
Rules of Department of Insurance

Division 400—Life, Annuities and Health

Chapter 6—Health Services Corporations

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Title 20—DEPARTMENT OF INSURANCE

Division 400—Life, Annuities and Health Chapter 6—Health Services Corporations

20 CSR 400-6.100 Establishment and Computation of Reserves

PURPOSE: This regulation describes the method of establishment and computation of reserves for health services corporations. This regulation is adopted pursuant to section 354.120, RSMo (1986) and to implement section 354.080, RSMo (1986).

(1) Reserves Computed.

(A) Any corporation subject to Chapter 354, RSMo which has been in existence more than twelve (12) months must file all financial statements necessary to document its dues income and benefit payments and administrative expenses for the preceding fiscal year with its application for a certificate of authority.

(B) Any such corporation with a corporate history of less than twelve (12) months must file this information for the period of its existence with a projection to cover the remainder of a twelve (12)-month period from its inception. If the corporation has been in existence less than three (3) months, a six (6)-month projection will be acceptable for these purposes.

(C) The information submitted should also describe any factors which would allow proration of the amounts payable under the terms of the health service contracts or any other factors having a bearing upon the reserve computation.

(2) Factors to be Considered in Reducing this Reserve Requirement.

(A) The primary consideration in any reductions of reserves must be the security for payment of the benefits stated in the membership contract. Any factors which would provide security for payment comparable to the reserve shall be considered.

(B) The director will consider the fact that a newly formed corporation might increase its membership rapidly for a short initial period tending to over-inflate apparent reserve requirements. A membership increasing steadily could be a factor in support of the reduction or suspension of the reserve requirement.

(C) Other factors to be considered include any long-term prepayment of dues or long-term membership contracts; contractual waiver by providers of health services of certain claims against the health services corporation; the size of the membership of such a corporation;

and any provisions to increase dues on large group contracts over a period of time.

(3) Reduction of Reserves.

(A) Any health service corporation subject to Chapter 354, RSMo may petition the director of insurance to reduce or suspend the financial reserves required by section 354.080, RSMo. The director shall give ten (10) days' notice of the hearing to the petitioning corporation and hear the matter pursuant to the provisions of 20 CSR 800-1.010.

(B) The director shall issue an order subsequent to the hearing based upon the best interests of the members and beneficiaries of the petitioning corporation. The order must state the factual bases and any other factors considered in permitting or refusing any decrease or suspension of reserve requirements.

Auth: sections 354.080 and 354.120, RSMo (1986). This rule was previously filed as 4 CSR 190-15.010. Original rule filed Sept. 19, 1974, effective Sept. 29, 1974.

20 CSR 400-6.200 Approval Criteria for Membership Contracts

PURPOSE: This regulation sets out the approval criteria for membership benefits. Those persons who purchase membership contracts from health services corporations are motivated by the same desire to prepay the cost of any illness as are those persons who purchase accident and sickness insurance from insurance companies. Both groups deserve an equal opportunity to receive benefits commensurate with the charges they pay and to know the meaning of those benefits provided. This regulation is adopted pursuant to section 354.120, RSMo (1986) and to implement section 354.085, RSMo (1986).

(1) Membership Contract Approval Criteria. The director of insurance in approving membership contract forms shall take into consideration the following: sections 375.930—375.948, 376.405 and 376.776—376.800, RSMo and 20 CSR 400-2.010 (Insured's Right to Examination of Individual Accident and Sickness Coverage), 20 CSR 400-5.700 (Accident and Sickness Insurance Advertising), 20 CSR 400-2.030 (Coordination of Benefits), 20 CSR 400-2.050 (Notice of Renewal Dates on Renewable Policies) and 20 CSR 400-2.060 (Policy Approval Criteria) where applicable, provided s/he may also consider future enactments pertaining to this subject.

(2) Hearing Provided.

(A) If any health service corporation is adversely affected by the application of any of these statutes or regulations to its membership contracts, it may request a hearing under the procedures contained in 20 CSR 800-1.010.

(B) The director shall hold the requested hearing pursuant to the provisions of 20 CSR 800-1.010. At that hearing the affected health service corporation must substantiate its claim that any such statute or regulation is not applicable to any or all of its membership contracts. The director shall issue an order finding the statute or regulation applicable or not applicable to the approval of the contracts.

Auth: sections 354.085 and 354.120, RSMo (1986). This rule was previously filed as 4 CSR 190-15.020. Original rule filed Sept. 26, 1974, effective Oct. 6, 1974.

Op. Atty. Gen. No. 112, Edmiston, 6-21-76. Insurance companies are required to pay a filing fee pursuant to section 374.230(6), RSMo for documents filed with the director of the Division of Insurance pursuant to sections 376.405, 376.675, 376.777, RSMo (1969) and section 379.321, RSMo (Supp. 1975). The filing fee imposed by section 374.230(6) is for each document and not each page of each document. The filing fee paid pursuant to section 374.230(6) is not, pursuant to section 148.400, RSMo, deductible from the premium tax payable by such companies.

20 CSR 400-6.300 Ambulatory Surgical Centers

PURPOSE: This regulation interprets section 197.240, RSMo to permit health service corporations to vary benefit amounts payable to ambulatory surgical centers. This regulation is adopted pursuant to section 354.120, RSMo (1986) and to implement sections 197.240, 354.085 and 354.090, RSMo (1986).

(1) Ambulatory Surgical Centers.

(A) No membership contract will be approved by the director which does not provide coverage for all health services performed at an ambulatory surgical center licensed under section 197.215, RSMo (1986) which are covered as a hospital inpatient benefit under that contract and are within the scope of the license of the ambulatory surgical center.

(B) In keeping with the essential purpose of ambulatory surgical centers, this regulation in no way shall be construed to require the same



level or dollar amount of benefits to be paid for health services performed in an ambulatory surgical center as is paid to a hospital or on account of inpatient hospital treatment.

(C) Any contract not in compliance with this regulation after April 30, 1976 shall be deemed to provide equal benefits in scope and amount for ambulatory surgical centers services as for inpatient hospital care until amended or replaced by an approved contract form.

Auth: sections 197.240, 354.085, 354.090 and 354.120, RSMo (1986). This rule was previously filed as 4 CSR 190-15.030. Original rule filed Dec. 30, 1975, effective Jan. 15, 1976.

20 CSR 400-6.400 Benefit Payment Standards

PURPOSE: This regulation describes those patterns which may constitute reason for the director of insurance to order an investigation. This regulation was adopted pursuant to section 354.120, RSMo (1986) and to implement sections 354.110, 354.115 and 354.170, RSMo (1986).

(1) Grounds for Investigation. Corporate problems and mere patterns of action will be established by receipt of written grievances from individual members of the health service corporation. The following patterns may appear and may constitute reason for the director of insurance to order an investigation of the operations of the health service corporation:

(A) Misrepresenting to members any pertinent facts or membership contract provisions relating to any benefits;

(B) Failing to acknowledge and act promptly upon communications concerning benefits arising under membership contracts;

(C) Failing to implement reasonable standards for the prompt investigation, evaluation and payment of proper benefits arising under membership contracts;

(D) Failing to affirm or deny benefits coverage within a reasonable time after proof of loss or service report requirements have been submitted by the member or beneficiary;

(E) Compelling members to institute litigation to recover substantially the same amount for which the claim was originally made where no substantial issue of law or fact exists; and

(F) Failing to provide promptly a reasonable explanation of the basis relied on in the membership contract, in relation to the facts or applicable law, for the denial of a benefit or for the offer of a compromise settlement.

Auth: sections 354.110, 354.115, 354.120 and 354.170, RSMo (1986). This rule was previously filed as 4 CSR 190-15.040. Original rule filed Sept. 18, 1974, effective Sept. 28, 1974.

20 CSR 400-6.500 Bylaws Required to be Filed

PURPOSE. This regulation specifies that current bylaws must be filed with the Department of Insurance. This regulation is adopted pursuant to section 354.120, RSMo (1986) and to implement sections 354.095, 354.105 and 354.110, RSMo (1986).

(1) Bylaws to be Filed.

(A) A current copy of all bylaws of any health service corporation requesting a certificate of authority pursuant to section 354.060, RSMo (1986) shall be included with that corporation's application for the certificate of authority.

(B) A copy of any amendment to the bylaws of this corporation shall be filed with the Department of Insurance not later than sixty (60) days after the effective date.

Auth: sections 354.095, 354.105, 354.110 and 354.120, RSMo (1986). This rule was previously filed as 4 CSR 190-15.060. Original rule filed Sept. 18, 1974, effective Sept. 28, 1974.

20 CSR 400-6.600 Conversion Privilege

PURPOSE: This regulation describes the conversion privilege to be accorded to family memberships on either a group or direct-pay basis. This regulation applies to health service corporations offering nongroup health care plans in Missouri. This regulation is adopted pursuant to section 354.120, RSMo (1986) and to implement section 354.085, RSMo (1986).

(1) Offer of Conversion.

(A) Whenever a family membership, either through a group or on a direct-pay basis, is terminated because of the death of the subscribing member, any one (1) or more of the surviving dependents of the member who were beneficiaries under the decedent's membership contract at the time of death shall have the option to become subscribing members of the health service corporation for not less than thirty (30) days after the death of that subscribing member. The conversion program

shall consist of an option for these dependents to choose among all those nongroup membership plans then being offered by that health service corporation.

(B) The conversion program shall be continuous with the terminated program with no intervening periods of contestability or waiting periods other than the unexpired portion of such provisions in the direct pay or group membership contract from which the conversion is being made.

(C) This option shall be explained in each certificate of coverage, description of benefits or other explanation of benefits afforded issued after April 30, 1976.

Auth: sections 354.085 and 354.120, RSMo (1986). This rule was previously filed as 4 CSR 190-15.070. Original rule filed Dec. 30, 1975, effective Jan. 15, 1976.