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.

TERRY L. SPIELER, Secretary.

5152S.03C

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Section A. Sections 354.442, 375.1152, 375.1155, 375.1175, 375.1255, and 376.1109, RSMo, are repealed and twelve new sections enacted in lieu thereof, to be known as sections 354.442, 375.024, 375.539, 375.1152, 375.1155, 375.1175, 375.1191, 375.1255, 376.882,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

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

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

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

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

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

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

(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.

(c) The time frames under which utilization review decisions shall be made for prospective, retrospective and concurrent decisions;

(d) The right to reconsideration;

(e) The right to an appeal, including the expedited and standard appeals processes and the time frames for such appeals;

(f) The right to designate a representative;

(g) A notice that all denials of claims shall be made by qualified clinical personnel and that all notices of denial shall include information about the basis of the decision; and

(h) Further appeal rights, if any;

(5) An explanation of an enrollee's financial responsibility for payment of premiums, coinsurance, co-payments, deductibles and any other charge, annual limits on an enrollee's financial responsibility, caps on payments for covered services and financial responsibility for noncovered health care procedures, treatments or services provided within the health maintenance organization;

(6) An explanation of an enrollee's financial responsibility for payment when services are provided by a health care provider who is not part of the health maintenance organization's network or by any provider without required authorization, or when a procedure, treatment or service is not a covered health care benefit;

(7) A description of the grievance procedures to be used to resolve disputes between a health maintenance organization and an enrollee, including:

(a) The right to file a grievance regarding any dispute between an enrollee and a health maintenance organization;

(b) The right to file a grievance when the dispute is about referrals or covered benefits;

(c) The toll-free telephone number which enrollees may use to file a grievance;

(d) The department of insurance, financial institutions and professional registration's toll-free consumer complaint hot line number;

(e) The time frames and circumstances for expedited and standard grievances;

(f) The right to appeal a grievance determination and the procedures for filing such an appeal;

(g) The time frames and circumstances for expedited and standard appeals;

(h) The right to designate a representative;

(i) A notice that all disputes involving clinical decisions shall be made by qualified clinical personnel; and

(j) All notices of determination shall include information about the basis of the decision and further appeal rights, if any;

(8) A description of a procedure for providing care and coverage twenty-four hours a day, seven days a week, for emergency services. Such description shall include the definition of emergency services and emergency medical condition, notice that emergency services are not subject to prior approval, and shall describe the enrollee's financial and other responsibilities regarding obtaining such services, including when such services are received outside the health maintenance organization's service area;

(9) A description of procedures for enrollees to select and access the health maintenance organization's primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients;

(10) A description of the procedures for changing primary and specialty care providers within the health maintenance organization;

(11) Notice that an enrollee may obtain a referral for covered services to a health care provider outside of the health maintenance organization's network or panel when the health maintenance organization does not have a health care provider with appropriate training and experience in the network or panel to meet the particular health care needs of the enrollee and the procedure by which the enrollee may obtain such referral;

(12) A description of the mechanisms by which enrollees may participate in the development of the policies of the health maintenance organization;

(13) Notice of all appropriate mailing addresses and telephone numbers to be utilized by enrollees seeking information or authorization;

(14) **[**A listing**]** **Listings** by specialty, which may be in **[**a**]** separate **[**document that is**]** **documents that are** updated annually, of the names, addresses and telephone numbers of all participating providers, including facilities, and in addition in the case of physicians, board certification; and

(15) The director of the department of insurance, financial institutions and professional registration shall develop a standard credentialing form which shall be used by all health carriers when credentialing health care professionals in a managed care plan. If the health carrier demonstrates a need for additional information, the director of the department of insurance, financial institutions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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, reports, or summaries;

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

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

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

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

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

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

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

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

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

(10) The age and collectibility of receivables;

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

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

and misleading information concerning an inquiry;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(12) Notwithstanding any other provision of law limiting the

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

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

6. This section shall not be interpreted to limit the powers granted the director by any laws or parts of laws of this state, nor shall this section be interpreted to supercede any laws or parts of laws of this state, except that if the insurer is a foreign insurer, the director's order under subsection 4 of this section may be limited to the extent 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 375.1246, the following words and phrases shall mean:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

proceeding;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(15) **"Netting agreement":**

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

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

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

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

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

(a) "Commodity contract", shall mean:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) The transaction of further business;

(2) The transfer of property;

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

(4) Waste of the insurer's assets;

(5) Dissipation and transfer of bank accounts;

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

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

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

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

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

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

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

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

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

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

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

(2) That the insurer is insolvent;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NAIC as eligible for netting; or

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

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

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

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

proceeding, including:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. The RBC plan shall be submitted:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. No long-term care insurance policy may:

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

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

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

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

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

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

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

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

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

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

requirement; or

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

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

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

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

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

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

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

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

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

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

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

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

(1) Past and prospective loss experience;

(2) Past and prospective expenses;

(3) Adequate contingency reserves; and

(4) All other relevant factors within and without the state.

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

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

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

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

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

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