Rules of  
Department of Insurance  
Division 400—Life, Annuities and Health  
Chapter 6—Health Services Corporations

<table>
<thead>
<tr>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 CSR 400-6.100 Establishment and Computation of Reserves</td>
<td>3</td>
</tr>
<tr>
<td>20 CSR 400-6.200 Approval Criteria for Membership Contracts</td>
<td>3</td>
</tr>
<tr>
<td>20 CSR 400-6.300 Ambulatory Surgical Centers</td>
<td>3</td>
</tr>
<tr>
<td>20 CSR 400-6.400 Benefit Payment Standards</td>
<td>4</td>
</tr>
<tr>
<td>20 CSR 400-6.500 Bylaws Required to be Filed</td>
<td>4</td>
</tr>
<tr>
<td>20 CSR 400-6.600 Conversion Privilege</td>
<td>4</td>
</tr>
</tbody>
</table>
(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.

PURPOSE: This regulation sets out the approval criteria for membership benefits. Those persons who purchase membership contracts from health service 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).

20 CSR 400-6.200 Approval Criteria for Membership Contracts

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

20 CSR 400-6.360 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).

(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 ambula-
tory surgical center as is paid to a hospital
or an 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

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 corpo-
rations:
(A) Misrepresenting to members any perti-
nent 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 stand-
ards 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 litiga-
tion 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 354.065, 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 cer-
ificate 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 and 354.120,
RSMo (1986). This rule was previously
filed as 4 CSR 190-15.070. Original rule

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 354.065, RSMo
(1986).

(1) Offer of Conversion.
(A) Whenever a family membership, either
through a group or an direct-pay basis, is
terminated because of the death of the sub-
scribing 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
subsiding member. The conversion program
shall consist of an option for these dependents
to choose among all those nongroup member-
ship plans then being offered by that health
service corporation.

(B) The conversion program shall be con-
tinuous with the terminated program with no
intervening periods of contestability or wait-
periods other than the unexpired portion of
such provisions in the direct pay or group
membership contract from which the conver-
sion 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 354.095 and 354.120,
RSMo (1986). This rule was previously
filed as 4 CSR 190-15.070. Original rule