Missouri

HHS Health Insurance Rate Review Grants-Cycle I

Grant Application

STATE: Missouri

APPLICATION COVER SHEET AND CHECK-OFF LIST

Indentifying Information:

Grant Opportunity: **HHS Health Insurance Rate Review Grants-Cycle I**

DUNS #:_____073659331_____ Grant Award: $1 million_____

Applicant:_Missouri Department of Insurance, Financial Institutions and Professional Registration__

Primary Contact Person, Name:___John M. Huff, Director _____

Telephone Number:____573-751-1927_____Fax number:__573-751-1165_____

Email address:____john.huff@difp.mo.gov_____

APPLICATION COVER SHEET AND CHECK-OFF LIST

REQUIRED CONTENTS

A complete proposal consists of the following material organized in the sequence below: Please ensure that the project narrative is page-numbered. The sequence is:

- ✓ Cover Sheet
- ✓ Forms/Mandatory Documents (Grants.gov).

  The following forms must be completed with an original signature and enclosed as part of the proposal:
- ✓ SF-424: Application for Federal Assistance
- ✓ SF-424A: Budget Information
- ✓ SF-424B: Assurances-Non-Construction Programs
- ✓ SF-LLL: Disclosure of Lobbying Activities
- ✓ Additional Assurance Certifications
- ✓ Required Letter of support and Memorandum of Agreement
- ✓ Applicant's Application Cover Letter
- ✓ Project Abstract
- ✓ Project Narrative
- ✓ Work plan and Time Line
- ✓ Proposed Budget (Narrative/Justifications)
- ✓ Required Appendices
- ✓ Resume/Job Description for Project Director and Assistant Director

Jeremiah W. (Jay) Nixon
Governor
State of Missouri

Office of the Director

Department of Insurance
Financial Institutions
and Professional Registration
John M. Huff, Director

July 6, 2010

Jay Angoff, Director
Office of Consumer Information and Insurance Oversight
United States Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Grants to States for Health Insurance Premium Review – Cycle I

Dear Director Angoff,

The Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP) is respectfully requesting grant funds in order to fund the enhancement of its health insurance rate review. Our department looks forward to working with the Department of Health and Human Services in a productive partnership to effectively deliver fair and reasonable health insurance rates to consumers.

As the regulator of the insurance industry in this state, the DIFP is deeply committed to ensuring consumers receive quality coverage under their insurance policies and are charged a fair and reasonable rate for that coverage. Our proposal requests funds in the amount of $1,000,000, which will be used for the construction and implementation of a rate review system to house health insurance rates, and to perform subsequent analysis of health insurance rates and required reporting to the Department of Health and Human Services.

Our department currently maintains a relative minimal amount of rate review authority in the health insurance market. However, we anticipate that combined with the additional authority to review rates as granted by the Patient Protection and Affordability Care Act, the utilization of our proposed new rate review system will position the DIFP to conduct a review and analysis of health insurance rates charged by carriers in this state. We will also be hosting meetings with both consumers and industry representatives to gather input on our rate review processes.

The DIFP has selected James Morris, Senior Counsel, to serve as Project Director for this initiative. Mr. Morris will oversee the administration of the grant funds and will maintain oversight of milestones and goals relating to the rate review grant. Mr. Morris may be contacted at james.morris@insurance.mo.gov or by phone at 573.751.3365.

Thank you for your interest in and consideration of this project.

Sincerely,

John M. Huff

ENCLOSURE

GOVERNOR OF MISSOURI

JEFFERSON CITY
65102

JEREMIAH W. (JAY) NIXON
GOVERNOR

P.O. Box 720
(573) 751-3222

July 6, 2010

Mr. John Huff
Department Director
Missouri Department of Insurance, Financial Institutions
and Professional Registration
301 W. High Street, Suite 530
Jefferson City, MO 65101

Dear Director Huff:

This correspondence serves as notice of support for your department's application for the Health Insurance Premium Review grant offered by the U.S. Department of Health and Human Services. I share your department's desire to make health insurance more accessible and affordable for Missouri consumers, and to increase the transparency of the health insurance system. I am asking your department to take the lead role in this process due to the expertise of your team and the department's strong track record of providing consumer protection to Missourians.

Missouri has a proud tradition of strong, state-based insurance regulation. This critical oversight of protecting consumers while ensuring strong, sustainable insurance markets is vital to maintaining competitive insurance rates and products. I support your efforts to build upon the premium review and reporting processes in Missouri.

By working together, Missouri will continue to maintain a high quality health care system that is increasingly accessible and affordable for the residents of our state.

Sincerely,

Jeremiah W. (Jay) Nixon
Governor

OMB Number: 4040-0004
Expiration Date: 03/31/2012

Application for Federal Assistance SF-424

* 1. Type of Submission:	* 2. Type of Application:	* If Revision, select appropriate letter(s):
☐ Preapplication	☒ New	
☒ Application	☐ Continuation	* Other (Specify):
☐ Changed/Corrected Application	☐ Revision	

* 3. Date Received:	4. Applicant Identifier:
07/07/2010	

5a. Federal Entity Identifier:	5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:	7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name:	Missouri Department of Insurance

* b. Employer/Taxpayer Identification Number (EIN/TIN):	* c. Organizational DUNS:
44-6000987	0736593310000

d. Address:

* Street1:	301 W High Street, Room 530
Street2:	
* City:	Jefferson City
County/Parish:	
* State:	MO: Missouri
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	65101-1517

e. Organizational Unit:

Department Name:	Division Name:

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:	Mr.	* First Name:	John
Middle Name:	M		
* Last Name:	Huff		
Suffix:			

Title:	Department Director
Organizational Affiliation:	
* Telephone Number:	573-751-1927
Fax Number:	
* Email:	john.huff@difp.mo.gov

Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

A: State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Ofc of Consumer Information & Insurance Oversight

11. Catalog of Federal Domestic Assistance Number:

93.511

CFDA Title:

Affordable Care Act (ACA) Grants to States for Health Insurance Premium Review

*** 12. Funding Opportunity Number:**

RFA-FD-10-999

* Title:

"Grants to States for Health Insurance Premium Review-Cycle I" Office of Consumer Information and Insurance Oversight (OCIIO)

13. Competition Identification Number:

ADOBE-FORMS-B

Title:

14. Areas Affected by Project (Cities, Counties, States, etc.):

Add Attachment | Delete Attachment | View Attachment

*** 15. Descriptive Title of Applicant's Project:**

HHS Grant to States for Health Insurance Premium Review

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant: mo-004 b. Program/Project: mo-all

Attach an additional list of Program/Project Congressional Districts if needed.

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 08/09/2010 * b. End Date: 09/30/2011

18. Estimated Funding ($):

* a. Federal	1,000,000.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	1,000,000.00

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on .

☒ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☐ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

☐ Yes ☒ No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

☒ ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix: Mr. * First Name: Grady

Middle Name:

* Last Name: Martin

Suffix:

* Title: Budget Officer

* Telephone Number: 573-751-7223 Fax Number:

* Email: grady.martin@difp.mo.gov

* Signature of Authorized Representative: Grady Martin * Date Signed: 07/07/2010

BUDGET INFORMATION - Non-Construction Programs

OMB Approval No. 4040-0006
Expiration Date 07/30/2010

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. N/A	93.511	$	$	$ 1,000,000.00	$	$ 1,000,000.00
2.						
3.						
4.						
5. Totals		$	$	$ 1,000,000.00	$	$ 1,000,000.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY (1) N/A	(2)	(3)	(4)	Total (5)
a. Personnel	$ 260,617.00	$	$	$	$ 260,617.00
b. Fringe Benefits	136,668.00				136,668.00
c. Travel	11,500.00				11,500.00
d. Equipment	3,600.00				3,600.00
e. Supplies	2,240.00				2,240.00
f. Contractual	397,183.00				397,183.00
g. Construction	0.00				
h. Other	188,192.00				188,192.00
i. Total Direct Charges (sum of 6a-6h)	1,000,000.00				$ 1,000,000.00
j. Indirect Charges					$
k. TOTALS (sum of 6i and 6j)	$ 1,000,000.00	$	$	$	$ 1,000,000.00
7. Program Income	$	$	$	$	$

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8.	$	$	$	$
9.				
10.				
11.				
12. TOTAL (sum of lines 8-11)	$	$	$	$

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 1,000,000.00	$ 250,000.00	$ 250,000.00	$ 250,000.00	$ 250,000.00
14. Non-Federal	$				
15. TOTAL (sum of lines 13 and 14)	$ 1,000,000.00	$ 250,000.00	$ 250,000.00	$ 250,000.00	$ 250,000.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS) (b)First	(c) Second	(d) Third	(e) Fourth
16.	$	$	$	$
17.				
18.				
19.				
20. TOTAL (sum of lines 16 - 19)	$	$	$	$

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:

22. Indirect Charges:

23. Remarks:

OMB Number: 4040-0003
Expiration Date: 7/30/2011

Key Contacts Form

*** Applicant Organization Name:**

Missouri Department of Insurance

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 1 Project Role:** Project Director

Prefix: Mr.

* First Name: John

Middle Name: M

* Last Name: Huff

Suffix:

Title: Department Director

Organizational Affiliation:

Missouri Department of Insurance

* Street1: 301 W High Street, Room 530

Street2:

* City: Jefferson City

County:

* State: MO: Missouri

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 65101-1517

* Telephone Number: 573-751-1927

Fax:

* Email: john.huff@difp.mo.gov

Delete Entry

Next Person

OMB Number: 4040-0003
Expiration Date: 7/30/2011

Key Contacts Form

*** Applicant Organization Name:**

Missouri Department of Insurance

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 2 Project Role:** Project Officer

Prefix: Mr.

* First Name: James

Middle Name:

* Last Name: Morris

Suffix:

Title: Senior Counsel

Organizational Affiliation:

Missouri Department of Insurance

* Street1: 301 W High Street, Room 530

Street2:

* City: Jefferson City

County:

* State: MO: Missouri

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 65101-1517

* Telephone Number: 573-526-3552

Fax:

* Email: james.morris@insurance.mo.gov

Delete Entry | Previous Person | Next Person

OMB Number: 4040-0003
Expiration Date: 7/30/2011

Key Contacts Form

*** Applicant Organization Name:**

Missouri Department of Insurance

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 3 Project Role:** Fiscal Contact

Prefix: Mrs.

* First Name: Shirley

Middle Name:

* Last Name: Gerling

Suffix:

Title: Fiscal Manager

Organizational Affiliation:

Missouri Department of Insurance

* Street1: 301 W High Street, Room 530

Street2:

* City: Jefferson City

County:

* State: MO: Missouri

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 65101-1517

* Telephone Number: 573-751-1942

Fax:

* Email: shirley.gerling@insurance.mo.gov

Delete Entry | Previous Person | Next Person

OMB Number: 4040-0010
Expiration Date: 08/31/2011

Project/Performance Site Location(s)

Project/Performance Site Primary Location ☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: Missouri Department of Insurance

DUNS Number: 0736593310000

* Street1: 301 W High Street, Room 530

Street2:

* City: Jefferso City County:

* State: MO: Missouri

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 65101-1517 * Project/ Performance Site Congressional District: mo-all

Project/Performance Site Location 1 ☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

DUNS Number:

* Street1:

Street2:

* City: County:

* State:

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: * Project/ Performance Site Congressional District:

Additional Location(s) Add Attachment Delete Attachment View Attachment

OMB Approval No.: 4040-0007
Expiration Date: 07/30/2010

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C.§§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U. S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee- 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

* SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	* TITLE
Grady Martin	Budget Officer
* APPLICANT ORGANIZATION	* DATE SUBMITTED
Missouri Department of Insurance	07/07/2010

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C.1352

Approved by OMB
0348-0046

1. * Type of Federal Action:
- [ ] a. contract
- [x] b. grant
- [ ] c. cooperative agreement
- [ ] d. loan
- [ ] e. loan guarantee
- [ ] f. loan insurance

2. * Status of Federal Action:
- [ ] a. bid/offer/application
- [x] b. initial award
- [ ] c. post-award

3. * Report Type:
- [x] a. initial filing
- [ ] b. material change

4. Name and Address of Reporting Entity:

[x] Prime [ ] SubAwardee

** Name:* Missouri Department of Insurance

** Street 1:* 301 W High Street, Room 530 *Street 2:*

** City:* Jefferson City *State:* MO: Missouri *Zip:* 65101-1517

Congressional District, if known: mo-004

5. If Reporting Entity in No.4 is Subawardee, Enter Name and Address of Prime:

6. * Federal Department/Agency:

Ofc Consumer Info. & Insurance Oversight

7. * Federal Program Name/Description:

Affordable Care Act (ACA) Grants to States for Health Insurance Premium Review

CFDA Number, *if applicable:* 93.511

8. Federal Action Number, *if known:*

9. Award Amount, *if known:*

$

10. a. Name and Address of Lobbying Registrant:

Prefix: ** First Name:* not applicable *Middle Name:*

** Last Name:* not applicable, no lobbying registrant *Suffix:*

** Street 1:* *Street 2:*

** City:* *State:* *Zip:*

b. Individual Performing Services (including address if different from No. 10a)

Prefix: ** First Name:* not applicable *Middle Name:*

** Last Name:* not applicable *Suffix:*

** Street 1:* *Street 2:*

** City:* *State:* *Zip:*

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

*** Signature:** Gray Martin

***Name:** *Prefix:* ** First Name:* Gray *Middle Name:*

** Last Name:* Martin *Suffix:*

Title: Budget Officer **Telephone No.:** 573-751-7273 **Date:** 07/07/2010

Grant Application Executive Summary

Proposed Initiative: The Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP) is applying for the HHS Grant to States for Health Insurance Premium Review – Cycle I to fund its construction and implementation of a rate review system to house health insurance rates, and perform subsequent analysis of health insurance rates and required reporting to HHS. Total funding requested equals $1,000,000.00.

Program Goal: The goal of Missouri's program will be to develop and facilitate a viable health insurance rate review infrastructure by collecting from insurance carriers necessary information relating to rate increases and analyzing that information.

Current Program Status: The DIFP currently maintains a very limited authority and practice with respect to the review of rates charged by carriers within the health insurance market in Missouri. There is no statutory requirement in Missouri for individual, small group or large group health insurance rates to be filed with or reviewed by the DIFP as a condition of their use in this state. Absent enhancements, the DIFP is not positioned to provide consumer protection with respect to the charging of unreasonable rates by carriers in the health insurance market.

Plan of Action: The DIFP proposes to enhance its health insurance rate review via a four-step approach: 1) Expanding the Scope of Current Review and Approval Activities; 2) Increasing Staffing for Rate Review; 3) Enhancing Information Technology Processes Related to Rate Review; and 4) Strengthening Consumer Protection Standards.

Missouri anticipates that the upcoming Federal Rules will provide the state with limited authority to collect rate filings for the purpose of submitting any unreasonable rate increases to HHS. The department will also seek input from all interested parties on the implementation of federal health reform, including rate review. The department will hold public forums across the state to allow consumers and insurance carriers to discuss ways to enhance transparency and consumer protection in the rate review process.

The DIFP will enhance its staffing by hiring additional health insurance rate analysts and actuaries. The department currently employs a staff actuary who has significant experience in health insurance rate review. The department will continue to utilize the services of this actuary, and also anticipates that additional personnel services relating to rate review and analysis will be needed.

The DIFP proposes the development and subsequent enhancement of health insurance rate review in this state under the deployment of a three-phase information technology infrastructure plan. These three phases include 1) Rate review data system design; 2) Rate review data system construction; and 3) Data analysis and leveraging of actuary and analysis staff to review rates and ensure company solvency.

The DIFP will enhance transparency in the rate filing process by posting to the department's Web site information pertaining to health insurance rates. This information will not only include rates themselves but also the carrier justification for such rates in a format that is easy-to-understand by average consumers. The rate review system will provide information to this portion of the Web site, ensuring that Missouri insurance consumers have access to the most up-to-date information detailing rate filings in this state.

Current Rate Review Process

General Health Insurance Rate Regulation Information and Filing Requirements

The department has regulatory authority over health insurance products offered by insurance companies, nonprofit health services corporations and HMOs in the individual market, the small group market and the large group market. The following matrix summarizes the department's current authority regarding the filing and review of health insurance rates in these three markets along with its authority to review rates for the "excepted benefits" of Medicare supplement and long-term care insurance. For comparison purposes, a matrix of the department's authority regarding the filing and review of property and casualty rates has also been provided.

Health

	Individual	Small Group	Large Group	Med Supp	Long-Term Care
Initial rates filed	No	No	No	Yes	Yes
Annual filing req.	No	No	No	Yes	No
Rate increase filed	No	No	No	Yes	Yes
Approval authority	No	No	No	Yes	No
Actuarial certification/ memo required	No	Yes - Annually	No	Yes - Annually	Yes - For initial rates

Property & Casualty

	Personal Lines	Commercial Lines	Work Comp	Title	Med Mal
Initial rates filed	Yes	Yes	Yes	Yes	Yes
Annual filing req.	No	No	No	No	No
Rate increase filed	Yes	Yes	Yes	Yes	Yes
Approval authority	No	No	No	Yes	No

Although Missouri law requires the filing and approval of all policies, contracts, certificates and evidences of coverage used by health insurers for the health insurance products they offer in the individual, small group and large group markets, there is no similar requirement regarding the rates for these products as indicated in the matrix above. The department does, however, have some very limited authority over the rates used in these three markets as explained below.

Small group rates: While small group rates are not filed with the department for review, such rates are subject to a number of statutory requirements including, but not limited to:

- The index rate for a rating period for any class of business cannot exceed the index rate for any other class of business by more than twenty percent (20%).
- For a class of business, the premium rates charged to small employers with similar case characteristics for the same or similar coverage cannot vary from the index rate by more than thirty-five percent (35%) of the index rate.
- An insurer in the small group market cannot use case characteristics, other than age, sex, industry, geographic area, family composition and group size without prior approval.
- Each insurer in the small group market must maintain a complete and detailed description of its rating and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted and sound actuarial assumptions and principles.

- Insurers in the small group market are required to annually file an actuarial certification of compliance with the small group rating laws. Actual rate information is to be made available to the director upon request and regulatory action may be taken against an insurer that fails to comply with Missouri's small group rating requirements.

In 2009 the department received eleven small group actuarial certifications of compliance. These eleven certifications were reviewed by the department's life and health staff actuary. Of the eleven certifications, one disclosed noncompliance with the small group law. In that instance, department staff worked with the applicable carrier to address the noncompliant provision and correct the deficiency.

Unfairly Discriminatory Rates: All health insurance rates are also subject to Missouri's Unfair Trade Practices Act, which prohibits insurers from discriminating between individuals of the same class and hazard in the amount of health insurance premium, policy fees or rates charged. This gives the department's Market Conduct section some limited authority to review health insurance rates. If the section has cause to believe an insurer's rates are unfairly discriminatory, in violation of the Missouri Unfair Trade Practices Act, it may seek a targeted exam that would include a review of that insurer's rates. However, Market Conduct does not currently have the statutory authority to investigate excessive health insurance rates or unreasonable rate increases.

Nonprofit Health Services Corporations (HSCs): The rates of HSCs are also not required to be filed with the department. However, unlike rates of other health insurers,

the rates of HSCs are regulated by the department. HSCs are prohibited from using rates that are excessive, inadequate or unfairly discriminatory. Rates are held to be excessive if they are unreasonably high in relation to the HSC's loss experience under policies with respect to the territory or classification to which such rates are applicable. If, after a public hearing, the director finds that a HSC's rates do not meet these standards, he/she can issue an order stating when the further use of such rates shall be prohibited. Only one HSC is currently licensed in Missouri.

While the department's authority over rates in the individual, small group and large group markets is limited, the department has greater authority over the rates for the excepted benefits of Medicare supplement and long-term care insurance as explained below.

Medicare Supplement: Medicare Supplement rates are required to be filed with and reviewed by the department. Among other requirements, Medicare supplement rate filings must include an actuarial certification that the rates requested are reasonable in relationship to the benefits provided by the policy or certificate.

Long-Term Care: Long-term care rates are also required to be filed with the department, along with an actuarial certification that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rates are reasonably expected to be sustainable over the life of the long-term care form with no future premium increases anticipated. In addition, the director may request an actuarial demonstration that benefits are reasonable in relation to premiums.

Current Level of IT Resources for Reviewing Health Insurance Rates

The department currently utilizes the System for Electronic Rate and Form Filing (SERFF), a product owned and operated by the National Association of Insurance Commissioners (NAIC) to receive and review forms filed with the department by insurance carriers. Small employer actuarial certifications of compliance are also received through the SERFF system, but data is not transferred to any systems within the department. As such, no internal IT resources are currently utilized for review of health insurance rates.

Current Level of Budget and Staffing for Reviewing Health Insurance Rates

The department has one staff actuary that reviews small employer actuarial certifications of compliance. The department estimates that less than five percent (5%) of the actuary's time is spent on the review of these actuarial certifications. Using that estimate, the department currently allocates $8,733.06 in salary and benefits toward the review of small employer actuarial certifications. The department also collects a $50 fee for every filing made with the department. As there were eleven small employer actuarial certification filed with the department is 2009, the department received $550 in filing revenue from insurance carriers.

Maintenance of Effort

The department will expend the same share of funds for rate review activities under the proposed plan of rate review as it expended in the fiscal year preceding the fiscal year for which the grant is awarded. Grant funds will only be used to enhance the state's existing rate review efforts and will not substitute for existing funding for such efforts.

Consumer Protections – Transparency

Generally speaking, the records of the department are public records and are open to the inspection of the public at all times, according to § 374.070, RSMo. The work product of the director, the director's employees and agents (including the work papers of examinations or investigations of entities or persons licensed by the department or of other entities as provided by law), and confidential communications to the director are not considered public records. 20 CSR 1-2.400 further clarifies what constitutes open and closed records of the department. However, as health insurance rates are not required to be filed with the department, there is no mechanism for public access to rates and rate filings. As such, the department is currently unable to provide summaries of rate changes offered in plain language for consumers and cannot give consumers advance notice of proposed rate changes.

Examination and Oversight

Due to Missouri's limited rate review authority, the department has not taken any action against insurance companies or held any formal hearings over the past two plan years regarding health insurance rates.

Proposed Rate Review Enhancements for Health Insurance

The department proposes to enhance its health insurance rate review by 1) Enhancing Rate Review Authority; 2) Increasing Staffing for Rate Review ; 3) Enhancing IT Processes Related to Rate Review; and 4) Strengthening Consumer Protection Standards.

By making these improvements, the department will be in a better position to educate and inform Missouri consumers so that they receive the full value for their health insurance dollar. In addition, these improvements will allow the department to protect consumers from unjustified health insurance rate increases.

Enhancing Rate Review Authority

The department currently has no statutory authority to collect or review health insurance rates as a condition of their use in the state. However, Missouri anticipates that the upcoming Federal Rules will provide the state with at least limited authority to collect rate filings for the purpose of submitting any unreasonable rate increases to HHS.

The department will also seek input from all interested parties on the implementation of federal health reform, including rate review. The department will hold public forums across the state to allow consumers and insurance carriers to discuss ways to enhance transparency and consumer protection in the rate review process.

Increasing Staffing for Rate Review

The department currently does not have the necessary staffing to conduct reviews of health insurance rate filings. As the department begins rate collection and review, it will seek to enhance its staffing by hiring additional health insurance rate analysts and qualified actuaries.

The department currently employs a staff actuary who has significant experience, through previous assignments outside the department, with health insurance rate review. The department will continue to utilize the services of this actuary, though

proposes an updated split of his work time. Currently, due to the department's relative lack of rate review authority, this actuary divides his work time between various duties including rate review, which comprises a relatively small portion of his time, and company solvency analysis, which constitutes the vast majority of his work time.

The department proposes to alleviate this actuary of a portion of his time currently devoted to company solvency and redirect his time to rate analysis. This new portion devoted solely to rate review and analysis is estimated at twenty-five percent (25%). As this actuary possesses the combination of rate review ability and financial solvency experience, the department will ask him to review rate filings not only in accordance with any test for unreasonableness, but also to ensure that the rates charged are consistent with the solvency of such carriers. The department will fund this actuary's rate analysis from this grant.

The department also anticipates that additional actuarial services will be needed to conduct further investigation into the justification provided on any rate deemed unreasonable or excessive. This grant will fund such services with the department's current actuary providing task direction for the additional actuarial services.

It is anticipated that an analyst and office support assistant will be needed to provide the initial intake and review of rate filings to determine whether all necessary information has been submitted in the correct format. This grant will fund such additional services.

The department currently employs a life and health manager who is responsible for the supervision of the department's life and health product analysts. The department proposes to redirect a portion of the manager's time to the supervision of the new rate

analyst and office support assistant. This new portion devoted to rate review is estimated at twenty-five percent (25%).

In addition the department currently employs an attorney who, among other job duties, reviews legal issues related to health insurance. The department proposes to redirect a portion of this attorney's time over the next year to overall grant implementation and reporting. This new portion devoted to rate review is estimated at fifty percent (50%). This grant will fund the additional duties of this attorney and the life and health manager, as they pertain to rate analysis.

Enhancing IT Processes Related to Rate Review

The state of Missouri proposes the development and subsequent enhancement of health insurance rate review in this state under the deployment of a three-phase information technology infrastructure plan. These three phases include 1) Rate Review Data System Design; 2) Rate Review Data System Construction; and 3) Data Analysis.

Rate Review Data System Design: The planning phase of this grant as it relates to information technology will be used to evaluate needs that currently exist within the department and stand as a barrier to providing feasible rate review. As part of this planning, the department will utilize the services of an individual to serve as an IT project manager. A successful candidate for this position would possess an experience factor relatable to past information technology projects. He/she would be able to oversee a project from its inception to completion and leave the department in a position to take over the management duties on a permanent basis. The project manager would assist in preparing the department for enhanced data reporting requirements to be

announced at a later date. Funds from this grant will be used to pay for this individual's services.

The department will also construct and formalize a plan detailing services to be executed by the department's existing information technology staff. Planning will include meeting with the department's information technology manager and applicable staff to determine what level of programming, ongoing support, etc. will be needed, not only as part of the implementation of this plan, but also post-implementation. Services of existing information technology staff and contract programming staff that pertain to duties under this initiative will be funded from this grant.

Rate Review Data System Construction: In light of the rather limited requirements pertaining to the reporting of health insurance rates to the department, the data collection phase of this process will be integral to the success of the department's initiative. The very collection of health insurance rates in Missouri would serve as a vast improvement to current procedures. By building upon such collection and assessing the validity of rate increases filed by carriers conducting business in this state, the department will provide consumer protections and exchange of information that will far exceed any currently in use by the department.

This grant will facilitate the department's construction of a data system which will house the rates and related increases filed for use in this state. This data system will be constructed with a format that will be searchable by various criteria germane to the carrier's filing. These criteria may include, but are not limited to: carrier, product type, market segment, rate, rate increase, effective date of rate/increase and date filed. In

addition, this data system will include the ability for users to run reports detailing not only a particular rate or increase, but also a set of rates and/or increases based upon parameters submitted by the user.

The department will also examine the leveraging of the SERFF system. The NAIC has provided the department preliminary specifications for enhanced utilization of SERFF which would include the filing of health insurance rates through this system for review by department staff. These enhancements to SERFF for rate filings would be paid from these grant funds. The NAIC estimates that these enhancements will be implemented in a phased approach with the first release to occur within three months of the release of reporting requirements by HHS. As alluded to more specifically in the NAIC specifications:

> *The initial release will focus on implementing the means for data collection; subsequent releases will incorporate reporting needs. Releasing functionality in this manner will allow a period of time during which data can then be submitted by insurers prior to any required reporting to HHS, thus avoiding manual data collection processes. Based on the requirements known at this time, the development will occur over an 8 month period beginning when the NAIC receives the reporting template and supporting documentation.*

The department's information technology enhancements will ensure compatibility between the department's data system and SERFF. The rates and increases filed

through SERFF will be transported to the department's data system via SERFF's existing Application Programming Interface (API) and housed in the same.

Data Analysis: The data system detailed earlier in this narrative will provide the structure and mechanism for the department's actuaries to perform rate analysis as it will collect a broad range of information to be taken into consideration when reviewing rate filings. Preliminary plans would direct the department to collect, store and analyze company information such as quarterly/annual financials, policy form filings, market share information and historical rate information. Through the relational analysis of this myriad of insurance company information, the department will be positioned to provide a thorough review of rate filings and a clear, complete picture of the company will be accessible to applicable department staff. The department believes this approach to the review of rate filings to be advantageous over a more limited approach of reviewing rate filings completely exclusive of these other aspects. The vital issue of solvency is one which must be taken into account in the complete analysis of rates filed for use with the department and will be with the construction of this database providing a direct link between rate filings and the financial filings of any given carrier conducting business in this state.

The department will fund actuarial rate analysis from this grant. As stated earlier, the department also anticipates that additional actuarial services relating to rate review and analysis will be needed. This grant would fund such services with the department's existing actuary providing task direction for the additional actuarial services.

Strengthening Consumer Protection Standards

The state will seek to enhance transparency in the rate filing process by posting to the department's Web site information pertaining to health insurance rates. This information will not only include rates themselves but also the carrier justification for such rates in a format that is easy-to-understand by average consumers. The database that will be constructed under this grant will provide virtually real-time information to this portion of the Web site, ensuring that Missouri insurance consumers have access to the most up-to-date information detailing rate filings in this state. The Web site will allow consumers to search for information pertaining to particular companies, date ranges, products, status, NAIC number, etc. It will also allow consumers to sort columns of information and view such in manageable formats, as well as submit comments to rate requests.

The department will also provide consumers a process narrative relating to Missouri's rate review procedures and how those procedures coordinate with HHS's rate review procedures. Serving as the pinnacle of the department's efforts to enhance consumer protection standards and employ a complete transparency in the rate review area, consumers will be able to sign-up for e-mail notifications when insurance carriers file rate requests.

Missouri's use of a large portion of the funds contained in this first grant will serve to construct and subsequently implement information technology structures and processes that will enhance consumer protection and further an open process of rate review in this state. Once these grant funds are utilized to alleviate the financial burden of constructing the aforementioned enhancements, the Missouri department will continue to provide technical support for these efforts.

Reporting to the Secretary on Rate Increase Patterns

Section 2794 of the PPACA requires grant participants to provide data to the Secretary of HHS on health insurance rates and rate trending. The department plans to utilize the data system described under the information technology portion of this narrative to report pertinent data to the Secretary. This data system will be robust in nature in that it will house all information the Secretary may desire to collect from states in efforts to effectively regulate health insurance rates in this state. It will provide electronic data exchange to programs and databases within HHS and any other governmental agency determined necessary. By constructing this internal data system and establishing an information link between it and HHS, rates deemed "unreasonable" will be very apparent, obvious and separate from those rates which are reasonable.

As the department maintains minimal rate review authority, historical rate trends will not be available to be provided to HHS until this data system is built and rates begin to be collected. Even upon the collection of health insurance rates, conclusions from such rate trends cannot be drawn until an acceptable baseline multitude of rate data is collected and analyzed. Though the department estimates this baseline of a few years, information relating to the same will be provided to HHS by the department in the interim. The state of Missouri will comply with reporting requirements outlined in any applicable federal statutes.

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

Project:

HHS Grant to States for Health Insurance Premium Review

*** Year:** 1

*** Funding Agency Goal:** Grants for health insurance premium review, Cycle I

*** Objective:**

To review health rates to ensure they are not excessive or unreasonable; provide transparency of rate information by creating an interactive web site; conduct outreach activities through public forums, web site creation and assistance from the Consumer Affairs unit within the Department; report unreasonable rates to HHS; and trend the data and report any anomalies to HHS.

*** Results or Benefits Expected:**

Strengthened consumer protections by ensuring the consumers are not paying excessive rates for coverage, better informed consumers through outreach activities, and compliance with the Affordable Care Act.

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
Creating the IT infrastructure to accept rate filings, process rate filings, and share rate filing information with HHS. We anticipate phases as described below.	IT Project Manager Project Manager	08/10/2010	01/31/2011	0
IT Phase I: System Design. IT will need to review the application requirements, analyze our current IT capabilities, identify additional IT systems needed and establishing a work plan.	IT Project Manager Project Manager	08/01/2010	10/31/2011	0
IT Phase II: System Construction. Currently, MO does not receive rate filings. MO will need to initiate data collection, implement policies, review policies for process improvements, and implement the process improvements.	IT Project Manager Project Manager	11/01/2010	02/28/2011	0
IT Phase III: Data Analysis: Initially, the analysis of data will be extensive to ensure an effective process, reliable submission format and data integrity. An analyst will receive the filings and prepare the filings for the actuary.	Actuary; Analyst	03/01/2011	12/31/2011	0

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
Phase IV: Data Reporting. MO will need to identify the system needs that would allow for collecting and sharing of information from various parties: insurance companies, HHS, the Public and NAIC.	IT Project Manager Project Manager	03/01/2011	12/31/2011	0
Phase V: the creation of an interactive web site that provides rate transparency to the public.	IT Project Manager Project Manager	03/01/2011	12/31/2011	0
Creation of a rate narrative for consumers available in hard copy or through e-mail.	Public Information Officer IT	03/01/2011	12/31/2011	0
Consumer and Industry outreach: conduct public forums, train consumer service representatives, create and issue press releases and other forms of media.	Public Information Officer, Consumer Affairs Project Manager	08/01/2010	05/31/2011	0

*** Criteria for Evaluating Results or Benefits Expected:**

A reduced number of uninsured; the number of rate filings compared to health form filings; better informed consumers; data for DIFP to analyze trends and make projections; and reporting to HHS.

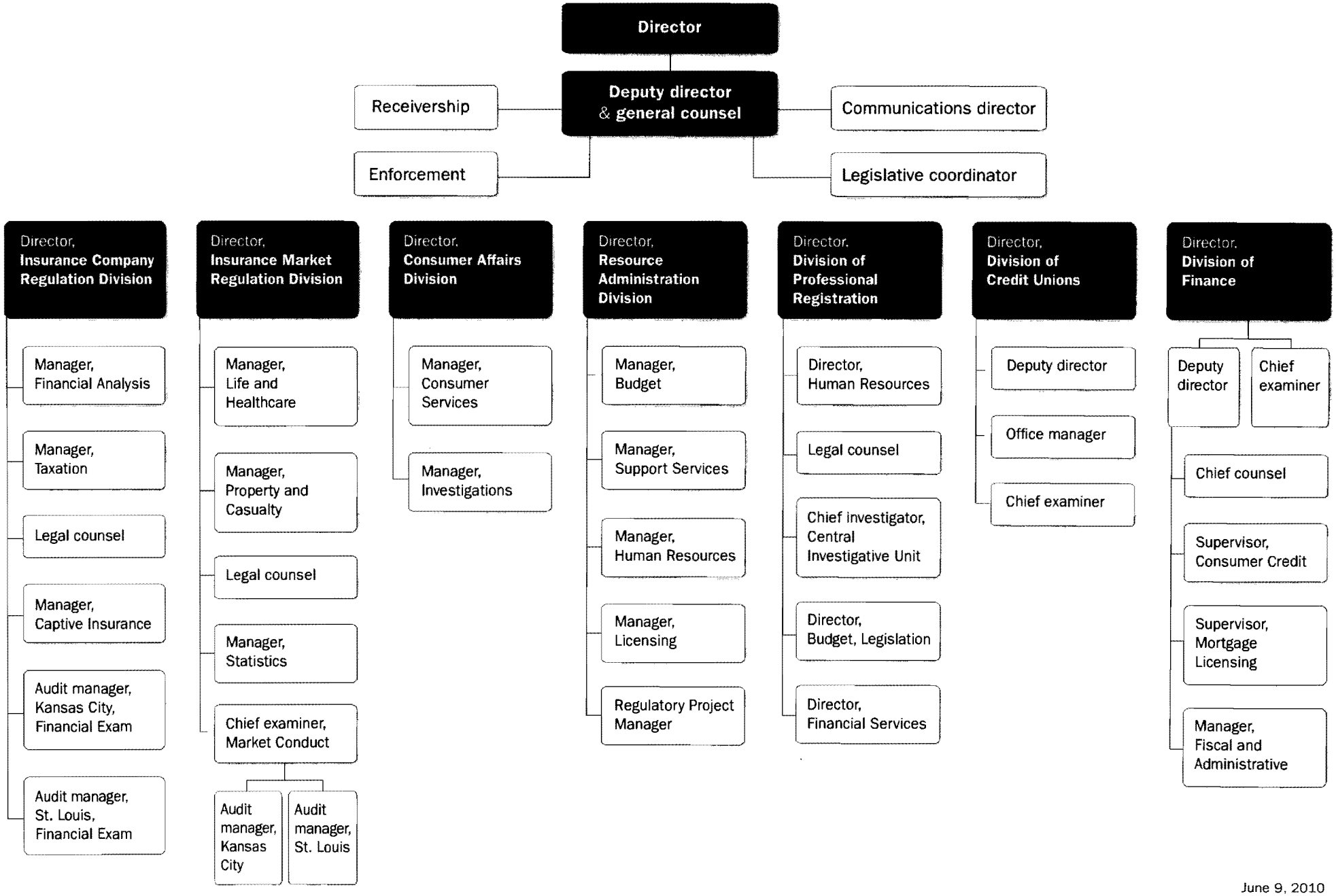
BUDGET JUSTIFICATION (August 9, 2010 through September 30, 2011)

	FTE	COSTS
Personnel:		
Rate Review Component		
Senior Counsel/Project Manager (50% effort for 14 months, $51,500 annual salary) Existing position responsible for overall grant implementation and reporting.	0.50	$30,042
L&H Manager (25% effort for 7 months, $53,550 annual salary) Existing position responsible for supervision and daily oversight of Insurance Product Analyst III and Office Support Assistant.	0.25	$7,809
Actuary (25% effort for 7 months, $114,577 annual salary) Existing position responsible for oversight and coordination of actuarial analysis of rate filings. Will provide direction and monitoring of contract actuarial services as needed.	0.25	$16,709
Actuary (100% effort for 7 months, $114,000 annual salary) New position responsible for analysis of premium rate filings received by department. Would provide additional investigation into rates deemed unreasonable or excessive.	1.00	$66,500
Insurance Product Analyst III (100% effort for 7 months, $37,968 annual salary) New position responsible for tracking receipt of rate filings, reviewing for completeness, providing follow-up as needed to ensure all information is available for rate review analysis by actuarial staff and reporting to HHS as required.	1.00	$22,148
Office Support Assistant (100% effort for 7 months, $24,576 annual salary) New position responsible for providing clerical support for rate review program staff.	1.00	$14,336
IT Infrastructure Component		
IT Project Manager (100% effort for 14 months, $58,650 annual salary) New	1.00	$68,425
Computer Information Tech Spec II (.50 effort for 14 months, $53,796 annual salary) Existing	0.50	$31,381
Fiscal and Grant Management		
Fiscal and Administrative Manager - (10% effort for 7 months, $56,000 annual salary) Existing position would be responsible for financial status reports, grant contracts and agreements, expenditure and tracking of grant funds.	0.10	$3,267
Total Salary	5.60	$260,617
Fringe: 52.44% of salary		$136,668
Travel:		
Travel is estimated at $2,500 each for 4.6 professional FTE.		$11,500
Equipment:		
Computer and software for new FTE is estimated at $900 each.		$3,600

Supplies:	
Office supplies and postage are estimated at $400 per FTE.	$2,240
Contractual:	
Actuarial Services (Rate Review) Funds will be used to contract for actuarial services as needed to provide additional review and analysis of rates deemed unreasonble or excessive. Estimated at $275 per hour for 500 hours.	$137,500
SERFF Enhancements (IT infrastructure) Funds will be used to enhance the System for Electronic Rate and Form Filing (SERFF) to accommodate electronic submission of rate filings including basic reporting.	$18,808
Contract programming and system development (IT infrastructure) Funds will be used to provide contract system design, system construction, testing and training. 1927 hours @ $125 per hour = $240,875	$240,875
Total Contractual	$397,183
Other:	
Training - Actuary and professional development training is estimated at $400 per FTE.	$2,240
Public Forums - Six locations will be chosen around the state to conduct public forums on rate review transparency and enhancement of consumer protection. Travel expenses for department staff, accomodations, public notice and transcription service are estimated at $3,000 per event.	$18,000
Rent - $2,677 each for 2.5 FTE and $1,562 each for 3.1 FTE.	$11,535
Telephone and Network Costs (2.5 @ 14 months 3.1@7 months) Estimated at $200 per month per FTE for internet, email, phone and other communication charges.	$11,340
Total Other	$43,115
Indirect:	$0
Carryover to FFY12	$145,077
Total	**$1,000,000**

Department of Insurance, Financial Institutions & Professional Registration

DIFP's organizational chart



June 9, 2010

John M. Huff, Director

Missouri Department of Insurance, Financial Institutions and Professional Registration

On Feb. 6, 2009, Gov. Jay Nixon appointed Missouri native John M. Huff as director of the Missouri Department of Insurance, Financial Institutions and Professional Registration. In this position, John leads Gov. Nixon's initiatives to protect consumers, including insurance policyholders and financial institution customers, during these difficult economic times.

An attorney, John brings 16 years of leadership experience in the insurance industry to a state department charged with protecting consumers through the regulation of professionals and businesses that impact Missourians' lives daily. The department regulates more than 500,000 professionals and 7,000 companies, including insurance companies, banks, credit unions and other professional corporations. He leads a team of 550 at the department.

One of his top priorities is using technology to improve the efficiency and effectiveness of license applications, renewals, complaints, enforcement actions and board and commission nominations. This effort includes partnering with associations and other states to streamline regulatory functions that will increase productivity, decrease costs, and speed the delivery of regulatory information and quality products to Missouri consumers.

John serves as a director and trustee on several boards promoting better financial services and education for Missourians:

- Missouri Health Insurance Pool, a nonprofit program that provides health insurance for Missourians unable to buy affordable coverage because of health problems.
- Missouri Council on Economic Education, which promotes economic and financial literacy.
- Missouri Consolidated Health Care Plan, a health insurance provider for state employees and retirees.
- Missouri State Employees Voluntary Life Insurance Commission, which provides a state-sponsored life insurance program to state employees.
- Alzheimer's Health State Plan Task Force, which will assess the impact of Alzheimer's and related dementia on Missourians, examine resources and make recommendations.

Before entering public service, John spent three years as an executive with Swiss Re, one of the world's leading reinsurance companies, most recently at the company's global headquarters in Zurich. Prior to that, John spent eight years with GE Insurance Solutions.

John earned his bachelor's degree in business administration from Southeast Missouri State University. In 1987, he earned an MBA at Saint Louis University, and graduated in 1990 from the Washington University School of Law in St. Louis. He and his wife and daughter live in Columbia.

12/7/2009

MISSOURI

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JAMES MORRIS

EDUCATION

University of Missouri School of Law Columbia, MO
Juris Doctor, 2004
- Certificate in Dispute Resolution

University of Missouri - Columbia Columbia, MO
Bachelor of Arts, 2001
- Major: Political Science

WORK EXPERIENCE

Missouri Department of Insurance, Financial Institutions & Professional Registration
Senior Counsel, Insurance Market Regulation Division
- July 2005 – present
- Review problematic insurance form and rate filings
- Develop and implement insurance legislation, administrative rules and Department bulletins
- Represent the Department of Insurance in administrative hearings
- Provide legal opinions to Department staff

Missouri Department of Revenue, General Counsel's Office
Legal Counsel, Bankruptcy Unit
- December 2004 – May 2005
- Drafted and filed bankruptcy case pleadings
- Represented the Department of Revenue in Federal Bankruptcy Court

Representative Blaine Luetkemeyer
Legal Extern
- January 2004 – May 2004
- Conducted legislative research
- Attended committee hearings
- Handled constituent questions and communication

ACTIVITIES

- Mizzou Alumni Association, Cole County Chapter
- Cole County Bar Association
- University of Missouri Mediation Clinic, Fall 2003
- Mizzou Student Athletic Board

OFFICE SUPPORT ASSISTANT (KEYBOARDING)

DEFINITION

This is mid-level clerical and keyboard support work of moderate difficulty and complexity involving a variety of tasks requiring independent work decisions within established policies and timeframes, usually requiring familiarity with specialized terminology and/or various software packages.

This description may not include all of the duties, knowledge, skills, or abilities associated with this classification.

EXAMPLES OF WORK

Types, utilizing a computer keyboard and word processing software, and edits a variety of material, frequently involving technical or specialized terminology; transcribes from dictating equipment.

Reviews documents for accuracy, completeness, and compliance.

Composes routine correspondence; proofreads and/or finalizes letters, memorandums, reports, or other documents for approval and/or signature.

Establishes and maintains filing systems; prepares records for storage and/or archiving.

Prepares purchase and supply requisitions, personnel and/or payroll records, time and leave records, expense accounts, or other program or agency documents; arranges travel and accommodations; maintains equipment and supply inventory.

Processes and distributes mail according to established procedures; prepares material for mailing utilizing automated equipment when applicable.

Serves as receptionist or information clerk; determines purpose of contact; provides general information and assists in preparation of forms if needed; directs individuals to proper destination; receives and distributes messages; and schedules and/or arranges appointments as necessary.

Prepares and summarizes data or reports from a variety of sources in accordance with specific instructions or procedures.

Enters and updates information in automated systems; develops routine spreadsheets and databases; utilizes various software packages in the performance of duties.

Operates standard office equipment.

Serves as a lead worker or supervisor providing guidance, direction, and training to a small group of clerical employees; reviews work for accuracy, timeliness, and compliance with instructions and procedures; evaluates employee performance as assigned.

Receives general supervision from a designated administrative supervisor, however, will work independently within established guidelines.

Performs other related work as assigned.

KNOWLEDGE, SKILLS AND ABILITIES (KSAs)

Intermediate knowledge of office practices, procedures, and equipment.

Intermediate knowledge of business math computations, grammar, composition, and spelling.

Intermediate knowledge of computer information systems and software.

Skill in the use of a keyboard.

Ability to understand and follow directions.

Ability to establish and/or maintain moderately complex records; use coding and filing systems; and retrieve and compile data.

Ability to prepare spreadsheets and reports.

Ability to make and apply routine decisions in accordance with policies and procedures.

Ability to review documents for accuracy and completeness.

Ability to complete assignments accurately within specified timeframes.

Ability to serve as a lead worker or supervisor as assigned.

Ability to establish and maintain effective working relationships with co-workers and the public.

EXPERIENCE AND EDUCATION

(The following requirements will determine merit system eligibility, experience and education ratings, and may be used to evaluate applicants for Missouri Uniform Classification and Pay System

positions not requiring selection from merit registers. When practical and possible, the Division of Personnel will accept substitution of experience and education on a year-for-year basis.)

Six or more months of experience in clerical or general office support work; and possession of a high school diploma or GED certificate.

(Training from an accredited vocational or business school in Office Management, Secretarial Science, or a closely related area may substitute on a month-for-month basis for the required experience at a rate of 3 earned credit hours, or 40 clock hours, for one month.)

(Earned credit hours from an accredited college or university may substitute on a month-for-month basis for the required experience at a rate of 3 earned credit hours for one month.)

(Revised 11/1/07)

FISCAL AND ADMINISTRATIVE MANAGER

DEFINITION

This is administrative and managerial work in the direction, planning, analysis, and coordination of fiscal and/or related administrative services. Duties may be in specialized areas such as accounting, auditing, budgeting, or purchasing, or may encompass responsibilities in one or more fiscal-related or administrative support areas.

(This classification is part of the broad-banded management service. The Division of Personnel may assign positions on any of the three bands or managerial levels based on duties and/or responsibilities.)

This description may not include all of the duties, knowledge, skills, or abilities associated with this classification.

EXAMPLES OF WORK

Directs or assists in the overall planning, development, and administration of the assigned fiscal or related administrative support programs or services ; assists in the direction of the development and implementation of departmental planning issues.

Directs or assists administrative personnel in general management aspects of policy development and program planning, management, and coordination as related to assigned responsibilities; assists in the evaluation of the effect of policy and/or organizational changes and new programs.

Reviews and/or revises programs in area of responsibility to ensure compliance of operations with laws, regulations, policies, plans, and procedures.

Participates in the development, implementation, or interpretation of new or revised program, departmental, or legislative initiatives.

Participates in conferences, training sessions, and meetings relating to areas of assigned responsibility .

Directs and/or participates in budget preparation, the preparation of periodic and special budgetary, financial and related statistical reports, the monitoring of expenditures according to budget allocations/appropriations, and recommends and/or initiates cost saving measures.

Reviews reliability and integrity of financial data and identification measurement and reporting means.

Recommends policies for improving fiscal or related administrative services, identifies opportunities for improving operations, and suggests solutions to identified problems.

Selects, trains, directs, and evaluates staff in assigned fiscal and/or related program areas.

Directs or assists in the direction of the compilation and presentation of financial data and reports for management.

Conducts investigations, institutes special studies, and prepares and/or reviews reports and related information to evaluate existing organizations, policies, procedures, and practices as related to the assigned program.

Represents and/or serves as a liaison for the assigned area of responsibility; maintains contact, cooperates with, and addresses federal, state, local, and community organizations, and other interested groups pertaining to the assigned programs.

Negotiates or administers contracts, grants, and cooperative agreements with federal, state, local, and community organizations.

Interprets and explains applicable federal and state legislation, rules, regulations, and procedures to subordinate staff, management, vendors, contracting agencies, and others.

Exercises considerable initiative and judgment in planning and carrying out assignments; receives general administrative direction; work is reviewed through conferences, reports, and evaluation of operational results.

Performs other related work as assigned.

KNOWLEDGE, SKILLS AND ABILITIES (KSAs)

Comprehensive knowledge of the principles and practices of public administration, including budgeting, fiscal administration, purchasing, program planning, policy formulation, and general administrative systems.

Comprehensive knowledge of general governmental accounting, auditing, and/or procurement principles, procedures, and related fiscal practices.

Comprehensive knowledge of governmental budgeting, fiscal management, and grants and contract management.

Comprehensive knowledge of an assigned specialty area.

Comprehensive knowledge of current issues and theories related to the assigned program.

Comprehensive knowledge of managerial techniques and administrative practices.

Ability to review, analyze, interpret, and/or prepare federal and state laws, rules, regulations, policies, and procedures as related to the assigned program.

Ability to testify as an expert witness.

Ability to formulate and initiate plans and procedures for the effective establishment and maintenance of fiscal controls and direct their application.

Ability to apply general concepts to specific problems of accounting, auditing, or purchasing procedures, and fiscal management practices based upon cost-effective evaluations.

Ability to develop, implement, and administer fiscal management systems.

Ability to analyze and evaluate policies and operations, and formulate recommendations

Ability to establish and maintain effective working relationships with departmental officials, legislators, staff associates, and the general public.

Ability to communicate effectively.

Ability to provide leadership and supervision to professional, technical, and related program staff.

Ability to manage change, provide program management, and achieve effective results.

Ability to develop short and long-range plans that meet established objectives and contribute to the overall goals and mission of the agency.

EXPERIENCE AND EDUCATION

(The following requirements will determine merit system eligibility, experience and education ratings, and may be used to evaluate applicants for Missouri Uniform Classification and Pay System positions not requiring selection from merit registers. When practical and possible, the Division of

Personnel will accept substitution of experience and education on a year-for-year basis.) The specific qualifications for a position allocated to this class may vary due to the spectrum of jobs included in this broad classification band. Depending on the duties of the specific job assignment, a position may require specialized and/or additional education, experience, and/or licensure/certification not included in the stated requirements.

A Bachelor's degree from an accredited college or university with a minimum of 15 earned credit hours in one or a combination of the following: Accounting, Finance, Economics, Public or Business Administration, or a closely related field; and,

Four or more years of professional experience in accounting, auditing, purchasing, budgeting, fiscal management, or in general management with some fiscal responsibility.

(Additional qualifying experience may substitute on a year-for-year basis for deficiencies in the required education.)

(Experience in the referenced areas at the level of Administrative Office Support Assistant (AOSA) may substitute on a year-for-year basis for deficiencies in the required education.)

(Earned graduate credit hours from an accredited college or university in the specified areas may substitute on a year-for-year basis for a maximum of two years of the required experience at a rate of 24 earned graduate credit hours for one year of experience.)

(Minor Revision 5/31/06)

COMPUTER INFORMATION TECHNOLOGY SPECIALIST II

DEFINITION

This is advanced professional, technical and consultative work in the support and coordination of computer information technology services and activities.

An employee in this class provides technical expertise in computer systems analysis and design; database and/or network administration; systems programming; cybersecurity; and/or other computer information technology specialties in a mainframe, midrange and/or microcomputer environment. Work is focused in multiple areas of a specialty or primarily in one highly technical area. Work includes conducting feasibility and impact studies of technology direction and providing recommendations. Duties may also include implementation of recommendations, project management and/or provision of technical consultative services. Work may also include some supervision of other technical staff; however the primary emphasis of the job is on the technical components. Positions at this level differ from Computer Information Technology Specialist Is in terms of the amount of direction provided and the scope and technical complexity of assignments. Work is performed under general supervision; however, the employee is expected to exercise initiative and independence in the performance of assigned responsibilities.

Any one position may not involve all of the specified duties or knowledges, skills and abilities, nor are the listed examples exhaustive.

EXAMPLES OF WORK

Develops, analyzes and/or coordinates highly complex project specifications such as flowcharts, logic diagrams and work flow diagrams relating to diverse organizational functions.

Provides consultative guidance in a specific area of technical expertise.

Acts as project team leader; establishes project schedules, assigns tasks, monitors progress against schedules, and conducts technical reviews of assigned projects; serves as a supervisor, as assigned

Provides cost benefit analysis of technology solutions to meet business needs.

Serves as a liaison for the organization in the areas of technology or infrastructure development.

Provides support for both internal and external organizational computer systems that span multiple platforms.

Researches, reviews, recommends and prepares requests for proposals and/or bid specifications for hardware and/or software purchases; evaluates bid responses.

Develops and evaluates quality control procedures and hardware and/or software standards.

Provides technical expertise in computer systems analysis and design; database and/or network administration; systems programming; and/or other computer information technology specialties.

Provides cybersecurity policies, coordinates the development of emergency plans, oversees cybersecurity awareness and training, coordinates and plans cybersecurity audits.

Defines computer system performance criteria and coordinates tuning of computer systems for optimum performance.

Coordinates computer systems disaster recovery planning.

Coordinates information strategic planning.

Coordinates computer systems management planning.

Performs other related work as assigned.

KNOWLEDGE, SKILLS AND ABILITIES (KSAs)

Thorough knowledge of the principles of computer programming and systems analysis, design, testing and documentation.

Thorough knowledge of the general operating principles and capabilities of computer hardware and software.

Considerable knowledge of software reference libraries and related utility programs.

Considerable knowledge of computer security systems and procedures.

Considerable knowledge of computer networking and telecommunications.

Considerable knowledge of computer operating systems.

Considerable knowledge of database management systems.

Considerable knowledge of the principles of cost benefit analysis.

Considerable knowledge of the principles of project management.

Considerable knowledge of the principles of disaster recovery.

Considerable knowledge of the procurement process.

Considerable knowledge of continuing trends and developments in computer hardware and software.

Considerable knowledge of various computer platforms.

Considerable knowledge of the information strategic planning process.

Considerable knowledge of the systems management process.

Working knowledge of agency's automated information systems.

Working knowledge of agency's functions and their interrelationships.

Ability to coordinate/organize projects involving multiple organizations and/or groups.

Ability to utilize project management tools, such as PERT or Gantt charts.

Ability to review and analyze computer program documentation.

Ability to prepare and maintain standards, policies, procedures, guidelines and technical manuals.

Ability to apply expertise in the troubleshooting and resolution of hardware and/or software problems.

Ability to communicate effectively.

Ability to train, assist or supervise others in subject matter area.

Ability to establish and maintain effective working relationships.

EXPERIENCE AND EDUCATION QUALIFICATIONS

(The following requirements will determine merit system eligibility, experience and education ratings, and may be used to evaluate applicants for Missouri Uniform Classification and Pay System positions not requiring selection from merit registers. When practical and possible, the Division of Personnel will accept substitution of experience and education on a year-for-year basis.)

Four years, including two years above the journey-level, of professional and technical computer information technology systems experience such as computer programming, systems analysis and design, or work with primary responsibility for the configuration of mainframe, midrange and/or microcomputer hardware and software, network administration or closely related areas; and graduation from an accredited four-year college or university with at least fifteen (15) semester hours in computer science, computer information systems or closely related areas. [Computer information technology systems experience such as computer programming, systems analysis and design or work with primary responsibility for the configuration of computer hardware and software in a mainframe, midrange and/or microcomputer environment may be substituted on a year-for-year basis for deficiencies in the stated education. Professional or technical experience involving the development of data bases or applications using business programming products (e.g., SAS, Culprit, FOCUS, GIS) may be substituted on a year-for-year basis for deficiencies in the stated education or experience for a **maximum** of two years. Graduate work in computer science, computer information systems or closely related areas may be substituted on a year-for-year basis for a maximum of one year of the stated general experience.]

OR

One year of experience as a Computer Information Technology Specialist I or Computer Information Technology Supervisor I, or two years of experience as a Computer Information Technologist III under the Missouri Uniform Classification and Pay System.

(Revised 5/1/05)

Missouri Office of Administration

Jay Nixon, Governor
Kelvin L. Simmons, Commissioner

- OA Home
- Personnel
- Information for Job Applicants
- Job Descriptions
- Classification Specification

Annual Salary Range: $55,548.00 - $79,728.00 **Index No:** 0167
Twice-A-Month Salary Range: $2,314.50 - $3,322.00 **Pay Grade:** A34
Job Category: Information Technology
Exam Components: Rating of Education and Experience, 100%
Selective Certification: Certification of eligibles names from the Computer Information Technology Specialist III register may be based on specialized experience in the areas of Application Development/Support, Data Base, Business/Systems Analysis, Systems Programming, Network, Cybersecurity, Communications Technology, and End User Support Help Desk. Applicants should describe any work experience in these areas completely.

COMPUTER INFORMATION TECHNOLOGY SPECIALIST III

DEFINITION

This is advanced highly professional, technical and consultative work in the support and coordination of computer information technology services and activities.

An employee in this class provides highly technical expertise in multiple specialties or in multiple complex areas of a specialty in a mainframe, midrange and/or microcomputer environment. Work includes coordinating and/or conducting highly complex feasibility and impact studies of technology direction and providing recommendations. Duties may include implementation and oversight of recommendations and project management activities. Duties may also include supervision of other technical staff but the primary emphasis of the job is on the highly technical components. Positions at this level differ from Computer Information Technology Specialist IIs in terms of the amount of direction provided and the scope and technical complexity of assignments. Work is performed under general supervision; however, the employee is expected to exercise considerable initiative and independence in the performance of assigned responsibilities.

Any one position may not involve all of the specified duties or knowledges, skills and abilities, nor are the listed examples exhaustive.

EXAMPLES OF WORK

Assumes responsibility for coordinating highly complex project management activities.

Develops, designs, maintains and oversees disaster recovery plans.

Coordinates, facilitates and/or provides multi-discipline technical direction in information strategic planning.

Provides highly technical consultative guidance to management, customers and/or other information technology staff.

Serves as a highly technical multi-discipline liaison for the organization in the areas of technology or infrastructure development.

Serves as a technical expert in computer systems analysis and design; database and/or network management; systems programming; and/or other information technology specialties.

Ensures effective and efficient systems integration of highly complex projects.

Provides guidance to ensure data and systems integrity.

Provides guidance in capacity planning.

Mentors and develops technical personnel in specialized areas of computer information technology.

Provides leadership and technical expertise in multiple specialized areas of computer information technology.

Provides cybersecurity policies, coordinates the development of emergency plans, oversees cybersecurity awareness and training, coordinates and plans cybersecurity audits.

Coordinates and develops multi-discipline standards and policies for information technology related issues.

Provides cost and benefit analysis or leads multi-discipline evaluation teams in the development and/or re-engineering of processes and/or the analysis of technology solutions to meet business needs.

Researches, reviews, recommends and prepares highly complex requests for proposals and/or bid specifications for hardware and/or software purchases; evaluates bid responses.

Performs supervisory functions as assigned, while retaining highly technical focus.

Performs other related work as assigned.

KNOWLEDGE, SKILLS AND ABILITIES (KSAs)

Thorough knowledge of the principles of computer programming and systems analysis, design, testing and documentation.

Thorough knowledge of the general operating principles and capabilities of computer hardware and software.

Thorough knowledge of the information strategic planning process.

Thorough knowledge of the systems management process.

Thorough knowledge of the principles of cost benefit analysis.

Thorough knowledge of the principles of project management.

Thorough knowledge of various computer platforms.

Thorough knowledge of continuing trends and developments in computer hardware and software.

Thorough knowledge of computer operating systems.

Considerable knowledge of software reference libraries and related utility programs.

Considerable knowledge of computer security systems and procedures.

Considerable knowledge of computer networking and telecommunications.

Considerable knowledge of database management systems.

Considerable knowledge of the principles of disaster recovery.

Considerable knowledge of the procurement process.

Considerable knowledge of agency's automated information systems.

Considerable knowledge of agency's functions and their interrelationships.

Ability to coordinate/organize projects involving multiple organizations and/or groups.

Ability to utilize project management tools, such as PERT or Gantt charts.

Ability to review and analyze computer program documentation.

Ability to prepare and maintain standards, policies, procedures, guidelines and technical manuals.

Ability to apply multi-discipline expertise in the troubleshooting and resolution of problems.

Ability to communicate effectively.

Ability to train and mentor or supervise others in subject matter areas.

Ability to establish and maintain effective working relationships.

EXPERIENCE AND EDUCATION QUALIFICATIONS

(The following requirements will determine merit system eligibility, experience and education ratings, and may be used to evaluate applicants for Missouri Uniform Classification and Pay System positions not requiring selection from merit registers. When practical and possible, the Division of Personnel will accept substitution of experience and education on a year-for-year basis.)

Five years, including three years of specialized experience at the level of Computer Information Technology Specialist I, of professional and technical computer information technology systems experience such as computer programming, systems analysis and design, or work with primary responsibility for the configuration of mainframe, midrange and/or microcomputer hardware and software, network administration or closely related areas; and graduation from an accredited four-year college or university with at least fifteen (15) semester hours in computer science, computer information systems or closely related areas. [Computer information technology systems experience such as computer programming, systems analysis and design or work with primary responsibility for the configuration of computer hardware and software in a mainframe, midrange and/or microcomputer environment may be substituted on a year-for-year basis for deficiencies in the stated education. Professional or technical experience involving the development of data bases or applications using business programming products (e.g., SAS, Culprit, FOCUS, GIS) may be substituted on a year-for-year basis for deficiencies in the stated education or experience for a **maximum** of two years. Graduate work in computer science, computer information systems or closely related areas may be substituted on a year-for-year basis for a maximum of one year of the stated general experience.]

OR

One year of experience as a Computer Information Technology Specialist II or two years of experience as a Computer Information Technology Specialist I under the Missouri Uniform Classification and Pay System.

(Revised 5/1/05)

Sub Menu Navigation

- Accounting
- Budget & Planning
- Commissioner

TITLE: **INSURANCE REGULATORY MANAGER (Life & Health)**

SALARY: **Will be based on education and experience**

LOCATION: **LIFE & HEALTH SECTION**
DIVISION OF MARKET REGULATION
JEFFERSON CITY, MISSOURI

DEFINITION:
This is advanced technical and supervisory work administering the review and analysis of rule, rate, and policy form filings for life and health companies operating in Missouri.

An employee in this class/position performs detailed and involved duties in administering the review, analysis, and approval or disapproval of insurance policies, contracts, and endorsements for accident and health insurers, life and annuity insurers, health service corporations, health maintenance organizations, fatemal benefit societies, and other types of insurance for conformance to state law and good insurance practices, as to forms and rate structures. An employee in this position receives general administrative direction from the Division Director of Market Regulation.

EXAMPLES OF WORK PERFORMED: (Duties and responsibilities may be added, deleted, or changed at any time at the discretion of management, formally or informally, either verbally or in writing.)

Supervises a technical staff involved in the examination of policies, rates, rules, forms, and certificates of authority, to determine compliance with Missouri statutes and department regulations. Analyzes, recommends, and assists in the preparation of legislation, regulations, and guidelines interpreting life and health insurance laws and participates in regulation hearings. Oversees the regulation of health service corporations and health maintenance organizations operating in the state of Missouri ensuring compliance with Chapter 354, RSMo. Prepares drafts of proposed regulations and legislation affecting life insurance policies and health policies and assists the Legal Section in their development and finalization. Testifies before the legislature on behalf of certain legislation pertinent to life and health insurance. Assists and educates Consumer Service Representatives on policy provisions and claim complaints from the general public. Provides information to department staff, insurance company representatives and general public regarding life insurance products and health insurance provisions. Participates in surveys conducted by federal agencies and state agencies. Represents the Department on various industry boards and committees and at various public functions and speaking engagements. Supervises and trains the professional and clerical staff of the Life and Health Section. Prepares employee performance appraisals for section employees. Reviews files of companies seeking licensure in Missouri. Reviews philosophy of operation and specifically reviews life and health products the company intends to market; participates in company pre-admission interviews; Makes recommendation for or against licensure.

EXAMPLES OF REQUIRED KNOWLEDGES, SKILLS AND ABILITIES:
Considerable knowledge of life and health insurance principles and practices. Including knowledge of claims, underwriting, and legal aspects of life and health insurance. Considerable knowledge of the provisions of life and health insurance policies, terminology, and related forms Considerable knowledge of federal and state laws and regulations pertaining to life insurance and health insurance. Considerable knowledge of life and health insurance policies, terminology, and familiarity with the operation of insurance companies. Considerable knowledge of health care delivery systems and compatible alternative funding mechanisms including an understanding of not-for-profit and for-profit prepaid health care programs. Knowledge of principles and practices of administration and supervision. Ability to supervise and train a staff of clerical and professional personnel. Ability to establish and maintain effective working relationships with department employees, insurance company officials, agents, insurers, trade association representatives, and federal, state, and local government officials. Ability to read, understand and analyze complex insurance information. Ability to communicate clearly and concisely.

EXPERIENCE AND TRAINING QUALIFICATIONS: (The following statement represents the minimum experience and training standards required. Equivalent substitution will be permitted in case of deficiencies in either experience or education.)

One year as an Insurance Product Analyst III, or three years as an Insurance Product Analyst II or related experience in the Missouri Department of Insurance, Financial Institutions & Professional Registration or equivalent experience in another state insurance department. (Possession of professional designation of Fellow Life Management Institute or Chartered Life Underwriter may be substituted for up to one year of the required experience.)

OR

Five years of responsible insurance experience in life and health rate analysis or research, underwriting, policy review and/or development, or closely related area; and graduation from an accredited four-year college or university with specialization in business administration, public administration, insurance, risk management, economics, or closely related area. (Possession of the professional designation of Fellow Life Management Institute or Chartered Life Underwriter may be substituted for up to one year of the required experience.)

TITLE: **INSURANCE PRODUCT ANALYST I/II**

MINIMUM SALARY:

LOCATION: Life and Health Section
Insurance Market Regulation Division
Jefferson City, MO

CLOSING DATE:

DEFINITION:
This is professional work in the Department of Insurance, Financial Institutions & Professional Registration (DIFP) reviewing and analyzing insurance products such as policy contract, rule and rate filings to ensure compliance with statutes and regulations as specified by the Missouri Insurance Code.

An employee in this class is assigned to the Life & Health section and is responsible for reviewing and analyzing insurance policy contract, endorsement, rider, advertising, rule and rate filings, and corresponding with company officials to communicate deficiencies, omissions and recommended revisions. In addition, the employee may review premium rates and loss ratio data to ensure compliance with published rates and minimum loss ratio standards. Until the more technical phases of the work are learned, the employee works under close supervision; thereafter, the employee is required to exercise judgement in the performance of assigned responsibilities. General supervision is received from the Insurance Product Section supervisor.

EXAMPLES OF WORK PERFORMED: (Duties and responsibilities may be added, deleted, or changed at any time at the discretion of management, formally or informally, either verbally or in writing.)

Analyze accident, health, HMO, PPO and/or life and annuity insurance contracts and related forms to ensure compliance with statutes and regulations and to evaluate potential impact on the insurance-buying public. Advise insurance company officials of the results of policy analysis and recommend revisions to correct identified deficiencies and omissions. Recommend the approval or disapproval of policy contracts and related insurance forms for use in the State of Missouri. Analyze advertising materials to ensure compliance with rules and regulations and to assess impact on the insurance-buying public. Provide assistance to the insurance-buying public and other governmental agencies relating to policy contract language, rates, coverage and exclusions. Counsel industry representatives regarding requirements for insurance forms submission and compliance with Missouri Statutes and regulations. Review premium rates and loss ratio data to ensure compliance with published rates and minimum loss ratio standards. Provide technical assistance to Department staff in the area of accident, health and/or life and annuity insurance filings. Perform other related work as assigned.

EXAMPLES OF REQUIRED KNOWLEDGE, SKILLS, AND ABILITIES:
Ability to communicate clearly and concisely. Working knowledge of statutes and regulations pertaining to insurance policy contracts and related forms. Working knowledge of state and federal insurance laws, contract laws and court decisions affecting the insurance industry.

Working knowledge of state laws and department regulations relating to assigned line(s) of insurance. Ability to interpret and apply Missouri statutes and regulations pertaining to insurance policy contracts and related forms. Ability to analyze insurance policy contracts and related forms and recommend revisions relating to identified deficiencies and omissions. Ability to establish and maintain effective working relationships with insurance agents, brokers, company representatives, and general public and other employees. Ability to analyze data and prepare reports.

EXPERIENCE AND TRAINING QUALIFICATIONS: (The following statement represents the minimum experience and training standards preferred. Equivalent substitution will be permitted in case of deficiencies in either experience or education.)

Graduation from an accredited four-year college or university with specialization in insurance, risk management, business or public administration or closely related areas; OR four years of professional or technical experience in one or more of the areas described below; and graduation from a standard high school. Completion or work towards RHU, CLU, FLMI or similar designations is desired.

AREAS OF QUALIFYING EXPERIENCE:

1. Experience in an insurance regulatory agency which involved interpretation, application and/or enforcement of statutes and regulations.

2. Experience in sales, underwriting, policy contract review and/or development of health insurance or other life & health lines of insurance.

3. Experience in health claims adjusting, health claims processing, risk management or closely related insurance experience.

Department of Insurance, Financial Institutions, and Professional Registration

TITLE: **Life & Health Actuary**
Insurance Solvency & Company Regulation Division

EXAMPLES OF WORK PERFORMED:

1. **Financial analysis:** Review annual actuarial opinion, memorandum, report, cashflow test from domestic companies.

2. **Supervise review of reserves of Missouri domestic life and health insurers:** Advise consulting actuaries performing financial examinations of domestic insurers with regard to general and specific areas of focus for actuarial analysis; advise and assist analysts with actuarial issues, especially for areas and insurers of concern with regard to reserve adequacy.

3. **Health insurance form actuarial compliance review:** Analyze health insurance rates, especially Medicare supplement and long-term care, both initial and proposed, for appropriateness, adequacy, and actuarial accuracy; review forms for compliance in cooperation with forms analysts upon request.

4. **Life insurance form actuarial compliance review:** Verify compliance with actuarial standards, laws and guidelines in cooperation with forms analysts.

5. **Audit actuarial submissions:** Review annual illustration actuary certifications, examine annual small group health law compliance reports.

6. **Evaluate proposed laws affecting life or health actuarial issues:** Estimate impact on DIFP and help create fiscal notes for proposed state legislation; analyze proposed DIFP regulations and bulletins to determine actuarial impact; develop department positions and comments regarding NAIC proposals.

7. **Participate in hearings and administrative actions as requested**

8. **Assist in actuarial analysis of life and health reinsurance treaties**

9. **Represent the Department as needed on NAIC committees:** Participate in LHATF activities and pertinent subgroups, task forces on Director's behalf.

EXAMPLES OF REQUIRED KNOWLEDGE, SKILLS AND ABILITIES:
Considerable knowledge of state statutes, regulations, and NAIC guidelines pertaining to life and health insurance companies. Considerable knowledge of departmental regulations affecting life and health insurers. Considerable knowledge of the structure and operations of life and health insurance companies. Considerable knowledge of health insurance rate calculations and regulations. Considerable knowledge of life, health, and annuity reserves and regulatory requirements.

Advanced knowledge of Standard Nonforfeiture Laws for Life Insurance and Annuities. Basic knowledge of laws regarding life, annuity, and health insurance contracts. Ability to analyze life and health insurance policies and annuity contracts. Ability to use a personal computer and department-supported software in actuarial analysis of life and annuity reserve and nonforfeiture calculations as well as health insurance rate, reserve, and experience calculations. Ability to comprehend and apply rules and statutes to detect and determine non-compliance, violations, and deviations from state insurance laws, regulations, and department procedures. Considerable knowledge of actuarial aspects of market conduct examinations and illustration actuary requirements.
Ability to communicate effectively with insurance company officials regarding complex compliance and actuarial matters. Ability to present clear and concise reports of findings and to prepare accurate written reports. Ability to direct and analyze results of actuarial aspects of financial examinations.

EXPERIENCE AND TRAINING QUALIFICATIONS:

Fellow of the Society of Actuaries, Member of the American Academy of Actuaries, generally qualified in life or health insurance, five years experience

OR

Associate of the Society of Actuaries, Member of the American Academy of Actuaries, generally qualified in life and health insurance, ten years experience, with a minimum of five years in financial reporting, product development, and/or compliance

TITLE: **Senior Enforcement Counsel**

LOCATION: **Department of Insurance, Financial Institutions and Professional Registration**
Jefferson City, Missouri

STARTING SALARY: **$45,000 or above based on experience**

CLOSING DATE:

DEFINITION:
The Missouri Department of Insurance, Financial Institutions and Professional Registration is seeking an individual qualified to serve in the capacity of Senior Enforcement Counsel. This individual will serve as lead attorney in handling administrative and civil enforcement cases, as well as various other legal duties or responsibilities which may be later assigned. This position offers the opportunity to manage litigation and protect consumers from fraud and other inappropriate conduct related to products and services governed by the Department. The successful candidate will work closely with department investigators, attorneys and other staff members to identify, prioritize and manage enforcement matters. General business knowledge and litigation experience is required.

EXAMPLES OF WORK PERFORMED: (Duties and responsibilities may be added, deleted, or changed at any time at the discretion of management, formally or informally, either verbally or in writing.)

Represent the Department at administrative hearings and in court proceedings. Prepare briefs on cases and other legal material as a basis for departmental action. Performs legal reviews of such matters as mergers, payment of dividends, premium rate increases and changes in financial stability. Draft orders, certificates, and other documents necessary to the operation of the Department. Write briefs, and findings of fact and conclusions of law. Participate in special assignments and projects related to legal issues. Drafts, edits, and/or summarizes proposed legislation and regulations related to insurance. Perform other duties as assigned.

EXAMPLES OF REQUIRED KNOWLEDGE, SKILLS AND ABILITIES:

Knowledge of general legal principles and practices and of the procedures and requirements for the conduct of administrative hearings. Knowledge of the legal framework within which the regulation of insurance companies takes place. Knowledge of the basic operations of insurance companies. Ability to analyze and interpret laws, rules and regulations. Ability to draft legislative proposals. Ability to deal effectively with insurance company representatives, attorneys and the general public. Ability to prepare cases for public hearing.

EXPERIENCE AND TRAINING QUALIFICATIONS: (The following statement represents the minimum experience and training standards required. Equivalent substitution will be permitted in case of deficiencies in either experience or education.)

Graduation from an accredited law school supplemented by membership in good standing in the Missouri Bar.
Professional experience in the practice of administrative law or litigation is required.

Missouri Revised Statutes

Chapter 379
Insurance Other Than Life
Section *379.934*

August 28, 2009

Establishment of class of business, reasons--number of classes that may be established--promulgation of rules for period of transition--establishment of additional classes.

379.934. 1. A small employer carrier may establish a class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following reasons:

(1) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers;

(2) The small employer carrier has acquired a class of business from another small employer carrier; or

(3) The small employer carrier provides coverage to one or more association groups that meet the requirements of subdivision (5) of subsection 1 of section 376.421, RSMo.

2. A small employer carrier may establish up to nine separate classes of business under subsection 1 of this section. A small employer carrier which immediately prior to the effective date of sections 379.930 to 379.952* had established more than nine separate classes of business may, on the effective date of sections 379.930 to 379.952*, establish no more than twelve separate classes of business, and shall reduce the number of such classes to eleven within one year after the effective date of sections 379.930 to 379.952*; ten within two years after such date; and nine within three years after such date.

3. The director may promulgate rules to provide for a period of transition in order for a small employer carrier to come into compliance with subsection 2 of this section in the instance of acquisition of an additional class of business from another small employer carrier.

4. The director may approve the establishment of additional classes of business upon application to the director and a finding by the director that such action would enhance the efficiency and fairness of the small employer marketplace.

(L. 1992 S.B. 796 § 3)

Effective 7-1-93

*See § 379.940 subsec. 5 for effective dates.

Missouri Revised Statutes

Chapter 379
Insurance Other Than Life
Section *379.936*

August 28, 2009

Premium rates, subject to conditions--no transfer out of class of business--disclosure required, contents--rating and renewal records required to be kept.

379.936. 1. Premium rates for health benefit plans subject to sections 379.930 to 379.952 shall be subject to the following provisions:

(1) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent;

(2) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to such employers under the rating system for that class of business shall not vary from the index rate by more than thirty-five percent of the index rate;

(3) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;

(b) Any adjustment, not to exceed fifteen percent annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business; and

(c) Any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual for the class of business;

(4) Adjustments in rates for claim experience, health status and duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer;

(5) Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any assessments paid or payable by small employer carriers pursuant to sections 379.942 and 379.943;

(6) A small employer carrier may utilize the employer's industry as a case characteristic in establishing premium rates, provided that the rate factor associated with any industry classification shall not vary by more than ten percent from the arithmetic mean of the highest and lowest rate factors associated with all industry classifications;

(7) In the case of health benefit plans issued prior to July 1, 1993, a premium rate for a rating period may exceed

the ranges set forth in subdivisions (1) and (2) of this subsection for a period of three years following July 1, 1993. In such case, the percentage increase in the premium rate charged to a small employer for a new rating period shall not exceed the sum of the following:

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;

(b) Any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the carrier's rate manual for the class of business;

(8) (a) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups which differ only by amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans;

(b) A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period;

(9) For the purposes of this subsection, a health benefit plan that utilizes a restricted provider network shall not be considered similar coverage to a health benefit plan that does not utilize such a network, provided that utilization of the restricted provider network results in substantial differences in claims costs;

(10) A small employer carrier shall not use case characteristics, other than age, sex, industry, geographic area, family composition, and group size without prior approval of the director;

(11) The director may promulgate rules to implement the provisions of this section and to assure that rating practices used by small employer carriers are consistent with the purposes of sections 379.930 to 379.952, including:

(a) Assuring that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans; and

(b) Prescribing the manner in which case characteristics may be used by small employer carriers.

2. A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage.

3. The director may suspend for a specified period the application of subdivision (1) of subsection 1 of this section as to the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the director either that the suspension is reasonable in light of the financial condition of the small employer carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

4. In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

(1) The extent to which premium rates for a specified small employer are established or adjusted based upon the

actual or expected variation in claims costs or actual or expected variation in health status of the employees of the small employer and their dependents;

(2) The provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and factors, other than claim experience, that affect changes in premium rates;

(3) The provisions relating to renewability of policies and contracts; and

(4) The provisions relating to any preexisting condition provision.

5. (1) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(2) Each small employer carrier shall file with the director annually on or before March fifteenth an actuarial certification certifying that the carrier is in compliance with sections 379.930 to 379.952 and that the rating methods of the small employer carrier are actuarially sound. Such certification shall be in a form and manner, and shall contain such information, as specified by the director. A copy of the certification shall be retained by the small employer carrier at its principal place of business.

(3) A small employer carrier shall make the information and documentation described in subdivision (1) of this section available to the director upon request.

(L. 1992 S.B. 796 § 4, A.L. 2007 H.B. 818)

Effective 1-01-08

Missouri Revised Statutes

Chapter 375
Provisions Applicable to All Insurance Companies
Section *375.934*

August 28, 2009

Unfair trade practices--conditions.

375.934. It is an unfair trade practice for any insurer to commit any practice defined in section 375.936 if:

(1) It is committed in conscious disregard of sections 375.930 to 375.948 or of any rules promulgated under sections 375.930 to 375.948; or

(2) It has been committed with such frequency to indicate a general business practice to engage in that type of conduct.

(L. 1959 H.B. 251 § 3, A.L. 1978 H.B. 1447, A.L. 1991 S.B. 53)

Missouri Revised Statutes

Chapter 375
Provisions Applicable to All Insurance Companies
Section *375.936*

August 28, 2009

Unfair practices defined.

375.936. Any of the following practices, if committed in violation of section 375.934, are hereby defined as unfair trade practices in the business of insurance:

(1) "Boycott, coercion, intimidation", entering into any agreement to commit, or by any concerted action committing any act of boycott, coercion or intimidation resulting in or tending to result in an unreasonable restraint of, or monopoly in, the business of insurance;

(2) "Defamation", making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of any insurer, and which is calculated to injure such insurer;

(3) "Failure to maintain complaint handling procedures", failure of any person to maintain a complete record of all the complaints which it has received for a period of not less than three years. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints, and the time it took to process each complaint. For purposes of this subdivision, "complaint" shall mean any written communication primarily expressing a grievance;

(4) "False information and advertising generally", making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any insurer in the conduct of his insurance business, which is untrue, deceptive or misleading;

(5) "False statements and entries:"

(a) Knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating or delivering to any person, or placing before the public, or knowingly causing, directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition or dealings of an insurer;

(b) Knowingly making any false entry of a material fact in any book, report or statement of any insurer or knowingly omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report or statement of such insurer;

(6) "Misrepresentations and false advertising of insurance policies", making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustrations, circular or statement, sales presentation, omission, or comparison which:

(a) Misrepresents the benefits, advantages, conditions, or terms of any policy;

(b) Misrepresents the dividends or share of the surplus to be received on any policy;

(c) Makes any false or misleading statements as to the dividends or share of surplus previously paid on any policy;

(d) Is misleading or is a misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates;

(e) Uses any name or title of any policy or class of policies misrepresenting the true nature thereof;

(f) Is a misrepresentation for the purpose of inducing or tending to induce the purchase, lapse, forfeiture, exchange, conversion, or surrender of any policy, including any intentional misquote of a premium rate;

(g) Is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any policy; or

(h) Misrepresents any policy as being shares of stock;

(7) "Misrepresentation in insurance applications", making false or fraudulent statements or representations on or relative to an application for a policy, for the purpose of obtaining a fee, commission, money, or other benefit from any insurer, agent, agency, broker or other person;

(8) "Prohibited group enrollments", no insurer shall offer more than one group contract of insurance through any person unless such person is licensed pursuant to law; however, this prohibition shall not apply to employer-employee relationships, nor to any such enrollments;

(9) "Rebates":

(a) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract of life insurance, life annuity, accident and health insurance or other insurance, or agreement as to such contract other than as plainly expressed in the insurance contract issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving, or selling, or purchasing or offering or to give, sell, or purchase as inducement to such insurance contract or annuity or in connection therewith, any stocks, bonds or other securities of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract;

(b) Nothing in subdivision (11) or paragraph (a) of this subdivision shall be construed as including within the definition of discrimination or rebates any of the following practices:

a. In the case of any contract of life insurance or life annuity, paying bonuses to nonparticipating policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance; provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interest of the company and its policyholders;

b. In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses;

c. Readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year;

(10) "Stock operations and advisory board contracts", issuing or delivering or permitting agents, officers or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance;

(11) "Unfair discrimination":

(a) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract;

(b) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever, including any unfair discrimination by not permitting the insured full freedom of choice in the selection of any duly licensed physician, surgeon, optometrist, chiropractor, dentist, psychologist, pharmacist, pharmacy, or podiatrist; except that the terms of this paragraph shall not apply to health maintenance organizations licensed pursuant to chapter 354, RSMo;

(c) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, canceling or limiting the amount of insurance coverage on a property or casualty risk because of the geographic location of the risk;

(d) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, canceling or limiting the amount of insurance coverage on a residential property risk, or the personal property contained therein, because of the age of the residential property;

(e) Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual because of the gender or marital status of the individual; however, nothing in this paragraph shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependent benefits;

(f) Refusing to insure solely because another insurer has refused to issue a policy, or has canceled or has refused to renew an existing policy for which that person was the named insured, nor shall any insurance company or its agent or representative require any applicant or policyholder to divulge in a written application or otherwise whether any insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance, provided that an insurer may require the name of the prior carrier in order to verify the applicant's previous claims or medical history;

(g) Canceling or refusing to insure or refusing to continue to insure a policy solely because of race, gender, color, creed, national origin, or ancestry of anyone who is or seeks to become insured;

(h) Terminating, or modifying coverage or refusing to issue or refusing to renew any property or casualty policy or contract of insurance solely because the applicant or insured or any employee of either is mentally or physically impaired; except that this paragraph shall not apply to accident and health insurance sold by a casualty insurer and, in addition, this paragraph shall not be interpreted to modify any other provision of law relating to the termination, modification, issuance or renewal of any insurance policy or contract;

(i) The provisions of paragraphs (c), (d), (e), (f), (g), and (h) of this subdivision shall not apply if:

a. The refusal, cancellation, limitation, termination or modification is for a business purpose which is not a mere pretext for unfair discrimination, or

b. The refusal, cancellation, limitation, termination or modification is required by law or regulatory mandate;

(12) "Unfair financial planning practices", an insurance producer, agent, broker or consultant:

(a) Holding himself out, directly or indirectly, to the public as a financial planner, investment adviser, financial consultant, financial counselor, or any other specialist engaged in the business of giving financial planning or advice relating to investments, insurance, real estate, tax matters, or trust and estate matters when such person is in fact engaged only in the sale of policies; provided, however, an insurance producer, agent, broker or consultant who has passed a professional course of study may use the symbol of the professional designation on his or her business card or stationery;

(b) Engaging in the business of financial planning without disclosing to the client prior to the execution of the agreement provided for in paragraph (c) of this subdivision or solicitation of the sale of a product or service that:

a. He is also an insurance salesperson; and

b. That a commission for the sale of an insurance product will be received in addition to a fee for financial planning, if such is the case. The disclosure requirement under this paragraph may be met by including it in any disclosure required by federal or state securities law;

(c) Charging fees, other than commissions, for financial planning by insurance agents, brokers or consultants, unless such fees are based upon a written agreement, which is signed by the party to be charged in advance of the performance of the services under the agreement. A copy of the agreement shall be provided to the party to be charged at the time the agreement is signed by the party and:

a. The services for which the fee is to be charged must be specifically stated in the agreement;

b. The amount of the fee to be charged or how it will be determined or calculated must be specifically stated in the agreement;

c. The agreement must state that the client is under no obligation to purchase any insurance product through the insurance agent, broker or consultant.

The insurance agent, broker or consultant shall retain a copy of the agreement for not less than three years after completion of services, and a copy shall be available to the director upon request;

(13) Any violation of section 375.445.

(L. 1959 H.B. 251 § 4, A.L. 1967 p. 516, A.L. 1969 p. 512, A.L. 1971 H.B. 508, A.L. 1976 S.B. 666, A.L. 1978 H.B. 1447, A.L. 1983 H.B. 127, A.L. 1991 S.B. 53)

Missouri Revised Statutes

Chapter 375
Provisions Applicable to All Insurance Companies
Section *375.938*

August 28, 2009

Director may investigate companies.

375.938. The director shall have power to examine and investigate into the affairs of every insurer in this state in order to determine whether such insurer has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by sections 375.934 and 375.937.

(L. 1959 H.B. 251 § 5, A.L. 1978 H.B. 1447, A.L. 1991 S.B. 53)

Missouri Revised Statutes

Chapter 354
Health Services Corporations--Health Maintenance Organizations
Section *354.152*

August 28, 2009

Premiums, dues or fees subject to restrictions--violation, hearing--order prohibiting.

354.152. Premiums, dues or fees made by each corporation shall be subject to the following provisions:

(1) Premiums, dues or fees shall not be excessive or inadequate, as herein defined, nor shall they be unfairly discriminatory;

(2) No premiums, dues or fees shall be held to be excessive unless such premiums, dues or fees are unreasonably high relative to the corporation's loss experience under policies, plans or contracts with respect to the territory or classification to which such premiums, dues or fees are applicable;

(3) No premiums, dues or fees shall be held to be inadequate unless such premiums, dues or fees are unreasonably low for the coverage provided and the continued use of such premiums, dues or fees endangers the solvency of the corporation using the same;

(4) If the director of the department of insurance, financial institutions and professional registration has reason to believe that any premiums, dues or fees do not meet the standards of this section, he shall hold a public hearing in connection therewith, provided* that within a reasonable period of time, which shall be not less than ten days before the date of such hearing, he shall mail written notice specifying the matters to be considered at such hearing to any corporation believed by him not to be in compliance with the provisions of this section;

(5) If the director, after such hearings, for good cause finds that such premiums, dues or fees do not meet the provisions of this section, he shall issue an order specifying in what respects any such premiums, dues or fees fails to meet the provisions of this section and stating when, within a reasonable period of time thereafter, the further use of such premiums, dues or fees by the corporation which is the subject of the examination shall be prohibited and a copy of such order shall be sent to such corporation.

(L. 1979 S.B. 93)

*Word "providing" appears in original rolls.

Medicare Supplement Insurance
Minimum Standards Act
20 CSR 400-3.650

coverage is provided by a health maintenance organization shall not include:

(I) Home office and overhead costs;

(II) Advertising costs;

(III) Commissions and other acquisition costs;

(IV) Taxes;

(V) Capital costs;

(VI) Administrative costs; and

(VII) Claims processing costs.

2. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

3. For purposes of applying paragraph (A)1. of this section and paragraph (C)3. of section (15) only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

4. For policies issued prior to July 30, 1992, expected claims in relation to premiums shall meet—

A. The originally filed anticipated loss ratio when combined with the actual experience since inception (the lifetime loss ratio);

B. The appropriate loss ratio requirement from parts (A)1.A.(I) and (II) of this section when combined with actual experience beginning with January 1, 2006, to date; and

C. The appropriate loss ratio requirement from parts (A)1.A.(I) and (II) of this section over the entire future period for which the rates are computed to provide coverage.

(B) Refund or Credit Calculation.

1. An issuer shall collect and file with the director by May 31 of each year the data contained in the applicable reporting form contained in Appendix A, included herein, for each type in a standard Medicare supplement benefit plan.

2. If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

3. For the purposes of this section, policies or certificates issued prior to July 30, 1992, the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after January 1, 2006. The first report shall be due by May 31, 2008.

4. A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a *de minimis* level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for thirteen (13)-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

(C) Annual Filing of Premium Rates. An issuer of Medicare supplement policies and certificates issued before or after the effective date of April 3, 1993, in this state shall file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the director in accordance with the filing requirements and procedures prescribed by the director. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years. As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the director, in accordance with the applicable filing procedures of this state—

I.

A. Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents necessary to justify the adjustment shall accompany the filing;

B. An issuer shall make premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date; and

C. If an issuer fails to make premium adjustments acceptable to the director, the director may order premium adjustments, refunds, or premium credits deemed necessary to achieve the loss ratio required by this section.

2. Any appropriate riders, endorsements, or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements, or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

(D) Public Hearings. The director may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of April 8, 1993, if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the director.

(15) Filing and Approval of Policies and Certificates and Premium Rates.

(A) An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the director in accordance with filing requirements prescribed by the director.

(B) An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the director in the state in which the policy or certificate was issued.

(C) An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the director in

accordance with the filing requirements and procedures prescribed by the director.

(D)

1. Except as provided in paragraph 2. of this subsection, an issuer shall not file for approval more than one (1) form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

2. An issuer may offer, with the approval of the director, up to four (4) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one (1) for each of the following cases:

A. The inclusion of new or innovative benefits;

B. The addition of either direct response or insurance producer marketing methods;

C. The addition of either guaranteed issue or underwritten coverage; and

D. The offering of coverage to individuals eligible for Medicare by reason of disability.

3. For the purposes of this section, a "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

(E)

1. Except as provided in subparagraph 1.A. of this subsection, an issuer shall continue to make available for purchase any policy form or certificate form issued after April 8, 1993, that has been approved by the director. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months.

A. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the director in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the director, the issuer shall no longer offer for sale the policy form or certificate form in this state.

B. An issuer that discontinues the availability of a policy form or certificate form pursuant to subparagraph 1.A. of this subsection shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the director of the discontinuance. The period of discontinuance may be reduced if the director determines that a shorter period is appropriate.

2. The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

3. A change in the rating structure or methodology shall be considered a discontinuance under paragraph 1. of this subsection unless the issuer complies with the following requirements:

A. The issuer provides an actuarial memorandum, in a form and manner prescribed by the director, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates; and

B. The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. Such actuarially equivalent policies or certificates shall be combined for filing purposes under paragraph (15)(H)11. The director may approve a change to the differential which is in the public interest.

(F)

1. Except as provided in paragraph (F)2. of this section, the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in section (14) of this rule.

2. Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

(G)

1. An issuer shall not present for filing or approval a rate structure for its Medicare supplement policies or certificates issued after January 1, 2000, based upon attained-age rating as a structure or methodology. Notwithstanding, an issuer may continue in-force policies and certificates issued prior to January 1, 2000.

2. Where an issuer files for approval of a rate structure for policy forms or certificate forms which reflects a change in methodology from attained age to issue age, the issuer must demonstrate the actuarial equivalency of the rates proposed with the previously approved attained-age rates as required by paragraph (15)(E)3. If the policy forms or certificate forms were at any time approved by the director under an issue-age methodology, the issuer must use the most recently approved issue-age rate schedule as its proposed rate schedule for the policy forms or certificate forms and need make no further showing of actuarial equivalency under (15)(E)3.

(H) Filing requirements and procedures for change of Medicare supplement insurance premium rate and for annual filing of premium rates.

1. When an issuer files for approval of annual premium rates for a plan under subsection (14)(C) or a change of premium rates for a plan under subsection (15)(C), the following documentation must be provided to the director as part of the rate filing in addition to any other documentation required by law or regulation:

A. A completed Medicare Supplement Rate Filing Document (Missouri Form 375-0065, revised 10/98), which can be accessed at the department's website at www.insurance.mo.gov.;

B. An actuarial memorandum supporting the rating schedule;

C. A report of durational experience (for standardized Medicare supplement plans only);

D. A projection correctly derived from reasonable assumptions;

E. A clear statement of all of the assumptions used to prepare the rate filing, including the source of trend;

F. All formulas used to prepare the projection except for formulas which can be ascertained from a cursory inspection of the projection itself; and

G. The issuer's current rate schedule and the proposed rate schedule for this state, including rates for disabled persons, if any, and all rating factors, including, but not limited to: area; smoker/non-smoker; standard/substandard.

2. The report of durational experience must contain for each calendar year of issue the following data by duration: incurred claims and earned premium; resultant loss ratio, and life-years. The durational split may be either by policy or certificate duration, calendar duration, or calendar year of experience within each calendar year of issue.

3. The projection must—

A. State the incurred claims and earned premium, resultant loss ratio, and corresponding life-years for each of the preceding calendar years beginning with the year in which the policy or certificate was first issued and must include the total for each category (incurred claims and earned premium, resultant loss ratio, and corresponding life-years) for all preceding calendar years;

B. State the projected incurred claims and projected earned premium, resultant loss ratios, and corresponding life-years for at least each of the ten (10) calendar years subsequent to the rate filing and must include the total for each category (projected incurred claims and projected earned premium, resultant loss ratio, and corresponding life-years) for all projected calendar years;

C. Include a calculation of the sums of the combined total figures reported under subparagraph A. of this paragraph and those reported under subparagraph B. of this paragraph; and

D. Include, for pre-standardized Medicare supplement plans, the respective totals of the incurred claims and earned premium, resultant loss ratio, and corresponding life-years for the period beginning April 28, 1996, or alternatively, January 1, 1996, through the end of the projection period described in subparagraph B. of this paragraph.

4. Where assumptions include interest, the totals for incurred claims accumulated/discounted with interest, earned premium accumulated/discounted with interest, and the resultant loss ratio must also be shown in all parts of the projection described in paragraph (H)3. of this section.

5. Both the report of durational experience and the projection must report Missouri and national data with respect to incurred claims, earned premium, loss ratio, and life-years. The projection must also report this information both with and without the rate change requested.

6. The issuer must specify whether the figures reported as incurred claims were determined by adding claims paid to unpaid claims reserves or by the actual runoff of claims. The method of determining the incurred claims must be consistent throughout the filing and supporting documentation.

7. Changes in active life reserves or claims expenses may not be included in incurred claims in the rate filing or any supplemental documentation.

8. For purposes of this section, "incurred claims" means the dollar amount of incurred claims.

9. Earned premium reported in the rate filing or any supporting documentation must include modal loadings and policy fees. An adjustment for premium refunds, if any, must also be made to earned premium and the details of the adjustment must be provided to the director with the filing. Changes in active life reserves may not be included in earned premium.

10. Life-years reported in a rate filing or supplemental documentation must be calculated in the same manner as for refund calculations.

11. Rate filings for each plan, type, and form level permitted under subsection (15)(D) for standardized Medicare supplement plans marketed after June 30, 1998, must demonstrate compliance with the requirements of subsection (11)(E). The "weighted average aged premium," must be recalculated for each filing using current data, unless the issuer demonstrates compliance under subparagraph (11)(E)1.A. The figure used in the calculation for the total number of insureds in-force for all age bands, age sixty-five (65) and over, must be the same as the figure reported on Missouri Form 375-0065 for the "Number of Missouri Aged Insureds."

12. For standardized Medicare supplement plans, the Medicare Supplement Rate Filing Document, the report of durational experience, and the projection must be provided separately for each plan, type, and form level permitted under subsection (15)(D).

13. For pre-standardized Medicare supplement rate plans, the information contained in the Medicare Supplement Rate Filing Document and projection may be pooled within a type.

14. The rates, rating schedule, and supporting documentation required to be filed under subsection (H) of this section as part of a rate filing and all supplementary documentation in connection with the rate filing must be accompanied by the certification of a qualified actuary that to the best of the actuary's knowledge and judgment, the following items are true with respect to the documentation submitted:

A. The assumptions present the actuary's best judgment as to the expected value for each assumption and are consistent with the issuer's business plan at the time of the filing;

B. The anticipated lifetime, future, and third-year loss ratios for the policy form or certificate form for which the rates are filed comply with the loss ratio requirements of subsection (14)(A) for policy forms or certificate forms of its type delivered or issued for delivery in this state;

C. With respect to rate filings concerning pre-standardized plans, the loss ratio for year 1996 (from April 28 or from January 1) through the end of the projection period complies with the loss ratio requirements of subsection (14)(A) for policies or certificates issued prior to July 30, 1992, and delivered or issued for delivery in this state;

D. Where the rate filing concerns a policy or certificate as to which rating methodologies have changed or are presented for approval based on a change in methodology, the percentage differential between the discontinued and subsequent (or new) rates has not changed;

E. All components of the filing, including rates, rating schedules, and supporting documentation, were prepared based on the current standards of practice promulgated by the Actuarial Standards Board;

F. The rate filing, including rates, rating schedule, and supporting documentation, is in compliance with the applicable laws and regulations of this state; and

G. The rates requested are reasonable in relationship to the benefits provided by the policy or certificate.

(16) Permitted Compensation Arrangements.

(A) An issuer or other entity may provide commission or other compensation to an insurance producer or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than two hundred percent (200%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

(B) The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five (5) renewal years.

(C) No issuer or other entity shall provide compensation to its insurance producers and no producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

(D) For purposes of this section, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards, and finder's fees.

(17) Required Disclosure Provisions.

(A) General Rules.

1. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

2. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal

Long-Term Care Insurance
20 CSR 400-4.100

3. The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

4. A general explanation for applying premium rate or rate schedule adjustments that shall include:

A. A description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and

B. The right to a revised premium rate or rate schedule as provided in paragraph (7)(B)3. of this rule if the premium rate or rate schedule is changed;

5. Information relating to premium rate increases.

A. Information regarding each premium rate increase on this policy form or similar policy forms over the past ten (10) years for this state or any other state that, at a minimum, identifies:

(I) The policy forms for which premium rates have been increased;

(II) The calendar years when the form was available for purchase; and

(III) The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

B. The insurer may, in a manner that is not misleading to the applicant, provide additional explanatory information related to the rate increases.

C. An insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.

D. If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of either the effective date of this regulation or the end of a twenty-four (24)-month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with subparagraph (7)(B)5.A. of this rule.

E. If the acquiring insurer in the provisions of subparagraph (7)(B)5.D. of this regulation, above, files for a subsequent rate increase, even within the twenty-four (24)-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in provisions of subparagraph (7)(B)5.D. of this regulation, above, the acquiring insurer shall make all disclosures required by paragraph (7)(B)5. above, including disclosure of the earlier rate increase referenced in the provisions of subparagraph (7)(B)5.D. of this regulation.

(C) An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under paragraphs (7)(B)1. and (7)(B)5. of this rule. If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

(D) An insurer shall use the Long-Term Care Personal Worksheet (Form LTC-B) and the Potential Rate Increase Disclosure Form (Form LTC-F) to comply with the requirements of subsections (7)(B) and (D) of this rule.

(E) An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least forty-five (45) days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by subsection (7)(B) when the rate increase is implemented.

(8) Initial Filing Requirements.

(A) This section applies to any long-term care policy issued in this state six (6) months following the effective date of this regulation.

(B) An insurer shall provide the information listed in this subsection to the director thirty (30) days prior to making a long-term care insurance form available for sale.

1. A copy of the disclosure documents required in section (7) of this regulation; and

2. An actuarial certification consisting of at least the following:

A. A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

B. A statement that the policy design and coverage provided have been reviewed and taken into consideration;

C. A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

D. A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

(I) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

(II) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(III) A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted);

(IV) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur;

(V) When the difference between the gross premium and the renewal net valuation premiums is not sufficient to cover expected renewal expenses, the description provided could demonstrate the type and level of change in the reserve assumptions that would be necessary for the difference to be sufficient.

(a) An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;

(b) If the gross premiums for certain age groups appear to be inconsistent with this requirement, the director may request a demonstration under subsection (8)(C) of this regulation based on a standard age distribution; and

E. Premium rate schedule.

(I) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or

(II) A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences. At a minimum, the insurer must provide that a broad range of expected combinations in a manner designed to provide a fair presentation for review by the director.

(C) The director may request additional information to be provided.

1. The director may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.

2. In the event the director asks for

additional information under this provision, the period in subsection (8)(B) of this regulation does not include the period during which the insurer is preparing the requested information.

(9) Prohibition Against Post-Claims Underwriting.

(A) All applications for long-term care insurance policies or certificates except those that are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

(B) Medication.

1. If an application for long-term care insurance contains a question that asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

2. If the medications listed in the application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

(C) Except for policies or certificates that are guaranteed issue:

1. The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate:

"Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy."

2. The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery:

"Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]"

3. Prior to issuance of a long-term care policy or certificate to an applicant age eighty (80) or older, the insurer shall obtain one (1) of the following:

A. A report of a physical examination;

B. An assessment of functional capacity;

C. An attending physician's statement; or

D. Copies of medical records.

(D) A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

(E) Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated and shall annually furnish this information to the insurance director on the Rescission Reporting Form for Long-Term Care Policies (Form LTC-A).

(10) Minimum standards for home health and community care benefits in long-term care insurance policies.

(A) A long-term care insurance policy or certificate shall not, if it provides benefits for home health care or community care services, limit or exclude benefits:

1. By requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided;

2. By requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community or institutional setting before home health care services are covered;

3. By limiting eligible services to services provided by registered nurses or licensed practical nurses;

4. By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification;

5. By excluding coverage for personal care services provided by a home health aide;

6. By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

7. By requiring that the insured or claimant have an acute condition before home health care services are covered;

8. By limiting benefits to services provided by Medicare-certified agencies or providers; or

9. By excluding coverage for adult day care services.

(B) A long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half (1/2) of one (1) year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

(C) Home health care coverage may be applied to the non-home health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate. This subsection is not intended to restrict home health care to a period of time which would make the benefit illusory. Fewer than three hundred sixty-five (365) benefit days and less than a twenty-five dollar ($25) daily maximum benefit constitute illusory home health care benefits.

(11) Requirement to Offer Inflation Protection.

(A) No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder, in addition to any other inflation protection, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one (1) of the following:

1. Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent (5%);

2. Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent (5%) for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

3. Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

(B) Where the policy is issued to a group,

the required offer in subsection (11)(A) of this rule, above, shall be made to the group policyholder; except, if the policy is issued to a group defined in section 376.1100.2(4)(a), RSMo, other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder.

(C) The offer in subsection (11)(A) of this rule, above, shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

(D) Information Required in or with the Outline of Coverage.

1. Insurers shall include the following information in or with the outline of coverage:

A. A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty (20)-year period; and

B. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

2. An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

(E) Inflation protection benefit increases under a policy that contains these benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

(F) An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

(G) Rejection of Inflation Protection.

1. Inflation protection as provided in paragraph (11)(A)1. of this rule, above, shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this subsection.

2. The rejection may be either in the application or on a separate form.

3. The rejection shall be considered a part of the application and shall state:

"I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans _____, and I reject inflation protection."

(12) Requirements for Application Forms and Replacement Coverage.

(A) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and producer, except where the coverage is sold without a producer, containing the questions may be used. With regard to a replacement policy issued to a group defined by section 376.1100.2(4)(a), RSMo, the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificateholder has been notified of the replacement:

1. "Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?"

2. "Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months?"

A. "If so, with which company?"

B. "If that policy lapsed, when did it lapse?"

3. "Are you covered by Medicaid?"

4. "Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?"

(B) Producers shall list any other health insurance policies they have sold to the applicant, including the following:

1. All policies sold that are still in force.

2. All policies sold in the past five (5) years that are no longer in force.

(C) Solicitations Other than Direct Response. Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its producer, shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage.

1. One (1) copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer.

2. The required notice shall be provided in the manner set forth in the Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long-Term Care Insurance Form (Form LTC-1).

(D) Direct Response Solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the manner set forth in the Notice to Applicant Regarding Replacement of Accident and Sickness or Long-Term Care Insurance Form (Form LTC-2).

(E) Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Notice shall be provided within five (5) working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

(F) Life insurance policies that accelerate benefits for long-term care shall comply with this section if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of 20 CSR 400-5.400. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

(13) Reporting Requirements.

(A) For purposes of this section:

1. "Policy" means only long-term care insurance;

2. Subject to subsection (13)(G), below, "claim" means a request for payment of benefits under an in-force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

3. "Denied" means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

4. "Report" means on a statewide basis.

(B) Every insurer shall maintain records for each producer of that producer's amount of replacement sales as a percent of the producer's total annual sales and the amount of lapses of long-term care insurance policies sold by the producer as a percent of the producer's total annual sales.

(C) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely producer activities regarding the sale of long-term care insurance.

(D) Every insurer shall report, annually by June 30, the ten percent (10%) of its producers

with the greatest percentages of lapses and replacements as measured by subsection (A) of this section, above. The required report is the Replacement and Lapse Reporting Form (Form LTC-G).

(E) Every insurer shall report annually by June 30, by completing Form LTC-G, the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year.

(F) Every insurer shall report annually by June 30, by completing Form LTC-G, the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year.

(G) Every insurer shall report annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied. The required report is the Claims Denial Reporting Form (Form LTC-E).

(H) Reports required under this section shall be filed with the director.

(14) Licensing. A producer is not authorized to sell, solicit or negotiate with respect to long-term care insurance except as authorized by section 375.018, RSMo.

(15) Discretionary Powers of Director. The director may upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this regulation with respect to a specific long-term care insurance policy or certificate upon a written finding that:

(A) The modification or suspension would be in the best interest of the insureds;

(B) The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

(C) One of the following:

1. The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care;

2. The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or

3. The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

(16) Reserve Standards.

(A) When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for the benefits shall be determined in accordance with section 376.380, RSMo. Claim reserves shall also be established in the case when the policy or rider is in claim status.

(B) Reserves for policies and riders subject to this subsection should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

(C) In the development and calculation of reserves for policies and riders subject to this subsection, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

1. Definition of insured events;
2. Covered long-term care facilities;
3. Existence of home convalescence care coverage;
4. Definition of facilities;
5. Existence or absence of barriers to eligibility;
6. Premium waiver provision;
7. Renewability;
8. Ability to raise premiums;
9. Marketing method;
10. Underwriting procedures;
11. Claims adjustment procedures;
12. Waiting period;
13. Maximum benefit;
14. Availability of eligible facilities;
15. Margins in claim costs;
16. Optional nature of benefit;
17. Delay in eligibility for benefit;
18. Inflation protection provisions; and
19. Guaranteed insurability option.
20. Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the AAA.

(D) When long-term care benefits are provided other than as in subsections (A) through (C) of this section, above, reserves shall be determined in accordance with section 376.410, RSMo, and 20 CSR 200-1.140.

(17) Loss Ratio.

(A) This section shall apply to all long-term care insurance policies or certificates except those covered under sections (8) and (18) of this regulation.

(B) Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%), calculated in a manner that provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

1. Statistical credibility of incurred claims experience and earned premiums;
2. The period for which rates are computed to provide coverage;
3. Experienced and projected trends;
4. Concentration of experience within early policy duration;
5. Expected claim fluctuation;
6. Experience refunds, adjustments or dividends;
7. Renewability features;
8. All appropriate expense factors;
9. Interest;
10. Experimental nature of the coverage;
11. Policy reserves;
12. Mix of business by risk classification; and
13. Product features such as long elimination periods, high deductibles and high maximum limits.

(C) Subsection (B) of this section, above, shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid if the policy complies with all of the following provisions:

1. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

2. The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of section 376.670, RSMo;

3. The policy meets the disclosure requirements of section 376.1109, RSMo;

4. Any policy illustration that meets the applicable requirements of sections 375.1500–375.1527, RSMo; and

5. An actuarial memorandum is filed with the department that includes:

A. A description of the basis on which the long-term care rates were determined;

B. A description of the basis for the reserves;

C. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

D. A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

E. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

F. The estimated average annual premium per policy and the average issue age;

G. A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

H. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

(18) Premium Rate Schedule Increases.

(A) This section shall apply as follows:

1. Except as provided in paragraph (18)(A)2., below, this section applies to any long-term care policy or certificate issued in this state six (6) months following the effective date of this regulation.

2. For certificates issued on or after the effective date of this proposed rule under a group long-term care insurance policy as defined in section 376.1100.2(4)(a), RSMo, which policy was in force at the time this proposed rule became effective, the provisions of this section shall apply on the policy anniversary following twelve (12) months after the effective date of this regulation.

(B) An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the director at least thirty (30) days prior to the notice to the policyholders and shall include:

1. Information required by section (7) of this regulation, above;

2. Certification by a qualified actuary that:

A. If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated; and

B. The premium rate filing is in compliance with the provisions of this section;

3. An actuarial memorandum justifying the rate schedule change request that includes:

A. Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale:

(I) Annual values for the five (5) years preceding and the three (3) years following the valuation date shall be provided separately;

(II) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(III) The projections shall demonstrate compliance with subsection (18)(C), below; and

(IV) For exceptional increases:

(a) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

(b) In the event the director determines, as provided in the provisions of paragraph (2)(A)4. of this regulation, that offsets may exist, the insurer shall use appropriate net projected experience;

B. Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

C. Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

D. A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and

E. In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer must also file composite rates reflecting projections of new certificates;

4. A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the director; and

5. Sufficient information for review of the premium rate schedule increase by the director.

(C) All premium rate schedule increases shall be determined in accordance with the following requirements:

1. Exceptional increases shall provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

2. Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

A. The accumulated value of the initial earned premium times fifty-eight percent (58%);

B. Eighty-five percent (85%) of the accumulated value of prior premium rate schedule increases on an earned basis;

C. The present value of future projected initial earned premiums times fifty-eight percent (58%); and

D. Eighty-five percent (85%) of the present value of future projected premiums not in subparagraph (18)(C)2.C., above, on an earned basis;

3. In the event that a policy form has both exceptional and other increases, the values in the provisions of subparagraphs (18)(C)2.B. and D., above, will also include seventy percent (70%) for exceptional rate increase amounts; and

4. All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in 20 CSR 200-1.140. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

(D) For each rate increase that is implemented, the insurer shall file for review by the director updated projections, as defined in the provisions of subparagraph (18)(B)3.A. of this rule, above, annually for the next three (3) years and include a comparison of actual results to projected values. The director may extend the period to greater than three (3) years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subsection (K) of this section, below, the projections required by this subsection shall be provided to the policyholder in lieu

of filing with the director.

(E) If any premium rate in the revised premium rate schedule is greater than two hundred percent (200%) of the comparable rate in the initial premium schedule, lifetime projections, as defined in the provisions of subparagraph (18)(B)3.A., above, shall be filed for review by the director every five (5) years following the end of the required period in subsection (D) of this section, above. For group insurance policies that meet the conditions in subsection (K) of this section, below, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the director.

(F) Director may request additional steps be taken by the insurer.

1. If the director has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subsection (C) of this section, above, the director may require the insurer to implement any of the following:

A. Premium rate schedule adjustments; or

B. Other measures to reduce the difference between the projected and actual experience.

2. In determining whether the actual experience adequately matches the projected experience, consideration should be given to the provisions of subparagraph (18)(B)3.E. of this regulation, if applicable.

(G) If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file the following documents:

1. A plan, subject to the director's approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the director may impose the condition in subsection (H) of this section, below; and

2. The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subsection (C) of this section, above, had the greater of the original anticipated lifetime loss ratio or fifty-eight percent (58%) been used in the calculations described in the provisions of subparagraphs (18)(C)2.A. and C., above.

(H) Significant Adverse Lapsation.

1. For a rate increase filing that meets the following criteria, the director shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve (12) months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

A. The rate increase is not the first rate increase requested for the specific policy form or forms;

B. The rate increase is not an exceptional increase; and

C. The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

2. In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the director may determine that a rate spiral exists. If it is determined that a rate spiral exists, the director may require the insurer to offer, without underwriting, to all in-force insureds subject to the rate increase the option to replace existing coverage with one (1) or more reasonably comparable products being offered by the insurer or its affiliates.

A. The offer shall:

(I) Be subject to the approval of the director;

(II) Be based on actuarially sound principles, but not be based on attained age; and

(III) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

B. The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

(I) The maximum rate increase determined based on the combined experience; and

(II) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent (10%).

(I) If the director determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the director may, in addition to the provisions of subsection (H) of this section, above, prohibit the insurer from either of the following:

1. Filing and marketing comparable coverage for a period of up to five (5) years; or

2. Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

(J) Subsections (A) through (I) of this section shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in subsection (2)(B), above, if the policy complies with all of the following provisions:

1. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

2. The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

A. Section 376.669, RSMo;

B. Section 376.670, RSMo;

C. Section 376.671, RSMo;

3. The policy meets the disclosure requirements of section 376.1109, RSMo;

4. The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:

A. Policy illustrations as required by sections 375.1500–375.1527, RSMo;

B. Disclosure requirements in 20 CSR 400-1.020; and

5. An actuarial memorandum is filed with the department that includes:

A. A description of the basis on which the long-term care rates were determined;

B. A description of the basis for the reserves;

C. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

D. A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

E. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

F. The estimated average annual premium per policy and the average issue age;

G. A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or

types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

H. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

(K) Subsections (F) and (H) of this section, above, shall not apply to group insurance policies as defined in section 376.1100.2(4)(a), RSMo, where:

1. The policies insure two hundred fifty (250) or more persons and the policyholder has five thousand (5,000) or more eligible employees of a single employer; or

2. The policyholder, and not the certificateholders, pays a material portion of the premium, which shall not be less than twenty percent (20%) of the total premium for the group in the calendar year prior to the year a rate increase is filed.

(19) Filing Requirement. Prior to an insurer or similar organization offering group long-term care insurance to a resident of this state pursuant to section 376.1103, RSMo, it shall file with the director evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this state.

(20) Filing Requirements for Advertising.

(A) Every insurer, health care service plan, or other entity providing long-term care insurance or benefits in this state shall provide a copy of any long-term care insurance advertisement intended for use in this state whether through written, radio or television medium to the director for review by the director to the extent it may be required under state law. In addition, all advertisements shall be retained by the insurer, health care service plan, or other entity for at least three (3) years from the date the advertisement was first used.

(B) The director may exempt from these requirements any advertising form or material when, in the director's opinion, that requirement may not be reasonably applied.

(21) Standards for Marketing.

(A) Every insurer, health care service plan, or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:

1. Establish marketing procedures and producer training requirements to assure that:

A. Any marketing activities, including any comparison of policies, by its producers will be fair and accurate; and

B. Excessive insurance is not sold or issued.

2. Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following:

"Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

3. Provide copies of the disclosure forms required in subsection (7)(C) of this regulation (Form LTC-B and Form LTC-F) to the applicant.

4. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance, except that in the case of qualified long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required.

5. Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with subsection (A) of this section, above.

6. If the state in which the policy or certificate is to be delivered or issued for delivery has a state senior health insurance assistance program approved by the director, the insurer shall, at solicitation, provide written notice to the prospective policyholder and certificateholder that the program is available and the name, address and telephone number of the program.

7. For long-term care health insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to the provisions of (4)(A)3. of this regulation.

8. Provide an explanation of contingent benefit upon lapse provided for in the provisions of paragraph (24)(D)3. and, if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying periods in paragraph (24)(D)4.

(B) In addition to the practices prohibited in sections 376.930 to 376.948, RSMo, the following acts and practices are prohibited:

1. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy or to take out a policy of insurance with another insurer.

2. High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

3. Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or insurance company.

4. Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

(C) Association Responsibility.

1. With respect to the obligations set forth in this subsection, the primary responsibility of an association, as defined in section 376.1100.2(4)(b), RSMo, when endorsing or selling long-term care insurance shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

2. The insurer shall file with the department the following material:

A. The policy and certificate;

B. A corresponding outline of coverage; and

C. All advertisements requested by the department.

3. The association shall disclose in any long-term care insurance solicitation, the following information:

A. The specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and

B. A brief description of the process under which the policies and the insurer issuing the policies were selected.

4. If the association and the insurer have