as these sections now apply to examiners of the department of commerce and insurance conducting examinations under section 374.190.

(L. 1983 H.B. 127)

---------- 354.215 8/28/1983 ----------

354.220. Director may bring suit to recover fees or sums. — 1. The director may bring suit to recover any fees or other sums which he is authorized by law to demand or collect.

2. Any corporation subject to the provisions of sections 354.010 to 354.380 or person liable for any fees or assessments who shall neglect or refuse to pay the same within ten days after written demand by the director shall be liable to pay double the amount of such fees or assessments; and any judgment recovered in such case shall be for double such amount and costs.

(L. 1983 H.B. 127)

---------- 354.220 8/28/1983 ----------

354.225. Enrollment representative, defined — annual report to furnish information — solicitors of members to be insurance agent or broker, exception. — 1. Any employee of a corporation subject to the provisions of sections 354.010 to 354.380 who, for compensation, solicits membership in a prepayment health services plan offered by such corporation, or offers or assumes to act in negotiation thereof, shall be an "**enrollment representative**" of such corporation. Every corporation subject to sections 354.010 to 354.380 shall furnish the director annually, at the time of filing its annual report, the name, title and address of such person employed by it as the corporation's enrollment representative.

2. Any person who, for compensation, solicits membership in a prepayment health services plan offered by a corporation subject to the provisions of sections 354.010 to 354.380, who is not an employee of such corporation, shall be an insurance agent or broker licensed to transact such business in the state of Missouri.

3. Enrollment representatives, agents and brokers soliciting, negotiating, procuring or making membership agreements for a corporation subject to the provisions of sections 354.010 to 354.380 shall be subject to all the insurance laws of this state applicable to agents and brokers authorized to solicit, negotiate, procure or make health insurance coverage in this state, including those provisions of chapter 375 relating to the education, licensing, appointment, termination and discipline of agents and brokers.

(L. 1983 H.B. 127, A.L. 1993 H.B. 709)

---------- 354.225 8/28/1993 ----------

354.230. License required for enrollment representative. — No person shall act in this state as an enrollment representative unless he is licensed by the director as provided in this chapter.

(L. 1983 H.B. 127)

---------- 354.230 8/28/1983 ----------

354.235. Enrollment representative — license issued when, qualifications. — 1. The director shall issue a license to any natural person who is at least eighteen years of age, and has complied with the requirements of sections 354.010 to 354.380, authorizing the licensee to act as an enrollment representative on behalf of any corporation subject to the provisions of sections 354.010 to 354.380.

2. Any license issued shall authorize only the licensee named in the license to act individually as an enrollment representative thereunder.

(L. 1983 H.B. 127, A.L. 1993 S.B. 709)

---------- 354.235 8/28/1993 ----------

354.240. Nonresident may be licensed — examination waived, when. — 1. A person not a legal resident of this state may be licensed to act in this state as an enrollment representative upon compliance with the provisions of this chapter provided that the state in which the person resides will accord the same privilege to a resident of this state. The director is authorized to enter into reciprocal agreements with the appropriate official of any other state waiving the written examination of any applicant residing in the other state; provided, the director deems the applicant fully qualified and competent; and

(1) That a written examination is required of applicants for similar licenses in the other state; and

(2) That the appropriate official in that state certifies that the applicant holds a currently valid license of similar type in that state and either passed a written examination or was the holder of such license prior to the time a written examination was required.

2. In the event that the applicant is a resident of a state which does not require a written examination, then the director shall subject him to a written examination under terms and conditions to be prescribed by the director of the department of commerce and insurance.

3. In the event that the applicant is a resident of another state in which the appropriate insurance official, as a general policy, has refused to permit legal residents of Missouri to become licensed as enrollment representatives and to transact the business of a health services corporation in such state, then the director shall not license any applicant from that state.

(L. 1983 H.B. 127)

---------- 354.240 8/28/1983 ----------

354.265. Nonrenewable temporary license issued, when. — A nonrenewable temporary license may be issued for a period not to exceed ninety days in cases where an applicant has theretofore filed a completed application for a license, has secured an appointment by a corporation subject to the provisions of sections 354.010 to 354.380, has paid the applicable fees and where the director is satisfied as to the applicant's business reputation.

(L. 1983 H.B. 127)

---------- 354.265 8/28/1983 ----------

354.275. Violations by enrollment representatives, penalties. — Any person willfully violating any of the provisions of sections 354.225 to 354.270 is guilty of a class A misdemeanor and on conviction thereof, if the offender holds a license under these sections, the court imposing sentence shall order the director of the department of commerce and insurance to revoke the license.

(L. 1983 H.B. 127)

---------- 354.275 8/28/1983 ----------

354.280. Officers of corporation found to be of known bad character or incompetent — authority to transact business, effect. — The director shall not grant or continue authority to transact insurance in this state as to any corporation subject to the provisions of sections 354.010 to 354.380, one or more of the managing officers of which is found by him, after hearing, to be of known bad character or to be so incompetent or untrustworthy as to make the proposed operation hazardous to the health services corporation's current or potential members; or which he has good reason to believe is affiliated directly or indirectly through ownership, control, reinsurance transactions or other insurance or business relations with any person or persons whose business operations are or have been detrimental to policyholders, stockholders, investors, creditors, members or the public by illegal or fraudulent manipulation or dissipation of assets or accounts, or of reinsurance of any insurance company or companies, or by similar injurious actions.

(L. 1983 H.B. 127)

---------- 354.280 8/28/1983 ----------

354.285. Management agreements to control corporation, notice to department, when — examination requirements — violations. — 1. All agreements or contracts under which any person, organization or corporation enjoys in fact the exclusive or dominant right to manage or control any corporation subject to the provisions of sections 354.010 to 354.380 to the substantial exclusion of the board of directors, officers, attorney in fact or other lawful management shall be filed with the director on his request.

2. The director, for the purpose of ascertaining the assets, conditions and affairs of any corporation subject to the provisions of sections 354.010 to 354.380, may examine the books, records, documents and assets of any person having a contract or agreement as provided in subsection 1 to the extent necessary to determine the financial condition of such corporation. The failure or refusal of any such person to submit his books, papers, accounts, records or affairs to the reasonable inspection or examination of the director shall be grounds for the suspension or revocation of the certificate of authority of the corporation to do business in this state.

3. No agreement or contract as provided in subsection 1 shall operate to the financial detriment of the corporation in such manner as to endanger its financial stability or otherwise be hazardous to the members and creditors of the corporation.

4. On examination of any agreement or contract, if the director finds it violates the provisions of this section, he shall proceed in accordance with the provisions of section 354.180.

5. Any person, organization or corporation having a management contract as provided in subsection 1 hereof shall within five days of execution of such contract provide notice of such contract to the director of the department of commerce and insurance.

(L. 1983 H.B. 127)

---------- 354.285 8/28/1983 ----------

354.290. Examiner's duties — examination contents — hearing on reports allowed — publication of report, when. — 1. Every examiner shall make a full and true report of every examination made by him, verified by his oath, which examination shall comprise only facts appearing upon the books, papers, records or documents of the corporation subject to the provisions of sections 354.010 to 354.380, or ascertained from the testimony sworn to by its officers or agents or other persons examined under oath, concerning its affairs and such conclusions and recommendations as may reasonably be warranted from the facts so disclosed.

2. The director shall grant a hearing to the corporation examined before filing any report and may withhold any report from public inspection for such time as he deems proper, and may, if he deem it for the interest of the public to do so, publish any report or the result of any examination as contained therein in one or more newspapers of the state.

(L. 1983 H.B. 127)

---------- 354.290 8/28/1983 ----------

354.295. Certificate of authority not to be issued if controlling management involved in improper actions. — The director shall not approve any declaration of organization or articles of incorporation or issue a certificate of authority to any company until he has found that there is no good reason to believe that the incorporators, directors and proposed officers are affiliated, directly or indirectly, through ownership, control, management, reinsurance transactions or other insurance or business relations with any person or persons known to have been involved in the improper manipulation of assets, accounts or reinsurance.

(L. 1983 H.B. 127)

---------- 354.295 8/28/1983 ----------

354.300. Certificate of authority suspended or revoked, when. — Other provisions of law notwithstanding, the director may suspend or revoke, after a hearing, the certificate of authority or license of any corporation subject to the provisions of sections 354.010 to 354.380 for the same reasons and upon the same grounds as set forth in section 354.355.

(L. 1983 H.B. 127)

---------- 354.300 8/28/1983 ----------

354.305. Corporation advertising assets also to show liabilities — penalties. — 1. Whenever any corporation subject to the provisions of sections 354.010 to 354.380 doing business in this state advertises its assets, either in any newspaper or periodical, or by any sign, circular, card, policy of insurance or certificate of renewal thereof, it shall, in the same connection, equally conspicuously advertise its liabilities, the same to be determined in the manner required in making statement to the department, and all advertisements purporting to show the amount of capital of the company shall show only the amount of capital actually paid up in cash.

2. Any corporation subject to the provisions of sections 354.010 to 354.380 or enrollment representative violating the provisions of this section shall, upon conviction thereof, be guilty of a class B misdemeanor, punishable as provided by law.

(L. 1983 H.B. 127, A.L. 2008 S.B. 788)

---------- 354.305 8/28/2008 ----------

354.315. Data processing system authorized, cost, amount allowed — amortization not to exceed ten years. — Notwithstanding any prohibitions or restrictions contained in the statutes, any corporation subject to the provisions of sections 354.010 to 354.380 may acquire by purchase electronic or mechanical machines constituting a data processing system, and thereafter may hold the system as an admitted asset for use in connection with the business of the company if

(1) The system shall have an aggregate cost of not less than twenty-five thousand dollars and its aggregate cost shall not exceed five percent of the admitted assets of the company;

(2) The cost of the component machines constituting the system shall be fully amortized over a period not to exceed ten calendar years. If a data processing system consists of separate component machines which are acquired at different times, then the cost of each component shall be fully amortized over a period not to exceed ten calendar years commencing with the date of acquisition of each component.

(L. 1983 H.B. 127)

---------- 354.315 8/28/1983 ----------

354.320. Corporate funds and securities use for private gain by officers and employees prohibited, penalty. — No officer, enrollment representative or employee of any corporation subject to the provisions of sections 354.010 to 354.380, formed under the laws of this state, or doing business herein, shall, directly or indirectly, use or employ, or permit others to use or employ, any of the money, funds or securities of such corporation for private profit or gain, except for reasonable compensation for services performed and reimbursement for expenses incurred, and any such use shall, upon conviction thereof, be a class E felony.

(L. 1983 H.B. 127, A.L. 2014 S.B. 491)

Effective 1-01-17

---------- 354.320 1/1/2017 ----------

354.325. Investigation by director of investments — records to be kept by division — criminal action, when. — 1. The director of the department of commerce and insurance shall, as often as he may deem proper, make careful inquiry and investigation as to the manner in which the money, funds or securities of corporations subject to the provisions of sections 354.010 to 354.380, doing business in this state, are invested or employed, and

record the result of such inquiry or investigation in records kept in his office for the inspection of members and public officials.

2. In the event of a violation of this section or of section 354.320, the prosecuting attorney of the proper county, or in the city of St. Louis, the circuit attorney, shall proceed at once by information or indictment against the offenders.

(L. 1983 H.B. 127)

---------- 354.325 8/28/1983 ----------

354.330. Public official failing to perform duties as to investment violations, penalty. — Any public official failing, neglecting or refusing to comply with any of the provisions of sections 354.320 and 354.325 shall be deemed guilty of a misdemeanor, and, upon conviction, shall be fined not less than five hundred dollars and forfeit his office.

(L. 1983 H.B. 127)

---------- 354.330 8/28/1983 ----------

354.335. Damages allowed if corporation without reasonable cause refuses to pay. — In any action against any corporation subject to the provisions of sections 354.010 to 354.380 to recover the amount of any loss under a policy of health insurance, if it appears from the evidence that such corporation has refused to pay such loss without reasonable cause or excuse, the court or jury may, in addition to the amount thereof and interest, allow the plaintiff damages not to exceed twenty percent of the first fifteen hundred dollars of the loss, and ten percent of the amount of the loss in excess of fifteen hundred dollars and a reasonable attorney's fee; and the court shall enter judgment for the aggregate sum found in the verdict.

(L. 1983 H.B. 127)

---------- 354.335 8/28/1983 ----------

354.340. Unsatisfied judgments against corporation — suspension or revocation of certificate of authority until judgment satisfied. — Whenever any judgment shall be obtained in any of the courts of this state against any corporation subject to the provisions of sections 354.010 to 354.380 doing business in this state, and said judgment shall remain unsatisfied for fifteen days after execution shall have been lawfully issued thereon, the certificate of authority or license to do business issued or granted to such corporation shall immediately be suspended or revoked by the director of the department of commerce and insurance, upon said director being notified thereof, and such insurance company shall, after such suspension or revocation, be prohibited from transacting any business in this state until such judgment shall be satisfied.

(L. 1983 H.B. 127)

---------- 354.340 8/28/1983 ----------

354.345. Court decree of specific performance — membership contract, failure of corporation to comply, procedure, effect. — Any person, who has heretofore obtained or may hereafter obtain, in any of the courts of this state, a decree against any corporation subject to the provisions of sections 354.010 to 354.380 doing business in this state, commanding or directing said corporation to specifically perform a membership contract, may, if the corporation against which said decree is obtained, fails, for a period of fifteen days after the rendition of said decree, to comply with the same, obtain a copy of said decree, certified to under the hand and seal of the clerk of the court in which said decree was rendered, and transmit the same, together with the certificate of said clerk, reciting therein the failure of such corporation to comply with said decree, and transmit the same to the director of the department of commerce and insurance of the state of Missouri, and immediately upon receipt thereof, the said director of the department of commerce and insurance shall cause such corporation to be notified of the fact of the filing of such certified copy of said decree and certificate, and if such corporation fails for a period of thirty days thereafter to comply with said decree, the certificate of authority or license to do business issued or granted to such corporation shall immediately be suspended or revoked by the director of the department of commerce and insurance, until such decree shall be satisfied; provided, however, the foregoing shall not be applicable while an appeal is pending if a supersedeas bond shall have been given.

(L. 1983 H.B. 127)

---------- 354.345 8/28/1983 ----------

354.350. Fraudulent or bad faith conduct — investigation by division — hearing, procedure. — 1. It is unlawful for any corporation subject to the provisions of sections 354.010 to 354.380 transacting business in this state to:

(1) Conduct its business fraudulently;

(2) Fail to carry out its contracts in good faith; or

(3) Habitually and as a matter of business practice compel claimants under policies or liability judgment creditors of its members to either accept less than the amount due under the terms of the policy or resort to litigation against the corporation to secure payment of the amount due.

2. If the director determines that a person has engaged, is engaging in, or has taken a substantial step toward engaging in an act, practice or course of business constituting a violation of this section or a rule adopted or order issued pursuant thereto or that a

person has materially aided or is materially aiding an act, practice, omission, or course of business constituting a violation of this section or a rule adopted or order issued pursuant thereto, the director may issue such administrative orders as authorized under section 374.046. Each practice in violation of this section is a level two violation under section 374.049. Each act as a part of a practice does not constitute a separate violation under section 374.049. The director may also suspend or revoke the license or certificate of authority of a corporation subject to the provisions of sections 354.010 to 354.380 or enrollment representative for any such willful violation.

3. If the director believes that a person has engaged, is engaging in, or has taken a substantial step toward engaging in an act, practice or course of business constituting a violation of this section or a rule adopted or order issued pursuant thereto or that a person has materially aided or is materially aiding an act, practice, omission, or course of business constituting a violation of this section or a rule adopted or order issued pursuant thereto, the director may maintain a civil action for relief authorized under section 374.048. Each practice in violation of this section is a level two violation under section 374.049. Each act as a part of a practice does not constitute a separate violation under section 374.049.

(L. 1983 H.B. 127, A.L. 2007 S.B. 66)

---------- 354.350 8/28/2007 ----------

354.355. Injunctions, permanent or temporary, grounds, procedure — dissolution of corporation or rehabilitation, procedure. — Whenever it shall appear to the director of the department of commerce and insurance, from any examination made by himself, or from the report of a person or persons appointed by him, or from the statements of the corporation subject to the provisions of sections 354.010 to 354.380, or from any knowledge or information in his possession

(1) That the corporation has refused to submit its books, papers, accounts or affairs to the reasonable inspection of the director or his deputy or his examiner; or

(2) That the corporation has, by contract of reinsurance or otherwise, transferred or attempted to transfer substantially its entire property or business, or entered into any transaction, the effect of which is to merge substantially its entire property or business in the property or business of any other corporation, association, society, order, partnership or individual without first having obtained the written approval of the director of the department of commerce and insurance as provided by law; or

(3) That the corporation is found, after an examination, to be in such condition that its further transaction of business will be hazardous to its policyholders or to its creditors or

to the public; or

(4) That the corporation has an officer who has refused to be examined under oath touching its affairs; or

(5) That the corporation has ceased to transact the business of insurance for a period of one year;

the director may institute a suit or proceedings in the circuit court in the county or city in which the corporation was organized or in which it has or last had its principal or chief office or place of business or in the county of Cole, to enjoin the corporation from further prosecution of its business, either temporarily or perpetually, or for a judgment dissolving the corporation or for both; and after the entry of the decree or judgment, the court upon the motion of the director of the department of commerce and insurance may order the liquidation, settlement and winding up of the affairs of such corporation or the rehabilitation of the corporation as provided in section 354.140 together with such other decrees and orders in connection therewith as the court shall deem advisable.

(L. 1983 H.B. 127 § 354.355 subsec. 1)

---------- 354.355 8/28/1983 ----------

354.357. Receivership, grounds, procedure. — 1. Whenever the director institutes proceedings under section 354.355, he may also institute proceedings in the same case for receivership for any organization or corporation having the exclusive or dominant right to manage or control the corporation subject to the provisions of sections 354.010 to 354.380 which is the subject of the main case, when it appears that a receiver is necessary for the preservation of the assets of the corporation or that a receiver is necessary to determine the assets of the corporation held by the organization or corporation. The duration of the receivership and the duties of the receiver shall be in the discretion of the court.

2. The director may apply to the circuit court of Cole County, Missouri, for an order appointing him as receiver or ancillary receiver, and directing him to conserve the assets within this state of any foreign or alien corporation subject to the provisions of sections 354.010 to 354.380 upon any of the following grounds:

(1) Upon any of the grounds specified in section 354.355; or

(2) That the corporation has been placed in conservatorship or receivership in its domiciliary state or sovereignty or elsewhere. The institution of and the operation of the receivership shall be in accordance with chapter 355.

(L. 1983 H.B. 127 § 354.355 subsecs. 2, 3)

---------- 354.357 8/28/1983 ----------

354.362. Newborn child coverage required — notice of birth, when, effect. — The provisions of section 376.406 shall apply to all health services corporations subject to the provisions of sections 354.010 to 354.380.

(L. 1983 H.B. 127)

---------- 354.362 8/28/1983 ----------

354.380. Certain provisions of insurance law to be applicable. — The provisions of sections 375.936 and 376.770 to 376.800 shall apply to all health services corporations subject to the provisions of sections 354.010 to 354.380.

(L. 1983 H.B. 127)

---------- 354.380 8/28/1983 ----------

354.400. Definitions. — As used in sections 354.400 to 354.636, the following terms shall mean:

(1) "**Basic health care services**", health care services which an enrolled population might reasonably require in order to be maintained in good health, including, as a minimum, emergency care, inpatient hospital and physician care, and outpatient medical services;

(2) "**Community-based health maintenance organization**", a health maintenance organization which:

(a) Is wholly owned and operated by hospitals, hospital systems, physicians, or other health care providers or a combination thereof who provide health care treatment services in the service area described in the application for a certificate of authority from the director;

(b) Is operated to provide a means for such health care providers to market their services directly to consumers in the service area of the health maintenance organization;

(c) Is governed by a board of directors that exercises fiduciary responsibility over the operations of the health maintenance organization and of which a majority of the directors consist of equal numbers of the following:

a. Physicians licensed pursuant to chapter 334;

b. Purchasers of health care services who live in the health maintenance organization's service area;

c. Enrollees of the health maintenance organization elected by the enrollees of such organization; and

d. Hospital executives, if a hospital is involved in the corporate ownership of the health maintenance organization;

(d) Provides for utilization review, as defined in section 374.500, under the auspices of a physician medical director who practices medicine in the service area of the health maintenance organization, using review standards developed in consultation with physicians who treat the health maintenance organization's enrollees;

(e) Is actively involved in attempting to improve performance on indicators of health status in the community or communities in which the health maintenance organization is operating, including the health status of those not enrolled in the health maintenance organization;

(f) Is accountable to the public for the cost, quality and access of health care treatment services and for the effect such services have on the health of the community or communities in which the health maintenance organization is operating on a whole;

(g) Establishes an advisory group or groups comprised of enrollees and representatives of community interests in the service area to make recommendations to the health maintenance organization regarding the policies and procedures of the health maintenance organization;

(h) Enrolls fewer than fifty thousand covered lives;

(3) "**Covered benefit**" or "**benefit**", a health care service to which an enrollee is entitled under the terms of a health benefit plan;

(4) "**Director**", the director of the department of commerce and insurance;

(5) "**Emergency medical condition**", the sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent lay person, possessing an average knowledge of health and medicine, to believe that immediate medical care is required, which may include, but shall not be limited to:

(a) Placing the person's health in significant jeopardy;

(b) Serious impairment to a bodily function;

(c) Serious dysfunction of any bodily organ or part;

(d) Inadequately controlled pain; or

(e) With respect to a pregnant woman who is having contractions:

a. That there is inadequate time to effect a safe transfer to another hospital before delivery; or

b. That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child;

(6) "**Emergency services**", health care items and services furnished or required to screen and stabilize an emergency medical condition, which may include, but shall not be limited to, health care services that are provided in a licensed hospital's emergency facility by an appropriate provider;

(7) "**Enrollee**", a policyholder, subscriber, covered person or other individual participating in a health benefit plan;

(8) "**Evidence of coverage**", any certificate, agreement, or contract issued to an enrollee setting out the coverage to which the enrollee is entitled;

(9) "**Health care services**", any services included in the furnishing to any individual of medical or dental care or hospitalization, or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability;

(10) "**Health maintenance organization**", any person which undertakes to provide or arrange for basic and supplemental health care services to enrollees on a prepaid basis, or which meets the requirements of Section 1301 of the United States Public Health Service Act;

(11) "**Health maintenance organization plan**", any arrangement whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services and at least part of such arrangement consists of providing and assuring the availability of basic health care services to enrollees, as distinguished from mere indemnification against the cost of such services, on a prepaid basis through insurance or otherwise, and as distinguished from the mere provision of service benefits under health service corporation programs;

(12) "**Individual practice association**", a partnership, corporation, association, or other legal entity which delivers or arranges for the delivery of health care services and which has entered into a services arrangement with persons who are licensed to practice medicine, osteopathy, dentistry, chiropractic, pharmacy, podiatry, optometry, or any other health profession and a majority of whom are licensed to practice medicine or osteopathy. Such an arrangement shall provide:

(a) That such persons shall provide their professional services in accordance with a compensation arrangement established by the entity; and

(b) To the extent feasible for the sharing by such persons of medical and other records, equipment, and professional, technical, and administrative staff;

(13) "**Medical group/staff model**", a partnership, association, or other group:

(a) Which is composed of health professionals licensed to practice medicine or osteopathy and of such other licensed health professionals (including dentists, chiropractors, pharmacists, optometrists, and podiatrists) as are necessary for the provisions of health services for which the group is responsible;

(b) A majority of the members of which are licensed to practice medicine or osteopathy; and

(c) The members of which (i) as their principal professional activity over fifty percent individually and as a group responsibility engaged in the coordinated practice of their profession for a health maintenance organization; (ii) pool their income from practice as members of the group and distribute it among themselves according to a prearranged salary or drawing account or other plan, or are salaried employees of the health maintenance organization; (iii) share medical and other records and substantial portions of major equipment and of professional, technical, and administrative staff; (iv) establish an arrangement whereby an enrollee's enrollment status is not known to the member of the group who provides health services to the enrollee;

(14) "**Person**", any partnership, association, or corporation;

(15) "**Provider**", any physician, hospital, or other person which is licensed or otherwise authorized in this state to furnish health care services;

(16) "**Uncovered expenditures**", the costs of health care services that are covered by a health maintenance organization, but that are not guaranteed, insured, or assumed by a person or organization other than the health maintenance organization, or those costs which a provider has not agreed to forgive enrollees if the provider is not paid by the health maintenance organization.

(L. 1983 H.B. 127, A.L. 1997 H.B. 335, A.L. 2007 S.B. 66)

---------- 354.400 8/28/2007 ----------

354.405. Certificate of authority, who may make application — foreign corporation may qualify, requirements — procedure. — 1. Notwithstanding any law of this state to the contrary, any person may apply to the director for a certificate of authority to establish and operate a health maintenance organization in compliance with this act. No person shall establish or operate a health maintenance organization in this state without obtaining a certificate of authority pursuant to sections 354.400 to 354.636. A foreign corporation may qualify pursuant to sections 354.400 to 354.636, subject to its registration to do business in this state as a foreign corporation pursuant to chapter 351 and compliance with the provisions of sections 354.400 to 354.636.

2. Every health maintenance organization doing business in this state on September 28, 1983, shall submit an application for a certificate of authority pursuant to subsection 3 of this section within one hundred twenty days of September 28, 1983. Each such applicant may continue to operate until the director acts upon the application. In the event that an application is not submitted or is denied pursuant to section 354.410, the applicant shall henceforth be treated as a health maintenance organization whose certificate of authority has been revoked. Any health maintenance organization licensed by the department of commerce and insurance prior to September 28, 1983, and complying with the paid-in capital or guarantee fund requirements of section 354.410 shall be issued a certificate of authority upon filing an amended certificate of authority and an amended articles of incorporation that conform with sections 354.400 to 354.636. When the annual statement of a health maintenance organization subject to the provisions of sections 354.400 to 354.636 is filed and all fees due from the health maintenance organization are tendered, the health maintenance organization's certificate of authority to do business in this state shall automatically be extended pending formal renewal by the director, or until such time as the director should refuse to renew the certificate.

3. Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the director, and shall set forth or be accompanied by the following:

(1) A copy of the organizational documents of the applicant such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(2) A copy of the bylaws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) A list of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers if the applicant is a corporation, and the partners or members if the applicant is a partnership or association;

(4) A copy of any contract made or to be made between any providers and persons listed in subdivision (3) of this subsection and the applicant;

(5) A copy of the form of evidence of coverage to be issued to the enrollees;

(6) A copy of the form of the group contract, if any, which is to be issued to employers, unions, trustees, or other organizations;

(7) Financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified

public accountants, a copy of the applicant's most recent certified financial statement shall be deemed to satisfy this requirement unless the director directs that additional or more recent financial information is required for the proper administration of sections 354.400 to 354.636;

(8) A description of the proposed method of marketing the plan, a financial plan which includes a three-year projection of operating results anticipated, and a statement as to the sources of working capital as well as any other sources of funding;

(9) If the applicant is not domiciled in this state, a power of attorney duly executed by such applicant appointing the director, the director's successors in office, and duly authorized deputies, as the true and lawful attorney of such applicant in and for this state upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state may be served;

(10) A statement reasonably describing the geographic area or areas to be served;

(11) A description of the complaints procedures to be utilized as required by section 354.445;

(12) A description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation;

(13) Evidence demonstrating that the health maintenance organization has provided its enrollees with adequate access to health care providers; and

(14) Such other information as the director may require to make the determinations required in section 354.410.

4. Every health maintenance organization shall file with the director notice of its intention to modify any of the procedures or information described in and required to be filed by this section. Such changes shall be filed with the director prior to the actual modification. If the director does not disapprove the modification within forty-five days of filing, citing specific reasons for noncompliance, such modification shall be deemed approved. If a filing that is deemed approved is a document described in subdivision (4), (5) or (6) of subsection 3 of this section, the director shall not disapprove the deemed filing for a period of twelve months thereafter. If at any time during that twelve-month period the director determines that any provision of the deemed filing is contrary to state law, the director shall notify the health maintenance organization of the specific provision that is contrary to state law, and any specific statute to which the provision is contrary to, and request that the health maintenance organization file, within thirty days of receipt of the request, an amendment form that modifies the provision to conform to the state law. Upon approval of the amendment form by the director, the health maintenance organization shall issue a copy of the amendment to each individual and entity to which

the deemed filing was previously issued and shall attach a copy of the amendment to the deemed filing when it is subsequently issued. Such amendment shall have the force and effect as if the amendment was in the original filing or policy.

5. A health maintenance organization shall file all contracts of reinsurance. Any agreement between the organization and an insurer shall be subject to the laws of this state regarding reinsurance. All reinsurance agreements and any modifications thereto shall be filed and approved.

6. When the director deems it appropriate, the director may exempt any item from the filing requirements of this section.

(L. 1983 H.B. 127, A.L. 1997 H.B. 335, A.L. 2003 H.B. 121)

---------- 354.405 8/28/2003 ----------

354.407. PACE projects not deemed health maintenance organizations, when. — Notwithstanding the provisions of section 354.405 to the contrary, a program for all-inclusive care for the elderly (PACE) project sponsored by a religious or charitable organization that is itself or is controlled by an entity organized under Section 501(c)(3) of the Internal Revenue Code and which has had its application for the operation of a PACE program approved by the Center for Medicare and Medicaid Services of the federal Department of Health and Human Services and is operating under such approval shall not be deemed to be engaged in any business required to be licensed pursuant to section 354.405. Such exemption shall apply only to business conducted pursuant to the approved PACE contract and not to any other business that such organization may conduct.

(L. 2002 S.B. 1094)

---------- 354.407 8/28/2002 ----------

354.410. Certificate issued, when — annual deposit, requirements — capital account, amount, contents. — 1. The director shall issue or deny a certificate of authority to any person filing an application pursuant to section 354.405. Issuance of a certificate of authority may then be granted upon payment of the application fee prescribed in section 354.500 if the director is satisfied that the following conditions are met:

(1) The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy, and possess good reputations;

(2) The health care organization constitutes an appropriate mechanism whereby the health maintenance organization will effectively provide or arrange for the provision of

basic health care services on a prepaid basis through insurance or otherwise, except to the extent of requirements for co-payments, coinsurance or deductibles;

(3) The health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the director may consider:

(a) The financial soundness of the arrangements for health care services and the schedule of charges used in connection therewith;

(b) The adequacy of working capital;

(c) Any agreement with an insurer, a government, or any other organization for insuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the health maintenance organization;

(d) Any agreement with providers for the provision of health care services; and

(e) Any deposit of cash or securities submitted in accordance with subsection 2;

(4) The health maintenance organization's arrangements for health care services and the schedule of charges used in connection therewith are financially sound;

(5) The working capital be adequate;

(6) Any agreement with an insurer, a health service corporation, a government, or any other organization for insuring the payment of the cost of health care services contain a provision for the automatic applicability of alternative coverage in the event of discontinuance of the health maintenance organization;

(7) There be an agreement with providers for the provision of health care services;

(8) The enrollees shall be afforded an opportunity to participate in matters of policy and operation pursuant to section 354.420;

(9) Nothing in the proposed method of operation, as shown by the information submitted pursuant to section 354.405 or by independent investigation, is contrary to the public interest; and

(10) The health maintenance organization is able to provide its enrollees with adequate access to health care providers.

2. Unless otherwise provided below, each health maintenance organization shall deposit with the director, or with any organization or trustee acceptable to the director through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that is acceptable to the director in the amount set forth in this subsection:

(1) The amount for an organization that is beginning operation shall be the greater of: (a) five percent of its estimated expenditures for health care services for its first year of operation, (b) twice its estimated average monthly uncovered expenditures for its first year of operation, or (c) one hundred fifty thousand dollars for a medical group/staff model, or three hundred thousand dollars for an individual practice association. At the beginning of each succeeding year, unless not applicable, the organization shall deposit with the director, or organization or trustee, cash, securities, or any combination of these or other measures acceptable to the director, in an amount equal to four percent of its estimated annual uncovered expenditures for that year.

(2) Unless not applicable, an organization that is in operation on September 28, 1983, shall make a deposit equal to the larger of: (a) one percent of the preceding twelve months' uncovered expenditures, or (b) one hundred fifty thousand dollars for a medical group/staff model, or three hundred thousand dollars for an individual practice association on the first day of the first calendar year beginning six months or more after September 28, 1983. In the second calendar year, if applicable, the amount of the additional deposit shall be equal to two percent of its estimated annual uncovered expenditures. In the third calendar year, if applicable, the additional deposit shall be equal to three percent of its estimated annual uncovered expenditures for that year, and in the fourth calendar year and subsequent years, if applicable, the additional deposit shall be equal to four percent of its estimated annual uncovered expenditures for each year. Each year's estimate, after the first year of operation, shall reasonably reflect the prior years' operating experience and delivery arrangements. The director may waive any of the deposit requirements set forth in subdivisions (1) and (2) above, whenever satisfied that the organization has sufficient net worth and an adequate history of generating net income to assure its financial viability for the next year, or its performance and obligations are guaranteed by an organization with sufficient net worth and an adequate history of generating net income, or the assets of the organization or its contracts with insurers, hospital or medical service corporations, governments, or other organizations are sufficient to reasonably assure the performance of its obligations.

3. When an organization has achieved a net worth not including land, buildings, and equipment, of at least one million dollars or has achieved a net worth including organization-related land, buildings, and equipment of at least five million dollars, the annual deposit requirements shall not apply. The annual deposit requirement shall not apply to an organization if the total amount of the deposit is equal to twenty-five percent of its estimated annual uncovered expenditures for the next calendar year, or the capital and surplus requirements for the formation or admittance of an accident and health insurer in this state, whichever is less. If the organization has a guaranteeing organization which has been in operation for at least five years and has a net worth not including land,

buildings, and equipment of at least one million dollars or which has been in operation for at least ten years and has a net worth including organization-related land, buildings, and equipment of at least five million dollars, the annual deposit requirement shall not apply; provided, however, that if the guaranteeing organization is sponsoring more than one organization, the net worth requirement shall be increased by a multiple equal to the number of such organizations. This requirement to maintain a deposit in excess of the deposit required of an accident and health insurer shall not apply during any time that the guaranteeing organization maintains a net worth at least equal to the capital and surplus requirements for an accident and health insurer for each organization it sponsors.

4. All income from deposits shall belong to the depositing organization and shall be paid to it as it becomes available. A health maintenance organization that has made a securities deposit may withdraw the securities deposit or any part thereof, first having deposited, in lieu thereof, a deposit of cash, securities, or any combination of these or other measures of equal amount and value to that withdrawn. Any securities shall be approved by the director before being substituted.

5. In any year in which an annual deposit is not required of an organization, at its request the director shall reduce the required deposit by one hundred thousand dollars for each two hundred fifty thousand dollars of net worth in excess of the amount that allows it not to make an annual deposit. If the amount of net worth no longer supports a reduction of its required deposit, the organization shall immediately redeposit one hundred thousand dollars for each two hundred fifty thousand dollars of reduction in net worth, provided that its total deposit shall not exceed the maximum required under this section. Notwithstanding any provisions of sections 354.400 to 354.636, the deposit held by the director shall in no case be less than one hundred fifty thousand dollars for a group staff/model or three hundred thousand dollars for an individual practice association model.

6. Each health maintenance organization that obtains a certificate of authority after September 28, 1983, shall have and maintain a capital account of at least one hundred fifty thousand dollars for a medical group/staff model, or three hundred thousand dollars for an individual practice association in addition to any deposit requirements under this section. The capital account shall be net of any accrued liabilities and be in the form of cash, securities or any combination of these or other measures acceptable to the director.

7. A certificate of authority shall be denied only after compliance with the requirements of section 354.490.

(L. 1983 H.B. 127, A.L. 1997 H.B. 335, A.L. 2013 S.B. 262)

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

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

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

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

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

(5) Contract with an insurance company licensed in this state, or with a health services corporation authorized to do business in this state, for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization;

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

(a) Additional health care services;

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

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

(7) Offer as an option one or more health benefit plans which contain deductibles, coinsurance, coinsurance differentials, or variable co-payments. Health benefit plans offered under this section that contain deductibles shall be permitted only when combined with any health savings account or health reimbursement account as described in the Medicare Reform Act, P.L. No. 108-173, Title XII, Section 1201, provided that:

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

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

(c) A distribution from the health savings account or health reimbursement account to pay a health care provider for a qualified medical expense is made within thirty days of the submission of a claim.

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

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

(L. 1983 H.B. 127, A. L. 2013 S.B. 262)

---------- 354.415 8/28/2013 ----------

354.420. Advisory panels to afford enrollees participation in policy decisions. — The governing body of each health maintenance organization shall establish a mechanism to afford the enrollees an opportunity to participate in matters of policy and operation through the establishment of advisory panels, the use of advisory referenda on major policy decisions, or the use of other mechanisms.

(L. 1983 H.B. 127)

---------- 354.420 8/28/1983 ----------

354.425. Bonding of officers who disburse or invest funds — bond requirements. — Any director, officer or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of such organization shall be fiduciaries of such funds. Every health maintenance organization shall maintain in force a surety bond on such officers and employees in an amount of not less than one hundred thousand dollars, or such other sum as may be prescribed by the director. All such bonds shall be written with at least a one-year discovery period and, if written with less than a three-year discovery period, shall contain a provision that no cancellation or termination of the bond, whether by or at the request of the insured or by the underwriter, shall take effect prior to the expiration of ninety days after written notice of such cancellation or termination has been filed with the director, unless an earlier date of such cancellation or termination is approved by the director.

(L. 1983 H.B. 127)

---------- 354.425 8/28/1983 ----------

354.430. Evidence of coverage, requirements — rights of enrollee — toll-free telephone number required. — 1. Every enrollee residing in this state is entitled to evidence of coverage. If the enrollee obtains coverage through an insurance policy or a contract issued by a health services corporation, whether by option or otherwise, the insurer or the health services corporation shall issue the evidence of coverage. Otherwise the health maintenance organization shall issue the evidence of coverage.

2. No evidence of coverage, or amendment thereto, shall be issued or delivered to any person in this state until a copy of the form of the evidence of coverage, or amendment thereto, has been filed with the director.

3. An evidence of coverage shall contain:

(1) No provisions or statements which are unjust, unfair, inequitable, misleading, or deceptive, or which encourage misrepresentation, or which are untrue, misleading, or deceptive as defined in subsection 1 of section 354.460; and

(2) A clear and complete statement, if a contract, or a reasonably complete summary, if a certificate, of:

(a) The health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(b) Any limitations on the services, kind of services, benefits or kinds of benefits to be provided, including any deductible or co-payment, coinsurance, or other cost-sharing feature as requested by the group contract holder or, in the case of nongroup coverage, the individual certificate holder;

(c) Where and in what manner information is available as to how services may be obtained;

(d) The total amount of payment for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts; and

(e) A clear and understandable description of the health maintenance organization's method for resolving enrollee complaints, including the health maintenance organization's toll-free customer service number and the department of commerce and insurance's consumer complaint hot line number.

4. Any subsequent change in an evidence of coverage may be made in a separate document issued to the enrollee.

5. A copy of the form of the evidence of coverage to be used in this state, and any amendment thereto, shall be subject to the filing of subsection 2 of this section unless it is subject to the jurisdiction of the director under the laws governing health insurance or health services corporations, in which event the filing provisions of those laws shall apply.

(L. 1983 H.B. 127, A.L. 1997 H.B. 335, A.L. 2013 S.B. 262)

---------- 354.430 8/28/2013 ----------

354.435. Annual reports filed with director, when — content — forms. — 1. Every health maintenance organization shall annually, on or before March first, file a report, verified by at least two principal officers, with the director, covering its preceding calendar year.

2. Such report shall be on forms prescribed by the director and shall include:

(1) A financial statement of the organization, including its balance sheet for the preceding calendar year;

(2) Any material changes in the information submitted pursuant to subsection 3 of section 354.405;

(3) The number of persons enrolled during the year, the number of enrollees, as of the end of the year, and the number of enrollments terminated during the year;

(4) A statement setting forth the amount of uncovered and covered expenses that are payable and are more than ninety days past due for the period of August first through December thirty-first of the preceding year;

(5) Such other information relating to the performance of the organization as is necessary to enable the director to carry out his duties under sections 354.400 to 354.636.

(L. 1983 H.B. 127, A.L. 2007 S.B. 66)

CROSS REFERENCE:

Forms approval required, RSMo 37.340; failure to obtain, personal liability, 37.390

---------- 354.435 8/28/2007 ----------

354.440. Information to be available to enrollees. — Every health maintenance organization shall make available to its enrollees:

(1) The most recent annual statement of financial condition, including a balance sheet and summary of receipts and disbursements;

(2) A description of the organizational structure and operation of the health care plan and a summary of any material changes since the issuance of the last report;

(3) A description of services and information as to where and how to secure them; and

(4) A clear and understandable description of the health maintenance organization's method for resolving enrollee complaints.

(L. 1983 H.B. 127)

---------- 354.440 8/28/1983 ----------

354.441. Disclosures to subscribers shall not be prohibited or restricted. — No health maintenance organization plan, medical group/staff model, independent practice association or any other entity shall prohibit or restrict any provider from disclosing to any subscriber, enrollee or member any information that such provider deems appropriate regarding the nature of treatment, risks or alternatives thereto, the availability of other therapy, consultation or test, the decision of any plan to authorize or deny services, or the process that the plan or any person contracting with the plan uses or proposes to use, to authorize or deny health care services or benefits. Any such prohibition or restriction contained in a contract with a provider entered into after August 28, 1997, shall be void and unenforceable.

(L. 1997 H.B. 335)

---------- 354.441 8/28/1997 ----------

354.442. Disclosure information to enrollees required, when. — 1. Each enrollee, and upon request each prospective enrollee prior to enrollment, shall be supplied with written disclosure information. In the event of any inconsistency between any separate written disclosure statement and the enrollee contract or evidence of coverage, the terms of the enrollee contract or evidence of coverage shall be controlling. The information to be disclosed in writing shall include at a minimum the following:

(1) A description of coverage provisions, health care benefits, benefit maximums, including benefit limitations;

(2) A description of any exclusions of coverage, including the definition of medical necessity used in determining whether benefits will be covered;

(3) A description of all prior authorization or other requirements for treatments and services;

(4) A description of utilization review policies and procedures used by the health maintenance organization, including:

(a) The circumstances under which utilization review shall be undertaken;

(b) The toll-free telephone number of the utilization review agent;

(c) The time frames under which utilization review decisions shall be made for prospective, retrospective and concurrent decisions;

(d) The right to reconsideration;

(e) The right to an appeal, including the expedited and standard appeals processes and the time frames for such appeals;

(f) The right to designate a representative;

(g) A notice that all denials of claims shall be made by qualified clinical personnel and that all notices of denial shall include information about the basis of the decision; and

(h) Further appeal rights, if any;

(5) An explanation of an enrollee's financial responsibility for payment of premiums, coinsurance, co-payments, deductibles and any other charge, annual limits on an enrollee's financial responsibility, caps on payments for covered services and financial responsibility for noncovered health care procedures, treatments or services provided within the health maintenance organization;

(6) An explanation of an enrollee's financial responsibility for payment when services are provided by a health care provider who is not part of the health maintenance organization's network or by any provider without required authorization, or when a procedure, treatment or service is not a covered health care benefit;

(7) A description of the grievance procedures to be used to resolve disputes between a health maintenance organization and an enrollee, including:

(a) The right to file a grievance regarding any dispute between an enrollee and a health maintenance organization;

(b) The right to file a grievance when the dispute is about referrals or covered benefits;

(c) The toll-free telephone number which enrollees may use to file a grievance;

(d) The department of commerce and insurance's toll-free consumer complaint hotline number;

(e) The time frames and circumstances for expedited and standard grievances;

(f) The right to appeal a grievance determination and the procedures for filing such an appeal;

(g) The time frames and circumstances for expedited and standard appeals;

(h) The right to designate a representative;

(i) A notice that all disputes involving clinical decisions shall be made by qualified clinical personnel; and

(j) All notices of determination shall include information about the basis of the decision and further appeal rights, if any;

(8) A description of a procedure for providing care and coverage twenty-four hours a day, seven days a week, for emergency services. Such description shall include the definition of emergency services and emergency medical condition, notice that emergency services are not subject to prior approval, and shall describe the enrollee's financial and other responsibilities regarding obtaining such services, including when such services are received outside the health maintenance organization's service area;

(9) A description of procedures for enrollees to select and access the health maintenance organization's primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients;

(10) A description of the procedures for changing primary and specialty care providers within the health maintenance organization;

(11) Notice that an enrollee may obtain a referral for covered services to a health care provider outside of the health maintenance organization's network or panel when the health maintenance organization does not have a health care provider with appropriate training and experience in the network or panel to meet the particular health care needs of the enrollee and the procedure by which the enrollee may obtain such referral;

(12) A description of the mechanisms by which enrollees may participate in the development of the policies of the health maintenance organization;

(13) Notice of all appropriate mailing addresses and telephone numbers to be utilized by enrollees seeking information or authorization;

(14) Listings by specialty, which may be in separate documents that are updated annually, of the names, addresses and telephone numbers of all participating providers, including facilities, and in addition in the case of physicians, board certification; and

(15) The director of the department of commerce and insurance shall develop a standard credentialing form which shall be used by all health carriers when credentialing health care professionals in a managed care plan. If the health carrier demonstrates a need for additional information, the director of the department of commerce and insurance may approve a supplement to the standard credentialing form. All forms and supplements shall meet all requirements as defined by the National Committee of Quality Assurance.

2. Each health maintenance organization shall, upon request of an enrollee or prospective enrollee, provide the following:

(1) A list of the names, business addresses and official positions of the membership of the board of directors, officers, controlling persons, owners or partners of the health maintenance organization;

(2) A copy of the most recent annual certified financial statement of the health maintenance organization, including a balance sheet and summary of receipts and disbursements prepared by a certified public accountant;

(3) A copy of the most recent individual, direct pay enrollee contracts;

(4) Information relating to consumer complaints compiled annually by the department of commerce and insurance;

(5) The procedures for protecting the confidentiality of medical records and other enrollee information;

(6) An opportunity to inspect drug formularies used by such health maintenance organization and any financial interest in a pharmacy provider utilized by such organization. The health maintenance organization shall also disclose the process by which an enrollee or his representative may seek to have an excluded drug covered as a benefit;

(7) A written description of the organizational arrangements and ongoing procedures of the health maintenance organization's quality assurance program;

(8) A description of the procedures followed by the health maintenance organization in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials;

(9) Individual health practitioner affiliations with participating hospitals, if any;

(10) Upon written request, written clinical review criteria relating to conditions or diseases and, where appropriate, other clinical information which the organization may consider in its utilization review. The health maintenance organization may include with the information a description of how such information will be used in the utilization review process;

(11) The written application procedures and minimum qualification requirements for health care providers to be considered by the health maintenance organization;

(12) A description of the procedures followed by the health maintenance organization in making decisions about which drugs to include in the health maintenance organization's drug formulary.

3. Nothing in this section shall prevent a health maintenance organization from changing or updating the materials that are made available to enrollees.

4. The information to be provided under subsections 1 and 2 of this section may be provided online unless a paper copy is requested by the enrollee. A request by the enrollee may include written, oral or electronic means. Such requested paper copy shall be provided to the enrollee within fifteen business days.

(L. 1997 H.B. 335, A.L. 2010 S.B. 583)

---------- 354.442 8/28/2010 ----------

354.443. Financial disclosures to the department required by health maintenance organizations, when. — 1. A health maintenance organization shall disclose to the department of commerce and insurance all financial arrangements, financial interest in, or contractual provisions with utilization review companies or any other health care provider that would encourage or limit the type, amount, duration and scope of services offered, restrict or limit referral or treatment to patients, including but not limited to financial incentives to limit, restrict or deny access to or delivery of medical or other services prior to the delivery of such services. Capitation arrangements between health maintenance organizations and health care providers shall not be considered an inducement to limit, restrict or deny access to medical services. The director shall review all financial arrangements filed with the department of commerce and insurance to determine if such arrangements offer an inducement to a provider to provide less than medically necessary services to an enrollee.

2. The capitation rate to be paid from the health maintenance organization to the health care provider is not required to be included with the financial arrangements to be filed with the department of commerce and insurance pursuant to subsection 1 of this section.

(L. 1997 H.B. 335)

---------- 354.443 8/28/1997 ----------

354.444. Administrative orders for violations — voluntary forfeitures, civil actions. — 1. If the director determines that a person has engaged, is engaged in, or has taken a substantial step toward engaging in an act, practice or course of business constituting a violation of sections 354.400 to 354.636, or a rule adopted or order issued pursuant thereto or that a person has materially aided or is materially aiding an act, practice, omission, or course of business constituting a violation of sections 354.400 to 354.636 or a rule adopted or order issued pursuant thereto, the director may issue such administrative orders as authorized under section 374.046. A violation of any of these sections is a level one violation under section 374.049.

2. If the director believes that a person has engaged, is engaging in, or has taken a substantial step toward engaging in an act, practice or course of business constituting a violation of sections 354.400 to 354.636, or a rule adopted or order issued pursuant thereto or that a person has materially aided or is materially aiding an act, practice, omission, or course of business constituting a violation of sections 354.400 to 354.636 or a rule adopted or order issued pursuant thereto, the director may maintain a civil action for relief authorized under section 374.048. A violation of any of these sections is a level one violation under section 374.049.

(L. 1997 H.B. 335, A.L. 2007 S.B. 66)

---------- 354.444 8/28/2007 ----------

354.445. Complaints by enrollees, organization to establish system. — Every health maintenance organization shall establish and maintain a complaint system which provides reasonable procedures for the resolution of written complaints initiated by enrollees.

(L. 1983 H.B. 127)

---------- 354.445 8/28/1983 ----------

354.450. Investments authorized. — With the exception of investments made in accordance with subdivisions (1) and (2) of subsection 1 of section 354.415 and subsection 2 of section 354.415, the investable funds of a health maintenance organization shall be invested only in securities or other investments permitted by the laws of this state for the investment of assets constituting the legal reserves of life insurance companies, or such other securities or investments as the director may permit.

(L. 1983 H.B. 127)

---------- 354.450 8/28/1983 ----------

354.455. Deposit required, how made. — Unless otherwise provided in sections 354.400 to 354.636, each health maintenance organization shall deposit with the director, or with any organization or trustee acceptable to him through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures acceptable to him, in the amount set forth in section 354.410.

(L. 1983 H.B. 127, A.L. 2007 S.B. 66)

---------- 354.455 8/28/2007 ----------

354.460. Advertising not to be untrue or misleading — deceptive solicitation — prohibited — how determined. — No health maintenance organization, or representative

thereof, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For purposes of sections 354.400 to 354.636:

(1) A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment with, a health maintenance organization;

(2) A statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue, if, in the total context in which such statement is made or such item of information is communicated, such statement or item of information may be reasonably understood by a reasonable person, not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage or the absence of any exclusion, limitation, or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a health maintenance organization plan, if such benefit, advantage, or absence of limitation, exclusion, or disadvantage does not, in fact, exist;

(3) An evidence of coverage shall be deemed to be deceptive if the evidence of coverage, taken as a whole, is misleading.

(L. 1983 H.B. 127 § 354.460 subsec. 1, A.L. 2007 S.B. 66)

---------- 354.460 8/28/2007 ----------

354.462. Enrollee, grounds for disenrollment. — An enrollee may not be disenrolled nor denied renewal except for the failure to pay the charge for such coverage, for fraudulent misuse of the system, for abusive conduct, for failure to establish a proper patient-physician relationship, or for such other reasons as may be allowed in rules promulgated by the director.

(L. 1983 H.B. 127 § 354.460 subsec. 2)

---------- 354.462 8/28/1983 ----------

354.464. Names not authorized for use, exceptions. — No health maintenance organization, unless licensed as an insurer, may use in its name, contracts, or literature any of the words "insurance", "casualty", "surety", "mutual", or any other words descriptive of the insurance, casualty, or surety business or deceptively similar to the name or description of any insurance or surety corporation doing business in this state when such words are deceptive or misleading. No person, if not in possession of a valid certificate of authority issued pursuant to sections 354.400 to 354.636, may use the phrase "health maintenance organization" or "HMO" in the course of its operation.

(L. 1983 H.B. 127 § 354.460 subsec. 3, A.L. 2007 S.B. 66)

---------- 354.464 8/28/2007 ----------

354.465. Examinations by division, when — costs, how paid. — 1. The director, or any duly appointed representative, may make an examination of the affairs of any health maintenance organization as often as he deems it necessary for the protection of the interests of the people of this state, but not less frequently than once every five years.

2. All costs incurred by the state as a result of making examinations under this section shall be paid by the organization being examined and remitted as provided in section 374.160.

(L. 1983 H.B. 127, A.L. 2014 H.B. 1968)

---------- 354.465 8/28/2014 ----------

354.470. Suspension or revocation, when — effect. — 1. The director may suspend, revoke or place conditions or restrictions on any certificate of authority issued to a health maintenance organization pursuant to sections 354.400 to 354.636 if the director finds that any of the following conditions exist:

(1) The health maintenance organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in any other information submitted pursuant to section 354.405, unless amendments to such submissions have been filed with and approved by the director;

(2) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of section 354.430;

(3) The health maintenance organization does not provide nor arrange for basic health care services;

(4) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(5) The health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation as required pursuant to section 354.420;

(6) The health maintenance organization has failed to implement the complaint system required by section 354.450 in a manner designed to reasonably resolve valid complaints;

(7) The health maintenance organization has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;

(8) The continued operation of the health maintenance organization would be hazardous to its enrollees;

(9) The person operating the health maintenance organization is in violation of the provisions of sections 375.930 to 375.948, except to the extent that the director has determined that the nature of health maintenance organizations renders the application of such sections clearly inappropriate; notwithstanding the foregoing, paragraph (b) of subdivision (11) of section 375.936 shall not apply to health maintenance organizations;

(10) The health maintenance organization has otherwise failed to substantially comply with sections 354.400 to 354.636.

2. A certificate of authority shall be suspended, revoked, or be subject to conditions or restrictions only after compliance with the requirements of section 354.490.

3. When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of such suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation whatsoever.

4. When the certificate of authority of a health maintenance organization is revoked, such health maintenance organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of such organization. It shall engage in no further advertising or solicitation whatsoever. The director may, by written order, permit such further operation of the health maintenance organization as the director may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

(L. 1983 H.B. 127, A.L. 1997 H.B. 335)

---------- 354.470 8/28/1997 ----------

354.475. Insurance companies or health service company may organize and operate a health maintenance organization. — 1. An insurance company licensed in this state, or a health services corporation authorized to do business in this state, may directly or through a subsidiary or affiliate organize and operate a health maintenance organization under the provisions of sections 354.400 to 354.636 so long as they comply with the provisions of section 354.410 as applicable thereto. Notwithstanding any other law to the contrary, any two or more such insurance companies, health services corporations, or subsidiaries or affiliates thereof, may jointly organize and operate a health maintenance organization.

2. Notwithstanding any other provision of law pertaining to insurance and health services corporations to the contrary, an insurer or a health services corporation may

contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations. The enrollees of a health maintenance organization shall be deemed to constitute a permissible group under such laws. Among other things, under such contracts, the insurer or health services corporation may make benefit payments to health maintenance organizations for health care services rendered by providers.

(L. 1983 H.B. 127, A.L. 2007 S.B. 66)

---------- 354.475 8/28/2007 ----------

354.480. Rehabilitation, liquidation, or conservation, grounds, procedure — enrollee's priorities — claims, priority. — 1. Any rehabilitation, liquidation, or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation, or conservation of an insurance company and shall be conducted under the supervision of the director pursuant to the laws governing the rehabilitation, liquidation, or conservation of an insurance company. The director may apply for an order directing him to rehabilitate, liquidate, or conserve a health maintenance organization upon any one or more grounds set out in section* 354.355, or section 375.560, or when, in his opinion, the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this state. Enrollees shall have the same priority in the event of liquidation or rehabilitation granted the policyholders of an insurer.

2. A claim by a health care provider for any uncovered expenditures has priority over claims of other health care providers, provided such provider of services agrees not to assert such claim against any enrollee of the health maintenance organization.

(L. 1983 H.B. 127)

*Word "chapter" appears in original rolls.

---------- 354.480 8/28/1983 ----------

354.485. Rules and regulations authorized. — The director may promulgate such reasonable rules and regulations in accordance with chapter 536 as are necessary or proper to carry out the provisions of sections 354.400 to 354.636.

(L. 1983 H.B. 127, A.L. 2007 S.B. 66)

---------- 354.485 8/28/2007 ----------

354.490. Certificate of authority, denial, suspension or revocation, grounds — procedure. — 1. When the director has cause to believe that grounds for the denial of an

application for a certificate of authority exist, that grounds for the suspension or revocation of a certificate of authority exist, or that grounds for the imposition of restrictions or conditions on a certificate of authority exist, the director shall notify the health maintenance organization in writing, specifically stating the grounds for denial, suspension, revocation, or conditions or restrictions and fixing a time of at least twenty days thereafter for a hearing on the matter.

2. After such hearing, or upon the failure of the health maintenance organization to appear at such hearing, the director shall take action as is deemed advisable, on the basis of written findings, which shall be mailed to the health maintenance organization. The action of the director shall be subject to review by the circuit court having jurisdiction. The court may, in disposing of the issue before it, modify, affirm, or reverse the order of the director in whole or in part.

3. The provisions of chapter 536 shall apply to proceedings pursuant to this section to the extent they are not in conflict with subsections 1 and 2 of this section.

(L. 1983 H.B. 127, A.L. 1997 H.B. 335)

---------- 354.490 8/28/1997 ----------

354.495. Fees to be paid to director. — Every health maintenance organization subject to sections 354.400 to 354.636 shall pay to the director the fees specified in section 374.230.

(L. 1983 H.B. 127, A.L. 2007 S.B. 66, A.L. 2018 S.B. 982)

Effective 1-01-19

---------- 354.495 1/1/2019 ----------

354.500. Conferences called by director as to suspected or potential violations. — If the director shall for any reason have cause to believe that any violation of sections 354.400 to 354.636 has occurred or is about to occur, the director may give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in such suspected violation, to arrange a conference with the alleged violators, or potential violators, or their authorized representatives, for the purpose of attempting to ascertain the facts relating to such suspected or potential violation, and, in the event it appears that any violation has occurred or is about to occur, to arrive at an adequate and effective means of correcting or preventing such violation. Proceedings under this subsection shall not be governed by any formal procedural requirements, and may be conducted in such manner as the director may deem appropriate under the circumstances.

(L. 1983 H.B. 127, A.L. 2007 S.B. 66)

---------- 354.500 8/28/2007 ----------

354.505. Laws regulating insurance or health service corporations not to apply, exceptions. — 1. Provisions of the insurance law and provisions of health services corporation laws shall not be applicable to any health maintenance organization granted a certificate of authority under sections 354.400 to 354.636 unless made specifically applicable by statute. This provision shall not apply to an insurer or health services corporation licensed and regulated pursuant to the insurance laws of the health services corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to sections 354.400 to 354.636.

2. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its duly authorized representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

(L. 1983 H.B. 127, A.L. 1997 H.B. 335)

---------- 354.505 8/28/1997 ----------

354.510. Public documents, all filings and required reports. — Unless otherwise provided, all applications, filings, and reports required under sections 354.400 to 354.636 shall be treated as public documents.

(L. 1983 H.B. 127, A.L. 2007 S.B. 66)

---------- 354.510 8/28/2007 ----------

354.515. Confidential information, diagnosis, treatment, health of enrollees or applicants, exceptions. — 1. Any data or information pertaining to the diagnosis, treatment, or health of any enrollee or applicant obtained from such person, or from any provider, by any health maintenance organization shall be held in confidence and shall not be disclosed to any person except as follows:

(1) To the extent that it may be necessary to carry out the purposes of sections 354.400 to 354.636;

(2) Upon the express consent of the enrollee or applicant;

(3) Pursuant to statute or court order for the production of evidence or the discovery thereof;

(4) In the event of a claim or litigation between such person and the health maintenance organization wherein such data or information is pertinent. A health maintenance organization shall be entitled to claim any statutory privileges against such disclosure which the provider who furnishes such information to the health maintenance

organization is entitled to claim, but no such claim or privilege against disclosure may be made against the director by such health maintenance organization.

2. Every health maintenance organization shall establish and maintain procedures to ensure that all mental health records of enrollees remain confidential. Such procedures and any subsequent amendments thereto shall be filed annually with the director.

(L. 1983 H.B. 127, A.L. 1997 H.B. 335)

---------- 354.515 8/28/1997 ----------

354.520. Mergers, consolidations, control of organization, requirements. — No person may take a tender for, or a request or invitation for tenders of, or enter into an agreement to exchange securities for, or acquire in the open market or otherwise, any voting security of a health maintenance organization, nor enter into any other agreement which if, after the consummation thereof, that person would, directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of the health maintenance organization. No person may enter into an agreement to merge or consolidate with, or to otherwise acquire control of a health maintenance organization, unless, at the time any offer, request, or invitation is made, or any agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the person has filed with the director, and has sent to the health maintenance organization, information required by chapter 382, and the offer, request, invitation, agreement, or acquisition has been approved by the director. Such approval by the director shall be governed by the provisions of chapter 382.

(L. 1983 H.B. 127)

---------- 354.520 8/28/1983 ----------

354.525. Health provision collective bargaining agreements or contracts — charge for coverage, how determined. — No employer in this state shall be required to pay more for health benefits as a result of the application of this section than would otherwise be required by any prevailing collective bargaining agreement, or other contract, for the provision of health benefits to its employees; provided, that the employer or benefits fund shall pay to the health maintenance organization chosen by each employee or member an amount equal to the lesser of (a) the amount paid on behalf of its other employees or members for health benefits; or (b) the health maintenance organization's charge for coverage approved by the director pursuant to section 354.435.

(L. 1983 H.B. 127)

---------- 354.525 8/28/1983 ----------

354.530. Severability clause. — If any section, term, or provision of sections 354.400 to 354.636 shall be adjudged invalid for any reason, such judgment shall not affect, impair, or invalidate any other section, term, or provision of sections 354.400 to 354.636, but the remaining sections, terms, and provisions shall be and remain in full force and effect.

(L. 1983 H.B. 127, A.L. 2007 S.B. 66)

---------- 354.530 8/28/2007 ----------

354.535. Pharmacist, emergency situation, may take an assignment of enrollee's right to reimbursement — health maintenance organizations shall only contract with entities licensed by the board of pharmacy — requirements for drug prescriptions, exceptions. — 1. If a pharmacy, operated by or contracted with by a health maintenance organization, is closed or is unable to provide health care services to an enrollee in an emergency, a pharmacist may take an assignment of such enrollee's right to reimbursement, if the policy or contract provides for such reimbursement, for those goods or services provided to an enrollee of a health maintenance organization. No health maintenance organization shall refuse to pay the pharmacist any payment due the enrollee under the terms of the policy or contract.

2. No health maintenance organization, conducting business in the state of Missouri, shall contract with a pharmacy, pharmacy distributor or wholesale drug distributor, nonresident or otherwise, unless such pharmacy or distributor has been granted a permit or license from the Missouri board of pharmacy to operate in this state.

3. Every health maintenance organization shall apply the same coinsurance, co-payment and deductible factors to all drug prescriptions filled by a pharmacy provider who participates in the health maintenance organization's network if the provider meets the contract's explicit product cost determination. If any such contract is rejected by any pharmacy provider, the health maintenance organization may offer other contracts necessary to comply with any network adequacy provisions of this act*. However, nothing in this section shall be construed to prohibit the health maintenance organization from applying different coinsurance, co-payment and deductible factors between generic and brand name drugs.

4. Health maintenance organizations shall not set a limit on the quantity of drugs which an enrollee may obtain at any one time with a prescription, unless such limit is applied uniformly to all pharmacy providers in the health maintenance organization's network.

5. Health maintenance organizations shall not insist or mandate any physician or other licensed health care practitioner to change an enrollee's maintenance drug unless the provider and enrollee agree to such change. For the purposes of this provision, a

maintenance drug shall mean a drug prescribed by a practitioner who is licensed to prescribe drugs, used to treat a medical condition for a period greater than thirty days. Violations of this provision shall be subject to the penalties provided in section 354.444. Notwithstanding other provisions of law to the contrary, health maintenance organizations that change an enrollee's maintenance drug without the consent of the provider and enrollee shall be liable for any damages resulting from such change. Nothing in this subsection, however, shall apply to the dispensing of generically equivalent products for prescribed brand name maintenance drugs as set forth in section 338.056.

(L. 1983 H.B. 127, A.L. 1997 H.B. 335, A.L. 1998 H.B. 1302)

*"This act" in 1997 referred to H.B. 335, 1997, which contained numerous sections. "This act" now also includes H.B. 1302, 1998. Consult Disposition of Sections tables for both years for definitive listings.

(2000) Section is not preempted by Employee Retirement Income Security Act (ERISA). Express Scripts, Inc. v. Wenzel, 102 F.Supp.2d 1135 (W.D.Mo.).

(2001) Section falls within savings clause of Employee Retirement Income Security Act (ERISA) as a regulation of insurance. Express Scripts, Inc. v. Wenzel, 262 F.3d 829 (8th Cir.).

---------- 354.535 8/28/1998 ----------

354.536. Continuation of dependent child coverage, when — dependent child defined. — 1. If a health maintenance organization plan provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children, such coverage shall continue while the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the enrollee for support and maintenance. Proof of such incapacity and dependency must be furnished to the health maintenance organization by the enrollee at least thirty-one days after the child's attainment of the limiting age. The health maintenance organization may require at reasonable intervals during the two years following the child's attainment of the limiting age subsequent proof of the child's disability and dependency. After such two-year period, the health maintenance organization may require subsequent proof not more than once each year.

2. If a health maintenance organization plan provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children, such plan, so long as it remains in force, until the dependent child attains the limiting age, shall remain in force at the option of the enrollee. The enrollee's election for continued coverage under

this section shall be furnished to the health maintenance organization within thirty-one days after the child's attainment of the limiting age. As used in this subsection, a dependent child is a person who is:

(1) Unmarried and no more than twenty-five years of age; and

(2) A resident of this state; and

(3) Not provided coverage as a named subscriber, insured, enrollee, or covered person under any group or individual health benefit plan, or entitled to benefits under Title XVIII of the Social Security Act, P.L. 89-97, 42 U.S.C. Section 1395, et seq.

(L. 2007 H.B. 818)

Effective 1-01-08

---------- 354.536 1/1/2008 ----------

354.540. Health maintenance organization of bordering states may be admitted to do business — procedure. — A health maintenance organization approved and regulated under the laws of another bordering state may be admitted to do business in this state by satisfying the director that it is fully and legally organized under the laws of its state, and that it complies with all requirements for health maintenance organizations organized within Missouri. The director may waive or modify the provisions of sections 354.400 to 354.636 if he determines that the same are not appropriate or necessary to a particular health maintenance organization of another state.

(L. 1983 H.B. 127, A.L. 2007 S.B. 66)

---------- 354.540 8/28/2007 ----------

354.545. Exempt plans and companies. — The provisions of sections 354.400 to 354.636 shall not apply to any labor organization's health plan providing services established and maintained solely for its members and their dependents, and facilities of not-for-profit corporations in existence on October 1, 1980, subject either to the provisions and regulations of Section 302 of the Labor-Management Relations Act, 29 U.S.C. 186 or the Labor-Management Reporting and Disclosure Act, 29 U.S.C. 401-538.

(L. 1983 H.B. 127, A.L. 2007 S.B. 66)

---------- 354.545 8/28/2007 ----------

354.546. Second medical opinion to be allowed by health maintenance organizations, procedure, costs. — 1. A health maintenance organization shall allow enrollees to seek a second medical opinion or consultation from the health maintenance organization's choice of other primary care physicians and specialty physicians at no

additional cost to the enrollee beyond what the enrollee would otherwise pay for an initial medical opinion or consultation.

2. If an enrollee chooses to seek a second medical opinion, and if the health maintenance organization does not employ or contract with another physician with the expertise necessary to provide a second medical opinion, then the health maintenance organization shall arrange for a referral to a physician with the necessary expertise to provide a second opinion or consultation and ensure that the enrollee obtains the covered benefit at no greater cost to the enrollee than if the benefit were obtained from participating physicians.

(L. 1998 S.B. 754)

CROSS REFERENCE:

Second medical opinions covered, when, 354.207

---------- 354.546 8/28/1998 ----------

354.550. Laws not applicable to community health companies. — The provisions of sections 354.400 to 354.636 shall not apply to community health corporations as defined by Public Law 94-63 so long as such corporations limit their activities to those described in Public Law 94-63.

(L. 1983 H.B. 127, A.L. 2007 S.B. 66)

---------- 354.550 8/28/2007 ----------

354.551. Health maintenance organizations may offer point of service (POS) riders, when. — 1. Missouri licensed health maintenance organizations shall be permitted to offer point of service riders (POS) to their approved health plan products, without being required to obtain a separate license as a health insurer pursuant to chapter 376, so long as medical and hospital expenses incurred under the POS rider do* not exceed ten percent of total medical and hospital expenses incurred for all health plan products sold.

2. Health maintenance organizations which have been licensed for at least one calendar year, who choose to insure the POS rider, shall maintain a net worth of the greater of:

(1) One million two hundred thousand dollars; or

(2) Two percent of total premium revenue for the immediately preceding twelve months plus fifty percent of uncovered liabilities as reported in the immediately preceding calendar quarter.

3. Health maintenance organizations which have been licensed for less than one calendar year, who choose to insure the POS rider, shall maintain a net worth of the

greater of:

(1) One million two hundred thousand dollars; or

(2) Ten percent of the yearly average of the three-year annual premium plus fifty percent of its average annual uncovered liabilities as projected in its application for a certificate of authority.

4. The department of commerce and insurance may modify the net worth requirements for a health maintenance organization which has been licensed for less than one calendar year if its actual results deviate materially from its projections. In addition to any other deposit required of a licensed health maintenance organization pursuant to section 354.410, any health maintenance organization which chooses to issue a POS rider shall deposit an additional six hundred thousand dollars** with the director of the department of commerce and insurance. Any health maintenance organization which issues a POS rider whose medical and hospital expenses incurred under the POS rider exceed*** ten percent of total medical and hospital expenses incurred for all health plan products sold shall either cease insuring new POS riders until it comes into compliance with the ten percent limitation of this section or meet the minimum net worth requirements and all other statutory and regulatory requirements of a Missouri domestic life insurance company.

(L. 1997 H.B. 335 § 11)

*Word "does" appears in original rolls.

**Word "dollars" does not appear in original rolls.

***Word "exceeds" appears in original rolls.

354.552. Community-based health maintenance organizations, requirements. — 1. A community-based health maintenance organization shall have available and accessible a sufficient number and type of physicians, specialists, and other providers as needed to:

(1) Provide the benefits covered by the plan;

(2) Meet the medical needs of the health plan's enrolled population;

(3) Provide members with a reasonable choice of primary care physicians and specialty physicians.

2. If a community-based health maintenance organization does not employ or contract with a physician with the expertise necessary to provide medically necessary care covered by the health plan, then the health maintenance organization shall arrange for a referral to

a physician with the necessary expertise and ensure that the members obtain the covered benefit at no greater cost to the member than if the benefit were obtained from participating physicians.

3. A community-based health maintenance organization's physicians, physician specialists and facilities shall be reasonably available. Primary health care services shall be in reasonable proximity to a member's personal residence or business, with due consideration given to the availability of physicians within the community-based health maintenance organization's service area. This provision shall not preclude a community-based health maintenance organization from arranging for the provision of member care outside the service area for a higher level of skill or specialty care than is available within the service area.

(L. 1997 H.B. 335 § 1)

---------- 354.552 8/28/1997 ----------

354.554. Standing referrals for certain members of community-based health maintenance organizations, when. — Each community-based health maintenance organization shall offer coverage that allows an enrollee who suffers from a life-threatening condition or a degenerative, disabling condition requiring a regimen of specialized medical treatment lasting for six months or more to receive a standing referral for specialty care case management by a physician or specialty care center with expertise in treating the condition. Under such specialty care case management, the provider shall coordinate primary and specialty care for the enrollee under a treatment plan approved by the health maintenance organization in consultation with the enrollee's primary care provider and the specialist physician or specialty care center.

(L. 1997 H.B. 335 § 2)

---------- 354.554 8/28/1997 ----------

354.556. Trustees, vacancies, elections. — 1. The terms of office of the trustees elected by the enrollees of the community-based health maintenance organization shall begin immediately upon their election.

2. If a vacancy occurs in the office of a trustee, the vacancy shall be filled for the unexpired term in the same manner as the office was previously filled, except that the board of trustees may appoint a qualified person to fill the vacancy in the office of an elected enrollee until the next regular election at which time an enrollee of the community-based health maintenance organization shall be elected for the unexpired term.

3. The elections of the enrollee members of the board of trustees shall be arranged for, managed and conducted by the board of trustees of the community-based health maintenance organization.

(L. 1997 H.B. 335 § 3)

---------- 354.556 8/28/1997 ----------

354.558. Materials provided to prospective purchasers. — A community-based health maintenance organization shall provide each prospective purchaser of its services with the following marketing materials prior to enrollment:

(1) A list of the health care providers who have a contractual agreement to provide services under the plan of coverage. It shall be a violation of the unfair trade practices act for a community-based health maintenance organization to falsely list that a provider has a contractual agreement to provide services under its plan of coverage;

(2) Information to describe how the community-based health maintenance organization will use utilization management to promote efficiency in the delivery of services in accordance with the terms of the contract for coverage. This information shall explain how the community-based health maintenance organization will encourage the use of treatment options that produce the most cost-effective results. The format and content of the descriptive information disclosed under this subdivision shall be approved by the department of commerce and insurance and shall include information regarding covered benefits available under the plan;

(3) Disclosure of grievance procedures established in accordance with regulations promulgated by the department of commerce and insurance for community-based health maintenance organizations. Included in this information shall be notification of how and when to contact the health plan and the department of commerce and insurance regarding a grievance; and

(4) Notice of the availability of coverage as described in section 354.554.

(L. 1997 H.B. 335 § 4)

---------- 354.558 8/28/1997 ----------

354.559. Disclosure to members, restrictions and prohibitions. — No community-based health maintenance organization shall prohibit or restrict any provider from disclosing to any subscriber, enrollee or member any information that such provider deems appropriate regarding the nature of treatment, risks or alternatives thereto, the availability of other therapy, consultation or test, the decision of any plan to authorize or deny services, or to process the plan or any person to authorize or deny services, or to

process the plan or any person contracting with the plan uses or proposes to use, to authorize or deny health care services or benefits. Any such prohibition or restriction contained in a contract with a provider entered into after August 28, 1997, shall be void and unenforceable. The standards used to determine if a community-based health maintenance organization has prohibited or restricted a provider's disclosure in violation of this section shall be those established by federal regulation of the Health Care Financing Administration for use in regulating managed care plans serving Medicare enrollees.

(L. 1997 H.B. 335 § 5)

---------- 354.559 8/28/1997 ----------

354.560. Payment arrangements, department to adopt rules — disclosure of financial arrangements — confidentiality. — 1. The director of the department of commerce and insurance shall adopt rules governing the use of payment arrangements by community-based health maintenance organizations which use payment withholding arrangements that place a physician at substantial financial risk. The standards for determining substantial financial risk and determining which payment arrangements are subject to rules shall be the same as provided for health maintenance organizations and competitive medical plans contracting with the Medicare program, as provided in 42 CFR 417.479, or its successor regulation.

2. The department of commerce and insurance may require that community-based health maintenance organizations disclose to the department financial arrangements or contractual provisions that place a physician at substantial financial risk. Such financial arrangements and contractual provisions which constitute substantial financial risk for the physician shall be reviewed by the department and shall be deemed approved if not disapproved by the director of the department within thirty days from the date that they are filed with the department.

3. The department of commerce and insurance shall promulgate rules governing the confidentiality of proprietary information disclosed to the department pursuant to this section. Proprietary information disclosed pursuant to this section shall not be construed to be a public record as defined in chapter 610.

(L. 1997 H.B. 335 § 6)

---------- 354.560 8/28/1997 ----------

354.562. Grievance procedures, rulemaking authority. — The director of the department of commerce and insurance shall promulgate rules governing grievance procedures for enrollees of a community-based health maintenance organization. Such

regulations shall be consistent with and not less or more stringent than federal regulations governing grievance procedures promulgated by the Health Care Financing Administration of the United States Department of Health and Human Services for Medicare enrollees in managed care plans.

(L. 1997 H.B. 335 § 7)

---------- 354.562 8/28/1997 ----------

354.563. Medicare rules to apply to community-based health maintenance organizations, when. — If the Health Care Financing Administration of the United States Department of Health and Human Services promulgates regulations governing the practice of utilization review in health maintenance organizations serving enrollees in the Medicare program, the director of the department of commerce and insurance may issue rules to apply those standards to community-based health maintenance organizations as defined in subdivision (3) of section 354.400.

(L. 1997 H.B. 335 § 8)

---------- 354.563 8/28/1997 ----------

354.565. Community-based health maintenance organization designation given, when — revocation. — The director of the department of commerce and insurance shall designate those health maintenance organizations which meet the criteria established in subdivision (3) of section 354.400 as community-based health maintenance organizations. After a community-based health maintenance organization has been so designated for two years, the director may revoke such designation at any time thereafter upon finding that the health maintenance organization has ceased to meet the established criteria for community-based health maintenance organizations.

(L. 1997 H.B. 335 § 9)

---------- 354.565 8/28/1997 ----------

354.567. Community-based health maintenance organizations subject to other laws regarding health maintenance organizations. — Community-based health maintenance organizations shall be subject to the same provisions of law as other health maintenance organizations to the extent they are not inconsistent with the provisions of sections 354.552 to 354.567.

(L. 1997 H.B. 335 § 10)

---------- 354.567 8/28/1997 ----------

354.570. Rulemaking — procedure. — No rule or portion of a rule promulgated pursuant to sections 192.068, 354.603, 376.423, 376.1353, 376.1356, 376.1378, 376.1387, *

354.560, 354.562 and 354.563 shall become effective unless it has been promulgated in accordance with the provisions of chapter 536.

(L. 1997 H.B. 335 § 14)

*Section number "376.1390" appears in original rolls, but was not enacted by H.B. 335, 1997.

---------- 354.570 8/28/1997 ----------

354.600. Definitions. — For purposes of sections 354.600 to 354.636 the following terms shall mean:

(1) "**Facility**", an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing facilities, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings;

(2) "**Health benefit plan**", a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services;

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

(4) "**Health care provider**" or "**provider**", a health care professional or a facility;

(5) "**Health carrier**", a health maintenance organization established pursuant to sections 354.400 to 354.636;

(6) "**Health indemnity plan**", a health benefit plan that is not a managed care plan;

(7) "**Intermediary**", a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network;

(8) "**Managed care plan**", a health benefit plan that either requires an enrollee to use, or creates incentives, including financial incentives, for an enrollee to use health care providers managed, owned, under contract with or employed by the health carrier;

(9) "**Network**", the group of participating providers providing services to a managed care plan;

(10) "**Participating provider**", a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than coinsurance, co-payments or deductibles, directly or indirectly from the health carrier;

(11) "**Primary care professional**" or "**primary care provider**", a participating health care professional designated by the health carrier to supervise, coordinate or provide initial care or continuing care to an enrollee, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the enrollee.

(L. 1997 H.B. 335, A.L. 2007 S.B. 66)

354.603. Sufficiency of health carrier network, requirements, criteria — access plan filed with the department, when. — 1. A health carrier shall maintain a network that is sufficient in number and types of providers to assure that all services to enrollees shall be accessible without unreasonable delay. In the case of emergency services, enrollees shall have access twenty-four hours per day, seven days per week. The health carrier's medical director shall be responsible for the sufficiency and supervision of the health carrier's network. Sufficiency shall be determined by the director in accordance with the requirements of this section and by reference to any reasonable criteria, including but not limited to provider-enrollee ratios by specialty, primary care provider-enrollee ratios, geographic accessibility, reasonable distance accessibility criteria for pharmacy and other services, waiting times for appointments with participating providers, hours of operation, and the volume of technological and specialty services available to serve the needs of enrollees requiring technologically advanced or specialty care.

(1) In any case where the health carrier has an insufficient number or type of participating providers to provide a covered benefit, the health carrier shall ensure that the enrollee obtains the covered benefit at no greater cost than if the benefit was obtained from a participating provider, or shall make other arrangements acceptable to the director.

(2) The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers, including local pharmacists, to the business or personal residence of enrollees. In determining whether a health carrier has complied with this provision, the director shall give due consideration to the relative availability of health care providers in the service area under, especially rural areas, consideration.

(3) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, and legal authority of its providers to furnish all contracted benefits to enrollees. The provisions of this subdivision shall not be construed to require any health care provider to submit copies of such health care provider's income tax returns to a health carrier. A health carrier may require a health care provider to obtain audited financial statements if

such health care provider received ten percent or more of the total medical expenditures made by the health carrier.

(4) A health carrier shall make its entire network available to all enrollees unless a contract holder has agreed in writing to a different or reduced network.

2. A health carrier shall file with the director, in a manner and form defined by rule of the department of commerce and insurance, an access plan meeting the requirements of sections 354.600 to 354.636 for each of the managed care plans that the health carrier offers in this state. The health carrier may request the director to deem sections of the access plan as proprietary or competitive information that shall not be made public. For the purposes of this section, information is proprietary or competitive if revealing the information will cause the health carrier's competitors to obtain valuable business information. The health carrier shall provide such plans, absent any information deemed by the director to be proprietary, to any interested party upon request. The health carrier shall prepare an access plan prior to offering a new managed care plan, and shall update an existing access plan whenever it makes any change as defined by the director to an existing managed care plan. The director shall approve or disapprove the access plan, or any subsequent alterations to the access plan, within sixty days of filing. The access plan shall describe or contain at a minimum the following:

(1) The health carrier's network;

(2) The health carrier's procedures for making referrals within and outside its network;

(3) The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of enrollees of the managed care plan;

(4) The health carrier's methods for assessing the health care needs of enrollees and their satisfaction with services;

(5) The health carrier's method of informing enrollees of the plan's services and features, including but not limited to the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;

(6) The health carrier's system for ensuring the coordination and continuity of care for enrollees referred to specialty physicians, for enrollees using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(7) The health carrier's process for enabling enrollees to change primary care professionals;

(8) The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, in the event of a reduction in service area or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how enrollees shall be notified of the contract termination, reduction in service area or the health carrier's insolvency or other modification or cessation of operations, and transferred to other health care professionals in a timely manner; and

(9) Any other information required by the director to determine compliance with the provisions of sections 354.600 to 354.636.

3. In reviewing an access plan filed pursuant to subsection 2 of this section, the director shall deem a managed care plan's network to be adequate if it meets one or more of the following criteria:

(1) The managed care plan is a Medicare + Choice coordinated care plan offered by the health carrier pursuant to a contract with the federal Centers for Medicare and Medicaid Services;

(2) The managed care plan is being offered by a health carrier that has been accredited by the National Committee for Quality Assurance at a level of accredited or better, and such accreditation is in effect at the time the access plan is filed;

(3) The managed care plan's network has been accredited by the Joint Commission on the Accreditation of Health Organizations for Network Adequacy, and such accreditation is in effect at the time the access plan is filed. If the accreditation applies to only a portion of the managed care plan's network, only the accredited portion will be deemed adequate;

(4) The managed care plan is being offered by a health carrier that has been accredited by the Utilization Review Accreditation Commission at a level of accredited or better, and such accreditation is in effect at the time the access plan is filed; or

(5) The managed care plan is being offered by a health carrier that has been accredited by the Accreditation Association for Ambulatory Health Care, and such accreditation is in effect at the time the access plan is filed.

(L. 1997 H.B. 335, A.L. 2001 H.B. 328 & 88, A.L. 2003 H.B. 121, A.L. 2018 S.B. 982)

354.606. Providers notified of specific covered services, when — hold harmless provision — cessation of operations procedure — selection standards for health care professionals, filing with the department. — 1. A health carrier shall establish a mechanism by which the participating provider shall be notified on an ongoing basis of

the specific covered health services for which the provider shall be responsible, including any limitations or conditions on services.

2. Every contract between a health carrier and a participating provider shall set forth a hold harmless provision specifying protection for enrollees. This requirement shall be met by including a provision substantially similar to the following:

"Provider agrees that in no event, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an enrollee or a person, other than the health carrier or intermediary, acting on behalf of the enrollee for services provided pursuant to this agreement. This agreement shall not prohibit the provider from collecting coinsurance, deductibles or co-payments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to enrollees. This agreement shall not prohibit a provider, except for a health care professional who is employed full time on the staff of a health carrier and has agreed to provide service exclusively to that health carrier's enrollees and no others, and an enrollee from agreeing to continue services solely at the expense of the enrollee, as long as the provider has clearly informed the enrollee that the health carrier may not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy; including, but not limited to, collecting from any insurance carrier providing coverage to a covered person."

3. Every contract between a health carrier and a participating provider shall set forth that in the event of a health carrier's or intermediary's insolvency or other cessation of operations, covered services to enrollees shall continue through the period for which a premium has been paid to the health carrier on behalf of the enrollee or until the enrollee's discharge from an inpatient facility, whichever time is greater.

4. The contract provisions satisfying the requirements of subsections 2 and 3 of this section shall:

(1) Be construed in favor of the enrollee;

(2) Survive the termination of the contract regardless of the reason for termination, including the insolvency of the health carrier; and

(3) Supersede any oral or written contrary agreement between a provider and an enrollee or the representative of an enrollee if the contrary agreement is inconsistent with

the hold harmless and continuation of covered services provisions required by subsections 2 and 3 of this section.

5. In no event shall a participating provider collect or attempt to collect from an enrollee any money owed to the provider by the health carrier nor shall a participating provider collect or attempt to collect from an enrollee any money in excess of the coinsurance, co-payments or deductibles. Failure of a health carrier to make timely payment of an amount owed to a provider in accordance with the provider's contract shall constitute an unfair claims settlement practice subject to sections 375.1000 to 375.1018.

6. (1) A health carrier shall develop selection standards for participating primary care professionals and each participating health care professional specialty. Such standards shall be in writing and used in determining the selection of health care professionals by the health carrier, its intermediaries and any provider networks with which it contracts. Selection criteria shall not be established in a manner that will:

(a) Allow a health carrier to avoid a high-risk population by excluding a provider because such provider is located in a geographic area that contains a population presenting a risk of higher than average claims, losses or health services utilization; or

(b) Exclude a provider because such provider treats or specializes in treating a population presenting a risk of higher than average claims, losses or health services utilization.

(2) Paragraphs (a) and (b) of subdivision (1) of this subsection shall not be construed to prohibit a health carrier from declining to select a provider who fails to meet the other legitimate selection criteria of the health carrier developed in compliance with sections 354.600 to 354.636.

(3) The provisions of sections 354.600 to 354.636 shall not require a health carrier, its intermediaries or the provider networks with which it contracts, to employ specific providers or types of providers, or to contract with or retain more providers or types of providers than are necessary to maintain an adequate network.

7. A health carrier shall file its selection standards for participating providers with the director. A health carrier shall also file any subsequent changes to its selection standards with the director. The selection standards shall be made available to licensed health care providers.

8. A health carrier shall notify a participating provider of the provider's responsibilities with respect to the health carrier's applicable administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data

reporting requirements, confidentiality requirements and any applicable federal or state programs.

9. No contract between a health carrier and a provider for the delivery of health care service, entered into or renewed after August 28, 2001, shall require the mandatory use of a hospitalist. For purposes of this subsection, "**hospitalist**" means a physician who becomes a physician of record at a hospital for a patient of a participating provider and who may return the care of the patient to that participating provider at the end of hospitalization.

10. A health carrier shall not offer an inducement under the managed care plan to a provider to provide less than medically necessary services to an enrollee.

11. A health carrier shall not prohibit a participating provider from advocating in good faith on behalf of enrollees within the utilization review or grievance processes established by the health carrier or a person contracting with the health carrier.

12. A health carrier shall require a provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care but shall not disclose individual identities, or investigating the grievances or complaints of enrollees, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records.

13. The rights and responsibilities of a provider under a contract between a health carrier and a participating provider shall not be assigned or delegated by the provider without the prior written consent of the health carrier.

14. A health carrier shall be responsible for ensuring that a participating provider furnishes covered benefits to all enrollees without regard to the enrollee's enrollment in the plan as a private purchaser of the plan or as a participant in a publicly financed program of health care service.

15. A health carrier shall notify the participating providers of their obligations, if any, to collect applicable coinsurance, co-payments or deductibles from enrollees pursuant to the evidence of coverage, or of the providers' obligations, if any, to notify enrollees of their personal financial obligations for noncovered services.

16. A health carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that may jeopardize patient health or welfare.

17. A health carrier shall establish a mechanism by which a participating provider may determine in a timely manner whether a person is covered by the carrier.

18. A health carrier shall not discriminate between health care professionals when selecting such professionals for enrollment in the network or when referring enrollees for health care services to be provided by such health care professional who is acting within the scope of his professional license.

19. A health carrier shall establish procedures for resolution of administrative, payment or other disputes between providers and the health carrier.

20. A contract between a health carrier and a provider shall not contain definitions or other provisions that conflict with the definitions or provisions contained in the managed care plan or sections 354.600 to 354.636.

(L. 1997 H.B. 335, A.L. 2001 H.B. 328 & 88)

---------- 354.606 8/28/2001 ----------

354.609. Termination of a contract, procedure. — 1. A health carrier and a participating provider shall provide at least sixty days written notice to each other before terminating the contract without cause. The written notice shall include an explanation of why the contract is being terminated. The health carrier shall provide written notice within thirty working days of receipt or issuance of a notice of termination to all enrollees who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for or without cause. Where a contract termination involves a primary care professional, all enrollees who are patients of such professional shall be notified. Within fifteen working days of the date that the provider either gives or receives notice of termination, the provider shall supply the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier.

2. (1) A health carrier shall not terminate a contract with a health care professional unless the health carrier provides to the health care professional a written explanation of the reasons for the proposed contract termination and an opportunity for a review or hearing as hereinafter provided. This subsection shall not apply in cases involving imminent harm to patients, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency.

(2) The notice of the proposed contract termination provided by the health carrier to the health care professional shall include:

(a) The reasons for the proposed action;

(b) Notice that the health care professional has the right to request a hearing or review, at the professional's discretion, before a panel appointed by the health carrier;

(c) A time limit of not less than thirty days within which a health care professional may request a hearing; and

(d) A time limit for a hearing date which shall be held within thirty days after the date of receipt of a request for a hearing.

(3) The hearing panel shall be comprised of at least three persons appointed by the health carrier. At least one person on such panel shall be a clinical peer in the same discipline and the same or similar specialty as the health care professional under review. The hearing panel may consist of more than three persons, provided however that the number of clinical peers on such panel shall constitute one-third or more of the total membership of the panel.

(4) The hearing panel shall render a decision on the proposed action within fifteen days after a hearing. Such decision shall include reinstatement of the health care professional by the health carrier, provisional reinstatement subject to conditions set forth by the health carrier or termination of the health care professional. Such decision shall be provided in writing to the health care professional.

(5) A decision by the hearing panel to terminate a health care professional shall be effective not less than thirty days after the receipt by the health care professional of the hearing panel's decision.

(6) In no event shall termination be effective earlier than sixty days from the receipt of the notice of termination.

3. Either party to a contract may exercise a right of nonrenewal at the expiration of the contract period set forth therein or upon sixty days' notice to the other party; provided, however, that any nonrenewal shall not constitute a termination for purposes of this section.

4. A health carrier shall develop and implement policies and procedures to ensure that a health care professional is regularly informed of information maintained by the health carrier to evaluate the performance or practice of the health care professional. The health carrier shall consult with health care professionals in developing methodologies to collect and analyze health care professional profiling data. The health carrier shall provide any such information and profiling data and analysis to the health care professionals. Such information, data or analysis shall be provided on a periodic basis appropriate to the nature and amount of data and the volume and scope of services provided. Any profiling data used to evaluate the performance or practice of a health care professional shall be measured against stated criteria and an appropriate group of health care professionals using similar treatment modalities serving a comparable patient population. Upon presentation of such information or data, each health care professional shall be given the opportunity to discuss the unique nature of the health care professional's patient

population which may have a bearing on the health care professional's profile and to work cooperatively with the health carrier to improve performance.

5. No health carrier shall terminate a contract or employment solely or in part because a health care provider in good faith:

(1) Advocates on behalf of an enrollee;

(2) Files a complaint against the health carrier;

(3) Appeals a decision of the health carrier;

(4) Provides information or files a report with the department of commerce and insurance; or

(5) Requests a hearing or review pursuant to this section.

6. A health carrier shall give a provider at least thirty days to review a managed care contract.

(L. 1997 H.B. 335)

---------- 354.609 8/28/1997 ----------

354.612. Continuation of care after provider termination, when. — 1. Contracts between health plans and providers shall include a provision for the continuation of care to enrollees for a period of up to ninety days by a provider who terminates or is terminated from a network where the continuation of care is medically necessary and in accordance with the dictates of medical prudence, including circumstances such as disability, pregnancy, or life-threatening illness.

2. Such provision for the continuation of care shall guarantee that the enrollee shall not be liable to the provider for any amounts owed for medical care other than deductibles or co-payment amounts specified in the certificate of coverage or other contract between the enrollee and the health plan.

3. In the event the terminated provider is authorized to continue treating the enrollee pursuant to this section, the health plan shall have an obligation to pay the terminated provider at the previously contracted rate for services provided to the enrollee.

(L. 1997 H.B. 335)

---------- 354.612 8/28/1997 ----------

354.615. Referrals to appropriate providers, when. — 1. If a health carrier determines that it does not have a health care provider with appropriate training and experience in its panel or network to meet the particular health care needs of an enrollee, the health carrier shall make a referral to an appropriate provider, pursuant to a treatment plan approved

by the health carrier in consultation with the primary care provider, the nonparticipating provider and the enrollee or enrollee's designee, at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received within the network.

2. A health carrier shall have a procedure by which an enrollee who needs ongoing care from a specialist may receive a standing referral to such specialist. If the health carrier, or the primary care provider in consultation with the medical director of the health carrier and an appropriate specialist, determines that such a standing referral is warranted, the carrier shall make such a referral to a specialist. In no event shall a health carrier be required to permit an enrollee to elect to have a nonparticipating specialist, except pursuant to the provisions of subsection 1 of this section. Such referral shall be pursuant to a treatment plan approved by the health carrier in consultation with the primary care provider, the specialist, and the enrollee or the enrollee's designee. Such treatment plan may limit the number of visits or the period during which such visits are authorized and may require the specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all necessary medical information.

3. A health carrier shall have a procedure by which a new enrollee upon enrollment, or an enrollee upon diagnosis, with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may receive a referral to a specialist with expertise in treating the life-threatening or degenerative and disabling disease or condition who shall be responsible for and capable of providing and coordinating the enrollee's primary and specialty care. If the health carrier, or primary care provider in consultation with a medical director of the health carrier and an appropriate specialist, determines that the enrollee's care would most appropriately be coordinated by such a specialist, the health carrier shall refer the enrollee to such specialist. In no event shall a health carrier be required to permit an enrollee to elect to have a nonparticipating specialist, except pursuant to the provisions of subsection 1 of this section. Such referral shall be pursuant to a treatment plan approved by the health carrier, in consultation with the primary care provider if appropriate, the specialist, and the enrollee or the enrollee's designee. Such specialist shall be permitted to treat the enrollee without a referral from the enrollee's primary care provider and may authorize such referrals, procedures, tests and other medical services as the enrollee's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan. If a health carrier refers an enrollee to a nonparticipating provider, services provided pursuant to the approved treatment plan shall be provided at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received within the network.

4. A health carrier shall have a procedure by which an enrollee with a life-threatening condition or disease, or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may receive a referral to a specialty care center with expertise in treating the life-threatening or degenerative and disabling disease or condition. If the health carrier, or the primary care provider or a specialist designated pursuant to this section, in consultation with a medical director of the health carrier, determines that the enrollee's care would most appropriately be provided by such a specialty care center, the health carrier shall refer the enrollee to such center. In no event shall a health carrier be required to permit an enrollee to elect to have a nonparticipating specialty care center, unless the health carrier does not have an appropriate specialty care center to treat the enrollee's disease or condition within its network. Such referral shall be pursuant to a treatment plan developed by the specialty care center and approved by the health carrier, in consultation with the primary care provider, if any, or a specialist designated pursuant to subsection 3 of this section, and the enrollee or the enrollee's designee. If a health carrier refers an enrollee to a specialty care center that does not participate in the health carrier's network, services provided pursuant to the approved treatment plan shall be provided at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received within the network. For purposes of this subsection, a **specialty care center** shall mean only such centers as are accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

(L. 1997 H.B. 335)

---------- 354.615 8/28/1997 ----------

354.618. Open referral health plans offered, when — definitions — obstetrician/gynecologist services to be offered, when — eye care providers, discrimination against, prohibited — exemptions. — 1. A health carrier shall be required to offer as an additional health plan, an open referral health plan whenever it markets a gatekeeper group plan as an exclusive or full replacement health plan offering to a group contract holder:

(1) In the case of group health plans offered to employers of fifty or fewer employees, the decision to accept or reject the additional open referral plan offering shall be made by the group contract holder. For health plans marketed to employers of over fifty employees, the decision to accept or reject shall be made by the employee;

(2) Contracts currently in existence shall offer the additional open referral health plan at the next annual renewal after August 28, 1997; however, multiyear group contracts

need not comply until the expiration of their current multiyear term unless the group contract holder elects to comply before that time;

(3) If an employer provides more than one health plan to its employees and at least one is an open referral plan, then all health benefit plans offered by such employer shall be exempt from the requirements of this section.

2. For the purposes of this act, the following terms shall mean:

(1) "**Open referral plan**", a plan in which the enrollee is allowed to obtain treatment for covered benefits without a referral from a primary care physician from any person licensed to provide such treatment;

(2) "**Gatekeeper group plan**", a plan in which the enrollee is required to obtain a referral from a primary care professional in order to access specialty care.

3. Any health benefit plan provided pursuant to the Medicaid program shall be exempt from the requirements of this section.

4. A health carrier shall have a procedure by which a female enrollee may seek the health care services of an obstetrician/gynecologist at least once a year without first obtaining prior approval from the enrollee's primary care provider if the benefits are covered under the enrollee's health benefit plan, and the obstetrician/gynecologist is a member of the health carrier's network. In no event shall a health carrier be required to permit an enrollee to have health care services delivered by a nonparticipating obstetrician/gynecologist. An obstetrician/gynecologist who delivers health care services directly to an enrollee shall report such visit and health care services provided to the enrollee's primary care provider. A health carrier may require an enrollee to obtain a referral from the primary care physician, if such enrollee requires more than one annual visit with an obstetrician/gynecologist.

5. Except for good cause, a health carrier shall be prohibited either directly, or indirectly through intermediaries, from discriminating between eye care providers when selecting among providers of health services for enrollment in the network and when referring enrollees for health services provided within the scope of those professional licenses and when reimbursing amounts for covered services among persons duly licensed to provide such services. For the purposes of this section, an eye care provider may be either an optometrist licensed pursuant to chapter 336 or a physician who specializes in opthamologic medicine, licensed pursuant to chapter 334.

6. Nothing contained in this section shall be construed as to require a health carrier to pay for health care services not provided for in the terms of a health benefit plan.

7. Any health carrier, which is sponsored by a federally qualified health center and is presently in existence and which has been in existence for less than three years shall be

exempt from this section for a period not to exceed two years from August 28, 1997.

8. A health carrier shall not be required to offer the direct access rider for a group contract holder's health benefit plan if the health benefit plan is being provided pursuant to the terms of a collective bargaining agreement with a labor union, in accordance with federal law and the labor union has declined such option on behalf of its members.

9. Nothing in this act shall be construed to preempt the employer's right to select the health care provider pursuant to section 287.140 in a case where an employee incurs a work-related injury covered by the provisions of chapter 287.

10. Nothing contained in this act shall apply to certified managed care organizations while providing medical treatment to injured employees entitled to receive health benefits under chapter 287 pursuant to contractual arrangements with employers, or their insurers, under section 287.135.

(L. 1997 H.B. 335, A.L. 1999 H.B. 343)

---------- 354.618 8/28/1999 ----------

354.621. Intermediary and participating provider requirements. — 1. Intermediaries and participating providers with whom they contract shall comply with all the applicable requirements of sections 354.600 to 354.636.

2. A health carrier's statutory responsibility to monitor the offering of covered benefits to enrollees shall not be delegated or assigned to the intermediary.

3. If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to the health carrier. The carrier shall monitor the timeliness and appropriateness of payments made to providers and health care services received by enrollees.

4. If applicable, an intermediary shall maintain the books, records, financial information and documentation of services provided to enrollees at its principal place of business in the state and preserve them for five years in a manner that facilitates regulatory review.

5. An intermediary shall allow a health carrier or the director access to the intermediary's books, records, financial information and any documentation of services provided to enrollees, as necessary to determine compliance with sections 354.600 to 354.636.

6. A health carrier shall have the right, in the event of the intermediary's insolvency, to require the assignment to the health carrier of the provisions of a provider's contract addressing the provider's obligation to furnish covered services.

(L. 1997 H.B. 335)

---------- 354.621 8/28/1997 ----------

354.624. Proposed provider contract forms filed with the director — contracts maintained at place of business, available for review, when. — 1. A health carrier shall file with the director all contract forms proposed for use with its participating providers and intermediaries. The forms shall not contain any information on compensation terms, rates or other payments by the carrier to participating providers or intermediaries and shall contain information on any term involving risk-sharing arrangements between the parties.

2. The health carrier shall maintain provider and intermediary contracts at its principal place of business in the state, or the health carrier shall have access to all contracts and provide copies to facilitate regulatory review upon twenty days' prior written notice from the director or at the time of any examination.

(L. 1997 H.B. 335)

---------- 354.624 8/28/1997 ----------

354.627. Liability of a health carrier, when. — 1. The executing of a contract by a health carrier shall not relieve the health carrier of its liability to any person with whom it has contracted for the provision of services, or of its responsibility for compliance with the law or applicable regulations.

2. All contracts shall be in writing and may be subject to review by the department of commerce and insurance.

3. All contracts shall comply with applicable requirements of the law and applicable regulations.

(L. 1997 H.B. 335)

---------- 354.627 8/28/1997 ----------

354.636. Contract requirements after January 1, 1998. — All provider and intermediary contracts delivered, issued for delivery, continued or renewed on or after January 1, 1998, shall comply with sections 354.600 to 354.636 unless otherwise provided by sections 354.600 to 354.636.

(L. 1997 H.B. 335)

---------- 354.636 8/28/1997 ----------

354.650. Definitions. — As used in sections 354.650 to 354.658, the following terms mean:

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

(2) "**Essential community provider**", an individual physician, licensed pursuant to the provisions of chapter 334, who meets the requirements set forth in section 354.652;

(3) "**Health care insurer**", any health maintenance organization licensed in the state of Missouri;

(4) "**Health professional shortage area**", an area designated by the Secretary of Health and Human Services as such pursuant to the guidelines established in Section 332(a)(1)(A) of the Public Service Act;

(5) "**Medically underserved area**", an area designated by the Secretary of Health and Human Services as such pursuant to the guidelines established in Section 42 U.S.C. 254c(b)(3);

(6) "**Medically underserved population**", eligible persons designated by the Secretary of Health and Human Services as such pursuant to the guidelines established in 42 U.S.C. 254c(b)(3);

(7) "**National committee for quality assurance**", a private not-for-profit organization created to promote improvements in the quality of patient care provided through managed care plans. The committee's primary function is to develop and provide oversight processes, performance measurement and accreditation for health plans, and to provide information on quality to the public, consumers, purchasers, health plans and other relevant parties;

(8) "**Principal site**", the private office of a primary care or specialist physician located within a medically underserved area or health professional shortage area in which initial patient care appointments, routine patient care examinations, routine patient treatments and patient care follow-up occur. The term "principal site" shall not include hospitals, laboratories, nursing homes, hospice centers, surgical centers and federally funded clinics.

(L. 1998 H.B. 1302 § 1)

---------- 354.650 8/28/1998 ----------

354.652. Designation as essential community provider, procedure, qualifications. — Any physician seeking a designation as an essential community provider shall:

(1) Apply to the director of the department;

(2) Document to the department that at least forty percent of the physician's practice is comprised of:

(a) Medicaid or uninsured patients, or both; or

(b) A combination of paragraph (a) and Medicare or underinsured patients, or both;

(3) Serve a medically underserved area or a health professional shortage area;

(4) Serve a medically underserved population;

(5) Spend at least twenty hours per week at a principal site;

(6) Be available to a medically underserved population on evenings and weekends at a principal site;

(7) Hold hospital staff privileges with a participating network hospital of the health care insurer;

(8) Not be a direct employee of a health care insurer, a for-profit or a not-for-profit hospital or health services corporation; and

(9) Meet the following quality standards in accordance with guidelines established by the National Committee for Quality Assurance:

(a) A current valid license to practice;

(b) Clinical privileges in good standing at the hospital designated by the physician as the primary admitting facility;

(c) A valid Drug Enforcement Agency or Controlled Dangerous Substances certificate, if applicable;

(d) Graduation from medical school, and completion of a residency or board certification if applicable;

(e) Work history;

(f) Current adequate malpractice insurance according to the managed care organization's policy; and

(g) Professional liability claims history.

(L. 1998 H.B. 1302 § 2)

---------- 354.652 8/28/1998 ----------

354.654. Department of health and senior services, duties — rulemaking authority. — 1. The department of health and senior services shall issue a letter of designation as an essential community provider to any physician who makes a written request and application to the department if such physician meets the qualifications of an essential community provider pursuant to the provisions of section 354.652.

2. The department shall keep the names and addresses of all essential community providers on record and shall release such information upon request.

3. The department shall promulgate rules and regulations for the administration of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is promulgated under the authority of this section, shall become effective only if the agency has fully complied with all of the requirements of chapter 536 including but not limited to, section 536.028, if applicable, after August 28, 1998. All rulemaking authority delegated prior to August 28, 1998, is of no force and effect and repealed as of August 28, 1998, however nothing in this act* shall be interpreted to repeal or affect the validity of any rule adopted and promulgated prior to August 28, 1998. If the provisions of section 536.028 apply, the provisions of this section are nonseverable and if any of the powers vested with the general assembly pursuant to section 536.028 to review, to delay the effective date, or to disapprove and annul a rule or portion of a rule are held unconstitutional or invalid, the purported grant of rulemaking authority and any rule so proposed and contained in the order of rulemaking shall be invalid and void, except that nothing in this act* shall affect the validity of any rule adopted and promulgated prior to August 28, 1998.

(L. 1998 H.B. 1302 § 3)

*"This act" (H.B. 1302, 1998) contained numerous sections. Consult Disposition of Sections table for a definitive listing.

---------- 354.654 8/28/1998 ----------

354.656. Inclusion of essential community providers in health care network, exceptions. — 1. Any health care insurer offering or marketing a group policy, plan or contract for health care services in an area designated pursuant to subdivision (4) or (5) of section 354.650 shall allow each essential community provider in such designated area to submit an application to such health care insurer and provide a copy of the letter of designation as provided in section 354.654. No health care insurer shall be required to offer a provider contract to an essential community provider. The department of health and senior services shall receive any application submitted and certify, if qualified; except that the department shall only issue the first one thousand certificates for application to health maintenance organizations.

2. The name of each essential community provider shall appear in publications distributed to consumers or enrollees of the policy, plan or contract of all network model managed care plans if the essential community provider is a participating primary care physician.

3. Nothing in this section shall be construed to limit the ability of a health care insurer to terminate the contract of any physician for cause.

4. The requirements of this section shall not apply to a health care insurer that is a medical group/staff model health maintenance organization that provides services to its enrollees through facilities that are owned or operated by the health maintenance organization.

(L. 1998 H.B. 1302 § 4)

---------- 354.656 8/28/1998 ----------

354.658. Designation nontransferable, site specific — annual affidavit required — notice of certain changes, required when. — 1. The designation of essential community provider shall not be transferable to another physician, health care provider or entity.

2. The designation of essential community provider shall be physician and site specific and shall not be effective at a site that has not been so designated pursuant to subdivision (8) of section 354.650.

3. The essential community provider shall submit an annual affidavit to the department stating that such community provider continues to meet the qualifications for which the provider was certified. The essential community provider shall notify the department of health and senior services within thirty days of any changes which may affect the certification requirements of the essential community provider.

(L. 1998 H.B. 1302 § 5)

---------- 354.658 8/28/1998 ----------

354.700. Definitions. — As used in sections 354.700 to 354.723, the following terms mean:

(1) "**Dental care services**", services included in the practice of dentistry as defined in section 332.071;

(2) "**Director**", the director of the department of commerce and insurance;

(3) "**Enrollee**", an individual who is enrolled in a prepaid dental plan as a principal subscriber together with such individual's dependents who are entitled to dental care benefits under the plan solely because of their status as dependents of the principal subscriber;

(4) "**Prepaid dental plan**", any contractual arrangement to provide, either directly or through arrangement with others, specified dental benefits to enrollees on a fixed prepayment basis or as a benefit of such enrollees' participation or membership in any other contract, agreement, or group or any corporation, partnership or other entity which undertakes to provide or arrange specified dental benefits on a prepayment or other basis or to indemnify for specified dental benefits;

(5) "**Prepaid dental plan corporation**", a corporation operating a prepaid dental plan;

(6) "**Provider**", any person licensed as a dentist pursuant to chapter 332.

(L. 1987 S.B. 272 § 1, A.L. 1992 S.B. 698)

---------- 354.700 8/28/1992 ----------

354.702. Prepaid dental plans, who may offer — certificate of authority required — certain state laws not to apply. — 1. A prepaid dental plan may not be established or operated in this state, nor may membership be solicited in such a plan unless the plan is offered by a prepaid dental plan corporation licensed under sections 354.700 to 354.723. The provisions of sections 354.700 to 354.723 shall not apply to an insurance company, or health services corporation or health maintenance organization licensed to do business pursuant to the laws of the state of Missouri.

2. By January 1, 1988, any person or other legal entity that is operating a prepaid dental plan in this state must submit an application for a certificate of authority to the director. Each such applicant may continue to operate until the director acts upon the application.

3. A prepaid dental plan corporation shall not be subject to the laws of this state relating to insurance or insurance companies except as herein provided.

(L. 1987 S.B. 272 § 2)

---------- 354.702 8/28/1987 ----------

354.703. Director may order violators to cease and desist, hearing — noncompliance, director's remedies. — 1. The director of the department of commerce and insurance may issue an order directing any person or entity to cease and desist from engaging in any act or practice in violation of sections 354.700 to 354.723. Within twenty days after service of the order to cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of sections 354.700 to 354.723, have occurred. Such hearing shall be conducted, and judicial review shall be available, as provided in chapter 536.

2. In the case of noncompliance with a cease and desist order issued pursuant to subsection 1 of this section, the director may institute a proceeding to obtain injunctive or other appropriate relief in the circuit court.

(L. 1989 S.B. 333)

---------- 354.703 8/28/1989 ----------

354.704. Application for certificate of authority, content. — An application for a certificate of authority to operate a prepaid dental plan corporation in this state shall be filed with the director on a form prescribed by the director. Such application shall be verified by an officer or authorized representative of the applicant and shall set forth, or be accompanied by, the following:

(1) A duly certified copy of the corporation's articles of incorporation or articles of association with all amendments;

(2) A copy of the corporation's bylaws or regulations governing the conduct of the internal affairs of the corporation;

(3) A list of the names, addresses, and official positions of the persons who are responsible for the conduct of the affairs of the corporation, including all members of the board of directors;

(4) A copy of any contract made or to be made between any providers and the applicant;

(5) A statement generally describing the prepaid dental plan to be offered and the corporation's facilities and personnel;

(6) A copy of contracts and contract certificates to be issued to the enrollees;

(7) A copy of any group enrollee contract which is to be issued;

(8) Financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent regular certified financial statement shall satisfy this requirement unless the director determines that additional or more recent financial information is required;

(9) A description of the proposed method of marketing the prepaid dental plan, a financial plan which includes a three-year projection of the initial operating results anticipated, and a statement as to the sources of funding;

(10) A description of the procedures to provide emergency dental benefits;

(11) A statement reasonably describing the geographic area to be served;

(12) A fee of two hundred dollars for issuance of a certificate of authority; and

(13) Such other information as the director may require.

(L. 1987 S.B. 272 § 3)

354.705. Certificate of authority granted, when. — 1. Issuance of a certificate of authority shall be granted by the director if the director is satisfied that the following conditions are met:

(1) The financial requirements of sections 354.700 to 354.723 have been fulfilled;

(2) The prepaid dental plan corporation is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees;

(3) The persons responsible for conducting the affairs of the prepaid dental plan corporation are competent and trustworthy and are professionally capable of providing or arranging for the provision of services offered;

(4) The arrangement with dentists for the provision of prepaid dental care services has been deemed sufficient; and

(5) Each officer responsible for conducting the affairs of the prepaid dental plan corporation has filed with the director, subject to the director's approval, a fidelity bond in the amount of fifty thousand dollars.

2. A certificate of authority shall expire at twelve midnight on June thirtieth next following the date of issuance or renewal. If the prepaid dental plan corporation remains in compliance with sections 354.700 to 354.723 and has paid a renewal fee of fifty dollars, its certificate shall be renewed for a period of time to the next June thirtieth.

(L. 1987 S.B. 272 § 4)

---------- 354.705 8/28/1987 ----------

354.707. Capital, surplus, security required — cash, securities, bond to be deposited or filed with director, director to return deposit, when — security subject to final judgments — security not required for prepaid dental plans funded by government — director may waive capital, surplus, security requirements, when. — 1. No prepaid dental plan corporation may commence or continue to do business with a capital of less than fifty thousand and a surplus of less than fifty thousand dollars.

2. No prepaid dental plan corporation may commence or continue to do business until the company has transferred to and deposited with the director, for the security of its enrollees, cash, securities, or a bond in the amount of the minimum capital of fifty thousand dollars. Such securities or bond shall be of a type approved by the director. The director shall not receive securities at an amount above their par value or above their current market value, whichever is less. If the market value of the securities on deposit falls below the minimum capital amount of fifty thousand dollars, the company shall deposit additional securities to equal the minimum amount.

(1) The cash or securities representing the deposit required by this section shall be deposited with the director who shall give receipts for all securities so deposited with him to the prepaid dental care corporation. The director shall upon the receipt of such securities deposit the same, in the presence of an authorized officer of the depositing corporation, in a safety deposit box accessible only to the director or his representative and an authorized employee of the corporation, or in the vault of any bank, trust company, or safety deposit company in the state of Missouri to be selected by the director, and the depositing corporation shall pay the fees for such boxes. So long as the depositing corporation continues solvent, the director shall permit such corporation to collect and receive the interest and dividends on the securities so deposited, and, from time to time, withdraw any such securities on depositing other acceptable securities in the place of those so withdrawn. If the director willfully fails, refuses, or neglects to faithfully keep, deposit, and account for any such securities received by him, or willfully fails, refuses, or neglects to furnish proper certificate of securities so held by him, the director shall be responsible therefor upon his official bond, and suit may be brought upon such bond by any person damaged by such failure, refusal, or neglect.

(2) An unpaid final judgment arising upon an enrollee contract or contract certificate shall be a lien on the deposit prescribed by this subsection, subject to execution after thirty days from the entry of final judgment. If the deposit is reduced, it shall be replenished within twenty days by the prepaid dental care corporation.

(3) Upon the liquidation or dissolution of a prepaid dental plan corporation and the satisfaction of all its debts and liabilities, any balance remaining of the deposit shall be returned by the director to the prepaid dental plan corporation.

(4) The deposit prescribed by this subsection shall not apply with respect to a prepaid dental plan corporation which is funded by a federal, state, or municipal government or by any political subdivision thereof to the extent and for such period of time that the prepaid dental plan corporation can demonstrate to the director the presence of operational commitments from such sources equivalent to such deposit.

3. The director may waive any of the requirements of subsection 1 or 2, or both, of this section for any prepaid dental plan corporation, if it is shown to his satisfaction that such corporation possesses not less than fifty thousand dollars equity in unencumbered fixed assets.

(L. 1987 S.B. 272 § 5)

354.710. Reserve requirements — reserve not required for prepaid dental plans funded by government — surplus requirement for prepaid dental plans in existence January 1, 1987, additional time. — 1. Every prepaid dental plan organization shall, not later than January 1, 1994, have accumulated reserves in the amount of two percent of its subscription income up to a maximum amount of one hundred fifty thousand dollars. One-third of such reserves shall be accumulated not later than January 1, 1990. Two-thirds of such reserves shall be accumulated not later than January 1, 1992. Such reserves shall constitute restricted surplus on the books of the company and shall be in addition to the deposit requirement of section 354.707. A prepaid dental plan organization shall maintain as a claim or loss reserve in cash or securities, assets sufficient to discharge all liabilities on all uncovered expenses arising under policies issued. Such liabilities on uncovered expenses shall be determined in accordance with generally accepted accounting principles for the actual contractual obligations with providers and shall not be recorded as unearned premium or deferred revenue.

2. The reserve prescribed by subsection 1 of this section shall not apply with respect to a prepaid dental plan corporation which is funded by a federal, state, or municipal government or by any political subdivision thereof and which meets the requirements of subdivision (4) of subsection 2 of section 354.707.

3. Any prepaid dental plan in existence prior to January 1, 1987, will have five years to meet the surplus requirements of subsection 1 of section 354.707. However, at no time shall the liabilities of a prepaid plan exceed its assets.

4. The reserve prescribed by subsection 1 of this section, and the fidelity bond prescribed by section 354.705, shall not be required of any prepaid dental plan operated and offered by any provider prior to August 28, 1987, which primarily serves low-income patients.

(L. 1987 S.B. 272 § 6, A.L. 1990 H.B. 998, A.L. 1992 S.B. 698, A.L. 1997 S.B. 150)

---------- 354.710 8/28/1997 ----------

354.712. Contract or contract certificate to be issued to enrollees, content, copy to be filed with director — newborn child to be covered, when, extent of coverage, notification of birth and additional premium, when, effect of. — 1. Every enrollee in a prepaid dental plan corporation shall be issued a contract setting out the dental care benefits covered by his prepayment or fee. If the enrollee is a beneficiary under a group contract, then the enrollee may alternatively be issued a contract certificate summarizing the dental care benefits covered by the prepayment.

2. Any contract that provides family coverage shall, as to such coverage of individuals in the family, also provide that the benefits applicable for children shall be payable with

respect to a newly born child of the insured from the instant of such child's birth to the same extent that such coverage applies to other individuals in the family. If payment of a specific premium or capitation amount is required to provide coverage for a child, the contract may require notification of birth of a newly born child and payment of the required premium or capitation amount shall be furnished to the corporation within thirty-one days after the date of birth in order to have the coverage continue beyond the thirty-one-day period.

3. No enrollee contract, contract certificate, or contract amendment shall be issued or delivered to any person in this state until a copy of the form has been filed with the director.

4. All enrollee contracts or contract certificates shall clearly set forth:

(1) The prepaid dental care benefits to which the enrollee is entitled;

(2) Any limitations of the benefits to be provided, including any deductible or co-payment feature;

(3) Where and in what manner information is available as to how services may be obtained; and

(4) The enrollee's obligation respecting charges for the prepaid dental plan contract.

5. Enrollee contracts, contract certificates, advertising matter, and sales material shall not contain any provision or statements that are deceptive, ambiguous, or misleading.

6. No enrollee contract, contract certificate, or contract amendments shall be used until such form is approved by the director. If the director does not approve or disapprove any such form within thirty days after its filing, it shall be deemed approved. If the director disapproves a form, the director shall notify the prepaid dental plan corporation in writing and specify the reasons for disapproval. The director shall grant a hearing on such disapproval within fifteen days after a request in writing is received from the prepaid dental plan corporation.

(L. 1987 S.B. 272 § 7)

---------- 354.712 8/28/1987 ----------

354.715. Providers of dental care, written contract with prepaid dental plan corporations, review and mediation procedures for enrollees required. — 1. Any provider of dental health care services who agrees with a prepaid dental plan corporation to provide dental care services to its enrollees shall reduce such agreement to a written contract with the prepaid dental plan corporation.

2. Each prepaid dental plan corporation shall establish procedures for review and mediation of complaints of enrollees concerning the quality of care rendered by a

participating dentist. In lieu of establishing such procedures, the corporation may agree in a written document submitted to the director to utilize the services of a peer review committee of a state, district, or local dental society which has been established for purposes of providing the type of review and mediation required. Enrollees and participating dentists shall be made aware of the review mechanism adopted by the prepaid dental plan corporation and shall be informed as to how to submit a complaint for review.

(L. 1987 S.B. 272 § 8)

---------- 354.715 8/28/1987 ----------

354.717. Director, powers — financial examinations, when, by whom made and paid. — 1. The director, or any person authorized by him, may examine the financial condition and the affairs and management of any prepaid dental plan corporation whenever the director deems necessary.

2. The director, or any of his duly appointed agents, may compel the attendance before him, and may examine, under oath, the directors, officers, agents, employees, solicitors, or any person, in reference to the condition, affairs, management of the business, or any matters relating thereto. The director may administer oaths or affirmations, and shall have power to summon and compel the attendance of witnesses, and to require and compel the production of records, books, papers, contracts, or other documents if necessary.

3. The expense of any examination shall be assessed by the director against the prepaid dental plan corporation examined and the examination assessment shall be paid by the corporation, on the order of the director, directly to the person or persons rendering the service.

4. In lieu of making an examination, the director may accept a full report of the most recent examination of a foreign or alien prepaid dental plan corporation certified by the appropriate examining official of another state, territory, commonwealth or district of the United States.

(L. 1987 S.B. 272 § 9)

---------- 354.717 8/28/1987 ----------

354.720. Annual report, required, content. — 1. Every prepaid dental plan corporation shall file with the director annually, on or before March first, a report verified by at least two principal officers covering the preceding calendar year.

2. Such report shall be on forms prescribed by the director and shall include:

(1) A financial statement of the corporation, including its balance sheet and receipts and disbursements for the preceding year;

(2) Any material changes in the information submitted pursuant to section 354.704;

(3) The number of persons enrolled during the year, the number of enrollees as of the end of the year, and the number of enrollments terminated during the year.

(L. 1987 S.B. 272 § 10)

---------- 354.720 8/28/1987 ----------

354.721. Agents, registration required — rules and regulations authorized. — 1. A prepaid dental plan corporation shall register the names of all persons acting as agents, for the solicitation of contracts, with the director within thirty days after September 28, 1987.

2. The director may, after notice and hearing, promulgate reasonable rules and regulations to provide for the licensing of agents and the termination or revocation of such licenses.

(L. 1987 S.B. 272 § 11)

---------- 354.721 8/28/1987 ----------

354.722. Revocation or suspension of certificate of authority, when — notice, civil suit authorized — suspension, revocation, activity permitted. — 1. The director may suspend or revoke any certificate of authority issued to a prepaid dental plan corporation pursuant to sections 354.700 to 354.723 if he finds that any of the following conditions exist:

(1) The prepaid dental plan corporation is operating substantially in contravention of its basic organizational document or is not fulfilling its contracts;

(2) The prepaid dental plan corporation is no longer financially responsible and may reasonably be expected to be unable to meet its contractual obligations to enrollees, or prospective enrollees;

(3) The prepaid dental plan corporation, or any person on its behalf, has advertised or merchandised its prepaid dental benefits in an untrue, misrepresentative, misleading, deceptive or unfair manner;

(4) The continued operation of the prepaid dental plan corporation would be hazardous to its enrollees; or

(5) The prepaid dental plan corporation has failed to substantially comply with the provisions of sections 354.700 to 354.723 or any rules or regulations promulgated thereunder.

2. If the director determines that a person has engaged, is engaging in, or has taken a substantial step toward engaging in an act, practice or course of business constituting a violation of sections 354.700 to 354.723 or a rule adopted or order issued pursuant thereto or that a person has materially aided or is materially aiding an act, practice, omission, or course of business constituting a violation of sections 354.700 to 354.723 or a rule adopted or order issued pursuant thereto, the director may issue such administrative orders as authorized under section 374.046. A violation of this section is a level two violation under section 374.049. The director may also suspend or revoke the certificate of authority of a corporation for any such willful violation.

3. When the certificate of authority of a prepaid dental plan corporation is suspended, the prepaid dental plan corporation shall not, during the period of such suspension, enroll any additional enrollees except newborn children or other newly acquired dependent of existing enrollees and shall not engage in any advertising or solicitation whatsoever.

4. When the certificate of authority of a prepaid dental plan corporation is revoked, such corporation shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of such corporation. It shall engage in no further advertising or solicitation whatsoever.

(L. 1987 S.B. 272 § 12, A.L. 2007 S.B. 66)

---------- 354.722 8/28/2007 ----------

354.723. Rulemaking authorized. — The director may, after notice and hearing, promulgate such reasonable rules and regulations as are necessary or proper to carry out the provisions of sections 354.700 to 354.723.

(L. 1987 S.B. 272 § 13)

---------- 354.723 8/28/1987 ----------

354.725. Exclusion, labor organization's health plans. — The provisions of sections 354.700 to 354.725 shall not apply to any labor organization's health plan existing on September 28, 1987, providing services on its premises established and maintained primarily for its members and their dependents.

(L. 1987 S.B. 272 § A)

---------- 354.725 8/28/1987 ----------

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