

SECOND REGULAR SESSION  
SENATE COMMITTEE SUBSTITUTE FOR  
HOUSE COMMITTEE SUBSTITUTE FOR

# HOUSE BILL NO. 1764

## 95TH GENERAL ASSEMBLY

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Reported from the Committee on Small Business, Insurance and Industry, April 22, 2010, with recommendation that the Senate Committee Substitute do pass.

4419S.04C

TERRY L. SPIELER, Secretary.

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### AN ACT

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

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

Section A. Sections 375.1152, 375.1155, 375.1175, 375.1255, and 376.1109, RSMo, are repealed and ten new sections enacted in lieu thereof, to be known as sections 375.539, 375.1152, 375.1155, 375.1175, 375.1191, 375.1255, 376.882, 376.1109, 376.1110,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

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

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

**(1) Adverse findings reported in financial condition and market conduct examination reports, audit reports, and actuarial opinions,**

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

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 or 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.**

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