

SECOND REGULAR SESSION
SENATE COMMITTEE SUBSTITUTE FOR
HOUSE BILL NO. 2205
95TH GENERAL ASSEMBLY

Reported from the Committee on Small Business, Insurance and Industry, May 10, 2010, with recommendation that the Senate Committee Substitute do pass.

5152S.03C

TERRY L. SPIELER, Secretary.

AN ACT

To repeal sections 354.442, 375.1152, 375.1155, 375.1175, 375.1255, and 376.1109, RSMo, and to enact in lieu thereof twelve new sections relating to insurance.

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

Section A. Sections 354.442, 375.1152, 375.1155, 375.1175, 375.1255, and
2 376.1109, RSMo, are repealed and twelve new sections enacted in lieu thereof, to
3 be known as sections 354.442, 375.024, 375.539, 375.1152, 375.1155, 375.1175,
4 375.1191, 375.1255, 376.882, 376.1109, 376.1110, and 376.1257, to read as follows:

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

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

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

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

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

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

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

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

- 17 (c) The time frames under which utilization review decisions shall be
18 made for prospective, retrospective and concurrent decisions;
- 19 (d) The right to reconsideration;
- 20 (e) The right to an appeal, including the expedited and standard appeals
21 processes and the time frames for such appeals;
- 22 (f) The right to designate a representative;
- 23 (g) A notice that all denials of claims shall be made by qualified clinical
24 personnel and that all notices of denial shall include information about the basis
25 of the decision; and
- 26 (h) Further appeal rights, if any;
- 27 (5) An explanation of an enrollee's financial responsibility for payment of
28 premiums, coinsurance, co-payments, deductibles and any other charge, annual
29 limits on an enrollee's financial responsibility, caps on payments for covered
30 services and financial responsibility for noncovered health care procedures,
31 treatments or services provided within the health maintenance organization;
- 32 (6) An explanation of an enrollee's financial responsibility for payment
33 when services are provided by a health care provider who is not part of the health
34 maintenance organization's network or by any provider without required
35 authorization, or when a procedure, treatment or service is not a covered health
36 care benefit;
- 37 (7) A description of the grievance procedures to be used to resolve
38 disputes between a health maintenance organization and an enrollee, including:
- 39 (a) The right to file a grievance regarding any dispute between an enrollee
40 and a health maintenance organization;
- 41 (b) The right to file a grievance when the dispute is about referrals or
42 covered benefits;
- 43 (c) The toll-free telephone number which enrollees may use to file a
44 grievance;
- 45 (d) The department of insurance, financial institutions and professional
46 registration's toll-free consumer complaint hot line number;
- 47 (e) The time frames and circumstances for expedited and standard
48 grievances;
- 49 (f) The right to appeal a grievance determination and the procedures for
50 filing such an appeal;
- 51 (g) The time frames and circumstances for expedited and standard
52 appeals;

- 53 (h) The right to designate a representative;
- 54 (i) A notice that all disputes involving clinical decisions shall be made by
55 qualified clinical personnel; and
- 56 (j) All notices of determination shall include information about the basis
57 of the decision and further appeal rights, if any;
- 58 (8) A description of a procedure for providing care and coverage
59 twenty-four hours a day, seven days a week, for emergency services. Such
60 description shall include the definition of emergency services and emergency
61 medical condition, notice that emergency services are not subject to prior
62 approval, and shall describe the enrollee's financial and other responsibilities
63 regarding obtaining such services, including when such services are received
64 outside the health maintenance organization's service area;
- 65 (9) A description of procedures for enrollees to select and access the health
66 maintenance organization's primary and specialty care providers, including notice
67 of how to determine whether a participating provider is accepting new patients;
- 68 (10) A description of the procedures for changing primary and specialty
69 care providers within the health maintenance organization;
- 70 (11) Notice that an enrollee may obtain a referral for covered services to
71 a health care provider outside of the health maintenance organization's network
72 or panel when the health maintenance organization does not have a health care
73 provider with appropriate training and experience in the network or panel to
74 meet the particular health care needs of the enrollee and the procedure by which
75 the enrollee may obtain such referral;
- 76 (12) A description of the mechanisms by which enrollees may participate
77 in the development of the policies of the health maintenance organization;
- 78 (13) Notice of all appropriate mailing addresses and telephone numbers
79 to be utilized by enrollees seeking information or authorization;
- 80 (14) [A listing] **Listings** by specialty, which may be in [a] separate
81 [document that is] **documents that are** updated annually, of the names,
82 addresses and telephone numbers of all participating providers, including
83 facilities, and in addition in the case of physicians, board certification; and
- 84 (15) The director of the department of insurance, financial institutions
85 and professional registration shall develop a standard credentialing form which
86 shall be used by all health carriers when credentialing health care professionals
87 in a managed care plan. If the health carrier demonstrates a need for additional
88 information, the director of the department of insurance, financial institutions

89 and professional registration may approve a supplement to the standard
90 credentialing form. All forms and supplements shall meet all requirements as
91 defined by the National Committee of Quality Assurance.

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

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

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

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

101 (4) Information relating to consumer complaints compiled annually by the
102 department of insurance, financial institutions and professional registration;

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

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

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

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

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

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

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

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

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

130 4. **The information to be provided under subdivision (14) of**
131 **subsection 1 of this section may be provided online unless a paper copy**
132 **is requested by the enrollee. A request by the enrollee may include**
133 **written, oral, or electronic means. Such requested paper copy shall be**
134 **provided to the enrollee within fifteen business days.**

375.024. 1. **The provisions of this section shall only apply to life**
2 **insurance producer examinations.**

3 2. **The director or, at the director's discretion, a vendor under**
4 **contract with the department, shall review license producer**
5 **examinations subject to the provisions of this section if, during any**
6 **twelve-month period beginning on September first of a year, the**
7 **examinations exhibit an overall pass rate of less than seventy percent**
8 **for first-time examinees.**

9 3. **In conformance with appropriate law relating to privacy, the**
10 **department shall collect demographic information, including, race,**
11 **gender, and national origin, from an individual taking a license**
12 **examination subject to the provisions of this section.**

13 4. **The department shall compile an annual report based on the**
14 **review required under subsection 2 of this section. The report shall**
15 **indicate whether there was any disparity in the examination pass rate**
16 **based on demographic information.**

17 5. **The director by rule may establish procedures as necessary to:**

18 (1) **Collect demographic information necessary to implement the**
19 **provisions of this section; and**

20 (2) **Ensure that a review required under subsection 2 of this**
21 **section is conducted and the resulting report is prepared. Any rule or**
22 **portion of a rule, as that term is defined in section 536.010, that is**
23 **created under the authority delegated in this section shall become**
24 **effective only if it complies with and is subject to all of the provisions**
25 **of chapter 536, and, if applicable, section 536.028. This section and**
26 **chapter 536, are nonseverable and if any of the powers vested with the**
27 **general assembly pursuant to chapter 536, to review, to delay the**

28 effective date, or to disapprove and annul a rule are subsequently held
29 unconstitutional, then the grant of rulemaking authority and any rule
30 proposed or adopted after August 28, 2010, shall be invalid and void.

31 6. The director shall deliver the report prepared under this
32 section to the governor, the lieutenant governor, the president pro tem
33 of the senate, and the speaker of the house of representatives not later
34 than December first of each year.

35 7. The first twelve-month period for which a license examination
36 review may be required under this section shall begin September 1,
37 2010.

38 8. The director shall deliver the initial report required under
39 this section, not later than December 1, 2011.

375.539. 1. The director of the department of insurance, financial
2 institutions and professional registration may deem an insurance
3 company to be in such financial condition that its further transaction
4 of business would be hazardous to policyholders, creditors, and the
5 public, if such company is a property or casualty insurer, or both a
6 property and casualty insurer, which has in force any policy with any
7 single net retained risk larger than ten percent of that company's
8 capital and surplus as of the December thirty-first next preceding.

9 2. The following standards, either singly or a combination of two
10 or more, may be considered by the director to determine whether the
11 continued operation of any insurer transacting an insurance business
12 in this state might be deemed to be hazardous to its policyholders,
13 creditors, or the general public:

14 (1) Adverse findings reported in financial condition and market
15 conduct examination reports, audit reports, and actuarial opinions,
16 reports, or summaries;

17 (2) The National Association of Insurance Commissioners
18 Insurance Regulatory Information System and its other financial
19 analysis solvency tools and reports;

20 (3) Whether the insurer has made adequate provision, according
21 to presently accepted actuarial standards of practice, for the
22 anticipated cash flows required by the contractual obligations and
23 related expenses of the insurer, when considered in light of the assets
24 held by the insurer with respect to such reserves and related actuarial
25 items including, but not limited to, the investment earnings on such

26 assets, and the considerations anticipated to be received and retained
27 under such policies and contracts;

28 (4) The ability of an assuming reinsurer to perform and whether
29 the insurer's reinsurance program provides sufficient protection for the
30 insurer's remaining surplus after taking into account the insurer's cash
31 flow and the classes of business written as well as the financial
32 condition of the assuming reinsurer;

33 (5) Whether the insurer's operating loss in the last twelve-month
34 period or any shorter period of time, including but not limited to net
35 capital gain or loss, change in non-admitted assets, and cash dividends
36 paid to shareholders, is greater than fifty percent of the insurer's
37 remaining surplus as regards to policyholders in excess of the minimum
38 required;

39 (6) Whether the insurer's operating loss in the last twelve-month
40 period or any shorter period of time, excluding net capital gains, is
41 greater than twenty percent of the insurer's remaining surplus as
42 regards to policyholders in excess of the minimum required;

43 (7) Whether a reinsurer, obligor, or any entity within the
44 insurer's insurance holding company system is insolvent, threatened
45 with insolvency, or delinquent in payment of its monetary or other
46 obligations, and which in the opinion of the director may affect the
47 solvency of the insurer;

48 (8) Contingent liabilities, pledges, or guaranties which either
49 individually or collectively involve a total amount which in the opinion
50 of the director may affect the solvency of the insurer;

51 (9) Whether any "controlling" person of an insurer is delinquent
52 in the transmitting to, or payment of, net premiums to the insurer. As
53 used in this subdivision, the term "controlling" shall have the same
54 meaning assigned to it in subdivision (2) of section 382.010;

55 (10) The age and collectibility of receivables;

56 (11) Whether the management of an insurer, including officers,
57 directors, or any other person who directly or indirectly controls the
58 operation of the insurer, fails to possess and demonstrate the
59 competence, fitness, and reputation deemed necessary to serve the
60 insurer in such position;

61 (12) Whether management of an insurer has failed to respond to
62 inquiries relative to the condition of the insurer or has furnished false

63 and misleading information concerning an inquiry;

64 (13) Whether the insurer has failed to meet financial and holding
65 company filing requirements in the absence of a reason satisfactory to
66 the director;

67 (14) Whether management of an insurer either has filed any false
68 or misleading sworn financial statement, or has released false or
69 misleading financial statement to lending institutions or to the general
70 public, or has made a false or misleading entry, or has omitted an entry
71 of material amount in the books of the insurer;

72 (15) Whether the insurer has grown so rapidly and to such an
73 extent that it lacks adequate financial and administrative capacity to
74 meet its obligations in a timely manner;

75 (16) Whether the insurer has experienced or will experience in
76 the foreseeable future cash flow or liquidity problems;

77 (17) Whether management has established reserves that do not
78 comply with minimum standards established by state insurance laws,
79 regulations, statutory accounting standards, sound actuarial principles
80 and standards of practice;

81 (18) Whether management persistently engages in material under
82 reserving that results in adverse development;

83 (19) Whether transactions among affiliates, subsidiaries, or
84 controlling persons for which the insurer receives assets or capital
85 gains, or both, do not provide sufficient value, liquidity, or diversity to
86 assure the insurer's ability to meet its outstanding obligations as they
87 mature;

88 (20) Any other finding determined by the director to be
89 hazardous to the insurer's policyholders, creditors, or general public.

90 3. For the purposes of making a determination of an insurer's
91 financial condition under this section, the director may:

92 (1) Disregard any credit or amount receivable resulting from
93 transactions with a reinsurer that is insolvent, impaired, or otherwise
94 subject to a delinquency proceeding;

95 (2) Make appropriate adjustments including disallowance to
96 asset values attributable to investments in or transactions with parents,
97 subsidiaries, or affiliates consistent with the National Association of
98 Insurance Commissioners Accounting Policies and Procedures Manual,
99 state laws and regulations;

100 **(3) Refuse to recognize the stated value of accounts receivable**
101 **if the ability to collect receivables is highly speculative in view of the**
102 **age of the account or the financial condition of the debtor;**

103 **(4) Increase the insurer's liability in an amount equal to any**
104 **contingent liability, pledge, or guarantee not otherwise included if**
105 **there is a substantial risk that the insurer will be called upon to meet**
106 **the obligation undertaken within the next twelve-month period.**

107 **4. If the director determines that the continued operation of the**
108 **insurer licensed to transact business in this state may be hazardous to**
109 **its policyholders, creditors, or the general public, then the director**
110 **may, to the extent authorized by law and in accordance with any**
111 **procedures required by law, issue an order requiring the insurer to:**

112 **(1) Reduce the total amount of present and potential liability for**
113 **policy benefits by reinsurance;**

114 **(2) Reduce, suspend, or limit the volume of business being**
115 **accepted or renewed;**

116 **(3) Reduce general insurance and commission expenses by**
117 **specified methods;**

118 **(4) Increase the insurer's capital and surplus;**

119 **(5) Suspend or limit the declaration and payment of dividend by**
120 **an insurer to its stockholders or to its policyholders;**

121 **(6) File reports in a form acceptable to the director concerning**
122 **the market value of an insurer's assets;**

123 **(7) Limit or withdraw from certain investments or discontinue**
124 **certain investment practices to the extent the director deems**
125 **necessary;**

126 **(8) Document the adequacy of premium rates in relation to the**
127 **risks insured;**

128 **(9) File, in addition to regular annual statements, interim**
129 **financial reports on the form adopted by the National Association of**
130 **Insurance Commissioners or in such format as promulgated by the**
131 **director;**

132 **(10) Correct corporate governance practice deficiencies, and**
133 **adopt and utilize governance practices acceptable to the director;**

134 **(11) Provide a business plan to the director in order to continue**
135 **to transact business in the state;**

136 **(12) Notwithstanding any other provision of law limiting the**

137 frequency or amount of premium rate adjustments, adjust rates for any
138 non-life insurance product written by the insurer that the director
139 considers necessary to improve the financial condition of the insurer.

140 5. An insurer subject to an order under subsection 4 of this
141 section may request a hearing before the director in accordance with
142 the provisions of chapter 536. The notice of hearing shall be served
143 upon the insurer pursuant to section 536.067. The notice of hearing
144 shall state the time and place of hearing and the conduct, condition, or
145 ground upon which the director based the order. Unless mutually
146 agreed between the director and the insurer, the hearing shall occur
147 not less than ten days nor more than thirty days after notice is served
148 and shall be either in Cole County or in some other place convenient
149 to the parties designated by the director. The director shall hold all
150 hearings under this subsection privately, unless the insurer requests
151 a public hearing, in which case the hearing shall be public.

152 6. This section shall not be interpreted to limit the powers
153 granted the director by any laws or parts of laws of this state, nor shall
154 this section be interpreted to supercede any laws or parts of laws of
155 this state, except that if the insurer is a foreign insurer, the director's
156 order under subsection 4 of this section may be limited to the extent
157 expressly provided by any laws or parts of laws of this state.

375.1152. For purposes of sections 375.570 to 375.750 and 375.1150 to
2 375.1246, the following words and phrases shall mean:

3 (1) "Allocated loss adjustment expenses", those fees, costs or expenses
4 reasonably chargeable to the investigation, negotiation, settlement or defense of
5 an individual claim or loss or to the protection and perfection of the subrogation
6 rights of any insolvent insurer arising out of a policy of insurance issued by the
7 insolvent insurer. "Allocated loss adjustment expenses" shall include all court
8 costs, fees and expenses; fees for service of process; fees to attorneys; costs of
9 undercover operative and detective services; fees of independent adjusters or
10 attorneys for investigation or adjustment of claims beyond initial investigation;
11 costs of employing experts for preparation of maps, photographs, diagrams,
12 chemical or physical analysis or for advice, opinion or testimony concerning
13 claims under investigation or in litigation; costs for legal transcripts or testimony
14 taken at coroner's inquests, criminal or civil proceedings; costs for copies of any
15 public records; costs of depositions and court-reported or -recorded

16 statements. "Allocated loss adjustment expenses" shall not include the salaries
17 of officials, administrators or other employees or normal overhead charges such
18 as rent, postage, telephone, lighting, cleaning, heating or similar expenses;

19 (2) "Ancillary state", any state other than a domiciliary state;

20 (3) "Creditor", a person having any claim, whether matured or unmatured,
21 liquidated or unliquidated, secured or unsecured, absolute, fixed or contingent;

22 (4) "Delinquency proceeding", any proceeding instituted against an insurer
23 for the purpose of liquidating, rehabilitating, reorganizing or conserving such
24 insurer, and any summary proceeding under sections 375.1160, 375.1162 and
25 375.1164;

26 (5) "Director", the director of the department of insurance, financial
27 institutions and professional registration;

28 (6) "Doing business" includes any of the following acts, whether effected
29 by mail or otherwise:

30 (a) The issuance or delivery of contracts of insurance to persons resident
31 in this state;

32 (b) The solicitation of applications for such contracts, or other negotiations
33 preliminary to the execution of such contracts;

34 (c) The collection of premiums, membership fees, assessments, or other
35 consideration for such contracts;

36 (d) The transaction of matters subsequent to execution of such contracts
37 and arising out of them; or

38 (e) Operating under a license or certificate of authority, as an insurer,
39 issued by the department of insurance, financial institutions and professional
40 registration;

41 (7) "Domiciliary state", the state in which an insurer is incorporated or
42 organized or, in the case of an alien insurer, its state of entry;

43 (8) "Fair consideration" is given for property or obligation:

44 (a) When in exchange for such property or obligation, as a fair equivalent
45 thereof, and in good faith, property is conveyed or services are rendered or an
46 obligation is incurred or an antecedent debt is satisfied; or

47 (b) When such property or obligation is received in good faith to secure a
48 present advance or antecedent debt in an amount not disproportionately small as
49 compared to the value of the property or obligation obtained;

50 (9) "Foreign country", any jurisdiction not in the United States;

51 (10) "Formal delinquency proceeding", any liquidation or rehabilitation

52 proceeding;

53 (11) "General assets", all property, real, personal, or otherwise, not
54 specifically mortgaged, pledged, deposited or otherwise encumbered for the
55 security or benefit of specified persons or classes of persons. As to specifically
56 encumbered property, "general assets" includes all such property or its proceeds
57 in excess of the amount necessary to discharge the sum or sums secured
58 thereby. Assets held in trust and on deposit for the security or benefit of all
59 policyholders or all policyholders and creditors, in more than a single state, shall
60 be treated as general assets;

61 (12) "Guaranty association", the Missouri property and casualty insurance
62 guaranty association created by sections 375.771 to 375.779, as amended, the
63 Missouri life and health insurance guaranty association created by sections
64 376.715 to 376.758, RSMo, as amended, and any other similar entity now or
65 hereafter created by the laws of this state for the payment of claims of insolvent
66 insurers. "Foreign guaranty association" means any similar entities now in
67 existence or hereafter created by the laws of any other state;

68 (13) "Insolvency" or "insolvent" means:

69 (a) For an insurer issuing only assessable fire insurance policies:

70 a. The inability to pay an obligation within thirty days after it becomes
71 payable; or

72 b. If an assessment be made within thirty days after such date, the
73 inability to pay such obligation thirty days following the date specified in the first
74 assessment notice issued after the date of loss;

75 (b) For any other insurer, that it is unable to pay its obligations when
76 they are due, or when its admitted assets do not exceed its liabilities plus the
77 greater of:

78 a. Any capital and surplus required by law for its organization; or

79 b. The total par or stated value of its authorized and issued capital stock;

80 (c) As to any insurer licensed to do business in this state as of August 28,
81 1991, which does not meet the standards established under paragraph (b) of this
82 subdivision, the term "insolvency" or "insolvent" shall mean, for a period not to
83 exceed three years from August 28, 1991, that it is unable to pay its obligations
84 when they are due or that its admitted assets do not exceed its liabilities plus any
85 required capital contribution ordered by the director under any other provisions
86 of law;

87 (d) For purposes of this subdivision "liabilities" shall include but not be

88 limited to reserves required by statute or by the department of insurance,
89 financial institutions and professional registration regulations or specific
90 requirements imposed by the director upon a subject company at the time of
91 admission or subsequent thereto;

92 (e) For purposes of this subdivision, an obligation is payable within ninety
93 days of the resolution of any dispute regarding the obligation;

94 (14) "Insurer", any person who has done, purports to do, is doing or is
95 licensed to do insurance business as described in section 375.1150, and is or has
96 been subject to the authority of, or to liquidation, rehabilitation, reorganization,
97 supervision, or conservation by, any insurance department of any state. For
98 purposes of sections 375.1150 to 375.1246, any other persons included under
99 section 375.1150 shall be deemed to be insurers;

100 (15) "Netting agreement":

101 (a) **A contract or agreement, including terms and conditions**
102 **incorporated by reference therein, including a master agreement which**
103 **master agreement, together with all schedules, confirmations,**
104 **definitions and addenda thereto and transactions under any thereof,**
105 **shall be treated as one netting agreement, that documents one or more**
106 **transactions between the parties to the agreement for or involving one**
107 **or more qualified financial contracts and that provides for the netting,**
108 **liquidation, setoff, termination, acceleration, or close out under or in**
109 **connection with one or more qualified financial contracts or present or**
110 **future payment or delivery obligations or payment or delivery**
111 **entitlements thereunder, including liquidation or close-out values**
112 **relating to such obligations or entitlements, among the parties to the**
113 **netting agreement;**

114 (b) **Any master agreement or bridge agreement for one or more**
115 **master agreements described in paragraph (a) of this subdivision; or**

116 (c) **Any security agreement or arrangement or other credit**
117 **enhancement or guarantee or reimbursement obligation related to any**
118 **contract or agreement described in paragraph (a) or (b) of this**
119 **subdivision; provided that any contract or agreement described in**
120 **paragraph (a) or (b) of this subdivision relating to agreements or**
121 **transactions that are not qualified financial contracts shall be deemed**
122 **to be a netting agreement only with respect to those agreements or**
123 **transactions that are qualified financial contracts;**

124 **(16)** "Preferred claim", any claim with respect to which the terms of
125 sections 375.1150 to 375.1246 accord priority of payment from the general assets
126 of the insurer;

127 **(17) "Qualified financial contract", any commodity contract,**
128 **forward contract, repurchase agreement, securities contract, swap**
129 **agreement, and any similar agreement that the director determines by**
130 **regulation, resolution, or order to be a qualified financial contract for**
131 **the purposes of sections 375.1150 to 375.1246;**

132 **(a) "Commodity contract", shall mean:**

133 **a. A contract for the purchase of sale of a commodity for future**
134 **delivery on, or subject to the rules of, a board of trade or contract**
135 **market under the Commodity Exchange Act, 7 U.S.C. Section 1, et seq.,**
136 **or a board of trade outside the United States;**

137 **b. An agreement that is subject to regulation under Section 19 of**
138 **the Commodity Exchange Act, 7 U.S.C. Section 1, et seq., and that is**
139 **commonly known to the commodities trade as a margin account, margin**
140 **contract, leverage account, or leverage contract;**

141 **c. An agreement or transaction that is subject to regulation**
142 **under Section 4c(b) of the Commodity Exchange Act, 7 U.S.C. Section**
143 **1, et seq., and that is commonly known to the commodities trade as a**
144 **commodity option;**

145 **d. Any combination of the agreements or transactions referred**
146 **to in this paragraph; or**

147 **e. Any option to enter into an agreement or transaction referred**
148 **to in this paragraph;**

149 **(b) "Forward contract", "repurchase agreement", "securities**
150 **contract", and "swap agreement" shall have the meaning set forth in the**
151 **Federal Deposit Insurance Act, 12 U.S.C. Section 1821(e)(8)(D), as**
152 **amended;**

153 **[(16)] (18) "Receiver", a receiver, liquidator, administrative supervisor,**
154 **rehabilitator or conservator, as the context requires;**

155 **[(17)] (19) "Reciprocal state", any state other than this state in which in**
156 **substance and effect, provisions substantially similar to subsection 1 of section**
157 **375.1176 and sections 375.1235, 375.1236, 375.1240, 375.1242 and 375.1244 have**
158 **been enacted and are in force, and in which laws are in force requiring that the**
159 **director of the state department of insurance, financial institutions and**
160 **professional registration or equivalent official be the receiver of a delinquent**

161 insurer, and in which some provision exists for the avoidance of fraudulent
162 conveyances and preferential transfers;

163 [(18)] **(20)** "Secured claim", any claim secured by mortgage, trust deed,
164 pledge, deposit as security, escrow, or otherwise, including a pledge of assets
165 allocated to a separate account established pursuant to section 376.309, RSMo;
166 but not including special deposit claims or claims against general assets. The
167 term also includes claims which have become liens upon specific deposit claims
168 or claims against general assets. The term also includes claims which have
169 become liens upon specific assets by reason of judicial process;

170 [(19)] **(21)** "Special deposit claim", any claim secured by a deposit made
171 pursuant to statute for the security or benefit of a limited class or classes of
172 persons, but not including any claim secured by general assets;

173 [(20)] **(22)** "State", any state, district, or territory of the United States
174 and the Panama Canal Zone;

175 [(21)] **(23)** "Transfer" shall include the sale and every other and different
176 mode, direct or indirect, of disposing of or of parting with property or with an
177 interest therein, or with the possession thereof, or of fixing a lien upon property
178 or upon an interest therein, absolutely or conditionally, voluntarily, by or without
179 judicial proceedings. The retention of a security title to property delivered to a
180 debtor shall be deemed a transfer suffered by the debtor.

375.1155. 1. Any receiver appointed in a proceeding under sections
2 375.1150 to 375.1246 may at any time apply for, and any court of general
3 jurisdiction may grant, such restraining orders, preliminary and permanent
4 injunctions, and other orders as may be deemed necessary and proper to prevent:

5 (1) The transaction of further business;

6 (2) The transfer of property;

7 (3) Interference with the receiver or with a proceeding under sections
8 375.1150 to 375.1246;

9 (4) Waste of the insurer's assets;

10 (5) Dissipation and transfer of bank accounts;

11 (6) The institution or further prosecution of any actions or proceedings;

12 (7) The obtaining of preferences, judgments, attachments, garnishments
13 or liens against the insurer, its assets or its policyholders;

14 (8) The levying of execution against the insurer, its assets or its
15 policyholders;

16 (9) The making of any sale or deed for nonpayment of taxes or

17 assessments that would lessen the value of the assets of the insurer;

18 (10) The withholding from the receiver of books, accounts, documents, or
19 other records relating to the business of the insurer; or

20 (11) Any other threatened or contemplated action that might lessen the
21 value of the insurer's assets or prejudice the rights of policyholders, creditors or
22 shareholders, or the administration of any proceeding under this act.

23 2. The receiver may apply to any court outside of the state for the relief
24 described in subsection 1 of this section.

25 **3. Notwithstanding anything to the contrary in this section, the**
26 **commencement of a delinquency proceeding under sections 375.1150 to**
27 **375.1246 shall not operate as a stay or prohibition of any right to cause**
28 **the netting, liquidation, setoff, termination, acceleration, or close out**
29 **of obligations, or enforcement of any security agreement or**
30 **arrangement or other credit enhancement or guarantee or**
31 **reimbursement obligation, under or in connection with any netting**
32 **agreement or qualified financial contract as provided for in section**
33 **375.1191.**

375.1175. 1. The director may petition the court for an order directing
2 him to liquidate a domestic insurer or an alien insurer domiciled in this state on
3 the basis:

4 (1) Of any ground for an order of rehabilitation as specified in section
5 375.1165, whether or not there has been a prior order directing the rehabilitation
6 of the insurer;

7 (2) That the insurer is insolvent;

8 (3) That the insurer is in such condition that the further transaction of
9 business would be hazardous, financially or otherwise, to its policyholders, its
10 creditors or the public;

11 (4) That the insurer is found to be in such condition after examination
12 that it could not meet the requirements for incorporation and authorization
13 specified in the law under which it was incorporated or is doing business; or

14 (5) That the insurer has ceased to transact the business of insurance for
15 a period of one year.

16 **2. Notwithstanding any other provision of this chapter, a**
17 **domestic insurer organized as a stock insurance company may**
18 **voluntarily dissolve and liquidate as a corporation under sections**
19 **351.462 to 351.482, provided that:**

20 **(1) The director, in his or her sole discretion, approves the**
21 **articles of dissolution prior to filing such articles with the secretary of**
22 **state. In determining whether to approve or disapprove the articles of**
23 **dissolution, the director shall consider, among other factors, whether:**

24 **(a) The insurer's annual financial statements filed with the**
25 **director show no written insurance premiums for five years; and**

26 **(b) The insurer has demonstrated that all policyholder claims**
27 **have been satisfied or have been transferred to another insurer in a**
28 **transaction approved by the director; and**

29 **(c) An examination of the insurer pursuant to sections 374.202 to**
30 **374.207 has been completed within the last five years; and**

31 **(2) The domestic insurer files with the secretary of state a copy**
32 **of the director's approval, certified by the director, along with articles**
33 **of dissolution as provided in section 351.462 or 351.468.**

375.1191. 1. Notwithstanding any other provision of sections
2 **375.1150 to 375.1246, including any other provision of sections 375.1150**
3 **to 375.1246 permitting the modification of contracts, or other law of a**
4 **state, no person shall be stayed or prohibited from exercising:**

5 **(1) A contractual right to cause the termination, liquidation,**
6 **acceleration, or close out of obligations under or in connection with**
7 **any netting agreement or qualified financial contract with an insurer**
8 **because of:**

9 **(a) The insolvency, financial condition, or default of the insurer**
10 **at any time, provided that the right is enforceable under applicable law**
11 **other than sections 375.1150 to 375.1246; or**

12 **(b) The commencement of a formal delinquency proceeding**
13 **under sections 375.1150 to 375.1246;**

14 **(2) Any right under a pledge, security, collateral, reimbursement,**
15 **or guarantee agreement or arrangement or any other similar security**
16 **arrangement or arrangement or other credit enhancement relating to**
17 **one or more netting agreements or qualified financial contracts;**

18 **(3) Subject to any provision of section 375.1198, any right to set**
19 **off or net out any termination value, payment amount, or other transfer**
20 **obligation arising under or in connection with one or more qualified**
21 **financial contracts where the counterparty or its guarantor is**
22 **organized under the laws of the United States or a state or a foreign**
23 **jurisdiction approved by the Securities Valuation Office (SVO) of the**

24 NAIC as eligible for netting; or

25 (4) If a counterparty to a master netting agreement or a qualified
26 financial contract with an insurer subject to a proceeding under
27 sections 375.1150 to 375.1246 terminates, liquidates, closes out, or
28 accelerates the agreement or contract, damages shall be measured as
29 of the date or dates of termination, liquidation, close out, or
30 acceleration. The amount of a claim for damages shall be actual direct
31 compensatory damages calculated in accordance with subsection 6 of
32 this section.

33 2. Upon termination of a netting agreement or qualified financial
34 contract, the net or settlement amount, if any, owed by a nondefaulting
35 party to an insurer against which an application or petition has been
36 filed under sections 375.1150 to 375.1246 shall be transferred to or on
37 the order of the receiver for the insurer, even if the insurer is the
38 defaulting party, notwithstanding any walkaway clause in the netting
39 agreement or qualified financial contract. For purposes of this
40 subsection, the term "walkaway clause" means a provision in a netting
41 agreement or a qualified financial contract that, after calculation of a
42 value of a party's position or an amount due to or from one of the
43 parties in accordance with its terms upon termination, liquidation, or
44 acceleration of the netting agreement or qualified financial contract,
45 either does not create a payment obligation of a party or extinguishes
46 a payment obligation of a party in whole or in part solely because of
47 the party's status as a nondefaulting party. Any limited two-way
48 payment or first method provision in a netting agreement or qualified
49 financial contract with an insurer that has defaulted shall be deemed
50 to be a full two-way payment or second method provision as against the
51 defaulting insurer. Any such property or amount shall, except to the
52 extent it is subject to one or more secondary liens or encumbrances or
53 rights of netting or setoff, be a general asset of the insurer.

54 3. In making any transfer of a netting agreement or qualified
55 financial contract of an insurer subject to a proceeding under sections
56 375.1150 to 375.1246, the receiver shall either:

57 (1) Transfer to one party, other than an insurer subject to a
58 proceeding under sections 375.1150 to 375.1246, all netting agreements
59 and qualified financial contracts between a counterparty or any
60 affiliate of the counterparty and the insurer that is the subject of the

61 proceeding, including:

62 (a) All rights and obligations of each party under each netting
63 agreement and qualified financial contract; and

64 (b) All property, including any guarantees or other credit
65 enhancement, securing any claims of each party under each netting
66 agreement and qualified financial contract; or

67 (2) Transfer none of the netting agreements, qualified financial
68 contracts, rights, obligations or property referred to in subdivision (1)
69 of this subsection, with respect to the counterparty and any affiliate of
70 the counterparty.

71 4. If a receiver for an insurer makes a transfer of one or more
72 netting agreements or qualified financial contracts, then the receiver
73 shall use its best efforts to notify any person who is party to the netting
74 agreements or qualified financial contracts of the transfer by 12:00
75 noon, the receiver's local time, on the business day following the
76 transfer. For purposes of this subsection, "business day" means a day
77 other than a Saturday, Sunday, or any day on which either the New
78 York Stock Exchange or the Federal Reserve Bank of New York is
79 closed.

80 5. Notwithstanding any other provision of sections 375.1150 to
81 375.1246, a receiver may not avoid a transfer of money or other
82 property arising under or in connection with a netting agreement or
83 qualified financial contract, or any pledge, security, collateral or
84 guarantee agreement or any other similar security arrangement or
85 credit support document relating to a netting agreement or qualified
86 financial contract, that is made before the commencement of a formal
87 delinquency proceeding under sections 375.1150 to 375.1246. However,
88 a transfer may be avoided pursuant to section 375.1192 if the transfer
89 was made with actual intent to hinder, delay or defraud the insurer, a
90 receiver appointed for the insurer, or existing or future creditors.

91 6. (1) In exercising the rights of disaffirmance or repudiation of
92 a receiver with respect to any netting agreement or qualified financial
93 contract to which an insurer is a party, the receiver for the insurer
94 shall either:

95 (a) Disaffirm or repudiate all netting agreements and qualified
96 financial contracts between a counterparty or any affiliate of the
97 counterparty and the insurer that is the subject of the proceeding; or

98 **(b) Disaffirm or repudiate none of the netting agreements and**
99 **qualified financial contracts referred to in paragraph (a) of this**
100 **subdivision, with respect to the person or any affiliate of the person.**

101 **(2) Notwithstanding any other provision of sections 375.1150 to**
102 **375.1246, any claim of a counterparty against the estate arising from**
103 **the receiver's disaffirmance or repudiation of a netting agreement or**
104 **qualified financial contract that has not been previously affirmed in**
105 **the liquidation or immediately preceding conservation or rehabilitation**
106 **case shall be determined and shall be allowed or disallowed as if the**
107 **claim had arisen before the date of the filing of the petition for**
108 **liquidation or, if a conservation or rehabilitation proceeding is**
109 **converted to a liquidation proceeding, as if the claim had arisen before**
110 **the date of the filing of the petition for conservation or**
111 **rehabilitation. The amount of the claim shall be the actual direct**
112 **compensatory damages determined as of the date of the disaffirmance**
113 **or repudiation of the netting agreement or qualified financial**
114 **contract. The term "actual direct compensatory damages" does not**
115 **include punitive or exemplary damages, damages for lost profit or lost**
116 **opportunity or damages for pain and suffering, but does include normal**
117 **and reasonable costs of cover or other reasonable measures of damages**
118 **utilized in the derivatives, securities or other market for the contract**
119 **and agreement claims.**

120 **7. The term "contractual right" as used in this section includes**
121 **any right set forth in a rule or bylaw of a derivatives clearing**
122 **organization, as defined in the Commodity Exchange Act, a multilateral**
123 **clearing organization, as defined in the Federal Deposit Insurance**
124 **Corporation Improvement Act of 1991, a national securities exchange,**
125 **a national securities association, a securities clearing agency, a**
126 **contract market designated under the Commodity Exchange Act, a**
127 **derivatives transaction execution facility registered under the**
128 **Commodity Exchange Act, or a board of trade, as defined in the**
129 **Commodity Exchange Act, or in a resolution of the governing board**
130 **thereof and any right, whether or not evidenced in writing, arising**
131 **under statutory or common law, or under law merchant, or by reason**
132 **of normal business practice.**

133 **8. The provisions of this section shall not apply to persons who**
134 **are affiliates of the insurer that is the subject of the proceeding.**

135 **9. All rights of counterparties under sections 375.1150 to 375.1246**
136 **shall apply to netting agreements and qualified financial contracts**
137 **entered into on behalf of the general account or separate accounts if**
138 **the assets of each separate account are available only to counterparties**
139 **to netting agreements and qualified financial contracts entered into on**
140 **behalf of that separate account.**

 375.1255. 1. "Company action level event" means with respect to any
2 insurer, any of the following events:

3 (1) The filing of an RBC report by the insurer which indicates that:

4 (a) The insurer's total adjusted capital is greater than or equal to its
5 regulatory action level RBC but less than its company action level RBC; or

6 (b) If a life and health insurer, the insurer has total adjusted capital
7 which is greater than or equal to its company action level RBC but less than the
8 product of its authorized control level capital and 2.5, and has a negative trend;

9 **(c) If a property and casualty insurer, the insurer has total**
10 **adjusted capital which is greater than or equal to its Company Action**
11 **Level RBC but less than the product of its Authorized Control Level**
12 **RBC and 3.0 and triggers the trend test determined in accordance with**
13 **the trend test calculation included in the Property and Casualty RBC**
14 **report instructions;**

15 (2) The notification by the director to the insurer of an adjusted RBC
16 report that indicates the event in paragraph (a) [or], (b), **or (c)** of subdivision (1)
17 of this subsection, if the insurer does not challenge the adjusted RBC report
18 pursuant to section 375.1265;

19 (3) If pursuant to section 375.1265 the insurer challenges an adjusted
20 RBC report that indicates the event described in subdivision (1) of this
21 subsection, the notification by the director to the insurer that the director has,
22 after a hearing, rejected the insurer's challenge.

23 2. In the event of a company action level event the insurer shall prepare
24 and submit to the director an RBC plan which shall:

25 (1) Identify the conditions in the insurer which contribute to the company
26 action level event;

27 (2) Contain proposals of corrective actions which the insurer intends to
28 take and would be expected to result in the elimination of the company action
29 level event;

30 (3) Provide projections of the insurer's financial results in the current

31 year and at least the four succeeding years, both in the absence of proposed
32 corrective actions and giving effect to the proposed corrective actions, including
33 projections of statutory operating income, net income, capital or surplus. The
34 projections for both new and renewal business might include separate projections
35 for each major line of business and separately identify each significant income,
36 expense and benefit component;

37 (4) Identify the key assumptions impacting the insurer's projections and
38 the sensitivity of the projections to the assumptions; and

39 (5) Identify the quality of, and problems associated with, the insurer's
40 business, including but not limited to its assets, anticipated business growth and
41 associated surplus strain, extraordinary exposure to risk, mix of business and use
42 of reinsurance in each case, if any.

43 3. The RBC plan shall be submitted:

44 (1) Within forty-five days of the company action level event; or

45 (2) If the insurer challenges an adjusted RBC report pursuant to section
46 375.1265 within forty-five days after notification to the insurer that the director
47 has, after a hearing, rejected the insurer's challenge.

48 4. Within sixty days after the submission by an insurer of an RBC plan
49 to the director, the director shall notify the insurer whether the RBC plan shall
50 be implemented or is, in the judgment of the director, unsatisfactory. If the
51 director determines the RBC plan is unsatisfactory, the notification to the insurer
52 shall set forth the reasons for the determination, and may set forth proposed
53 revisions which will render the RBC plan satisfactory, in the judgment of the
54 director. Upon notification from the director, the insurer shall prepare a revised
55 RBC plan, which may incorporate by reference any revisions proposed by the
56 director, and shall submit the revised RBC plan to the director:

57 (1) Within forty-five days after the notification from the director; or

58 (2) If the insurer challenges the notification from the director pursuant
59 to section 375.1265, within forty-five days after a notification to the insurer that
60 the director has, after a hearing, rejected the insurer's challenge.

61 5. In the event of a notification by the director to an insurer that the
62 insurer's RBC plan or revised RBC plan is unsatisfactory, the director may at the
63 director's discretion, subject to the insurer's right to a hearing under section
64 375.1265, specify in the notification that the notification constitutes a regulatory
65 action level event.

66 6. Every domestic insurer that files an RBC plan or revised RBC plan

67 with the director shall file a copy of the RBC plan or revised RBC plan with the
68 chief insurance regulatory official in any state in which the insurer is authorized
69 to do business if:

70 (1) Such state has an RBC provision, substantially similar to subsection
71 1 of section 375.1267; and

72 (2) The chief insurance regulatory official of that state has notified the
73 insurer of its request for the filing in writing, in which case the insurer shall file
74 a copy of the RBC plan or revised RBC plan in that state no later than the later
75 of:

76 (a) Fifteen days after the receipt of notice to file a copy of its RBC plan
77 or revised RBC plan with the state; or

78 (b) The date on which the RBC plan or revised RBC plan is filed under
79 subsection 3 or 4 of this section.

**376.882. 1. If a Medicare supplement policy issued, delivered, or
2 renewed in this state on or after January 1, 2011, is cancelled for any
3 reason, the insurer shall refund the unearned portion of any premium
4 paid beyond the month in which the cancellation is effective. Any
5 refund shall be returned to the policyholder within twenty days from
6 the date the insurer receives notice of the cancellation.**

**7 2. The policyholder may notify the insurer of cancellation of such
8 Medicare supplement policy by sending verbal, written, or electronic
9 notification.**

376.1109. 1. The director may adopt regulations that include standards
2 for full and fair disclosure setting forth the manner, content and required
3 disclosures for the sale of long-term care insurance policies, terms of renewability,
4 initial and subsequent conditions of eligibility, nonduplication of coverage
5 provisions, coverage of dependents, preexisting conditions, termination of
6 insurance, continuation or conversion, probationary periods, limitations,
7 exceptions, reductions, elimination periods, requirements for replacement,
8 recurrent conditions and definitions of terms. Regulations adopted pursuant to
9 sections 376.1100 to 376.1130 shall be in accordance with the provisions of
10 chapter 536, RSMo.

11 2. No long-term care insurance policy may:

12 (1) Be canceled, nonrenewed or otherwise terminated on the grounds of
13 the age or the deterioration of the mental or physical health of the insured
14 individual or certificate holder; or

15 (2) Contain a provision establishing a new waiting period in the event
16 existing coverage is converted to or replaced by a new or other form within the
17 same company, except with respect to an increase in benefits voluntarily selected
18 by the insured individual or group policyholder; or

19 (3) Provide coverage for skilled nursing care only or provide significantly
20 more coverage for skilled care in a facility than for lower levels of care.

21 3. No long-term care insurance policy or certificate other than a policy or
22 certificate thereunder issued to a group as defined in paragraph (a) of subdivision
23 (4) of subsection 2 of section 376.1100:

24 (1) Shall use a definition of preexisting condition which is more restrictive
25 than the following: "Preexisting condition" means a condition for which medical
26 advice or treatment was recommended by, or received from, a provider of health
27 care services, within six months preceding the effective date of coverage of an
28 insured person;

29 (2) May exclude coverage for a loss or confinement which is the result of
30 a preexisting condition unless such loss or confinement begins within six months
31 following the effective date of coverage of an insured person.

32 4. The director may extend the limitation periods set forth in subdivisions
33 (1) and (2) of subsection 3 of this section as to specific age group categories in
34 specific policy forms upon findings that the extension is in the best interest of the
35 public.

36 5. The definition of preexisting condition provided in subsection 3 of this
37 section does not prohibit an insurer from using an application form designed to
38 elicit the complete health history of an applicant, and, on the basis of the answers
39 on that application, from underwriting in accordance with that insurer's
40 established underwriting standards. Unless otherwise provided in the policy or
41 certificate, a preexisting condition, regardless of whether it is disclosed on the
42 application, need not be covered until the waiting period described in subdivision
43 (2) of subsection 3 of this section expires. No long-term care insurance policy or
44 certificate may exclude or use waivers or riders of any kind to exclude, limit or
45 reduce coverage or benefits for specifically named or described preexisting
46 diseases or physical conditions beyond the waiting period described in subdivision
47 (2) of subsection 3 of this section.

48 6. No long-term care insurance policy may be delivered or issued for
49 delivery in this state if such policy:

50 (1) Conditions eligibility for any benefits on a prior hospitalization

51 requirement; or

52 (2) Conditions eligibility for benefits provided in an institutional care
53 setting on the receipt of a higher level of institutional care; or

54 (3) Conditions eligibility for any benefits other than waiver of premium,
55 post-confinement, post-acute care or recuperative benefits on a prior
56 institutionalization requirement.

57 7. A long-term care insurance policy containing post-confinement,
58 post-acute care or recuperative benefits shall clearly label in a separate
59 paragraph of the policy or certificate entitled "Limitations or Conditions on
60 Eligibility for Benefits" such limitations or conditions, including any required
61 number of days of confinement.

62 8. A long-term care insurance policy or rider which conditions eligibility
63 of noninstitutional benefits on the prior receipt of institutional care shall not
64 require a prior institutional stay of more than thirty days.

65 9. No long-term care insurance policy or rider which provides benefits only
66 following institutionalization shall condition such benefits upon admission to a
67 facility for the same or related conditions within a period of less than thirty days
68 after discharge from the institution.

69 10. The director may adopt regulations establishing loss ratio standards
70 for long-term care insurance policies provided that a specific reference to
71 long-term care insurance policies is contained in the regulation.

72 11. Long-term care insurance applicants shall have the right to return the
73 policy or certificate within thirty days of its delivery and to have the premium
74 refunded if, after examination of the policy or certificate, the applicant is not
75 satisfied for any reason. Long-term care insurance policies and certificates shall
76 have a notice prominently printed on the first page or attached thereto stating
77 in substance that the applicant shall have the right to return the policy or
78 certificate within thirty days of its delivery and to have the premium refunded
79 if, after examination of the policy or certificate, other than a certificate issued
80 pursuant to a policy issued to a group defined in paragraph (a) of subdivision (4)
81 of subsection 2 of section 376.1100, the applicant is not satisfied for any
82 reason. This subsection shall also apply to denials of applications and any refund
83 must be made within thirty days of the return or denial.

84 **12. (1) If a long-term care insurance policy issued, delivered, or**
85 **renewed in this state on or after January 1, 2011, is cancelled for any**
86 **reason, the insurer shall refund the unearned portion of any premium**

87 paid beyond the month in which the cancellation is effective. Any
88 refund shall be returned to the policyholder within twenty days from
89 the date the insurer receives notice of the cancellation. Long-term care
90 insurance policies and certificates shall have a notice prominently
91 printed on the first page or attached thereto stating in substance that
92 the applicant shall be entitled to a refund of the unearned premium if
93 the policy is cancelled for any reason.

94 (2) The policyholder may notify the insurer of cancellation of
95 such long-term care insurance policy at anytime by sending verbal,
96 written, or electronic notification.

376.1110. 1. No insurance company licensed to transact business
2 in this state shall deliver or issue for delivery in this state any policy
3 or certificate of long-term care insurance, unless the classification of
4 risks and the premium rates pertaining to such policy or certificate
5 have been filed with and approved by the director.

6 2. Rates for long-term care insurance shall not be excessive,
7 inadequate, or unfairly discriminatory. In no event shall the rates
8 charged to any policy holder or certificate holder increase by more
9 than fifteen percent during any annual period, unless the insurer can
10 clearly document a material and significant change in the risk
11 characteristics of all its in force long-term care insurance policies or
12 certificates. All rates for long-term care insurance shall be made in
13 accordance with the following provisions and due consideration shall
14 be given to:

- 15 (1) Past and prospective loss experience;
- 16 (2) Past and prospective expenses;
- 17 (3) Adequate contingency reserves; and
- 18 (4) All other relevant factors within and without the state.

19 3. The director shall approve or disapprove a rate filing within
20 forty-five days after the filing and submission thereof. The failure of
21 the director to take action approving or disapproving a submitted rate
22 filing within the stipulated time shall be deemed an approval thereof
23 until such time as the director shall notify the submitting company of
24 his or her disapproval thereof. If a rate filing is disapproved, the
25 reasons therefor shall be stated in writing. Any notice of disapproval
26 shall state that a hearing shall be granted, if so requested.

376.1257. 1. Each health benefit plan that is delivered, issued for

2 delivery, or renewed in this state that provides coverage for cancer
3 chemotherapy treatment shall provide coverage for a prescribed, orally
4 administered anticancer medication used to kill or slow the growth of
5 cancerous cells on a basis no less favorable than intravenously
6 administered or injected cancer medications that are covered under the
7 health benefit plan. As used in this section, the term "health benefit
8 plan" shall have the same meaning ascribed to it in section 376.1350.

9 2. The provisions of this section shall not apply to a
10 supplemental insurance policy, including a life care contract,
11 accident-only policy, specified disease policy, hospital policy providing
12 a fixed daily benefit only, Medicare supplement policy, long-term care
13 policy, short-term major medical policies of six months or less duration,
14 or any other supplemental policy as determined by the director of the
15 department of insurance, financial institutions and professional
16 registration.

17 3. An increase in patient cost sharing for anticancer medications
18 shall not be allowed to achieve compliance with the provisions of this
19 section.

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