HCS SCS SB 583 -- INSURANCE REGULATION

SPONSOR: Champion (Hobbs)

COMMITTEE ACTION: Voted "do pass" by the Committee on Insurance Policy by a vote of 8 to 0.

This substitute changes the laws regarding insurance regulation.

TRAILER DEALER LIABILITY INSURANCE (Section 301.560, RSMo)

Currently, a trailer dealer is required to provide a copy of a current dealer garage liability insurance policy when submitting his or her licensure application. The substitute removes this requirement.

NONRESIDENT MOTORIST FINANCIAL RESPONSIBILITY (Sections 303.025 and 303.040)

A nonresident motorist operating a vehicle within the state is required to maintain financial responsibility that meets the requirements of his or her state. If a nonresident motorist is found guilty of not maintaining financial responsibility, he or she will have his or her driving privileges suspended in Missouri and the Director of the Department of Revenue must notify the appropriate official of his or her state.

An uninsured nonresident motorist involved in an accident in this state and the responding law enforcement must notify the department director of the accident, and any resident motorist involved in an accident with an uninsured nonresident motorist may report it to the department director.

HEALTH INSURANCE COVERAGE FOR AUTISM SPECTRUM DISORDER (Sections 337.300 - 337.345 and 376.1224)

The substitute establishes provisions regarding the diagnosis and treatment of autism spectrum disorders (ASD). The substitute:

(1) Establishes the Behavior Analyst Advisory Board under the State Committee of Psychologists within the Department of Insurance, Financial Institutions and Professional Registration to establish licensure and registration requirements for behavior analysts, assistant behavior analysts, and line therapists who provide applied behavior analysis therapies to children with ASD;

(2) Requires all group health benefit plans that are delivered, issued, continued, or renewed on or after January 1, 2011, written inside or outside the state, to provide coverage for the diagnosis and treatment of ASD;

(3) Requires the department director to grant a small employer who offers a group health plan a waiver from offering ASD coverage if the employer demonstrates by actual experience over any consecutive 12-month period that the cost of providing the coverage has resulted in at least a 2.5% increase in health plan premium costs to the employer over a calendar year;

(4) Prohibits carriers from denying or refusing to issue insurance coverage on, refusing to contract with, refusing to renew or reissue coverage on, or terminating or restricting coverage on an individual or his or her dependent because the individual is diagnosed with ASD;

(5) Limits the coverage provided by an insurance carrier for ASD to medically necessary treatment that is ordered by the insured individual's licensed treating physician or psychologist in accordance with a treatment plan. An ASD treatment plan must include all elements necessary for a health benefit plan or carrier to pay the claim. Except for inpatient services, the health benefit plan or carrier can review, at its expense, the treatment plan not more than once every three months unless the individual's treating physician or psychologist agrees that a more frequent review is necessary;

(6) Specifies that coverage for individuals younger than 19 years of age for the applied behavior analysis (ABA) services will have a maximum benefit of $36,000 per year with no limit on the number of visits to an ASD service provider. No coverage will be required for individuals older than 18 years of age. Coverage of services may be subject to general exclusions and limitations of the contract or benefit plan including coordination of benefits, services provided by family members, and utilization review of health care services but cannot be denied on the basis that it is educational or habilitative in nature;

(7) Prohibits ASD services from being subject to any greater deductible, co-insurance, or co-payment than other physical health care services provided by the health benefit plan. Payments and reimbursements for ABA services can only be made to an ASD service provider with certain specified exceptions;

(8) Requires these provisions to apply to any healthcare plan issued to employees and their dependents under the Missouri Consolidated Health Care Plan that is delivered, issued, continued, or renewed on or after January 1, 2011. These provisions also apply to plans that are established, extended, modified, or renewed on or after January 1, 2011, by self-insured governmental plans, self-insured group arrangements, multiple employer welfare arrangements, and self-insured school district

health plans;

(9) Exempts the MO HealthNet Program and supplemental insurance policies from the provisions of the substitute;

(10) Specifies that a health carrier or other entity that is subject to these provisions is not required to reimburse for ASD services provided by any school-based service;

(11) Requires individual health benefit plans to offer ASD coverage as an option but will not automatically be applied to an individually underwritten health benefit plan; and

(12) Requires, beginning February 1, 2012, the department to submit an annual report to the General Assembly regarding the implementation of the coverage and specified cost analysis data for ASD service claims from health insurers.

DISCLOSURE OF HEALTH INSURANCE INFORMATION (Sections 354.442 and 376.1450)

The substitute allows an insurer to provide health insurance information regarding an enrollee's health benefit plan online unless a paper copy is requested by the enrollee by written, oral, or electronic means. Requests for a paper copy must be provided to the enrollee within 15 business days of the request.

LIFE INSURANCE PRODUCER LICENSE EXAMINATIONS (Section 375.024)

The Director of the Department of Insurance, Financial Institutions and Professional Registration or a vendor under contract with the department is required to review life insurance producer license examinations if, during any 12-month period beginning on September 1, the overall pass rate of first-time examinees is less than 70%. The department must collect certain specified demographic information, in conformance with the appropriate privacy laws, from examinees and compile an annual report based on the review. The report must indicate if there was any disparity in the pass rate based on the demographic information. The department director may establish procedures to collect the necessary information to implement the provisions of the substitute. Beginning December 1, 2011, the department director must deliver an annual report on the review to the Governor, Lieutenant Governor, Speaker of the House of Representatives, and President Pro Tem of the Senate no later than December 1.

REGULATORY ACTIONS AGAINST INSURANCE COMPANIES OPERATING IN HAZARDOUS FINANCIAL CONDITIONS (Sections 375.539 and 375.1255)

The Director of the Department of Insurance, Financial Institutions and Professional Registration is authorized to determine whether an insurance company is in a hazardous financial condition. The department director may deem any property or casualty insurance company which has any policy in force with a net retained risk that exceeds 10% of the company's capital and surplus to be in a hazardous financial condition. The substitute specifies the factors for the department director to consider when determining whether an insurance company may be in a hazardous financial condition. The department director may consider adverse findings reported in financial condition and market conduct examination reports, audit reports, and actuarial opinions, reports, or summaries when determining whether the continued operation of the insurer may be hazardous to Missouri's policyholders, creditors, or the general public. If the department director determines that the continued operation of an insurer may be hazardous, the department director may issue an order requiring the insurer to take various actions including requiring the insurer to reduce its total amount of present and potential liability for policy benefits by reinsurance, reduce its volume of business, increase its capital and surplus, or document the adequacy of premium rates in relation to the risks insured. Any insurer subject to an order from the department director can request a hearing to be conducted in private unless the insurer requests a public hearing.

Risk-based capital (RBC) reporting requirements for property and casualty insurance companies are revised to allow the department to require a property and casualty insurance company to take action if its risk-based capital fails the National Association of Insurance Commissioners (NAIC) RBC trend test. The RBC trend test for property and casualty insurance companies is specified as a company action level event where the insurer has total adjusted capital which is greater than or equal to its Company Action Level RBC but less than the product of its Authorized Control Level RBC and 3.0 triggers the trend test determined in accordance with the trend test calculation included in the Property and Casualty RBC report instructions. Risk-based capital tests the adequacy of an insurance company's capital to meet the risks posed by its investment portfolio and the types and volume of insurance it underwrites.

INSURERS SUPERVISION, REHABILITATION AND LIQUIDATION ACT
(Sections 375.1152 and 375.1155)

The substitute changes the laws regarding the Insurers Supervision, Rehabilitation and Liquidation Act to allow for the treatment of qualified financial contracts in insurance insolvency proceedings. The substitute:

(1) Defines “qualified financial contract” as a commodity contract, forward contract, repurchase agreement, securities contract, swap agreement, and any similar agreement that the department director determines by rule to be a qualified financial contract and "netting agreement" as a contract or agreement that documents one or more transactions between the parties to the agreement for or involving one or more qualified financial contracts and that provides for the netting, liquidation, setoff, termination, acceleration, or close out under or in connection with one or more qualified financial contracts or present or future payment or delivery obligations or payment of delivery entitlements thereunder among the parties to the netting agreement; and

(2) Specifies that the commencement of a delinquency proceeding does not operate as a stay or prohibition of any right to cause of netting, liquidation, setoff, termination, acceleration, or close out of obligations or an enforcement of any security agreement or other credit guarantee in connection with any netting agreement or qualified financial contract.

LIQUIDATION OF CERTAIN DOMESTIC INSURANCE COMPANIES (Section 375.1175)

A domestic insurance company that is organized as a stock insurance company is allowed to voluntarily dissolve and liquidate as a corporation if the department director approves the articles of dissolution and the company files with the Secretary of State a copy of the department director’s certified approval along with the articles.

In determining whether to approve a dissolution, the department director must consider whether the insurers’ annual financial statements show no written insurance premiums for five years, the insurer has demonstrated that all policyholder claims have been satisfied or transferred to another insurer, and a market conduct examination of the insurer has been completed within the last five years.

MISSOURI LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT (Sections 376.717, 376.718, 376.724, 376.725, 376.732 - 376.735, 376.737, 376.738, 376.740, 376.743, and 376.758)

The laws regarding the Missouri Life and Health Insurance Guaranty Association Act are revised to make them consistent with the model act adopted by the National Association of Insurance Commissioners. The substitute:

(1) Clarifies that structured settlement annuities are covered by the guaranty association and are subject to a cap of $250,000

and specifies the rules for determining how the responsibility for coverage of these types of annuities is allocated among state guaranty associations;

(2) Expands the list of areas in which the guaranty association will not provide coverage including:

(a) Any portion of a policy or contract to the extent that the required assessments are preempted by federal or state law;

(b) An obligation that does not arise under the express written terms of the policy or contract issued by the insolvent insurer;

(c) Certain contracts which establish benefits by reference to a portfolio of assets not owned by the insurer;

(d) An unallocated annuity contract;

(e) Certain types of indexed policies; and

(f) A policy providing any hospital, medical, prescription drug, or other health care benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code, commonly known as Medicare Part C & D, or any of its regulations;

(3) Defines the "principal place of business" of a corporation for the purpose of applying the residency test that determines which state guaranty association has coverage responsibility;

(4) Makes several technical changes regarding:

(a) The guaranty association's options in providing coverage;

(b) The handling of terminated policies;

(c) The guaranty association's standing to appear or intervene in litigation;

(d) The guaranty association's assignment and subrogation rights;

(e) The guaranty association's general powers and the handling of reinsurance contracts;

(f) The handling of assessments of insurers to fund the guaranty association's operations; and

(g) Additional requirements for the association's plan of operation; and

(5) Exempts any member insurer who is impaired or insolvent prior to August 28, 2010, from the provisions of the substitute.

HEALTH INSURANCE FOR ADOPTED CHILDREN (Section 376.816)

All health carriers or health benefit plans, except Missouri Medicaid plans, which are issued, delivered, continued, or renewed to a Missouri resident on or after January 1, 2011, are required to include coverage for adopted children on the same basis as other dependents of the enrollee.

MEDICARE SUPPLEMENT AND LONG-TERM CARE INSURANCE POLICIES (Sections 376.882 and 376.1109)

When any federal Medicare supplement or long-term care insurance policy issued, delivered, or renewed in Missouri on or after January 1, 2011, is canceled for any reason, the insurer must refund the unearned portion of any premium paid beyond the month in which the cancellation is effective. Any refund must be returned to the policyholder within 20 days from the date the insurer receives notice of the cancellation. A policyholder may cancel a federal Medicare supplement policy by sending verbal, written, or electronic notification.

A long-term care insurance policy must contain a notice which informs an applicant that he or she is entitled to a refund of unearned premiums if the policy is canceled for any reason.

IDENTIFICATION INFORMATION IN CERTAIN COURT PLEADINGS (Sections 452.430, 454.515, and 525.233)

Currently, any pleadings other than interlocutory or final judgments in divorce or legal separation cases filed prior to August 28, 2009, will only be inspected by the parties, an attorney of record, upon order of the court, or in certain circumstances by the Family Support Division of the Department of Social Services. The clerk is required to redact Social Security numbers from any judgment or pleading before releasing them to the public. The substitute changes these requirements, so that they apply to pleadings in modification proceedings filed prior to August 28, 2009, and a licensed title insurer or his or her designee will be allowed to inspect the pleadings in these cases. Any person authorized to inspect the pleadings in these cases can also receive or make copies of documents without the clerk being required to redact the Social Security number unless the court specifically orders the clerk to do otherwise. The clerk will no longer be required to redact the Social Security number from pleadings from cases prior to August 28, 2009, but only from any copy of a judgment or satisfaction of judgment.

The substitute requires a lien on real estate that is obtained based on a judgment or order for unpaid child support or maintenance to contain only the last four digits of the obligor's Social Security number instead of the full number and requires a notice of garnishment and a writ of sequestration to contain only the last four digits of a person's Social Security number instead of the full number.

CHILDREN'S INSURANCE ELIGIBILITY (Section 1)

The Department of Social Services is required to provide all state licensed child-care providers who receive federal or state aid and all public school districts with written information regarding the eligibility criteria and application procedures for obtaining health insurance coverage through the State Children's Health Insurance Program (SCHIP). This information is to be distributed to the parents at the time of enrollment. The Department of Elementary and Secondary Education is required to add an attachment to the application for the free and reduced lunch program which will require the parent or guardian to check a box indicating whether the child has health insurance. If the child does not have health insurance and the parent or guardian's income does not exceed the highest level established by federal law, the school district must provide a notice to the parent or guardian that the uninsured child may qualify for health insurance coverage under SCHIP. The Department of Elementary and Secondary Education, in collaboration with the Department of Social Services, must submit an annual report to the Governor and the committee chairs of the House of Representatives Budget Committee and the Senate Appropriations Committee on the number of families in each district receiving free or reduced lunches, the number of families that indicated the absence of health insurance coverage on the forms, the number of families that received information on SCHIP, and the number of families who applied for coverage under SCHIP because of the receipt of the information.

The substitute contains an emergency clause for the provisions regarding the inspection of pleadings in divorce and legal separation cases filed prior to August 28, 2009.

FISCAL NOTE: Estimated Cost on General Revenue Fund Unknown greater than $1,022,765 in FY 2011, Unknown greater than $1,387,168 in FY 2012, and Unknown greater than $1,411,557 in FY 2013. Estimated Cost on Other State Funds of Unknown exceeding $180,946 in FY 2011, Unknown exceeding $317,627 in FY 2012, and Unknown exceeding $353,594 in FY 2013.

PROPONENTS: Supporters say that the bill will allow individuals who wish to cancel a policy to be able to do so and get a refund

of their unearned premiums which is good public policy.

Testifying for the bill were Representative Weter for Senator Champion; and Department of Insurance, Financial Institutions and Professional Registration.

OPPONENTS: There was no opposition voiced to the committee.

OTHERS: Others testifying on the bill say that they support the overall legislation but would like it to be stronger on the canceling of long-term care policies.

Testifying on the bill was Silver Haired Legislature.