1. Truthfully responding to an insurer's request for confirmation of suitability information;

2. Filing a complaint; or

3. Cooperating with the investigation of a complaint.

(H) (Reserved)

1. Sales made in compliance with FINRA requirements pertaining to suitability and supervision of annuity transactions shall satisfy the requirements under this rule. This subsection applies to FINRA broker-dealer sales of annuities if the suitability and supervision is similar to those applied to variable annuity sales. However, nothing in this subsection shall limit the director's ability to enforce (including investigate) the provisions of this rule.

2. For paragraph (4)(H)1. of this rule to apply, an insurer shall—

A. Monitor the FINRA member broker-dealer using information collected in the normal course of an insurer's business; and

B. Provide to the FINRA member broker-dealer information and reports that are reasonably appropriate to assist the FINRA member broker-dealer to maintain its supervision system.

(I) Failure to comply with the requirements set forth in section (4) of this rule shall constitute false information and/or misrepresentations and false advertising of insurance policies and/or misrepresentation in insurance applications as those terms are used in section 375.936(4), (6), and (7), RSMo.

(5) Insurance Producer Training.

(A) An insurance producer shall not solicit the sale of an annuity product unless the insurance producer has adequate knowledge of the product to recommend the annuity and the insurance producer is in compliance with the insurer's standards for product training. An insurance producer may rely on insurer-provided product-specific training standards and materials to comply with this subsection.

(B) (Reserved)

1. (Reserved)

A. An insurance producer who engages in the sale of annuity products shall complete a one- (1-) time four (4) credit training course approved by the director and provided by a director-approved education provider.

B. Insurance producers who hold a life insurance line of authority on the effective date of this rule and who desire to sell annuities shall complete the requirements of this subsection within six (6) months after the effective date of this rule. Individuals who obtain a life insurance line of authority on or after the effective date of this rule may not engage in the sale of annuities until the annuity training course required under this subsection has been completed.

2. The minimum length of the training required under subsection (5)(B) of this rule shall be sufficient to qualify for at least four (4) CE credits, but may be longer.

3. The training required under subsection (5)(B) of this rule shall include information on the following topics:

A. The types of annuities and various classifications of annuities;

B. Identification of the parties to an annuity;

C. How product specific annuity contract features affect consumers;

D. The application of income taxation of qualified and non-qualified annuities;

E. The primary uses of annuities; and

F. Appropriate sales practices, replacement, and disclosure requirements.

4. Providers of courses intended to comply with subsection (5)(B) of this rule shall cover all topics listed in the prescribed outline and shall not present any marketing information or provide training on sales techniques or provide specific information about a particular insurer's products. Additional topics may be offered in conjunction with and in addition to the required outline.

5. A provider of an annuity training course intended to comply with subsection (5)(B) of this rule shall register as a CE provider in this state and comply with the rules and guidelines applicable to insurance producer continuing education courses as set forth in section 375.020, RSMo.

6. Annuity training courses may be conducted and completed by classroom or self-study methods in accordance with section 375.020, RSMo.

7. Providers of annuity training shall comply with the reporting requirements in accordance with section 375.020, RSMo.

8. The satisfaction of the training requirements of another state that are substantially similar to the provisions of this subsection shall be deemed to satisfy the training requirements of this subsection in this state.

9. An insurer shall verify that an insurance producer has completed the annuity training course required under this subsection before allowing the producer to sell an annuity product for that insurer. An insurer may satisfy its responsibility under this subsection by obtaining certificates of completion of the training course or obtaining reports provided by director-sponsored database systems or vendors or from a reasonably reliable commercial database vendor that has a reporting arrangement with approved insurance education providers.

(C) Failure to comply with the requirements set forth in section (5) of this rule shall constitute false information and/or misrepresentations and false advertising of insurance policies and/or misrepresentation in insurance applications as those terms are used in section 375.936(4), (6), and (7), RSMo.

(6) Recordkeeping.

(A) Insurers, general agents, independent agencies, and insurance producers shall maintain or be able to make available to the director records of the information collected from the consumer and other information used in making the recommendations that were the basis for insurance transactions for a period of not less than three (3) years after the insurance transaction is completed by the insurer. An insurer is permitted, but shall not be required, to maintain documentation on behalf of an insurance producer.

(B) Records required to be maintained by this rule may be maintained in paper, photographic, micro-process, magnetic, mechanical or electronic media, or by any process that accurately reproduces the actual document.

AUTHORITY: sections 375.020, 374.045, 375.141, 375.143, and 375.144, RSMo Supp. 2013, and sections 375.934, 375.936, and 375.948, RSMo 2000. Original rule filed Sept. 30, 2016.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Tamara W. Kopp, Receivership Counsel, Director's Office, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 400—Life, Annuities and Health
Chapter 13—Health Insurance Rates

PROPOSED RULE

20 CSR 400-13.100 Health Insurance Rates

PURPOSE: This rule prescribes the form and content of the rate

information required to be submitted to the Missouri Department of Insurance, Financial Institutions and Professional Registration and sets forth the standards of review applicable to such filings.

(1) Scope. This rule is applicable to rates for health benefit plans that are subject to section 376.465.7, RSMo.

(2) Definitions. As used in this rule, the following terms mean:

(A) "Director," means the Director of the Department of Insurance, Financial Institutions and Professional Registration or the director's designee;

(B) "Health benefit plan," means those health benefit plans described under section 376.465.7, RSMo, and shall include student health plans;

(C) "Rate," means the amount of money a health carrier charges as a condition of providing coverage under a health benefit plan;

(D) "Rate filing," means a submission through SERFF that contains rates and rate filing justifications as well as other documents required by this rule and that assist the director in making determinations consistent with 45 CFR 154.215 and section 376.465, RSMo;

(E) "Rate filing justification," means actuarial data and other related information provided by a health carrier that supports the use of the proposed rate;

(F) "Student health plan," means a type of health coverage maintained pursuant to an agreement between an institution of higher education and a health carrier under which coverage is provided in connection with enrollment as a student at that institution of higher education, regardless of how the coverage is underwritten or issued;

(G) "System for Electronic Rate and Form Filing" or "SERFF," means the web-based interface system used for the submission of rate filings and form filings.

(3) All rates, rate filings, rate filing justifications, and any communication or notices filed under this rule shall be submitted through SERFF.

(4) All rate filings must conform to the requirements of 20 CSR 100-9.100.

(5) All proposed rates and rate filings for health benefit plans to be delivered, issued for delivery, continued, or renewed on or after January 1, 2018, shall contain the following:

(A) Rates for each health benefit plan including all variations based on age, rating area, and tobacco use, in an Excel spreadsheet, or other format as allowed by the director;

(B) Identification of all policy forms to which the rate filing will apply, including SERFF tracking number, policy form number, and plan identification number. A rate filing shall be made separately and apart from a policy form filing;

(C) The total number of in-force policies or certificates to which the rate filing will apply;

(D) The rate filing justification as described in section (6) of this rule; and

(E) Any other data or information that provides a sufficient basis for the director to determine if the proposed rates are reasonable and to complete the review under the standards outlined in 45 CFR Part 154.

(6) A health carrier shall submit a rate filing justification as follows.

(A) Part 1 of the rate filing justification shall be submitted on a form and in the manner prescribed by 45 CFR 154.215(d). Part 1 shall include the following data and information:

1. Historical and projected claims experience;

2. Trend projections related to utilization and service or unit cost;

3. Any claims assumptions related to benefit changes;

4. Allocation of the overall rates to claims and non-claims costs;

5. Per enrollee per month allocation of current and projected premium; and

6. Three- (3-) year history of rates for the product associated with the rate filing.

(B) Part 2 of the rate filing justification shall contain a brief, non-technical, consumer-oriented explanation of the proposed rates contained in Part 1 and any modifications contained therein. This explanation shall include a simple and brief narrative describing the data, information, and assumptions the health carrier used to develop the rate. Part 2 shall include, but not be limited to, the following:

1. An explanation of the most significant factors underlying a rate increase or decrease, where applicable, including a brief description of the relevant claims and non-claims expense increases reported in Part 1; and

2. A brief description of the overall experience of the policy, including historical and projected expenses and loss ratios.

(C) Part 3 of the rate justification shall contain an actuarial memorandum that contains the reasoning and assumptions supporting the data and information contained in Part 1 of the rate justification. The actuarial memorandum shall be submitted by a qualified actuary who represents the health carrier and who is a member of the American Academy of Actuaries.

1. A health carrier may submit a public version of Part 3 that redacts properly designated trade secrets or proprietary information. This redacted document shall be clearly denoted as the Part 3 Public Version. The health carrier may only redact information that is trade secret or proprietary under Missouri law. The Part 3 Public Version shall be submitted in SERFF as a document separate from other rate information.

2. If a health carrier submits a Part 3 Public Version, the health carrier must also submit an un-redacted version. This un-redacted version shall contain all of the required data and information with no redactions. The un-redacted version shall be clearly denoted as the Part 3 Confidential Version and submitted in SERFF as a document separate from other rate information.

(7) Any trade secret information included as a part of the rate filing justification must be designated as such by the health carrier and shall be subject to the provisions of sections 417.450-417.467, RSMo, and 20 CSR 10-2.400. All data and information contained within a rate filing or rate filing justification that is not clearly designated as either trade secret or proprietary under Missouri law, filed under this rule, will be open to the public.

(8) A health carrier shall submit rates and rate filing justifications, as outlined in this rule, to the Centers for Medicare and Medicaid Services on the same date it submits the information to the director, consistent with the requirements of 45 CFR Part 154.

(9) The director shall designate annual filing deadlines and posting dates, not inconsistent with the requirements of 45 CFR Part 154. The designation of annual filing deadlines may be announced through a bulletin or other electronic means as determined by the director.

(10) All proposed rates shall be posted, in summary form, at a uniform time on the department's website.

(11) The department shall allow the submission of public comments regarding proposed rates in written form, submitted to the department by mail or in an electronic format.

(12) A rate shall be determined to be unreasonable if the rate is excessive, inadequate, unfairly discriminatory, or unjustified.

(A) A rate is excessive if it is unreasonably high for the coverage provided under the health benefit plan.

(B) A rate is inadequate if it is unreasonably low for the coverage provided under the health benefit plan or the use of such rates endangers the solvency of the health carrier using the rate.

(C) A rate is unfairly discriminatory when a health carrier makes or permits differences in rates between individuals of the same class or of essentially the same risk when such differences are not permissible pursuant to section 375.936, RSMo, or when differences in rates do not reasonably correspond to differences in expected costs.

(D) A rate is unjustified if the heath carrier provides a rate justification that is incomplete or otherwise does not provide a sufficient basis upon which the reasonableness of a rate can be determined.

(13) The director's review of rates shall, at a minimum, consider the following:

(A) The reasonableness of the assumptions used by the health carrier to develop the proposed rate increase and the validity of the historical data underlying the assumptions;

(B) The health carrier's data related to past projections and actual experience;

(C) The reasonableness of assumptions used by the health carrier to estimate the rate impact of the federal risk adjustment program under 42 U.S.C. Section 18063; and

(D) The health carrier's data related to implementation and ongoing utilization of a market-wide single risk pool, essential health benefits, actuarial values, and other market standards or rules established under state or federal law.

(14) The director's review of rates may consider the following, to the extent the director believes any to be applicable to the rate filing under review:

(A) Medical cost trend changes by major service categories;

(B) Impact of changes in utilization of services by major service categories;

(C) Impact of cost-sharing changes by major service categories, including actuarial values;

(D) Impact of changes in benefits, including essential health benefits and non-essential health benefits;

(E) Impact of changes in enrollee risk profile and pricing, including rating limitations for age and tobacco use under 42 U.S.C. Section 300gg;

(F) Impact of over- and under-estimation of medical trends in the previous three (3) years on the current premium rate;

(G) Impact of changes in reserve needs;

(H) Impact of changes in administrative costs related to programs that improve health care quality;

(I) Impact of changes in other administrative costs;

(J) Impact of changes in applicable taxes and licensing or regulatory fees;

(K) Medical loss ratio;

(L) The health carrier's capital and surplus;

(M) The impacts of geographic factors and variations;

(N) The impact of changes within a single risk pool to all products or plans within the risk pool; and

(O) The impact of risk adjustment payments and charges.

(15) Pursuant to section 376.465.10(4), RSMo, written notice of the director's determination that proposed rates are reasonable or unreasonable shall be provided within sixty (60) days after a complete rate submission to the director. This sixty- (60-) day time frame may be extended pursuant to a mutual agreement between the director and the health carrier.

(A) Proposed rates that are determined to be reasonable will be considered final and the filing will be closed upon the same date as the director's notice.

(B) Proposed rates that are determined to be unreasonable will be considered open for amendment by the carrier pursuant to section (16) of this rule.

(16) Pursuant to section 376.465.11, RSMo, after receiving written notice from the director that a proposed rate is unreasonable, if a health carrier elects to amend proposed rates or request reconsideration of the director's determination, the carrier shall notify the director and submit any amendments or additions to the rate filing or rate filing justification within thirty (30) days after the date the carrier receives written notice of the director's determination. The thirty- (30-) day time frame may be extended pursuant to a mutual agreement between the director and the health carrier.

(A) If a health carrier chooses to file an amended rate, it shall file the amended rate and a rate filing justification supporting the amended rate.

(B) If a health carrier chooses to request reconsideration, it shall notify the director, in writing, of its request for reconsideration and may submit any additional rate filing justification that it believes further supports the proposed rate. The director shall review such information and make a determination as to whether the proposed rate is reasonable or unreasonable.

(17) When a health carrier receives written notice that a proposed rate is unreasonable and the health carrier decides to implement the proposed rate notwithstanding the director's determination, the health carrier shall notify the director of its decision to use the rate within thirty (30) days after receiving notice of the director's determination. The director shall make the determination that the rate is unreasonable publicly available on the department's website at the same time as final rates are posted on the department's website.

AUTHORITY: section 374.045, RSMo Supp. 2013, and section 376.465, CCS HCS SS SCS SBS 865 and 866, Second Regular Session, Ninety-eighth General Assembly 2016. Original rule filed Oct. 3, 2016.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Department of Insurance, Financial Institutions and Professional Registration, Attention: Amy V. Hoyt, PO Box 690, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days of publication of this notice in the Missouri Register. A public hearing is scheduled for 10:00 a.m., Friday, December 2, 2016, at the Harry S Truman State Office Building, Room 530, 301 West High Street, Jefferson City, Missouri.

SPECIAL NEEDS: If you have any special needs addressed by the Americans with Disabilities Act, please notify us at (573) 751-2619 at least five (5) working days prior to the hearing.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 700—Insurance Licensing
Chapter 1—Insurance Producers

PROPOSED AMENDMENT

20 CSR 700-1.145 Standards of Commercial Honor and Principles of Trade in Life, Annuity, and Long-Term Care Insurance Sales. The division is amending subsection (1)(A).

PURPOSE: This amendment clarifies the standard to which producers are held with regard to the exchange or replacement of variable life, annuity, or long-term care products.