IN THE CIRCUIT COURT OF COLE COUNTY, MISSOURI

BARBARA FINCH, and MARY LUCY BRENNER, Plaintiffs, vs. ROBIN CARNAHAN, in her official capacity as Missouri Secretary of State, Serve at: Office of the Secretary of State State Capitol, Room 208 Jefferson City, Missouri 65101 and SUSAN MONTEE, in her official capacity as Missouri State Auditor, Serve at: Office of the State Auditor 301 West High Street, Office 880 Jefferson City, Missouri 65101 and JOHN DIEHL, in his official capacity as Missouri State Representative, Serve at: MO House of Representatives 201 West Capitol Avenue, Room 201C Jefferson City, Missouri 65101 and RON RICHARD, in his official capacity as Missouri Speaker of the House, Serve at: MO House of Representatives 201 West Capitol Avenue Room 308 Jefferson City, MO 65101	)	Case _____ Div. _____

and)
)
CHARLIE SHIELDS, in his official)
capacity as President Pro Tem of)
the Missouri Senate,)
Serve at:)
MO Senate)
201 West Capitol Avenue)
Room 326)
Jefferson City, MO 65101)
)
Defendants.)

PETITION CHALLENGING THE CONSTITUTIONALITY OF H.B. 1764, THE OFFICIAL BALLOT TITLE, FISCAL NOTE, AND FISCAL NOTE SUMMARY AND REQUEST FOR RELIEF

COME NOW Plaintiffs Barbara Finch ("Finch") and Mary Lucy Brenner ("Brenner") (jointly "Plaintiffs"), and for their claims against Defendants Secretary of State Robin Carnahan, State Auditor Susan Montee, Representative John Diehl, Speaker of the House Ron Richard, and President Pro Tem Charlie Shields, jointly or severally, as the law may allow, state:

Introduction

1. Plaintiffs challenge the Constitutionality of SS SCS HCS House Bill 1764 (the "Bill"), and any efforts to place the Bill on the August 3rd, 2010, ballot that do not comply with Missouri law.

2. The Bill violates Missouri law and the Missouri Constitution.

3. Alternatively or concurrently, as the law may allow, Plaintiffs seek to overturn the actions of approving unlawful and inaccurate ballot language which will mislead and confuse Missouri voters.

4. The referendum language, official ballot title, fiscal note, and fiscal note summary prepared by the Defendants are unconstitutional, misleading, insufficient, unfair, and/or unlawful.

Parties

5. Plaintiff Brenner is an individual and resides in Osage County. Brenner, is and at all relevant times herein, has been a Missouri citizen, voter and taxpayer.

6. Plaintiff Finch is an individual and resides in St. Louis County. Finch, is and at all relevant times herein, has been a Missouri citizen, voter and taxpayer.

7. As Missouri citizens, voters, and taxpayers, the Plaintiffs have standing to challenge the Bill, in that, if the Bill is placed on the ballot, electoral, legislative, and governmental resources will be expended on an unconstitutional, misleading, insufficient, unfair and/or unlawful ballot referendum.

8. The Missouri Constitution and Missouri Statutes set forth a mandatory process elected officials must follow in order to place a bill or referendum proposal on a ballot.

9. Plaintiffs have the right to challenge elected officials to follow the rules set forth by the Missouri Constitution and Missouri Statutes and to hold them accountable when they fail to do so.

10. Brenner has personal interest at stake and a legally protectable interest in this litigation in that, if the Bill passes voter scrutiny, her supplemental insurance premiums will likely increase due to the increased number of uninsured Missourians.

11. Furthermore, if the Bill passes, Brenner faces significant health risks associated with the increase of illnesses stemming from fewer insured Missourians.

12. Finch has personal interest at stake and a legally protectable interest in this litigation in that, if the Bill passes her supplemental insurance premiums will likely increase due to the increased number of uninsured Missourians.

13. In support of Plaintiffs' allegations, under the federal Patient Protection and Affordable Care Act ("PPACA"), the Congressional Budget Office has estimated that average premiums would be 7 percent to 10 percent lower because of the influx of enrollees with below average spending for health care who would purchase coverage because of the new subsidies to be provided and the individual mandate contained in the PPACA. In contrast, an analysis by Wellpoint indicated that the impact of guarantee issue (included in the part of the PPACA that the Missouri Bill appears to leave untouched) without an effective individual mandate (from which the Missouri Bill purports to exempt Missourians) would be premium increases ranging from 20 percent to 80 percent. *See,* Senator Joan Bray's comments to the Auditor, contained within **Exhibit J** (citing Congressional Budget Office, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act*, at 6, November 30, 2009; and Wellpoint, *Health Care Reform Premium Impact in Missouri*, at 8, undated (available at http://www.politico.com/staticPPM143_091023_missouri_premium_impacts_analysis.html)).

14. Furthermore, in order to establish taxpayer standing for a constitutional challenge, Plaintiffs "need only show that [their] taxes went or will go to public funds that have or will be expended due to the challenged action." ***National Solid Waste Management Association v. Director of the Department of Natural Resources***, 964 S.W.2d 818 (Mo. banc 1998).

15. In this case, according to the fiscal note prepared by the Auditor, the Department of Insurance, Financial Institutions and Professional Registration, the Department of Mental Health, the Department of Social Services, and the Office of Administration indicated that, if

passed, the statutory changes which would be implemented by the Bill are anticipated to have an unknown negative fiscal impact, due to the uncertain interaction of the statutes with the PPACA, meaning tax revenues are likely to be spent if the statutory changes are to take effect. *See*, Missouri State Auditor's Office Fiscal Note (10-10), dated June 7, 2010, attached hereto and incorporated herein by reference as **Exhibit J**.

16. The negative fiscal impact anticipated by the above referenced entities could be significant; the entities which anticipated a negative fiscal impact were purportedly unable to gauge the extent of the impact. To the extent that such negative fiscal impact is significant, it could result in higher taxes levied upon Plaintiffs and other Missouri citizens.

17. Furthermore, Senator Joan Bray and the Missouri Health Advocacy Alliance voluntarily provided information to the Auditor relating to possible consequences if the Bill passed, and were also of the opinion that Missouri citizens were likely to experience significantly increased insurance premiums. See **Exhibit J.**

18. As such, Plaintiffs have standing to pursue their Constitutional claims as well as claims under Chapter 116, RSMo.

19. Defendant, Robin Carnahan (the "Secretary of State"), is and at all relevant times herein, has been the duly elected, qualified and acting Secretary of the State of Missouri. As such, she is charged by law with implementing the provisions of the Missouri Constitution and Chapter 116, RSMo., relating to ballot referendums. She is charged with upholding and complying with the Missouri Constitution in the discharge of her statutory duties.

20. Defendant, Susan Montee (the "Auditor"), is and at all relevant times herein, has been the duly elected, qualified and acting Auditor of the State of Missouri. As such, she is charged by law with implementing the provisions of Chapter 116, RSMo., relating to fiscal notes

and fiscal note summaries for ballot referendums. She is charged with upholding and complying with the Missouri Constitution in the discharge of her statutory duties.

21. Defendant, John Diehl (the "Sponsor"), is and at all relevant times herein, has been the duly elected, qualified and acting Missouri State Representative for District 87. As such he is charged by law with upholding the Missouri Statutes relating to ballot referendums. He is charged with upholding and complying with the Missouri Constitution in the discharge of his duties. Acting in his official capacity as Missouri State Representative for District 87, he sponsored and introduced the Bill on or about January 21, 2010.

22. Defendant, Ron Richard (the "Speaker"), is and at all relevant times herein, has been the duly elected, qualified and acting Missouri Speaker of the House. As such he is charged by law with upholding the Missouri statutes relating to ballot referendums. He is charged with upholding and complying with the Missouri Constitution in the discharge of his duties.

23. Defendant, Charlie Shields (the "President Pro Tem"), is and at all relevant times herein, has been the duly elected, qualified and acting Missouri Speaker of the House. As such he is charged by law with upholding the Missouri Statutes relating to ballot referendums. He is charged with upholding and complying with the Missouri Constitution in the discharge of his duties.

Jurisdiction and Venue

24. This court has jurisdiction over this matter and venue is proper in Cole County, Missouri, pursuant to the Missouri Constitution and Section 116.190 RSMo.

25. This action is timely filed within the ten day period provided for in Section 116.190.1.

26. This Court has general jurisdiction over Plaintiffs' additional claims.

General Allegations

27. On or about January 21, 2010, Sponsor introduced HB 1764 ("Introduced Bill") to the Missouri General Assembly. The Introduced Bill purported to repeal Section 375.1175 and enact one new section relating to the liquidation of certain domestic insurance companies. A true and accurate copy of the Introduced Bill is attached hereto and incorporated herein as **Exhibit A**.

28. The Introduced Bill included the following title statement:

> To repeal section 375.1175, RSMo, and to enact in lieu thereof one new section relating to liquidation of certain domestic insurance companies.

Id.

29. On or about March 18, 2010, the Missouri House of Representatives Insurance Policy Committee approved House Committee Substitute for House Bill No. 1764 ("House Committee Substitute"). A true and accurate copy of the House Committee Substitute is attached hereto and incorporated herein as **Exhibit B.**

30. The House Committee Substitute amended the Introduced Bill by adding three new subsections adding factors for the Director of the Department of Insurance ("Director") to consider when determining whether to approve a voluntary dissolution of a domestic insurer.

31. The House Committee Substitute included the following title statement mirroring the Introduced Bill's title statement:

> To repeal section 375.1175, RSMo, and to enact in lieu thereof one new section relating to the liquidation of certain domestic insurance companies.

Id.

32. On or about March 31, 2010, the Missouri House of Representatives adopted changes made by the Insurance Policy Committee and passed the Perfected House Committee

Substitute for House Bill No. 1764 ("Perfected Bill"). A true and accurate copy of the Perfected Bill is attached hereto and incorporated herein as **Exhibit C.**

33. The Perfected Bill included the following title statement mirroring both the Introduced Bill and the House Committee Substitutes:

> To repeal section 375.1175, RSMo, and to enact in lieu thereof one new section relating to the liquidation of certain domestic insurance companies.

Id.

34. On or about April 20, 2010, the Small Business, Insurance, and Industry Senate Committee approved Senate Committee Substitute for House Committee Substitute for House Bill No. 1764 ("Senate Committee Substitute"). A true and accurate copy of the Senate Committee Substitute is attached hereto and incorporated herein as **Exhibit D**.

35. The Senate Committee Substitute proposed to repeal existing statutes relating to insurance and enact ten new sections in lieu thereof including proposed section 375.539 giving the Director authority to find an insurer in a hazardous condition along with the possible consequences of such a finding; proposed section 375.1152 regarding definitions; proposed section 375.1155 authorizing certain injunctions against certain insurers; proposed section 375.1175 relating to the liquidation of certain insurers; proposed section 375.1191 regarding rights and responsibilities relating to certain parties; proposed section 375.1255 relating to company action level events; proposed section 376.882 relating to the cancellation of Medicare supplemental policies; proposed section 376.1109 authorizing the director to adopt regulations relating to full and fair disclosure and long-term insurance policies; proposed section 376.1110 relating to risks and rates of long-term insurance policies; and proposed section 376.1257 relating to policies covering cancer chemotherapy treatment.

36. The Senate Committee Substitute modified the title statement to read:

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

Id.

37. The original purpose and subject of the Introduced Bill addressed the liquidation of certain domestic insurance companies.

38. On or about May 4, 2010, the Missouri Senate adopted the Senate Substitute for Senate Committee Substitute for House Committee Substitute for House Bill No. 1764 ("Senate Substitute"). A true and accurate copy of the Senate Substitute is attached hereto and incorporated herein as **Exhibit E**.

39. In addition to liquidation of certain domestic insurance companies, the Senate Substitute added an entirely new section relating to a mandatory health care system and health insurance.

40. In addition, the Senate Substitute added a referendum clause attempting to submit the Bill to Missouri voters on August 3, 2010:

> Shall the Missouri Statutes be amended to:
>
> Deny the government authority to penalize citizens for refusing to purchase private health insurance or infringe upon the right to offer or accept direct payment for lawful healthcare services?
>
> Modify laws regarding the liquidation of certain domestic insurance companies?

Id.

41. The Senate Substitute modified the title statement from the Senate Committee Substitute to read:

> To repeal section 375.1175, RSMo, and to enact in lieu thereof two new sections relating to insurance, with a referendum clause.

Id.

42. The Senate Substitute strayed from the Introduced Bill's original purpose.

43. The Senate Substitute includes more than a single subject.

44. On or about May 11, 2010, the Missouri General Assembly passed the Truly Agreed to and Finally Passed Senate Substitute for Senate Committee Substitute for House Committee Substitute for House Bill No. 1764 (the "Bill"). A true and accurate copy of the Bill is attached hereto and incorporated herein as **Exhibit F**.

45. The Bill is titled:

> AN ACT, to repeal section 375.1175, RSMo, and to enact in lieu thereof two new sections relating to insurance, with a referendum clause.

Id.

46. The Bill purports to enact two new statutory provisions including one relating to a mandatory health care system and health insurance coupled with one new section relating to the liquidation of certain insurers, including a referendum clause.

47. The referendum clause purports to submit the Bill containing the two separate provisions to Missouri voters on the Tuesday next following the first Monday in August, 2010. (August 3, 2010). The official ballot title, as prepared by the legislature, reads:

> Shall the Missouri Statutes be amended to:
>
> Deny the government authority to penalize citizens for refusing to purchase private health insurance or infringe upon the right to offer or accept direct payment for lawful healthcare services?
>
> Modify laws regarding the liquidation of certain domestic insurance companies?

Id.

48. On May 21, 2010, the Secretary of State sent a memo to local election authorities to give notice that a Special Election was called by the Missouri General Assembly to be held on

August 3, 2010. A true and accurate copy of the memo is attached hereto and incorporated herein as **Exhibit G**.

49. The Secretary of State's May 21, 2010 memo did not contain a sample ballot. The memo stated that "Certification, legal notice, and sample official ballot will be sent to you as soon as possible after the Official Ballot Title, including the fiscal note summary, is certified in accordance with Chapter 116, RSMo." *Id.*

50. On May 25, 2010, the Bill was delivered to the Secretary of State. *See*, Memo from Secretary of State's Office to Election Authorities, attached hereto and incorporated by reference as **Exhibit H**.

51. The May 25, 2010 memo states:

> The Certification, legal notice of special election, and sample official ballot will be sent to you as soon as possible after the Official Ballot Title, including the fiscal note summary, is certified in accordance with chapter 116. Our office has transmitted SS SCS HCS House Bill 1764 to the State Auditor's Office and it will take, at a minimum, 10 days for preparation of the fiscal note and fiscal note summary. **See Section 116.175 RSMo**.

Id.

52. On May 25, 2010, the Secretary of State transmitted the Bill to the Auditor for preparation of the fiscal note and fiscal note summary to be certified pursuant to Section 116.175 RSMo.

53. On or about June 7, 2010, the Auditor certified the fiscal note and fiscal note summary.

54. On or about June 7, 2010, the Secretary of State certified the official ballot title language. A true and accurate copy of the official ballot title is attached hereto and incorporated herein as **Exhibit I**. The official ballot title reads:

Shall the Missouri Statutes be amended to:

Deny the government authority to penalize citizens for refusing to purchase private health insurance or infringe upon the right to offer or accept direct payment for lawful healthcare services?

Modify laws regarding the liquidation of certain domestic insurance companies?

It is estimated this proposal will have no immediate costs or savings to state or local governmental entities. However, because of the uncertain interaction of the proposal with implementation of the federal Patient Protection and Affordable Care Act, future costs to state governmental entities are unknown.

Id.

COUNT I
CLAIMS FOR VIOLATION OF THE MISSOURI CONSTITUTION ARTICLE III, SECTION 21

COME NOW Plaintiffs Barbara Finch ("Finch") and Mary Lucy Brenner ("Brenner") (jointly "Plaintiffs"), and for Count I of their claims against Defendants Secretary of State Robin Carnahan, State Auditor Susan Montee, Representative John Diehl, Speaker of the House Ron Richard, and President Pro Tem Charlie Shields, jointly or severally, as the law may allow, state:

55. Plaintiffs restate and incorporate herein paragraphs 1 through 54 as if fully set out verbatim.

56. Article III, Section 21 of the Missouri Constitution states that "no bill shall be so amended in its passage through either house as to change its original purpose." **Mo. Const. Art. III, § 21.**

57. Article III, § 21 of the Missouri Constitution requires an analysis of the Bill as introduced compared to the Bill as finally passed. ***Missouri Ass'n. of Club Executives v. State, 208 S.W.3d 885, 888 (Mo. 2006).***

58. The Introduced Bill and the Perfected Bill from the Missouri House of Representatives contained provisions relating only to the liquidation of certain domestic insurers.

59. As evidenced by the Introduced and Perfected Bill, the original purpose of the Bill was to only change the law with regards to liquidation of certain domestic insurers.

60. The Perfected Bill was amended by the Senate Committee Substitute on or about April 20, 2010, which was then amended by the Senate with the passage of the Senate Substitute on or about May 4, 2010.

61. The Senate Substitute added new provisions relating to a mandatory health care system and health insurance coupled with the provision relating to the liquidation of certain domestic insurers.

62. The Bill as finally passed, contains Senate Substitute's newly added provision relating to a mandatory health care system and health insurance.

63. This amendment from the Senate Substitute changed the original purpose of the Bill by adding a new provision focusing on a mandatory health care system and health insurance.

64. On or about May 4, 2010, the date the Senate passed Senate Substitute, was the first time when the provisions relating to a mandatory health care system and health insurance were included in HB 1764.

65. The Bill was finally agreed upon and passed a week later on or about May 11, 2010.

66. Upon information and belief, the title and substance of the modification and substitution of the original Introduced Bill represents an attempt by the legislature to cram new provisions into HB 1764 and minimize the amount of discussion relating to the new provisions.

67. This practice is known as legislative log-rolling. Adding versions to a bill "during the next-to-last day of the session were not remotely within the original purpose of the bill, but rather constitute a textbook example of the legislative log-rolling that section 21 is intended to

prevent." ***Missouri Ass'n of Club Executives*, at 888**; *see also* ***National Solid Waste Management Association* at 820** (". . . last-minute amendment about which even the most wary legislatures could hardly have given their considered attention and about which concerned citizens likely had no input . . . " held unconstitutional).

68. The Introduced Bill was amended by Senate Committee Substitute and Senate Substitute in such a way that changed the original purpose of HB 1764 in violation of the Missouri Constitution, Article III, Section 21.

WHEREFORE, Plaintiffs respectfully pray for a judgment from this Court:

A. Declaring SS SCS HCS HB 1764 unconstitutional;

B. Removing SS SCS HCS HB 1764 from the ballot;

C. Awarding Plaintiffs their attorneys' fees, expenses and costs; and

D. Granting Plaintiffs any additional relief the Court deems just and proper.

COUNT II
CLAIMS FOR VIOLATION OF THE MISSOURI CONSTITUTION ARTICLE III, SECTION 23

COME NOW Plaintiffs Barbara Finch ("Finch") and Mary Lucy Brenner ("Brenner") (jointly "Plaintiffs"), and for Count II of their claims against Defendants Secretary of State Robin Carnahan, State Auditor Susan Montee, Representative John Diehl, Speaker of the House Ron Richard, and President Pro Tem Charlie Shields, jointly or severally, as the law may allow, state:

69. Plaintiff restates and incorporates herein paragraphs 1 through 68 as if fully set out verbatim.

70. Article III, Section 23 of the Missouri Constitution states that "[n]o bill shall contain more than one subject which shall be clearly expressed in its title[.]"

71. As long as "the matter is germane, connected and congruous, the law does not violate the single subject rule." ***Hammerschmidt v. Boone County*, 877 S.W.2d 98, 102 (Mo. 1994)**. A single subject will include "all matters that fall within or reasonably relate to the general core purpose of the proposed legislation." *Id.*

72. The Bill contains two distinct, unrelated, and separate subjects in violation of the Missouri Constitution in that the provisions of the Bill relating to prohibiting the government from compelling certain persons from participating in health care systems are completely unrelated to the provisions relating to the liquidation of certain domestic insurance companies.

73. The Bill purports to add a new and distinct statutory provision with a subject relating to a mandatory health care system and health insurance.

74. Upon information and belief, said provision is in reaction to the PPACA . Said provision purports to deny authority to compel "any person, employer, or health care provider to participate in any health care system." **Exhibit F**. Furthermore, said provision states that direct payment for health care services is allowed and may not be penalized. Said provision also states that "the purchase or sale of health insurance in private health care systems shall not be prohibited..." *Id.*

75. The Bill also contains the original statutory provision relating to the liquidation of certain domestic insurers. Said provision permits domestic stock insurance companies to voluntarily dissolve and liquidate provided that certain requirements are met. Said provision is unconnected and unrelated to the first provision in HB 1764 relating to the subject of a mandatory health care system and health insurance.

76. The Bill contains two separate subjects in that the above provisions are unconnected, incongruous and not reasonably related to a single subject.

77. The multiple subjects found in the Bill is further evidenced in the referendum clause which will unreasonably require Missouri voters to provide a single vote for two unconnected questions.

78. Question number one of the referendum asks if the Missouri Statutes should be amended to "Deny the government authority to penalize citizens for refusing to purchase private health insurance or infringe upon the right to offer or accept direct payment for lawful healthcare services?" **Exhibits F and I.**

79. Question number two of the referendum asks if the Missouri Statutes should be amended to "Modify laws regarding the liquidation of certain domestic insurance companies." *Id.*

80. These two questions have no reasonable relation and underscore the two distinct subjects found in the Bill.

81. The official ballot title is confusing and misleading to voters and requires them to choose one answer to two separate questions. Voters may be forced to determine which of the two subjects is most important. A vote of "yes" or "no" will not conclusively determine whether a voter was in favor of or against *both* changes to the law, because the changes are not directed toward a single related goal or purpose. Voters are likely more willing to vote to approve the entire measure if the voter supports one of the separate and distinct proposed changes.

82. Even if the Bill is deemed to have only one subject, the title does not clearly express a single subject in that the title is overly broad and fails to adequately give notice of the contents of the Bill.

83. The Bill's title is:

> AN ACT to repeal section 375.1175, RSMo, and to enact in lieu thereof two new sections relating to insurance, with a referendum clause.

Exhibit F.

84. One purpose of Article III § 23 of the Missouri Constitution is "to assure that the people are fairly apprised, through such publication of legislative proceedings as is usually made, of the subjects of legislation that are being considered in order that they have [an] opportunity of being heard thereon...." ***Hammerschmidt*, at 101.**

85. The Bill's title fails to clearly or adequately describe the subject the Bill in a way that gives adequate notice to citizens of the contents of the Bill. Specifically, the title stating the bill contains "two new sections relating to insurance" does not give adequate or reasonable notice to citizens that the Bill purports to prohibit the government from compelling participation in health care systems.

86. The Bill's title is not reasonably related to the Bill's core purpose. The title does not clearly express a single subject in that the title is overly broad and general in a way that would render meaningless the single subject restriction under Art. 3, § 23 of the Missouri Constitution.

87. The Bill's title stating that it is "relating to insurance" covers the universe of insurance. Insurance is an extremely broad topic containing many unrelated and incompatible subtopics, such as regulation of companies, regulation and licensing of insurance producers, issues as to coverage, legal venue and procedure issues, formation and dissolution of companies, among countless others.

88. It follows that simply because two topics or proposed statutory changes can fall under the broad title "relating to insurance" does not mean that such title is clear when any

multiple part question is posed to Missouri voters. For example, how can a reasonable voter reconcile questions such as "should the law be changed to (a) disallow stacking of uninsured motorist policies and (b) require mandatory criminal background checks for administrative professionals who routinely review claims materials?" Such questions, while certainly "relating to insurance," address distinct subjects that are not clearly expressed in a title which only describes the proposed statutory changes as "relating to insurance."

89. Such is this case. The provision dealing with voluntarily dissolving an insurance business is completely unconnected with the provision prohibiting mandatory purchase of health insurance.

90. The Bill contains two distinct subjects, expressed in an overly broad title, and therefore violates the Art. III, Section 23 of the Missouri Constitution.

WHEREFORE, Plaintiffs respectfully pray for a judgment from this Court:

A. Declaring SS SCS HCS Bill 1764 unconstitutional;

B. Removing SS SCS HCS House Bill 1764 from the ballot;

C. Awarding Plaintiffs their attorneys' fees, expenses and costs; and

D. Granting Plaintiffs any additional relief the Court deems just and proper.

COUNT III
CHALLENGE PURSUANT TO SECTION 116.190, RSMO. OF THE AUDITOR'S FISCAL NOTE AND FISCAL NOTE SUMMARY

COME NOW Plaintiffs Barbara Finch ("Finch") and Mary Lucy Brenner ("Brenner") (jointly "Plaintiffs"), and for Count III of their claims against Defendants Secretary of State Robin Carnahan, State Auditor Susan Montee, Representative John Diehl, Speaker of the House Ron Richard, and President Pro Tem Charlie Shields, jointly or severally, as the law may allow, state:

91. Plaintiff restates and incorporates herein paragraphs 1 through 90 as if fully set out verbatim.

92. As stated above, the Bill identifies two distinct proposed changes to the Missouri Statutes:

a. the uniform healthcare portion which was added to the Bill as a senate substitute; and

b. the modification of laws regarding liquidation of certain domestic insurance companies, in accordance with the Bill as originally introduced.

93. When the Bill was passed, it was referred to the Auditor for preparation of a fiscal note and fiscal note summary in accordance with Section 116.175 RSMo.

94. Section 116.175.1 mandates that the Auditor "shall assess the fiscal impact of the proposed statement."

95. Section 116.175.1 further provides that the Auditor "may consult with the state departments, local government entities, the general assembly and others with knowledge pertinent to the cost of the proposal."

96. Pursuant to this section, the Auditor requested information from a number of such entities. A list of these entities may be found on the Auditor's Fiscal Note, **Exhibit J**.

97. Many of the entities from whom input was sought by the Auditor provided input, and many did not respond.

98. The Auditor's Fiscal Note does not contain any independent assessment, nor any comments or conclusions from the Auditor, but instead merely incorporates the responses from the entities that responded to her request for input.

99. The Auditor's fiscal summary, which was included in the Secretary of State's Certification of Official Ballot Title, states as follows:

> It is estimated this proposal will have no immediate costs or savings to the state or local governmental entities. However, because of the uncertain interaction of the proposal with implementation of the federal Patient Protection and Affordable Care Act, future costs to state governmental entities are unknown.

100. Of the 22 entities that responded to the Auditor's request for input, 18 of them indicated that the bill or proposal would have no impact on their department or entity, that they did not anticipate a financial impact upon their department, that any immediate costs could be absorbed into an existing budget, or that they were deferring to the response of a different entity.

101. Of the 22 entities that responded to the Auditor's request for input, the remaining four entities, including the Department of Insurance, Financial Institutions and Professional Registration, the Department of Mental Health, the Department of Social Services, and the Office of Administration indicated that, if passed, the statutory changes which would be implemented by the bill may have an unknown ***negative*** fiscal impact, due to the uncertain interaction of the statutes with the PPACA.

102. Upon information and belief, of the 22 entities that responded to the Auditor's request for input, the entities which responded that they anticipate an unknown negative fiscal impact are those which have greater expertise and experience estimating the costs of insurance and healthcare related issues, and are those entities that would be expected to experience *any* fiscal impact from the statutory changes contained in the Bill.

103. None of the entities which responded commented or provided any information as to the potential financial impact of the statutory changes regarding the liquidation of insurance companies.

104. The Auditor's Fiscal Note and Fiscal Note Summary do not address in any manner the anticipated fiscal impact of the statutory changes regarding the liquidation of insurance companies.

105. One of the statutory changes in regard to the liquidation of insurance companies provides a mechanism whereby an insurance company may voluntarily dissolve and liquidate, if, in the Director of the Department of Insurance's ("Director") sole discretion, he or she approves articles of dissolution for the company. ***See*** **Exhibit F**.

106. It is inconceivable that the Department of Insurance, Financial Institutions and Professional Registration would not anticipate *some* fiscal impact from these statutory changes when the Director would be given the added burden of reviewing and approving articles of dissolution when certain domestic insurance companies attempt to voluntarily liquidate.

107. The Attorney General's Office's response to the Auditor's request stated that they assume that any costs to that entity could be absorbed with existing resources. **Exhibit J.**

108. The Secretary of State's Office likewise indicated that while there would be administrative costs associated with the publishing of the ballot measure, those costs would likewise be absorbed into its current budget. ***Id.***

109. In contrast, despite the added duties of the Director, the Department of Insurance did not address any fiscal impact if the bill were to pass, and did not state that this was because any anticipated costs could be absorbed into its current budget.

110. The Auditor could not have assumed that the Department of Insurance could absorb the costs of this aspect of the bill absent a statement from the Department of Insurance that this was the case.

111. Because the Auditor knew or should have known that there would be a fiscal impact to the Department of Insurance based upon the statutory changes contained in the bill, a response which failed to address such impact was incomplete.

112. The Auditor must adequately, in non-argumentative and non-prejudicial language, explain the fiscal consequences of a bill to the public. ***Missouri Municipal League*, at 582.**

113. While the Auditor is not required in every instance to independently assess the fiscal impact of a bill, if she is going to rely upon the statements of entities responding to her request for input, she has a non-delegable duty to independently examine the comments for reasonableness, completeness, and a reasonable relationship between the agency comment and the proposal. ***Id.***

114. The Auditor or a representative from her office has testified that it is the Auditor's practice to evaluate responses and follow up with entities whose responses were unclear. ***Id.***

115. The Auditor's Fiscal Note, and the subsequent Fiscal Note Summary prepared by the Auditor does not adequately convey the fiscal consequences to the public of the proposal in non-prejudicial and non-argumentative language and is otherwise in violation of law in that, to wit:

a. The Fiscal Note and Fiscal Note Summary do not contain any information or reference to the anticipated or possible fiscal impact of the statutory changes to laws governing the liquidation of domestic insurance companies;

b. The responses used to create the Fiscal Note and summarized to create the Fiscal Note Summary were incomplete, unreasonable, and do not demonstrate a reasonable relationship between the proposal and the

response because they failed to address one of the two subjects of the bill – that portion dealing with the liquidation of domestic insurance companies. Thus, the Auditor should have sought more information from the responding entities, or, being unable to reasonably rely upon the incomplete and unreasonable responses received, performed an independent analysis of the fiscal impact of the proposal so that the public can intelligently determine whether they support the proposal.

c. The Fiscal Note Summary does not adequately or accurately summarize the findings contained in the Fiscal Note in that the only entities that anticipated any fiscal impact to their department, stated that they anticipated a ***negative*** fiscal impact, albeit in an unknown amount. Absolutely no entity responding to the request for input stated that they anticipated any potential positive fiscal impact if the bill was passed. However, the Fiscal Note Summary does not address the anticipated negative impact of the bill on Missouri's agencies and departments, only that the impact is unknown. This is misleading to Missouri voters who may assume that the fiscal impact of the bill could be positive, when in actuality the only anticipated fiscal impact was a negative impact.

WHEREFORE, Plaintiffs respectfully pray for a judgment from this Court:

A. Finding and declaring that the fiscal note and fiscal note summary statement certified by the Auditor with respect to the proposed referendum are insufficient, unfair, argumentative, and/or misleading;

B. Certifying the following summary statement to the Auditor with respect to the proposed ballot referendum:

> It is estimated this proposal will have no immediate costs or savings to state or local governmental entities. However, because of the uncertain interaction of the proposal with implementation of the federal Patient Protection and Affordable Care Act, certain governmental entities predict a negative fiscal impact in an unknown amount.

C. In the alternative, remanding the matter to the Auditor for redrafting the ballot title and summary statement consistent in a manner that cures the defects complained of herein;

D. Awarding Plaintiffs their attorneys' fees, expenses and costs;

F. Granting Plaintiffs any additional relief the Court deems just and proper.

COUNT IV
VIOLATION OF SECTION 116.240 RSMO

COME NOW Plaintiffs Barbara Finch ("Finch") and Mary Lucy Brenner ("Brenner") (jointly "Plaintiffs"), and for Count IV of their claims against Defendants Secretary of State Robin Carnahan, State Auditor Susan Montee, Representative John Diehl, Speaker of the House Ron Richard, and President Pro Tem Charlie Shields, jointly or severally, as the law may allow, state:

116. Plaintiffs restate and incorporate herein paragraphs 1 though 115 as if fully set out verbatim

117. Section 116.240, RSMo., provides:

> Not later than the tenth Tuesday prior to an election at which a statewide ballot measure is to be voted on, the secretary of state shall send each election authority a certified copy of the legal notice to be published. The legal notice shall include the date and time of the election and a sample ballot.

118. The tenth Tuesday preceding the August 3, 2010 election was May 25, 2010.

119. On May 25, 2010, the Secretary of State's Office received the bill from the legislature. ***See*, May 25, 2010 Memo from Secretary of State's Office to Election Authorities, attached hereto and incorporated by reference as Exhibit H.**

120. Previously, on May 21, 2010, the Secretary of State's Office sent a memo to the election authorities stating that the legislature had called a special election for the purpose of holding a vote on the bill. ***See* May 21, 2010 Memo from Secretary of State's Office to Election Authorities, attached hereto and incorporated by reference as Exhibit G.**

121. The May 21, 2010, memo states:

> The Certification, legal notice of special election, and sample official ballot will be sent to you as soon as possible after the Official Ballot Title, including the fiscal note summary, is certified in accordance with chapter 116.

Exhibit G.

122. The May 25, 2010, memo states:

> The Certification, legal notice of special election, and sample official ballot will be sent to you as soon as possible after the Official Ballot Title, including the fiscal note summary, is certified in accordance with chapter 116. Our office has transmitted SS SCS HCS House Bill 1764 to the State Auditor's Office and it will take, at a minimum, 10 days for preparation of the fiscal note and fiscal note summary. **See Section 116.175 RSMo.**

Exhibit H.

123. Plaintiffs are unaware whether a certified copy of the legal notice to be published including a sample ballot has ever been delivered to election authorities. However, it is indisputable that a certified copy of the legal notice which included a sample ballot was not sent to the election authorities on or before May 25, 2010.

124. While the Court of Appeals in ***State ex rel. Nixon v. Blunt*, 135 S.W.3d 416 (Mo. App. 2004)** held that the Secretary of State was not precluded from sending an amended notice

to the election authorities, no authority exists for the Secretary of State to send notice otherwise complying with Section 116.240 for the first time after the tenth Tuesday preceding the election.

125. In this case, the "notice" provided on May 25, 2010, did not comply with the mandatory language of Section 116.240 because it did not include a certified copy of the legal notice to be published, including a sample ballot.

126. Based upon the foregoing, placing the ballot measure on the August 3, 2010, ballot would be in violation of Section 116.240.

127. There is no authority for a court to move this measure to a different election, and any attempt to do so would be a violation of the separation of powers because Section B of the bill itself as passed by the legislature states:

> This act is hereby submitted to the qualified voters of this state for approval or rejection at an election which is hereby ordered and which shall be held and conducted *on Tuesday next following the first Monday in August, 2010*, pursuant to the laws and constitutional provisions of this state for the submission of referendum measures by the general assembly, and this act shall *become effective when approved by a majority of the votes cast thereon at such election and not otherwise.*

Exhibit F (emphasis added).

128. Thus, by the terms of the Bill, even if this measure is approved by the voters at any other election, it would nonetheless not become law and be wholly ineffective.

129. Based upon the foregoing, Section 116.240 has been violated, and this Court must remove this ballot measure from the August 3, 2010, ballot.

WHEREFORE, Plaintiffs respectfully pray for a judgment of from this Court:

A. Finding and declaring that the Bill be held in violation of Chapter 116 RSMo and remove the Bill from the August ballot;

B. Awarding Plaintiffs their attorneys' fees, expenses and costs;

C. Granting Plaintiffs any additional relief the Court deems just and proper.

CARSON & COIL, P.C.

By: _____

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ATTORNEYS FOR PLAINTIFFS

SECOND REGULAR SESSION

HOUSE BILL NO. 1764

95TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE DIEHL.

4419L.01I D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal section 375.1175, RSMo, and to enact in lieu thereof one new section relating to liquidation of certain domestic insurance companies.

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

Section A. Section 375.1175, RSMo, is repealed and one new section enacted in lieu thereof, to be known as section 375.1175, to read as follows:

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

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

(2) That the insurer is insolvent;

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

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

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

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

(1) The director, in the director's sole discretion, approves the articles of dissolution prior to filing such articles with the secretary of state; and

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

SECOND REGULAR SESSION

HOUSE COMMITTEE SUBSTITUTE FOR

HOUSE BILL NO. 1764

95TH GENERAL ASSEMBLY

4419L.02C D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal section 375.1175, RSMo, and to enact in lieu thereof one new section relating to the liquidation of certain domestic insurance companies.

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

Section A. Section 375.1175, RSMo, is repealed and one new section enacted in lieu thereof, to be known as section 375.1175, to read as follows:

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

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

(2) That the insurer is insolvent;

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

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

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

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

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

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

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

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

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

SECOND REGULAR SESSION

[PERFECTED]

HOUSE COMMITTEE SUBSTITUTE FOR

HOUSE BILL NO. 1764

95TH GENERAL ASSEMBLY

4419L.02P D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal section 375.1175, RSMo, and to enact in lieu thereof one new section relating to the liquidation of certain domestic insurance companies.

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

Section A. Section 375.1175, RSMo, is repealed and one new section enacted in lieu thereof, to be known as section 375.1175, to read as follows:

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

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

(2) That the insurer is insolvent;

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

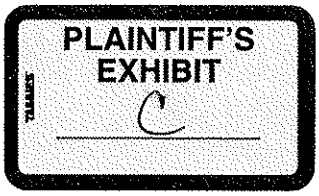
(4) That the insurer is found to be in such condition after examination that it could not meet the requirements for incorporation and authorization specified in the law under which it was incorporated or is doing business; or

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

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

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

(a) The insurer's annual financial statements filed with the director show no written



insurance premiums for five years; and

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

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

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

SECOND REGULAR SESSION

SENATE COMMITTEE SUBSTITUTE FOR

HOUSE COMMITTEE SUBSTITUTE FOR

HOUSE BILL NO. 1764

95TH GENERAL ASSEMBLY

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

TERRY L. SPIELER, Secretary.

4419S.04C

AN ACT

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

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

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

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

2. The following standards, either singly or a combination of two or more, may be considered by the director to determine whether the continued operation of any insurer transacting an insurance business in this

PLAINTIFF'S EXHIBIT D

state might be deemed to be hazardous to its policyholders, creditors, or the general public:

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

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

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

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

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

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

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

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

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

(10) The age and collectibility of receivables;

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

(12) Whether management of an insurer has failed to respond to inquiries relative to the condition of the insurer or has furnished false and misleading information concerning an inquiry;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

insurer to:

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

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

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

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

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

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

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

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

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

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

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

(12) Notwithstanding any other provision of law limiting the frequency or amount of premium rate adjustments, adjust rates for any non-life insurance product written by the insurer that the director considers necessary to improve the financial condition of the insurer.

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

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

375.1152. For purposes of sections 375.570 to 375.750 and 375.1150 to 375.1246, the following words and phrases shall mean:

(1) "Allocated loss adjustment expenses", those fees, costs or expenses reasonably chargeable to the

investigation, negotiation, settlement or defense of an individual claim or loss or to the protection and perfection of the subrogation rights of any insolvent insurer arising out of a policy of insurance issued by the insolvent insurer. "Allocated loss adjustment expenses" shall include all court costs, fees and expenses; fees for service of process; fees to attorneys; costs of undercover operative and detective services; fees of independent adjusters or attorneys for investigation or adjustment of claims beyond initial investigation; costs of employing experts for preparation of maps, photographs, diagrams, chemical or physical analysis or for advice, opinion or testimony concerning claims under investigation or in litigation; costs for legal transcripts or testimony taken at coroner's inquests, criminal or civil proceedings; costs for copies of any public records; costs of depositions and court-reported or -recorded statements. "Allocated loss adjustment expenses" shall not include the salaries of officials, administrators or other employees or normal overhead charges such as rent, postage, telephone, lighting, cleaning, heating or similar expenses;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) For purposes of this subdivision "liabilities" shall include but not be limited to reserves required by statute or by the department of insurance, financial institutions and professional registration regulations or specific

requirements imposed by the director upon a subject company at the time of admission or subsequent thereto;

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

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

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

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

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

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

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

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

(a) "Commodity contract", shall mean:

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

b. An agreement that is subject to regulation under Section 19 of the Commodity Exchange Act, 7 U.S.C.

Section 1, et seq., and that is commonly known to the commodities trade as a margin account, margin contract, leverage account, or leverage contract;

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

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

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

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

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

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

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

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

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

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

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

(1) The transaction of further business;

(2) The transfer of property;

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

(4) Waste of the insurer's assets;

(5) Dissipation and transfer of bank accounts;

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

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

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

(9) The making of any sale or deed for nonpayment of taxes or assessments that would lessen the value of the assets of the insurer;

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

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

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

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

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

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

(2) That the insurer is insolvent;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

accordance with subsection 6 of this section.

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

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

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

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

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

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

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

5. Notwithstanding any other provision of sections 375.1150 to 375.1246, a receiver may not avoid a

transfer of money or other property arising under or in connection with a netting agreement or qualified financial contract, or any pledge, security, collateral or guarantee agreement or any other similar security arrangement or credit support document relating to a netting agreement or qualified financial contract, that is made before the commencement of a formal delinquency proceeding under sections 375.1150 to 375.1246. However, a transfer may be avoided pursuant to section 375.1192 if the transfer was made with actual intent to hinder, delay or defraud the insurer, a receiver appointed for the insurer, or existing or future creditors.

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

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

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

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

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

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

subject of the proceeding.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. The RBC plan shall be submitted:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. No long-term care insurance policy may:

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

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

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

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

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

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

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

of the public.

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

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

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

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

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

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

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

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

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

11. Long-term care insurance applicants shall have the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or

certificate, other than a certificate issued pursuant to a policy issued to a group defined in paragraph (a) of subdivision (4) of subsection 2 of section 376.1100, the applicant is not satisfied for any reason. This subsection shall also apply to denials of applications and any refund must be made within thirty days of the return or denial.

12. (1) If a long-term care insurance policy issued, delivered, or renewed in this state on or after January 1, 2011, is cancelled for any reason, the insurer shall refund the unearned portion of any premium paid beyond the month in which the cancellation is effective. Any refund shall be returned to the policyholder within twenty days from the date the insurer receives notice of the cancellation. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall be entitled to a refund of the unearned premium if the policy is cancelled for any reason.

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

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

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

(1) Past and prospective loss experience;

(2) Past and prospective expenses;

(3) Adequate contingency reserves; and

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

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

376.1257. 1. Each health benefit plan that is delivered, issued for delivery, or renewed in this state that provides coverage for cancer chemotherapy treatment shall provide coverage for a prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected cancer medications that are covered under the health benefit plan. As used in this section, the term "health benefit plan" shall have the same meaning ascribed to it in section 376.1350.

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

4419S.05F

SENATE SUBSTITUTE

FOR

SENATE COMMITTEE SUBSTITUTE

FOR

HOUSE COMMITTEE SUBSTITUTE

FOR

HOUSE BILL NO. 1764

AN ACT

To repeal section 375.1175, RSMo, and to enact in lieu thereof two new sections relating to insurance, with a referendum clause.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF MISSOURI, AS FOLLOWS:

Section A. Section 375.1175, RSMo, is repealed and two new sections enacted in lieu thereof, to be known as sections 1.330 and 375.1175, to read as follows:

1.330. 1. No law or rule shall compel, directly or indirectly, any person, employer, or health care provider to participate in any health care system.

2. A person or employer may pay directly for lawful health care services and shall not be required by law or rule to pay penalties or fines for paying directly for lawful health care services. A health care provider may accept direct payment for lawful health care

services and shall not be required by law or rule to pay penalties or fines for accepting direct payment from a person or employer for lawful health care services.

3. Subject to reasonable and necessary rules that do not substantially limit a person's options, the purchase or sale of health insurance in private health care systems shall not be prohibited by law or rule.

4. This section does not:

(1) Affect which health care services a health care provider or hospital is required to perform or provide;

(2) Affect which health care services are permitted by law;

(3) Prohibit care provided under workers' compensation as provided under state law;

(4) Affect laws or regulations in effect as of January 1, 2010;

(5) Affect the terms or conditions of any health care system to the extent that those terms and conditions do not have the effect of punishing a person or employer for paying directly for lawful health care services or a health care provider or hospital for accepting direct payment from a person or employer for lawful health care services.

5. As used in this section, the following terms shall mean:

(1) "Compel", any penalties or fines;

(2) "Direct payment or pay directly", payment for lawful health care services without a public or private third party, not including an employer, paying for any portion of the service;

(3) "Health care system", any public or private entity whose function or purpose is the management of, processing of, enrollment of individuals for or payment for, in full or in part, health care services or health care data or health care information for its participants;

(4) "Lawful health care services", any health-related service or treatment to the extent that the service or treatment is permitted or not prohibited by law or regulation that may be provided by persons or businesses otherwise permitted to offer such services; and

(5) "Penalties or fines", any civil or criminal penalty or fine, tax, salary or wage withholding or surcharge or any named fee with a similar effect established by law or rule by a government established, created or controlled agency that is used to punish or discourage the exercise of rights protected under this section.

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

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

(2) That the insurer is insolvent;

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

(4) That the insurer is found to be in such condition after

examination that it could not meet the requirements for incorporation and authorization specified in the law under which it was incorporated or is doing business; or

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

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

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

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

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

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

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

Section B. This act is hereby submitted to the qualified voters of

this state for approval or rejection at an election which is hereby ordered and which shall be held and conducted on Tuesday next following the first Monday in August, 2010, pursuant to the laws and constitutional provisions of this state for the submission of referendum measures by the general assembly, and this act shall become effective when approved by a majority of the votes cast thereon at such election and not otherwise.

Section C. Pursuant to chapter 116, RSMo, and other applicable constitutional provisions and laws of this state allowing the general assembly to adopt ballot language for the submission of this act to the voters of this state, the official ballot title of this act shall be as follows:

"Shall the Missouri Statutes be amended to:

- Deny the government authority to penalize citizens for refusing to purchase private health insurance or infringe upon the right to offer or accept direct payment for lawful healthcare services?
- Modify laws regarding the liquidation of certain domestic insurance companies?".

SECOND REGULAR SESSION

[TRULY AGREED TO AND FINALLY PASSED]

SENATE SUBSTITUTE FOR

SENATE COMMITTEE SUBSTITUTE FOR

HOUSE COMMITTEE SUBSTITUTE FOR

HOUSE BILL NO. 1764

95TH GENERAL ASSEMBLY

4419S.05T 2010

AN ACT

To repeal section 375.1175, RSMo, and to enact in lieu thereof two new sections relating to insurance, with a referendum clause.

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

Section A. Section 375.1175, RSMo, is repealed and two new sections enacted in lieu thereof, to be known as sections 1.330 and 375.1175, to read as follows:

1.330. 1. No law or rule shall compel, directly or indirectly, any person, employer, or health care provider to participate in any health care system.

2. A person or employer may pay directly for lawful health care services and shall not be required by law or rule to pay penalties or fines for paying directly for lawful health care services. A health care provider may accept direct payment for lawful health care services and shall not be required by law or rule to pay penalties or fines for accepting direct payment from a person or employer for lawful health care services.

3. Subject to reasonable and necessary rules that do not substantially limit a person's options, the purchase or sale of health insurance in private health care systems shall not be prohibited by law or rule.

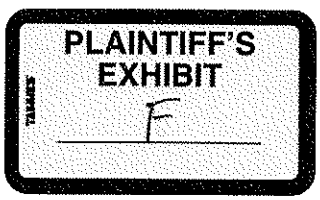
4. This section does not:

(1) Affect which health care services a health care provider or hospital is required to perform or provide;

(2) Affect which health care services are permitted by law;

(3) Prohibit care provided under workers' compensation as provided under state law;

(4) Affect laws or regulations in effect as of January 1, 2010;



(5) Affect the terms or conditions of any health care system to the extent that those terms and conditions do not have the effect of punishing a person or employer for paying directly for lawful health care services or a health care provider or hospital for accepting direct payment from a person or employer for lawful health care services.

5. As used in this section, the following terms shall mean:

(1) "Compel", any penalties or fines;

(2) "Direct payment or pay directly", payment for lawful health care services without a public or private third party, not including an employer, paying for any portion of the service;

(3) "Health care system", any public or private entity whose function or purpose is the management of, processing of, enrollment of individuals for or payment for, in full or in part, health care services or health care data or health care information for its participants;

(4) "Lawful health care services", any health-related service or treatment to the extent that the service or treatment is permitted or not prohibited by law or regulation that may be provided by persons or businesses otherwise permitted to offer such services; and

(5) "Penalties or fines", any civil or criminal penalty or fine, tax, salary or wage withholding or surcharge or any named fee with a similar effect established by law or rule by a government established, created or controlled agency that is used to punish or discourage the exercise of rights protected under this section.

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

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

(2) That the insurer is insolvent;

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

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

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

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

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

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

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

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

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

Section B. This act is hereby submitted to the qualified voters of this state for approval or rejection at an election which is hereby ordered and which shall be held and conducted on Tuesday next following the first Monday in August, 2010, pursuant to the laws and constitutional provisions of this state for the submission of referendum measures by the general assembly, and this act shall become effective when approved by a majority of the votes cast thereon at such election and not otherwise.

Section C. Pursuant to chapter 116, RSMo, and other applicable constitutional provisions and laws of this state allowing the general assembly to adopt ballot language for the submission of this act to the voters of this state, the official ballot title of this act shall be as follows:

"Shall the Missouri Statutes be amended to:

- Deny the government authority to penalize citizens for refusing to purchase private health insurance or infringe upon the right to offer or accept direct payment for lawful healthcare services?
- Modify laws regarding the liquidation of certain domestic insurance companies?".

ROBIN CARNAHAN
SECRETARY OF STATE
STATE OF MISSOURI

JAMES C. KIRKPATRICK
STATE INFORMATION CENTER
(573) 751-4936

ELECTIONS DIVISION
(573) 751-2301

MEMO

TO: **Local Election Authorities**

FROM: **Waylene Hiles**
Deputy Secretary of State for Elections

DATE: **May 21, 2010**

RE: **SS SCS HCS HOUSE BILL 1764**

This memo is to provide you with notice that a Special Election has been called by 95th General Assembly (Second Regular Session) to be held in the State of Missouri on the 3rd day of August, 2010 for the purpose of voting on a proposition presented in SS SCS HCS House Bill 1764.

The Certification, legal notice of special election, and sample official ballot will be sent to you after our office receives delivery of SS SCS HCS House Bill 1764 from the Missouri Legislature and the Official Ballot Title is certified in accordance with Chapter 116, RSMo.

PLAINTIFF'S EXHIBIT

PO BOX 1767 • JEFFERSON CITY, MISSOURI • 65102
www.sos.mo.gov

ROBIN CARNAHAN
SECRETARY OF STATE
STATE OF MISSOURI

JAMES C. KIRKPATRICK
STATE INFORMATION CENTER
(573) 751-4936

ELECTIONS DIVISION
(573) 751-2301

MEMO

TO: **Election Authorities**

FROM: **Waylene Hiles**
Deputy Secretary of State for Elections

DATE: **May 25, 2010**

SUBJECT: **SS SCS HCS House Bill 1764**

Enclosed please find SS SCS HCS House Bill 1764, which was delivered to the Secretary of State's Office today. The 95th General Assembly (Second Regular Session) has called a Special Election to be held on the 3rd day of August, 2010, for the purpose of voting on a proposition presented in SS SCS HCS House Bill 1764.

The Certification, legal notice of special election, and sample official ballot will be sent to you as soon as possible after the Official Ballot Title, including the fiscal note summary, is certified in accordance with Chapter 116, RSMo. Our office has transmitted SS SCS HCS House Bill 1764 to the State Auditor's Office and it will take, at a minimum, 10 days for preparation of the fiscal note and fiscal note summary. See Section 116.175, RSMo.

We strongly encourage you to not print your ballots until you receive the Certification, legal notice of special election, and the sample official ballot.

SECOND REGULAR SESSION

[TRULY AGREED TO AND FINALLY PASSED]

SENATE SUBSTITUTE FOR

SENATE COMMITTEE SUBSTITUTE FOR

HOUSE COMMITTEE SUBSTITUTE FOR

HOUSE BILL NO. 1764

95TH GENERAL ASSEMBLY

4419S.05T 2010

AN ACT

To repeal section 375.1175, RSMo, and to enact in lieu thereof two new sections relating to insurance, with a referendum clause.

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

Section A. Section 375.1175, RSMo, is repealed and two new sections enacted in lieu thereof, to be known as sections 1.330 and 375.1175, to read as follows:

1.330. 1. No law or rule shall compel, directly or indirectly, any person, employer, or health care provider to participate in any health care system.

2. A person or employer may pay directly for lawful health care services and shall not be required by law or rule to pay penalties or fines for paying directly for lawful health care services. A health care provider may accept direct payment for lawful health care services and shall not be required by law or rule to pay penalties or fines for accepting direct payment from a person or employer for lawful health care services.

3. Subject to reasonable and necessary rules that do not substantially limit a person's options, the purchase or sale of health insurance in private health care systems shall not be prohibited by law or rule.

4. This section does not:

(1) Affect which health care services a health care provider or hospital is required to perform or provide;

(2) Affect which health care services are permitted by law;

(3) Prohibit care provided under workers' compensation as provided under state law;

EXPLANATION — Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

STATE OF MISSOURI

Office of
Secretary of State

CERTIFICATION OF OFFICIAL BALLOT TITLE

I, Robin Carnahan, Secretary of State, in compliance with Section 116.180, RSMo, do hereby certify the following language as the official ballot title for SS SCS HCS House Bill 1764 passed by the 95th General Assembly (Second Regular Session) in 2010. The official ballot title shall read as follows:

Shall the Missouri Statutes be amended to:

- Deny the government authority to penalize citizens for refusing to purchase private health insurance or infringe upon the right to offer or accept direct payment for lawful healthcare services?
- Modify laws regarding the liquidation of certain domestic insurance companies?

It is estimated this proposal will have no immediate costs or savings to state or local governmental entities. However, because of the uncertain interaction of the proposal with implementation of the federal Patient Protection and Affordable Care Act, future costs to state governmental entities are unknown.

IN TESTIMONY WHEREOF, I hereunto set my hand and affix the seal of my office in the City of Jefferson, State of Missouri, this 7th day of June, 2010.

Robin Carnahan

Secretary of State

SEAL OF THE SECRETARY OF STATE MISSOURI

Comm. 27 (01-01)

PLAINTIFF'S EXHIBIT 1

MISSOURI STATE AUDITOR'S OFFICE
FISCAL NOTE (10-10)

Subject

HB1764 with a referendum clause. (Received May 25, 2010)

Date

June 7, 2010

Description

This proposal would repeal Section 375.1175, RSMo, and enact in lieu thereof two new sections relating to insurance.

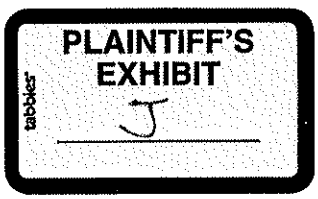
The proposal is to be voted on in August, 2010.

Public comments and other input

The State Auditor's Office requested input from the **Attorney General's Office,** the **Department of Agriculture,** the **Department of Economic Development,** the **Department of Elementary and Secondary Education,** the **Department of Higher Education,** the **Department of Health and Senior Services,** the **Department of Insurance, Financial Institutions and Professional Registration,** the **Department of Mental Health,** the **Department of Natural Resources,** the **Department of Corrections,** the **Department of Labor and Industrial Relations,** the **Department of Revenue,** the **Department of Public Safety,** the **Department of Social Services,** the **Governor's Office,** the **Missouri House of Representatives,** the **Department of Conservation,** the **Department of Transportation,** the **Office of Administration,** the **Office of State Courts Administrator,** the **Missouri Senate,** the **Secretary of State's Office,** the **Office of the State Public Defender,** the **Office of the State Treasurer, Boone County, Cole County, Greene County, Jackson County Legislators, St. Louis County,** the **City of Jefferson,** the **City of Kansas City,** the **City of St. Louis,** the **City of Springfield, Cape Girardeau 63 School District, Hannibal 60 School District, Rockwood R-VI School District, Linn State Technical College, Metropolitan Community College, University of Missouri, St. Louis Community College.**

Senator Joan Bray provided information to the State Auditor's Office.

The Missouri Health Advocacy Alliance provided information to the State Auditor's Office.



Assumptions

The **Attorney General's Office** indicated they assume the costs of this proposal are unknown, but can be absorbed with existing resources.

The **Department of Economic Development** indicated this proposal would have no impact on their department.

The **Department of Higher Education** indicated that this bill would have no direct, foreseeable fiscal impact on their department.

The **Department of Insurance, Financial Institutions and Professional Registration** indicated the impact on the Department is unknown. If approved by the voters, this statutory change may have an unknown negative fiscal impact because the interaction of these state statutory changes with future federal government implementation, including federal regulations, is uncertain.

The Patient Protection and Affordable Care Act will provide federal funding for health care to Missourians. This funding includes, but is not limited to: Missouri's share of $5 billion to provide health insurance coverage for Missourians with pre-existing medical conditions; Missouri's share of $5 billion to establish a temporary reinsurance subsidy for Missouri businesses to continue to offer health insurance to early retirees; Missouri's share of $30 million to provide health insurance consumer assistance and Missouri's share of $250 million to establish meaningful health insurance rate review.

The **Department of Mental Health** indicated the impact on the Department is unknown.

If approved by the voters, this statutory change may have an unknown negative fiscal impact because the interaction of these state statutory changes with future federal government implementation, including federal regulations, is uncertain.

The Patient Protection and Affordable Care Act will provide federal funding to expand health care coverage to Missourians currently not insured by private or public insurance plans. This funding includes, but is not limited to:

1. An estimated $21.4 billion from 2014 to 2023 to expand physical and mental health care coverage to thousands of currently uninsured Missourians, for example an individual whose income is at or below $14,400 or a Missouri family of four whose income is at or below $29,327;

2. In addition to general medical care, this coverage could include the following types of services for those who need them:

    a. Early diagnosis and treatment for children with developmental disabilities, including children with Autism,

b. Ongoing treatment for children and adults with serious, ongoing mental illnesses, and

c. Treatment for children and adults affected by alcohol and other drug addictions.

The **Department of Natural Resources** indicated they would not anticipate a direct fiscal impact from this proposal.

The **Department of Corrections** indicated this proposal will have no impact on the department.

The **Department of Revenue** indicated this has no fiscal impact on their department.

The **Department of Public Safety** indicated they defer to Missouri Consolidate Health Care Plan's response to this proposal.

The **Department of Social Services** indicated the impact on the Department is unknown. If approved by the voters, this statutory change may have an unknown negative fiscal impact because the interaction of these state statutory changes with future federal government implementation, including federal regulations, is uncertain.

The Patient Protection and Affordable Care Act will provide federal funding for services to Missourians. This funding includes, but is not limited to an estimated $21.4 billion from 2014 to 2023 to provide health care coverage to more uninsured Missourians and increased Medicare Part D coverage for seniors by closing the donut hole by 2020.

The **Governor's Office** indicated there should be no added costs or savings to the Governor's Office if this statutory change is passed by the voters.

Officials from the **Missouri House of Representatives** indicated the proposal has no fiscal impact to the operations budget of their agency.

The **Department of Conservation** indicated no adverse fiscal impact to their department would be expected as a result of this legislation and referendum proposal.

The **Office of Administration** indicated that if approved by the voters this statutory change will not result in any cost or savings to the Office of Administration. However, it may have a statewide negative fiscal impact (amount unknown) because of the uncertain interaction of these statutory changes with future federal government implementation, including federal regulations.

The Patient Protection and Affordable Care Act provides federal funding for services to Missourians. This funding includes, but is not limited to:

- Health care coverage to more uninsured Missourians—$21.4 billion from 2013-2024.
- Health insurance coverage for Missourians with pre-existing medical conditions—Missouri's share of $5 billion.
- Temporary reinsurance subsidy for Missouri businesses to continue to offer health insurance to early retirees—Missouri's share of $5 billion.
- Increased Medicare Part D coverage for seniors.

The **Office of State Courts Administrator** indicated there is no cost to the courts for this proposal.

Officials from the **Missouri Senate** indicated this proposal appears to have no fiscal impact as it relates to their agency.

Officials from the **Secretary of State's Office** indicated their office is required to pay for publishing in local newspapers the full text of each statewide ballot measure as directed by Article I, Section 26, 27, 28 of the Missouri Constitution and Section 116.230-116.290, RSMo. The Secretary of State's office is provided with core funding to handle a certain amount of normal activity resulting from each year's legislative session. Funding for this item is adjusted each year depending upon the election cycle with $1.3 million historically appropriated in odd numbered fiscal years and $100,000 appropriated in even numbered fiscal years to meet these requirements. The appropriation has historically been an estimated appropriation because the final cost is dependent upon the number of ballot measures approved by the General Assembly and the initiative petitions certified for the ballot. In FY 2009, at the August and November elections, there were 5 statewide Constitutional Amendments or ballot propositions that cost $1.35 million to publish (an average of $270,000 per issue). Therefore, the Secretary of State's office assumes, for the purposes of this fiscal note, that it should have the full appropriation authority it needs to meet the publishing requirements.

Officials from the **Office of the State Public Defender** indicated this proposal will not have any significant impact on their office.

Officials from the **Office of the State Treasurer** indicated this proposal will have no impact on their office.

Officials from the **City of Jefferson** indicated the City does not anticipate any fiscal impact should this proposal become law.

Officials from **Linn State Technical College** indicated that based on the information presented, there appears to be no fiscal impact to their organization.

Metropolitan Community College indicated currently, this legislation would have no significant fiscal impact on their organization, although it could be quite significant in the future.

Senator Joan Bray provided information in opposition to this proposal. Below is a summary of her information:

Fiscal Comment

This initiative petition contains language that is designed to enable the State of Missouri to opt out of the federal health care reform law, the Patient Protection and Affordable Care Act (PPACA). More specifically, the legislation would opt out of the "individual mandate" of PPACA. Assuming this provision could legally be implemented in Missouri, it would have a substantial negative fiscal impact on our state. And in assessing the fiscal impact, we have to assume that the bill could actually take effect.

A. Consequences of Opting Out of the Individual mandate

Taken literally, this language would opt out of just one provision - the individual mandate - of the federal health care law. Thus, all of the federal law's "private market insurance reforms" would still go into effect, including reforms requiring insurance companies to serve people regardless of any pre-existing conditions. As noted by Congress in PPACA, the impact of such market reforms without an individual mandate would result in individuals making "an economic and financial decision to forego health insurance coverage" until they get sick, thereby causing health care premiums to skyrocket in our state.[1] Thus, PPACA provisions encouraging healthy individuals to purchase insurance are "essential to creating effective health insurance markets."

Furthermore, the individual mandate is intertwined with the "guaranteed issue" requirements and the health care exchange provisions of the Act. In order to receive a premium subsidy, an individual must purchase insurance through the health insurance exchange. Under this legislation, Missouri would not be able to operate an exchange under the terms of PPACA, thus Missourians would be denied the opportunity to receive premium subsidies. If Missouri votes against health reform, billions of dollars in help with the costs of purchasing insurance for hard-working Missourians is lost. The loss of these dollars would of course have an additional economic impact on our state through lost jobs, economic activity and tax revenue that would be generated by these health insurance premiums.

The Department of Insurance and the State Auditor's office must calculate the fiscal impact of implementing federal "guaranteed issue" requirements of the PPACA law without an individual mandate on the cost of health care premiums in our state, its economy and the state budget. The Congressional Budget Office has estimated that average premiums would be 7 percent to 10 percent lower because of the influx of enrollees with below average spending for health care who would purchase coverage because of the new subsidies to be provided and the individual mandate. The State Auditor should take this into account and assume that Missouri health insurance premiums would be at least 7 percent to 10 percent higher under the proposed ballot

[1] Patient Protection and Advocacy Act of 2010, § 1501(a)(2)(A).

measure.[2] In fact, other studies show an even greater impact from implementing insurance reforms without an individual mandate. An analysis by Wellpoint indicated that the impact of guaranteed issue without an effective individual mandate would be premium increases ranging from 20 percent to 80 percent.[3] In New Jersey, premiums rose by 24 percent in the employment based larger group market and between 112 percent and 155 percent in the non-group indemnity insurance market between 1996 and 2000 when that state implemented community rating and guaranteed issue without an individual mandate - which is what would happen under the literal language of this bill.[4]

Of course, this would affect not only private insurance premiums but the Missouri Consolidated Health Care Plan and Medicaid as well. This change would affect the cost of all state and local government employees' health insurance benefits. Moreover, to the extent that the state purchases or subsidizes goods and services from many firms that offer health insurance to their workers, it would raise the price of goods purchased by the state and diminish the impact of state grants for education by raising the price of health insurance received by school employees.

In addition, the lack of an individual mandate would simply cause fewer people to purchase health care insurance such as private health insurance or employer-sponsored health insurance. With fewer people covered, Missouri health providers would receive fewer payments for services, have less income and, thereby, limit state revenue. The State Auditor's office must analyze the negative fiscal impact this decrease in the number of insured and insurance premiums collected would have on our state.

B. Other Related Fiscal Consequences

In addition to the specific negative impact of opting out of the individual mandate, the real intent of the proposed ballot measure is to opt out of federal health care reform entirely, which could cost Missouri billions of federal dollars in low-income subsidies and Medicaid funds, not to mention access to many other funding streams created by PPACA. For example, one estimate by the Missouri Department of Social Services indicated that Missouri would receive more than $21 billion in federal Medicaid funds over a ten-year period starting in 2014. The State Auditor, with assistance from the relevant state departments, should analyze the financial impact of opting out entirely from federal health care reform. Even if we were to assume that this legislation is not intended to opt out of federal reform entirely, the lack of a mandate would surely have a negative impact on the number of Missourians that enroll in all forms of insurance, including Medicaid, thereby reducing the flow of federal funds to our state.

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[2] Congressional Budget Office, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act*, at 6, November 30, 2009.
[3] Wellpoint, *Health Care Reform Premium Impact in Missouri*, at 8, undated (available at: http://www.politico.com/static/PPM143_091023_missouri_premium_impacts_analysis.html).
[4] Uwe E. Reinhardt, *The Case for Mandating Health Insurance*, October 23, 2009 (available at: http://economix.blogs.nytimes.com/2009/10/23/the-case-for-mandating-health-insurance/).

The legislation would also undoubtedly have a substantial negative financial impact on state services. More people would be uninsured and would go without medically necessary treatment until they were at the point of requiring more expensive emergency room care, which would also have a negative impact on premiums for all Missourians. More people would become sick, lose their jobs and rely on state-funded health care services instead of the private insurance market at the point at which they are healthy.

The specific language in the bill also would have unintended consequences well beyond opting out of federal health care reform. The bill would limit government's ability to mandate that anyone participate in any type of health insurance system, not just the system created by the federal health care reform law. The ballot measure would, for example, prohibit the state from making legislative changes to enroll more individuals in Medicaid (MO HealthNet) managed care programs, such as those recommended by the Senate's "Reboot Government" working group in which I participated. While the bill exempts from its prohibition any laws or regulations already in place as of January 1, 2010, it does not exempt future efforts to expand mandatory risk-based managed care, which would require new state legislation. Arizona's Medicaid managed care program identified substantial state costs in response to a similar proposal in that state.[5] Missouri's Medicaid program should undertake a similar analysis of the consequences of such language in Missouri. The State Auditor's fiscal note must take into account the financial impact of limiting the state's options to mandate participation in a managed care system.

C. Unintended Litigation Costs

Finally, the legislation would place Missouri squarely in conflict with federal law, leading to unnecessary, burdensome and costly litigation with the federal government, including the Department of Justice. The costs of this litigation may also include attorneys' fees awarded against the state - given the obvious conflict with federal law and the lack of any legal merit to the State's position in such litigation in light of the federal supremacy clause.

The multitude of unintended consequences of this radical measure are impossible to foresee, but doubtless would include substantial negative fiscal consequences for Missouri. Insofar as other states are already pursuing lawsuits contesting the constitutionality of the federal law, Missouri need not expend resources to test this issue under either a ballot issue or a lawsuit. This would simply drive up state costs with no apparent benefit to the state. If other states' lawsuits are successful, the federal law will be declared illegal and the goal will have been realized. If they are unsuccessful, then the state costs for this ballot and for a lawsuit will have been wasted.

To conclude, it is critical that the state analyze what would happen if this measure were actually implemented rather than simply assume that this measure will go away

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[5] Public Letter from Anthony D. Rodgers, Director of The Arizona Health Care Cost Containment System, at 2-3, dated September 18, 2008.

with litigation. This requires a careful analysis of all of the fiscal consequences of the measure, including the unintended consequences.

The Missouri Health Advocacy Alliance provided information in opposition to this proposal. Below is a summary of their information:

The fiscal impact of the adoption of the ballot measure outlined in HB 1764 would be seen in at least three areas:

> Referencing House Bill 1764
>
> Section 1.330.1. No law or rule shall compel, directly or indirectly, any person, employer, or health care provider to participate in any health care system.
>
> Section 1.330.2. A person or employer may pay directly for lawful health care services and shall not be required by law or rule to pay penalties or fines for paying directly for lawful health care services. A health care provider may accept direct payment for lawful health care services and shall not be required by law or rule to pay penalties or fines for accepting direct payment from a person or employer for lawful health care services.
>
> The effect of Section 1.330.1 of House Bill 1764 would be to exempt Missouri residents from the requirements of the federal law, entitled the Patient Protection and Affordability Act (PPACA), that requires citizens to carry health insurance or face an IRS imposed penalty, commonly called the "individual mandate."

Increases in the cost of State and Local Employees' Health Plans:

PPACA will require Missouri to adopt a policy of guaranteed issue, a requirement that insurers provide insurance to any person who applies for coverage regardless of health status, but the ballot initiative would preclude *requiring* all individuals to purchase insurance. Studies have demonstrated[1] that states with "guarantee issue" and no "individual mandate" have seen increases as much as 24% in premium costs for large group market insurance[2]. (New Jersey between 1994-2000 saw an increase of 24% in this market after the 1993 implementation of guaranteed issue)

It is reasonable to assume, based on other states' experiences, the cost of providing employer-sponsored health insurance coverage for state and local government employees will rise by a significant percentage as a result of not implementing the federally mandated requirement for individuals to purchase insurance.

This increase in rates would impact <u>all</u> state and local employees' health plans. The fiscal impact on Missouri Consolidated Health Care Plan, the state employees' plan, could be a 24% increase in the cost of their health plans similar to the experience in New Jersey.

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[1] Health Affairs 23, no.4 (2004)165-167. http://content.healthaffairs.org/cgi/content/full/23/4/167

[2] Uwe E. Reinhardt PhD Princeton, *The Case for Mandating Health Insurance:* October 23, 2009. Available at http://economix.blogs.nytimes.com/2009/10/23/the-case-for-mandating-health-insurance/

Small businesses, small political subdivisions and sole proprietors that rely on the individual or small group market, according to industry analysis[3], should see a greater impact of guaranteed issue in the absence of an effective mandate ranges from an increase of 20% to 80%, and thus we show the midpoint increase of 50%.

Decreases in premium taxes collected by the state:

Two factors must be considered when estimating premium taxes collected as a result of PPACA and HB 1764.

PPACA would require all Missourians to purchase health insurance policies. The ballot initiative put forward by HB 1764 would exempt Missouri from such a requirement, thereby decreasing the number of people who will choose to purchase insurance and therefore fewer policies will result in decreases in premium taxes.

Wellpoint conducted an industry analysis[4] on the cost of insurance in Missouri if PPACA's "guaranteed issue" and "community rating" provisions are implemented without an "individual mandate" to carry insurance. Under such a scenario (which would happen under HB 1764) the cost of health insurance, especially for younger, healthier persons in the individual and small group markets, will rise dramatically. Estimated increases in premium cost for this group are 80 to 120%. The effect of higher premiums, experienced in other states,[5] is a significant increase in the number of persons deciding to drop coverage, further depriving the state of premium tax revenue.

The estimated loss of Premium Tax is unknown, but could be a significant percentage of the premium tax amount collected ($56.6 million was collected in CY 08). Premium tax revenue is split 50/50 between state General Revenue and the County Foreign Insurance Fund except for domestic Stock Property and Casualty Companies that pay premium tax to the County Stock Fund. The County Foreign Insurance Fund is later distributed to school districts throughout the state. County Stock Funds are later distributed to the school district and county treasurer of the county in which the principal officer of the insurer is located. It is unknown the extent to which each of these funds may be impacted, but it is predictable they will see some loss in revenue.

The disruption of Managed Care and Provider Networks:

There is a serious risk of unintended consequences posed by potential interpretations of the phrase "health care system" as stated HB 1764 Section 1.330.1. *No law or rule shall compel, directly or indirectly, any person, employer, or health care provider to participate in any health care system.*

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[3] Wellpoint, *Health Care Reform Impact in Missouri*, undated. Available at http://www.politico.com/static/PPM143_091023_missouri_premium_impacts_analysis.html

[4] Wellpoint, *Health Care Reform Impact in Missouri*, undated. Available at http://www.politico.com/static/PPM143_091023_missouri_premium_impacts_analysis.html

[5] Health Affairs 23, no.4 (2004)165-167. http://content.healthaffairs.org/cgi/content/full/23/4/167

The law could prohibit Missouri from enrolling people into MoHealthNet or MCHCP managed care plans. This would have the effect of implementing as system commonly referred to as "Any Willing Provider" (AWP)

A Bush Administration Council of Economic Advisors[6] study done in 2004 concluded that AWP provisions in practice can raise insurance cost as high as 5.3%.

This increase in rates would impact all state and local employees' health plans. The fiscal impact of a 5.3% increase in the cost of the health plans on Missouri Consolidated Health Care Plan could be as high as $26 million dollars per year (based on the $540 per month per member cost[7] of insuring MCHCP membership of an estimated 107,000 lives with an average of 75% state/employer contribution per covered life.)

The managed care potion of the state's MoHealthNet program for pharmacy, physician services, chronic care risk management and major medical are funded with hundreds of millions of dollars in Missouri General Revenue and the Federal Medicaid Match, which accounts for almost twice as much as the State's obligations. Increases in costs associated with restrictions to the state's ability to enter into future managed care or other network-based contracts are difficult to estimate but evidence suggests it would be significant. Managed care rates are discounted from what would otherwise be paid under fee-for-service and the Mercer company indicated 2.7% in savings over fee-for-service. These savings would be lost if this legislation is implemented. The State Auditor should seek input from the MOHealthNet Division on the financial cost of restricting its ability to require participation in managed care plans.

In addition to increased costs in these three areas, the State would experience significant litigation costs and likely have to pay attorney's fees should it have to defend the position expressed in HB 1764. If the provisions of HB 1764 become law, the State would also lose access to low-income subsidies or premium credits that Missourians would otherwise receive when they enroll in health insurance plans through the newly required and later implemented insurance exchanges. This loss in premium credits would result in a loss of economic activity and tax revenue for the state.

The State Auditor's Office did not receive a response from the **Department of Agriculture,** the **Department of Elementary and Secondary Education,** the **Department of Health and Senior Services,** the **Department of Labor and Industrial Relations,** the **Department of Transportation, Boone County, Cole County, Greene County, Jackson County Legislators, St. Louis County,** the **City of Kansas City,** the **City of St. Louis,** the **City of Springfield, Cape Girardeau 63 School District, Hannibal 60 School District, Rockwood R-VI School District, University of Missouri, St. Louis Community College.**

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[6] Council of Economic Advisors, *Effect of State Regulations on the Price of Health Insurance Policies:* July 23,2004 based on Showalter Study; William J. Congdon, Amanda Kowalski, Mark H. Showalter. Available at http://www.jonmckane.com/Health%20Insurance/Showalter%20Study.pdf

[7] Missouri Consolidated Health Care Plan *2009 Annual Report: http://www.mchcp.org/About%20Us/aboutus_AnnualReport.asp*

Fiscal Note Summary

It is estimated this proposal will have no immediate costs or savings to state or local governmental entities. However, because of the uncertain interaction of the proposal with implementation of the federal Patient Protection and Affordable Care Act, future costs to state governmental entities are unknown.