
**Rules of
Department of Insurance
Division 100—Division of Consumer Affairs
Chapter 2—Unfair Trade Practices**

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Title 20—DEPARTMENT OF INSURANCE

Division 100—Division of Consumer Affairs

Chapter 2—Unfair Trade Practices

20 CSR 100-2.100 Unfair Financial Planning Practices

PURPOSE: This rule defines in part false information and advertising under section 375.936(4), RSMo (1986).

(1) No insurance agent or insurance broker licensed by the Missouri Department of Insurance shall—

(A) Represent him/herself, directly or indirectly, to the public as a financial planner, advisor, consultant or counselor in a manner as to imply or offer any services other than—

1. Those authorized by his/her issued insurance licenses;

2. Those authorized by other issued professional licenses; or

3. Those not requiring a license. This provision is not intended to prevent persons who hold a financial planning consultant designation from using this designation when they are only selling insurance;

(B) Represent him/herself as being in the business of financial planning without disclosing to the client that s/he is licensed as an insurance agent or an insurance broker in Missouri; and

(C) Charge a fee or other form of compensation for financial planning when that person is selling insurance unless that person is licensed as an insurance broker and complies with the requirements of section 375.116, RSMo.

Auth: section 374.045, RSMo (1986). This rule was previously filed as 4 CSR 190-10.120. Original rule filed Oct. 16, 1989, effective April 15, 1990.

20 CSR 100-2.200 Unfair Discrimination on the Basis of Blindness, Partial Blindness or Physical or Mental Impairment

PURPOSE: This regulation identifies specific acts or practices which are prohibited by section 375.936, RSMo (1986). It follows the National Association of Insurance Commissioners model regulation dealing with discrimination based on blindness or partial blindness and its model regulation dealing with discrimination based on physical or mental impairment.

(1) Unfairly Discriminatory Acts or Practices Regarding Blindness or Partial Blindness. The following are identified as acts or practices which constitute unfair discrimination between individuals of the same class: refusing to insure, or refusing to continue to insure, or limiting the amount, extent or kind of coverage available to an individual or charging an individual a different rate for the same coverage solely because of blindness or partial blindness.

(A) With respect to all other conditions, including the underlying cause of blindness, persons who are blind or partially blind shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as are sighted persons.

(B) Refusal to insure includes denial by an insurer of disability insurance coverage on the grounds that the policy defines disability as being presumed in the event that the insured loses his/her eyesight. However, an insurer may exclude from coverage disabilities consisting solely of blindness or partial blindness when this condition existed at the time the policy was issued.

(2) Unfairly Discriminatory Acts or Practices Regarding Physical or Mental Impairment. The following are identified as acts or practices in life and health insurance which constitute unfair discrimination between individuals of the same class: refusing to insure, or refusing to continue to insure, or limiting the amount, extent or kind of coverage available to an individual, or charging a different rate for the same coverage solely because of a physical or mental impairment, except where the refusal, limitation or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.

Auth: sections 374.045 and 375.936, RSMo (1986). This rule was previously filed as 4 CSR 190-13.170. Original rule filed Feb. 10, 1978, effective Aug. 11, 1978. Rescinded and readopted: Filed March 7, 1985, effective Aug. 11, 1985.

20 CSR 100-2.300 The Actual Payment Must Be the Basis for Policy or Plan Calculations

PURPOSE: This rule effectuates or aids in the interpretation of the following sections: 354.085 and 354.430.3(1), RSMo relating to certain policy forms that contain provisions which are deceptive, ambiguous, misleading, unfair, unjust, or inequitable; 354.350 and 375.445, RSMo regarding the carrying out of contracts in good faith; 354.410.1(2) and

354.430.3(2), RSMo pertaining to reasonable requirements for copayments; 354.085, 376.405 and 376.777, RSMo regarding whether policy forms contain such words, phraseology, conditions and provisions which are specific, certain and reasonably adequate to meet the needed requirements for the protection of those insured; and 354.410.1(9), RSMo relating to operating contrary to the public interest.

(1) Definitions. As used in this rule—

(A) "Actual payment" means the real total dollar amount actually paid or to be paid in fact, by a health insurer, or by the health insurer and the insured when the insured is responsible for some part of the cost, to a health services provider for a health service(s) pursuant to a health plan. Annual adjustments in amounts paid to providers which are based on referral rates, quality or cost effectiveness measurements, or other similar contractual provisions may be excluded from the calculation of actual payment, at the option of the health insurer;

(B) "Expense participation" means a financial contribution that the insured is required by the health plan to pay for a health service(s). "Expense participation" includes, but is not limited to, these forms of expense participation: deductibles, copayments, coinsurance, and additional charges by the health insurer that are caused by a failure to follow the utilization management or other requirements of the health plan;

(C) "Health insurer" means any person, fraternal benefit society, and any other legal entity engaged in the business of insurance, including agents, brokers, adjusters, public adjuster and third-party administrators. "Health insurer" shall also mean health services corporations, health maintenance corporations, prepaid limited health care service plans, optometric and other similar health service plans, preferred provider plans, managed care plans, point-of-service plans, and multiple employer self-insured health plans. For the purpose of this rule, these foregoing entities are deemed to be engaged in the business of insurance. "Health insurer" shall also include all companies organized, incorporated or doing business under the provisions of Chapters 374, 375, 376, 378, 379, RSMo; provided that only persons or entities which offer, issue, manage or administer a health plan shall be deemed to be a "health insurer;"

(D) "Health plan" means any insurance contract, policy or certificate, or any contract, plan or arrangement, which provides for the payment of a health service provider's charges for health services provided to insureds.



“Health plan” does not include any policy of workers compensation insurance or the medical payments portion of any automobile, homeowners or other property and casualty insurance policy;

(E) “Health services” means any service or product for which provision for benefits has been made under a health plan, including but not limited to, the health care and services provided by hospitals, or other health care institutions, organizations, associations or groups, and by doctors of medicine, osteopathy, chiropractic, psychiatry, optometry, and podiatry, and shall also include nursing services, preventative health care services, health screening, prenatal care, medical appliances, equipment and supplies, drugs, medicines, ambulance services, mental health services, emergency care services, basic services, supplemental services, and other therapeutic services and supplies, and laboratory analysis, physical examinations, the rendering of assistance to physicians, and services for drug and alcohol abuse, physiotherapy, anesthesiology, and anesthesia;

(F) “Health services provider” means any person or entity providing health services;

(G) “Insured” means any individual covered by a health plan; and

(H) “Person” means any natural or artificial entity, or aggregate of such entities, including, but not limited to, individuals, partnerships, associations, trusts or corporations.

(2) Under any health plan which provides for expense participation, whether in the form of coinsurance, copayments, a deductible or otherwise, such that the expense participation is to be computed as a percentage of, or as a function of the health service provider’s charge(s) for a health service(s), the charge used in such computation shall always and solely be no greater than the actual payment(s) made to the health service provider.

(3) Under any health plan which establishes benefit maximums or caps, such benefit maximums or caps shall always and solely be determined using a basis that is no greater than the actual payment(s) made to the health service provider.

(4) Nothing in this rule limits a health insurer’s right to pay some or all of an insured’s expense participation share of any charge for health services, or to exceed an insured’s benefit maximum or cap.

(5) This rule addresses the basis for calculating expense participation and benefit maximums or caps, and in no way affects the relationship or negotiations between health insurers and health services providers.

(6) This rule applies to all claims processed for a health plan on or after January 1, 1996.

*Auth: sections 354.085, 354.120, 354.485, 374.045, and 376.405, RSMo (1994).**
Original rule filed May 1, 1995, effective Dec. 30, 1995.

** Original authority: 354.085, RSMo (1973), amended 1983; 354.120, RSMo (1973), amended 1983, 1993; 354.485, RSMo (1983); 374.045, RSMo (1967), amended 1993; and 376.405, RSMo (1959), amended 1984.*