SECOND REGULAR SESSION

[C O R R E C T E D**]**

[TRULY AGREED TO AND FINALLY PASSED**]**

HOUSE COMMITTEE SUBSTITUTE FOR

SENATE COMMITTEE SUBSTITUTE FOR

SENATE BILL NO. 583

95TH GENERAL ASSEMBLY

2010

3574L.07T

AN ACT

To repeal sections 208.215, 301.560, 303.025, 303.040, 354.442, 375.1152, 375.1155, 375.1175, 375.1255, 376.717, 376.718, 376.724, 376.725, 376.732, 376.733, 376.734, 376.735, 376.737, 376.738, 376.740, 376.743, 376.758, 376.816, 376.1109, and 376.1450, RSMo, and to enact in lieu thereof thirty new sections relating to insurance regulation, with penalty provisions and an emergency clause for certain sections.

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

Section A. Sections 208.215, 301.560, 303.025, 303.040, 354.442, 375.1152, 375.1155, 375.1175, 375.1255, 376.717, 376.718, 376.724, 376.725, 376.732, 376.733, 376.734, 376.735, 376.737, 376.738, 376.740, 376.743, 376.758, 376.816, 376.1109, and 376.1450, RSMo, are repealed and thirty new sections enacted in lieu thereof, to be known as sections 208.215, 301.560, 303.025, 303.040, 354.442, 375.024, 375.539, 375.1152, 375.1155, 375.1175, 375.1191, 375.1255, 376.717, 376.718, 376.724, 376.725, 376.732, 376.733, 376.734, 376.735, 376.737, 376.738, 376.740, 376.743, 376.758, 376.816, 376.882, 376.1109, 376.1450, and 1, to read as follows:

208.215. 1. MO HealthNet is payer of last resort unless otherwise specified by law. When any person, corporation, institution, public agency or private agency is liable, either pursuant to contract or otherwise, to a participant receiving public assistance on account of personal injury to or disability or disease or benefits arising from a health insurance plan to which the participant may be entitled, payments made by the department of social services or MO HealthNet division shall be a debt

EXPLANATION–Matter enclosed in bold-faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

due the state and recoverable from the liable party or participant for all payments made **[**in**] on** behalf of the participant and the debt due the state shall not exceed the payments made from MO HealthNet benefits provided under sections 208.151 to 208.158 and section 208.162 and section 208.204 on behalf of the participant, minor or estate for payments on account of the injury, disease, or disability or benefits arising from a health insurance program to which the participant may be entitled. **Any health benefit plan as defined in section 376.1350, third party administrator, administrative service organization, and pharmacy benefits manager, shall process and pay all properly submitted medical assistance subrogation claims or MO HealthNet subrogation claims using standard electronic transactions or paper claim forms:**

(1) For a period of three years from the date services were provided or rendered; however, an entity:

(a) Shall not be required to reimburse for items or services which are not covered under MO HealthNet;

(b) Shall not deny a claim submitted by the state solely on the basis of the date of submission of the claim, the type or format of the claim form, failure to present proper documentation of coverage at the point of sale, or failure to provide prior authorization;

(c) Shall not be required to reimburse for items or services for which a claim was previously submitted to the health benefit plan, third party administrator, administrative service organization, or pharmacy benefits manager by the health care provider or the participant and the claim was properly denied by the health benefit plan, third party administrator, administrative service organization, or pharmacy benefits manager for procedural reasons, except for timely filing, type or format of the claim form, failure to present proper documentation of coverage at the point of sale, or failure to obtain prior authorization;

(d) Shall not be required to reimburse for items or services which are not covered under or were not covered under the plan offered by the entity against which a claim for subrogation has been filed; and

(e) Shall reimburse for items or services to the same extent that the entity would have been liable as if it had been properly billed at the point of sale, and the amount due is limited to what the entity would have paid as if it had been properly billed at the point of sale; and

(2) If any action by the state to enforce its rights with respect to such claim is commenced within six years of the state's submission of such claim.

2. The department of social services, MO HealthNet division, or its contractor

may maintain an appropriate action to recover funds paid by the department of social services or MO HealthNet division or its contractor that are due under this section in the name of the state of Missouri against the person, corporation, institution, public agency, or private agency liable to the participant, minor or estate.

3. Any participant, minor, guardian, conservator, personal representative, estate, including persons entitled under section 537.080, RSMo, to bring an action for wrongful death who pursues legal rights against a person, corporation, institution, public agency, or private agency liable to that participant or minor for injuries, disease or disability or benefits arising from a health insurance plan to which the participant may be entitled as outlined in subsection 1 of this section shall upon actual knowledge that the department of social services or MO HealthNet division has paid MO HealthNet benefits as defined by this chapter promptly notify the MO HealthNet division as to the pursuit of such legal rights.

4. Every applicant or participant by application assigns his right to the department of social services or MO HealthNet division of any funds recovered or expected to be recovered to the extent provided for in this section. All applicants and participants, including a person authorized by the probate code, shall cooperate with the department of social services, MO HealthNet division in identifying and providing information to assist the state in pursuing any third party who may be liable to pay for care and services available under the state's plan for MO HealthNet benefits as provided in sections 208.151 to 208.159 and sections 208.162 and 208.204. All applicants and participants shall cooperate with the agency in obtaining third-party resources due to the applicant, participant, or child for whom assistance is claimed. Failure to cooperate without good cause as determined by the department of social services, MO HealthNet division in accordance with federally prescribed standards shall render the applicant or participant ineligible for MO HealthNet benefits under sections 208.151 to 208.159 and sections 208.162 and 208.204. A **[**recipient**]** **participant** who has notice or who has actual knowledge of the department's rights to third-party benefits who receives any third-party benefit or proceeds for a covered illness or injury is either required to pay the division within sixty days after receipt of settlement proceeds the full amount of the third-party benefits up to the total MO HealthNet benefits provided or to place the full amount of the third-party benefits in a trust account for the benefit of the division pending judicial or administrative determination of the division's right to third-party benefits.

5. Every person, corporation or partnership who acts for or on behalf of a person who is or was eligible for MO HealthNet benefits under sections 208.151 to 208.159 and sections 208.162 and 208.204 for purposes of pursuing the applicant's or participant's claim which accrued as a result of a nonoccupational or nonwork-related incident or occurrence resulting in the payment of MO HealthNet benefits shall notify

the MO HealthNet division upon agreeing to assist such person and further shall notify the MO HealthNet division of any institution of a proceeding, settlement or the results of the pursuit of the claim and give thirty days' notice before any judgment, award, or settlement may be satisfied in any action or any claim by the applicant or participant to recover damages for such injuries, disease, or disability, or benefits arising from a health insurance program to which the participant may be entitled.

6. Every participant, minor, guardian, conservator, personal representative, estate, including persons entitled under section 537.080, RSMo, to bring an action for wrongful death, or his attorney or legal representative shall promptly notify the MO HealthNet division of any recovery from a third party and shall immediately reimburse the department of social services, MO HealthNet division, or its contractor from the proceeds of any settlement, judgment, or other recovery in any action or claim initiated against any such third party. A judgment, award, or settlement in an action by a **[**recipient**]** **participant** to recover damages for injuries or other third-party benefits in which the division has an interest may not be satisfied without first giving the division notice and a reasonable opportunity to file and satisfy the claim or proceed with any action as otherwise permitted by law.

7. The department of social services, MO HealthNet division or its contractor shall have a right to recover the amount of payments made to a provider under this chapter because of an injury, disease, or disability, or benefits arising from a health insurance plan to which the participant may be entitled for which a third party is or may be liable in contract, tort or otherwise under law or equity. Upon request by the MO HealthNet division, all third-party payers shall provide the MO HealthNet division with information contained in a 270/271 Health Care Eligibility Benefits Inquiry and Response standard transaction mandated under the federal Health Insurance Portability and Accountability Act, except that third-party payers shall not include accident-only, specified disease, disability income, hospital indemnity, or other fixed indemnity insurance policies.

8. The department of social services or MO HealthNet division shall have a lien upon any moneys to be paid by any insurance company or similar business enterprise, person, corporation, institution, public agency or private agency in settlement or satisfaction of a judgment on any claim for injuries or disability or disease benefits arising from a health insurance program to which the participant may be entitled which resulted in medical expenses for which the department or MO HealthNet division made payment. This lien shall also be applicable to any moneys which may come into the possession of any attorney who is handling the claim for injuries, or disability or disease or benefits arising from a health insurance plan to which the participant may be entitled which resulted in payments made by the department or MO HealthNet division. In each case, a lien notice shall be served by

certified mail or registered mail, upon the party or parties against whom the applicant or participant has a claim, demand or cause of action. The lien shall claim the charge and describe the interest the department or MO HealthNet division has in the claim, demand or cause of action. The lien shall attach to any verdict or judgment entered and to any money or property which may be recovered on account of such claim, demand, cause of action or suit from and after the time of the service of the notice.

9. On petition filed by the department, or by the participant, or by the defendant, the court, on written notice of all interested parties, may adjudicate the rights of the parties and enforce the charge. The court may approve the settlement of any claim, demand or cause of action either before or after a verdict, and nothing in this section shall be construed as requiring the actual trial or final adjudication of any claim, demand or cause of action upon which the department has charge. The court may determine what portion of the recovery shall be paid to the department against the recovery. In making this determination the court shall conduct an evidentiary hearing and shall consider competent evidence pertaining to the following matters:

(1) The amount of the charge sought to be enforced against the recovery when expressed as a percentage of the gross amount of the recovery; the amount of the charge sought to be enforced against the recovery when expressed as a percentage of the amount obtained by subtracting from the gross amount of the recovery the total attorney's fees and other costs incurred by the participant incident to the recovery; and whether the department should, as a matter of fairness and equity, bear its proportionate share of the fees and costs incurred to generate the recovery from which the charge is sought to be satisfied;

(2) The amount, if any, of the attorney's fees and other costs incurred by the participant incident to the recovery and paid by the participant up to the time of recovery, and the amount of such fees and costs remaining unpaid at the time of recovery;

(3) The total hospital, doctor and other medical expenses incurred for care and treatment of the injury to the date of recovery therefor, the portion of such expenses theretofore paid by the participant, by insurance provided by the participant, and by the department, and the amount of such previously incurred expenses which remain unpaid at the time of recovery and by whom such incurred, unpaid expenses are to be paid;

(4) Whether the recovery represents less than substantially full recompense for the injury and the hospital, doctor and other medical expenses incurred to the date of recovery for the care and treatment of the injury, so that reduction of the charge sought to be enforced against the recovery would not likely result in a double recovery or unjust enrichment to the participant;

(5) The age of the participant and of persons dependent for support upon the participant, the nature and permanency of the participant's injuries as they affect not only the future employability and education of the participant but also the reasonably necessary and foreseeable future material, maintenance, medical rehabilitative and training needs of the participant, the cost of such reasonably necessary and foreseeable future needs, and the resources available to meet such needs and pay such costs;

(6) The realistic ability of the participant to repay in whole or in part the charge sought to be enforced against the recovery when judged in light of the factors enumerated above.

10. The burden of producing evidence sufficient to support the exercise by the court of its discretion to reduce the amount of a proven charge sought to be enforced against the recovery shall rest with the party seeking such reduction. **The computerized records of the MO HealthNet division, certified by the director or his designee, shall be prima facie evidence of proof of moneys expended and the amount of the debt due the state.**

11. The court may reduce and apportion the department's or MO HealthNet division's lien proportionate to the recovery of the claimant. The court may consider the nature and extent of the injury, economic and noneconomic loss, settlement offers, comparative negligence as it applies to the case at hand, hospital costs, physician costs, and all other appropriate costs. The department or MO HealthNet division shall pay its pro rata share of the attorney's fees based on the department's or MO HealthNet division's lien as it compares to the total settlement agreed upon. This section shall not affect the priority of an attorney's lien under section 484.140, RSMo. The charges of the department or MO HealthNet division or contractor described in this section, however, shall take priority over all other liens and charges existing under the laws of the state of Missouri with the exception of the attorney's lien under such statute.

12. Whenever the department of social services or MO HealthNet division has a statutory charge under this section against a recovery for damages incurred by a participant because of its advancement of any assistance, such charge shall not be satisfied out of any recovery until the attorney's claim for fees is satisfied, **[**irrespective**] regardless** of whether **[**or not**]** an action based on participant's claim has been filed in court. Nothing herein shall prohibit the director from entering into a compromise agreement with any participant, after consideration of the factors in subsections 9 to 13 of this section.

13. This section shall be inapplicable to any claim, demand or cause of action arising under the workers' compensation act, chapter 287, RSMo. From funds recovered pursuant to this section the federal government shall be paid a portion

thereof equal to the proportionate part originally provided by the federal government to pay for MO HealthNet benefits to the participant or minor involved. The department or MO HealthNet division shall enforce TEFRA liens, 42 U.S.C. 1396p, as authorized by federal law and regulation on permanently institutionalized individuals. The department or MO HealthNet division shall have the right to enforce TEFRA liens, 42 U.S.C. 1396p, as authorized by federal law and regulation on all other institutionalized individuals. For the purposes of this subsection, "permanently institutionalized individuals" includes those people who the department or MO HealthNet division determines cannot reasonably be expected to be discharged and return home, and "property" includes the homestead and all other personal and real property in which the participant has sole legal interest or a legal interest based upon co-ownership of the property which is the result of a transfer of property for less than the fair market value within thirty months prior to the participant's entering the nursing facility. The following provisions shall apply to such liens:

(1) The lien shall be for the debt due the state for MO HealthNet benefits paid or to be paid on behalf of a participant. The amount of the lien shall be for the full amount due the state at the time the lien is enforced;

(2) The MO HealthNet division shall file for record, with the recorder of deeds of the county in which any real property of the participant is situated, a written notice of the lien. The notice of lien shall contain the name of the participant and a description of the real estate. The recorder shall note the time of receiving such notice, and shall record and index the notice of lien in the same manner as deeds of real estate are required to be recorded and indexed. The director or the director's designee may release or discharge all or part of the lien and notice of the release shall also be filed with the recorder. The department of social services, MO HealthNet division, shall provide payment to the recorder of deeds the fees set for similar filings in connection with the filing of a lien and any other necessary documents;

(3) No such lien may be imposed against the property of any individual prior to the individual's death on account of MO HealthNet benefits paid except:

(a) In the case of the real property of an individual:

a. Who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution, to spend for costs of medical care all but a minimal amount of his or her income required for personal needs; and

b. With respect to whom the director of the MO HealthNet division or the director's designee determines, after notice and opportunity for hearing, that he cannot reasonably be expected to be discharged from the medical institution and to return home. The hearing, if requested, shall proceed under the provisions of chapter 536, RSMo, before a hearing officer designated by the director of the MO HealthNet

division; or

(b) Pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual;

(4) No lien may be imposed under paragraph (b) of subdivision (3) of this subsection on such individual's home if one or more of the following persons is lawfully residing in such home:

(a) The spouse of such individual;

(b) Such individual's child who is under twenty-one years of age, or is blind or permanently and totally disabled; or

(c) A sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution;

(5) Any lien imposed with respect to an individual pursuant to subparagraph b of paragraph (a) of subdivision (3) of this subsection shall dissolve upon that individual's discharge from the medical institution and return home.

14. The debt due the state provided by this section is subordinate to the lien provided by section 484.130, RSMo, or section 484.140, RSMo, relating to an attorney's lien and to the participant's expenses of the claim against the third party.

15. Application for and acceptance of MO HealthNet benefits under this chapter shall constitute an assignment to the department of social services or MO HealthNet division of any rights to support for the purpose of medical care as determined by a court or administrative order and of any other rights to payment for medical care.

16. All participants receiving benefits as defined in this chapter shall cooperate with the state by reporting to the family support division or the MO HealthNet division, within thirty days, any occurrences where an injury to their persons or to a member of a household who receives MO HealthNet benefits is sustained, on such form or forms as provided by the family support division or MO HealthNet division.

17. If a person fails to comply with the provision of any judicial or administrative decree or temporary order requiring that person to maintain medical insurance on or be responsible for medical expenses for a dependent child, spouse, or ex-spouse, in addition to other remedies available, that person shall be liable to the state for the entire cost of the medical care provided pursuant to eligibility under any public assistance program on behalf of that dependent child, spouse, or ex-spouse during the period for which the required medical care was provided. Where a duty of support exists and no judicial or administrative decree or temporary order for support has been entered, the person owing the duty of support shall be liable to the state for the entire cost of the medical care provided on behalf of the dependent child

or spouse to whom the duty of support is owed.

18. The department director or the director's designee may compromise, settle or waive any such claim in whole or in part in the interest of the MO HealthNet program. Notwithstanding any provision in this section to the contrary, the department of social services, MO HealthNet division is not required to seek reimbursement from a liable third party on claims for which the amount it reasonably expects to recover will be less than the cost of recovery or for which recovery efforts will not be cost-effective. Cost-effectiveness is determined based on the following:

(1) Actual and legal issues of liability as may exist between the **[**recipient**]** **participant** and the liable party;

(2) Total funds available for settlement; and

(3) An estimate of the cost to the division of pursuing its claim.

301.560. 1. In addition to the application forms prescribed by the department, each applicant shall submit the following to the department:

(1) Every application other than a renewal application for a motor vehicle franchise dealer shall include a certification that the applicant has a bona fide established place of business. Such application shall include an annual certification that the applicant has a bona fide established place of business for the first three years and only for every other year thereafter. The certification shall be performed by a uniformed member of the Missouri state highway patrol or authorized or designated employee stationed in the troop area in which the applicant's place of business is located; except that in counties of the first classification, certification may be performed by an officer of a metropolitan police department when the applicant's established place of business of distributing or selling motor vehicles or trailers is in the metropolitan area where the certifying metropolitan police officer is employed. When the application is being made for licensure as a boat manufacturer or boat dealer, certification shall be performed by a uniformed member of the Missouri state water patrol stationed in the district area in which the applicant's place of business is located or by a uniformed member of the Missouri state highway patrol stationed in the troop area in which the applicant's place of business is located or, if the applicant's place of business is located within the jurisdiction of a metropolitan police department in a first class county, by an officer of such metropolitan police department. A bona fide established place of business for any new motor vehicle franchise dealer, used motor vehicle dealer, boat dealer, powersport dealer, wholesale motor vehicle dealer, trailer dealer, or wholesale or public auction shall be a permanent enclosed building or structure, either owned in fee or leased and actually occupied as a place of business by the applicant for the selling, bartering,

trading, servicing, or exchanging of motor vehicles, boats, personal watercraft, or trailers and wherein the public may contact the owner or operator at any reasonable time, and wherein shall be kept and maintained the books, records, files and other matters required and necessary to conduct the business. The applicant's place of business shall contain a working telephone which shall be maintained during the entire registration year. In order to qualify as a bona fide established place of business for all applicants licensed pursuant to this section there shall be an exterior sign displayed carrying the name of the business set forth in letters at least six inches in height and clearly visible to the public and there shall be an area or lot which shall not be a public street on which multiple vehicles, boats, personal watercraft, or trailers may be displayed. The sign shall contain the name of the dealership by which it is known to the public through advertising or otherwise, which need not be identical to the name appearing on the dealership's license so long as such name is registered as a fictitious name with the secretary of state, has been approved by its line-make manufacturer in writing in the case of a new motor vehicle franchise dealer and a copy of such fictitious name registration has been provided to the department. Dealers who sell only emergency vehicles as defined in section 301.550 are exempt from maintaining a bona fide place of business, including the related law enforcement certification requirements, and from meeting the minimum yearly sales;

(2) The initial application for licensure shall include a photograph, not to exceed eight inches by ten inches but no less than five inches by seven inches, showing the business building, lot, and sign. A new motor vehicle franchise dealer applicant who has purchased a currently licensed new motor vehicle franchised dealership shall be allowed to submit a photograph of the existing dealership building, lot and sign but shall be required to submit a new photograph upon the installation of the new dealership sign as required by sections 301.550 to 301.573. Applicants shall not be required to submit a photograph annually unless the business has moved from its previously licensed location, or unless the name of the business or address has changed, or unless the class of business has changed;

(3) Every applicant as a new motor vehicle franchise dealer, a used motor vehicle dealer, a powersport dealer, a wholesale motor vehicle dealer, trailer dealer, or boat dealer shall furnish with the application a corporate surety bond or an irrevocable letter of credit as defined in section 400.5-103, RSMo, issued by any state or federal financial institution in the penal sum of twenty-five thousand dollars on a form approved by the department. The bond or irrevocable letter of

credit shall be conditioned upon the dealer complying with the provisions of the statutes applicable to new motor vehicle franchise dealers, used motor vehicle dealers, powersport dealers, wholesale motor vehicle dealers, trailer dealers, and boat dealers, and the bond shall be an indemnity for any loss sustained by reason of the acts of the person bonded when such acts constitute grounds for the suspension or revocation of the dealer's license. The bond shall be executed in the name of the state of Missouri for the benefit of all aggrieved parties or the irrevocable letter of credit shall name the state of Missouri as the beneficiary; except, that the aggregate liability of the surety or financial institution to the aggrieved parties shall, in no event, exceed the amount of the bond or irrevocable letter of credit. The proceeds of the bond or irrevocable letter of credit shall be paid upon receipt by the department of a final judgment from a Missouri court of competent jurisdiction against the principal and in favor of an aggrieved party. Additionally, every applicant as a new motor vehicle franchise dealer, a used motor vehicle dealer, a powersport dealer, a wholesale motor vehicle dealer, **[**trailer dealer,**]** or boat dealer shall furnish with the application a copy of a current dealer garage policy bearing the policy number and name of the insurer and the insured;

(4) Payment of all necessary license fees as established by the department. In establishing the amount of the annual license fees, the department shall, as near as possible, produce sufficient total income to offset operational expenses of the department relating to the administration of sections 301.550 to 301.573. All fees payable pursuant to the provisions of sections 301.550 to 301.573, other than those fees collected for the issuance of dealer plates or certificates of number collected pursuant to subsection 6 of this section, shall be collected by the department for deposit in the state treasury to the credit of the "Motor Vehicle Commission Fund", which is hereby created. The motor vehicle commission fund shall be administered by the Missouri department of revenue. The provisions of section 33.080, RSMo, to the contrary notwithstanding, money in such fund shall not be transferred and placed to the credit of the general revenue fund until the amount in the motor vehicle commission fund at the end of the biennium exceeds two times the amount of the appropriation from such fund for the preceding fiscal year or, if the department requires permit renewal less frequently than yearly, then three times the appropriation from such fund for the preceding fiscal year. The amount, if any, in the fund which shall lapse is that amount in the fund which exceeds the multiple of the appropriation from such fund for the preceding fiscal year.

2. In the event a new vehicle manufacturer, boat manufacturer, motor vehicle dealer, wholesale motor vehicle dealer, boat dealer, powersport dealer, wholesale motor vehicle auction, trailer dealer, or a public motor vehicle auction submits an application for a license for a new business and the applicant has complied with all the provisions of this section, the department shall make a decision to grant or deny the license to the applicant within eight working hours after receipt of the dealer's application, notwithstanding any rule of the department.

3. Upon the initial issuance of a license by the department, the department shall assign a distinctive dealer license number or certificate of number to the applicant and the department shall issue one number plate or certificate bearing the distinctive dealer license number or certificate of number and two additional number plates or certificates of number within eight working hours after presentment of the application. Upon renewal, the department shall issue the distinctive dealer license number or certificate of number as quickly as possible. The issuance of such distinctive dealer license number or certificate of number shall be in lieu of registering each motor vehicle, trailer, vessel or vessel trailer dealt with by a boat dealer, boat manufacturer, manufacturer, public motor vehicle auction, wholesale motor vehicle dealer, wholesale motor vehicle auction or new or used motor vehicle dealer.

4. Notwithstanding any other provision of the law to the contrary, the department shall assign the following distinctive dealer license numbers to:

New motor vehicle franchise dealers ..... D-0 through D-999

New powersport dealers and motorcycle franchise dealers ..... D-1000 through D-1999

Used motor vehicle, used powersport, and used motorcycle dealers ..... D-2000 through D-9999

Wholesale motor vehicle dealers ..... W-0 through W-1999

Wholesale motor vehicle auctions ..... WA-0 through WA-999

New and used trailer dealers. ..... T-0 through T-9999

Motor vehicle, trailer, and boat manufacturers ..... DM-0 through DM-999

Public motor vehicle

auctions . . . . . A-0 through A-1999
Boat dealers . . . . . M-0 through M-9999
New and used recreational motor vehicle
dealers . . . . . RV-0 through RV-999

For purposes of this subsection, qualified transactions shall include the purchase of salvage titled vehicles by a licensed salvage dealer. A used motor vehicle dealer who also holds a salvage dealer's license shall be allowed one additional plate or certificate number per fifty-unit qualified transactions annually. In order for salvage dealers to obtain number plates or certificates under this section, dealers shall submit to the department of revenue on August first of each year a statement certifying, under penalty of perjury, the dealer's number of purchases during the reporting period of July first of the immediately preceding year to June thirtieth of the present year. The provisions of this subsection shall become effective on the date the director of the department of revenue begins to reissue new license plates under section 301.130, or on December 1, 2008, whichever occurs first. If the director of revenue begins reissuing new license plates under the authority granted under section 301.130 prior to December 1, 2008, the director of the department of revenue shall notify the revisor of statutes of such fact.

5. Upon the sale of a currently licensed new motor vehicle franchise dealership the department shall, upon request, authorize the new approved dealer applicant to retain the selling dealer's license number and shall cause the new dealer's records to indicate such transfer.

6. In the case of new motor vehicle manufacturers, motor vehicle dealers, powersport dealers, recreational motor vehicle dealers, and trailer dealers, the department shall issue one number plate bearing the distinctive dealer license number and may issue two additional number plates to the applicant upon payment by the manufacturer or dealer of a fifty dollar fee for the number plate bearing the distinctive dealer license number and ten dollars and fifty cents for each additional number plate. Such license plates shall be made with fully reflective material with a common color scheme and design, shall be clearly visible at night, and shall be aesthetically attractive, as prescribed by section 301.130. Boat dealers and boat manufacturers shall be entitled to one certificate of number bearing such number upon the payment of a fifty dollar fee. Additional number plates and as many additional certificates of number may be obtained upon payment of a fee of ten dollars and fifty cents for each additional plate or certificate. New motor vehicle manufacturers shall not be issued or possess more

than three hundred forty-seven additional number plates or certificates of number annually. New and used motor vehicle dealers, powersport dealers, wholesale motor vehicle dealers, boat dealers, and trailer dealers are limited to one additional plate or certificate of number per ten-unit qualified transactions annually. New and used recreational motor vehicle dealers are limited to two additional plates or certificate of number per ten-unit qualified transactions annually for their first fifty transactions and one additional plate or certificate of number per ten-unit qualified transactions thereafter. An applicant seeking the issuance of an initial license shall indicate on his or her initial application the applicant's proposed annual number of sales in order for the director to issue the appropriate number of additional plates or certificates of number. A motor vehicle dealer, trailer dealer, boat dealer, powersport dealer, recreational motor vehicle dealer, motor vehicle manufacturer, boat manufacturer, or wholesale motor vehicle dealer obtaining a distinctive dealer license plate or certificate of number or additional license plate or additional certificate of number, throughout the calendar year, shall be required to pay a fee for such license plates or certificates of number computed on the basis of one-twelfth of the full fee prescribed for the original and duplicate number plates or certificates of number for such dealers' licenses, multiplied by the number of months remaining in the licensing period for which the dealer or manufacturers shall be required to be licensed. In the event of a renewing dealer, the fee due at the time of renewal shall not be prorated. Wholesale and public auctions shall be issued a certificate of dealer registration in lieu of a dealer number plate. In order for dealers to obtain number plates or certificates under this section, dealers shall submit to the department of revenue on August first of each year a statement certifying, under penalty of perjury, the dealer's number of sales during the reporting period of July first of the immediately preceding year to June thirtieth of the present year.

7. The plates issued pursuant to subsection 3 or 6 of this section may be displayed on any motor vehicle owned by a new motor vehicle manufacturer. The plates issued pursuant to subsection 3 or 6 of this section may be displayed on any motor vehicle or trailer owned and held for resale by a motor vehicle dealer for use by a customer who is test driving the motor vehicle, for use and display purposes during, but not limited to, parades, private events, charitable events, or for use by an employee or officer, but shall not be displayed on any motor vehicle or trailer hired or loaned to others or upon any regularly used service or wrecker vehicle. Motor vehicle dealers may display their dealer plates on a

tractor, truck or trailer to demonstrate a vehicle under a loaded condition. Trailer dealers may display their dealer license plates in like manner, except such plates may only be displayed on trailers owned and held for resale by the trailer dealer.

8. The certificates of number issued pursuant to subsection 3 or 6 of this section may be displayed on any vessel or vessel trailer owned and held for resale by a boat manufacturer or a boat dealer, and used by a customer who is test driving the vessel or vessel trailer, or is used by an employee or officer on a vessel or vessel trailer only, but shall not be displayed on any motor vehicle owned by a boat manufacturer, boat dealer, or trailer dealer, or vessel or vessel trailer hired or loaned to others or upon any regularly used service vessel or vessel trailer. Boat dealers and boat manufacturers may display their certificate of number on a vessel or vessel trailer when transporting a vessel or vessels to an exhibit or show.

9. (1) Every application for the issuance of a used motor vehicle dealer's license shall be accompanied by proof that the applicant, within the last twelve months, has completed an educational seminar course approved by the department as prescribed by subdivision (2) of this subsection. Wholesale and public auto auctions and applicants currently holding a new or used license for a separate dealership shall be exempt from the requirements of this subsection. The provisions of this subsection shall not apply to current new motor vehicle franchise dealers or motor vehicle leasing agencies or applicants for a new motor vehicle franchise or a motor vehicle leasing agency. The provisions of this subsection shall not apply to used motor vehicle dealers who were licensed prior to August 28, 2006.

(2) The educational seminar shall include, but is not limited to, the dealer requirements of sections 301.550 to 301.573, the rules promulgated to implement, enforce, and administer sections 301.550 to 301.570, and any other rules and regulations promulgated by the department.

303.025. 1. No owner of a motor vehicle registered in this state, or required to be registered in this state, shall operate, register or maintain registration of a motor vehicle, or permit another person to operate such vehicle, unless the owner maintains the financial responsibility which conforms to the requirements of the laws of this state. **No nonresident shall operate or permit another person to operate in this state a motor vehicle registered to such nonresident unless the nonresident maintains the financial responsibility which conforms to the requirements of the laws**

of the nonresident's state of residence. Furthermore, no person shall operate a motor vehicle owned by another with the knowledge that the owner has not maintained financial responsibility unless such person has financial responsibility which covers the person's operation of the other's vehicle; however, no owner **or nonresident** shall be in violation of this subsection if he or she fails to maintain financial responsibility on a motor vehicle which is inoperable or being stored and not in operation. The director may prescribe rules and regulations for the implementation of this section.

2. A motor vehicle owner shall maintain the owner's financial responsibility in a manner provided for in section 303.160, or with a motor vehicle liability policy which conforms to the requirements of the laws of this state. **A nonresident motor vehicle owner shall maintain the owner's financial responsibility which conforms to the requirements of the laws of the nonresident's state of residence.**

3. Any person who violates this section is guilty of a class C misdemeanor. However, no person shall be found guilty of violating this section if the operator demonstrates to the court that he or she met the financial responsibility requirements of this section at the time the peace officer, commercial vehicle enforcement officer or commercial vehicle inspector wrote the citation. In addition to any other authorized punishment, the court shall notify the director of revenue of any person convicted pursuant to this section and shall do one of the following:

(1) Enter an order suspending the driving privilege as of the date of the court order. If the court orders the suspension of the driving privilege, the court shall require the defendant to surrender to it any driver's license then held by such person. The length of the suspension shall be as prescribed in subsection 2 of section 303.042. The court shall forward to the director of revenue the order of suspension of driving privilege and any license surrendered within ten days;

(2) Forward the record of the conviction for an assessment of four points; **[**or**]**

(3) In lieu of an assessment of points, render an order of supervision as provided in section 302.303, RSMo. An order of supervision shall not be used in lieu of points more than one time in any thirty-six-month period. Every court having jurisdiction pursuant to the provisions of this section shall forward a record of conviction to the Missouri state highway patrol, or at the written direction of the Missouri state highway patrol, to the department of revenue, in a manner approved by the director of the department of public safety. The

director shall establish procedures for the record keeping and administration of this section**; or**

(4) For a nonresident, suspend the nonresident's driving privileges in this state in accordance with section 303.030 and notify the official in charge of the issuance of licenses and registration certificates in the state in which such nonresident resides in accordance with section 303.080.

4. Nothing in sections 303.010 to 303.050, 303.060, 303.140, 303.220, 303.290, 303.330 and 303.370 shall be construed as prohibiting the department of insurance, financial institutions and professional registration from approving or authorizing those exclusions and limitations which are contained in automobile liability insurance policies and the uninsured motorist provisions of automobile liability insurance policies.

5. If a court enters an order of suspension, the offender may appeal such order directly pursuant to chapter 512, RSMo, and the provisions of section 302.311, RSMo, shall not apply.

303.040. 1. The operator or owner of every motor vehicle which is involved in an accident within this state**, including a nonresident operator or owner of a motor vehicle,** or the owner of a legally or illegally parked car which is in any manner involved in an accident within this state, with an uninsured motorist, upon the streets or highways thereof, or on any publicly or privately owned parking lot or parking facility generally open for use by the public, in which any person is killed or injured or in which damage to property of any one person, including himself, in excess of five hundred dollars is sustained, and the owner or operator of every motor vehicle which is involved in an accident within this state if such owner or operator does not carry motor vehicle liability insurance shall, within thirty days after such accident, report the matter in writing to the director. Such report, the form of which shall be prescribed by the director, shall provide the operator with notice of the following:

(1) That it is the responsibility of the operator, not the state, to bring an action at law on the claim of the operator arising out of the accident;

(2) That the security deposited shall only be applied to the payment of a judgment against the person or persons on whose behalf the deposit was made;

(3) That the department of revenue shall return the deposit to the depositor after the expiration of one year from the date of the accident, or as otherwise provided in section 303.060. In addition, the report shall contain such information as will enable the director to determine whether the requirements for

the deposit of security under section 303.030 are inapplicable by reason of the existence of insurance or other exceptions specified in this chapter, or whether the required financial responsibility has been met by the owner or operator of the motor vehicle as required by section 303.025. The director may rely upon the accuracy of such information unless and until he has reason to believe that the information is erroneous. If such operator be physically incapable of making such report, the owner of the motor vehicle involved in such accident shall, within thirty days after learning of the accident, make such report. If the operator is also the owner and is incapable of filing such report as is required by this section, then the report will be filed as soon as the operator-owner is so capable. If the report is late by reason of incapability, a doctor's certificate must accompany the report certifying same. The operator or the owner shall furnish such additional relevant information as the director shall require.

2. If any party involved in an accident files a report under this section, the director shall notify, within ten days after receipt of the report, all other parties involved in the accident as specified in the report that a report has been filed and such other parties shall then furnish, within ten days, the director with such information as the director may request.

3. If any party involved in an accident in this state is a nonresident uninsured motorist, the nonresident uninsured operator or owner of the motor vehicle and any law enforcement agency responding to such accident shall report the involvement of an uninsured nonresident motorist in an accident occurring in this state to the director, and any resident operator or owner of a motor vehicle involved in an accident with an uninsured nonresident motorist may report such accident to the director in accordance with the provisions of subsections 1 and 2 of this section.

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

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

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

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

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

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

(b) The toll-free telephone number of the utilization review agent;

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

(d) The right to reconsideration;

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

(f) The right to designate a representative;

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

(h) Further appeal rights, if any;

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

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

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

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

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

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

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

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

grievances;

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

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

(h) The right to designate a representative;

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

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

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

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

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

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

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

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

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

(15) The director of the department of insurance, financial institutions

and professional registration shall develop a standard credentialing form which shall be used by all health carriers when credentialing health care professionals in a managed care plan. If the health carrier demonstrates a need for additional information, the director of the department of insurance, financial institutions and professional registration may approve a supplement to the standard credentialing form. All forms and supplements shall meet all requirements as defined by the National Committee of Quality Assurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. The information to be provided under subsections 1 and 2 of this section may be provided online unless a paper copy is requested by the enrollee. A request by the enrollee may include written, oral or electronic means. Such requested paper copy shall be provided to the enrollee within fifteen business days.

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

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

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

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

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

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

(2) Ensure that a review required under subsection 2 of this section is conducted and the resulting report is prepared. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions

of chapter 536, and, if applicable, section 536.028. This section and chapter 536, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2010, shall be invalid and void.

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

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

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

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

2. The following standards, either singly or a combination of two or more, may be considered by the director to determine whether the continued operation of any insurer transacting an insurance business in this state might be deemed to be hazardous to its policyholders, creditors, or the general public:

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

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

(3) Whether the insurer has made adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and

related expenses of the insurer, when considered in light of the assets held by the insurer with respect to such reserves and related actuarial items including, but not limited to, the investment earnings on such assets, and the considerations anticipated to be received and retained under such policies and contracts;

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

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

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

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

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

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

(10) The age and collectibility of receivables;

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

insurer in such position;

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

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

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

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

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

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

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

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

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

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

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

(2) Make appropriate adjustments including disallowance to asset values attributable to investments in or transactions with parents,

subsidiaries, or affiliates consistent with the National Association of Insurance Commissioners Accounting Policies and Procedures Manual, state laws and regulations;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

taken at coroner's inquests, criminal or civil proceedings; costs for copies of any public records; costs of depositions and court-reported or -recorded statements. "Allocated loss adjustment expenses" shall not include the salaries of officials, administrators or other employees or normal overhead charges such as rent, postage, telephone, lighting, cleaning, heating or similar expenses;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) A contract or agreement (including terms and conditions incorporated by reference therein), including a master settlement agreement (which master settlement 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;

[(16)**] (17) "Qualified financial contract", any commodity contract, forward contract, repurchase agreement, securities contract, swap agreement, and any similar agreement that the director determines by rule to be a qualified financial contract for purposes of sections 375.1150 to 375.1246. For purposes of this subdivision, the following terms shall mean:**

(a) "Commodity contract":

a. A contract for the purchase or sale of a commodity for future delivery on or subject to the rules of the 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", the same meaning as set forth in the Federal Deposit Insurance Act, 12 U.S.C. Section 1821(e)(8)(D), as amended;

(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 any other provision of this section to the contrary, the commencement of a delinquency proceeding under sections 375.1150 to 375.1246 does not operate as a stay or prohibition of any right to cause of netting, liquidation, setoff, termination, acceleration or close out of obligations, or 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 provision 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, or 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 similar security agreement 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 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 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. (1) 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.

(2) For purposes of this subsection, "walkaway clause" means a provision in a netting agreement or 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 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.

(3) 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, 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 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 shall 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 under section 375.1182 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. 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. 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 such 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.

376.717. 1. Sections 376.715 to 376.758 shall provide coverage for the policies and contracts specified in subsection 2 of this section:

(1) To persons who, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees or payees of the persons covered under subdivision (2) of this subsection; and

(2) To persons who are owners of or certificate holders under such policies or contracts **[**and**], other than structured settlement annuities,** who:

(a) Are residents of this state; or

(b) Are not residents, but only under all of the following conditions:

a. The insurers which issued such policies or contracts are domiciled in this state;

b. **[**Such insurers never held a license or certificate of authority in the states in which such persons reside;**] The persons are not eligible for coverage by an association in any other state due to the fact that the insurer was not licensed in such state at the time specified in such state's guaranty association law; and**

c. **[**Such**] The** states **in which the persons reside** have associations similar to the association created by sections 376.715 to 376.758**[**; and

d. Such persons are not eligible for coverage by such associations**]**.

(3) For structured settlement annuities specified in subsection 2 of this section, subdivisions (1) and (2) of subsection 1 of this section shall not apply, and sections 376.715 to 376.758 shall, except as provided in subdivisions (4) and (5) of this subsection, provide coverage to a person who is a payee under a structured settlement annuity, or beneficiary of a payee if the payee is deceased, if the payee:

(a) Is a resident, regardless of where the contract owner resides; or

(b) Is not a resident, but only under both of the following

conditions:

a. (i) The contract owner of the structured settlement annuity is a resident; or

(ii) The contract owner of the structure settlement annuity is not a resident, but:

i. The insurer that issued the structured settlement annuity is domiciled in this state; and

ii. The state in which the contract owner resides has an association similar to the association created under sections 376.715 to 376.758; and

b. Neither the payee or beneficiary nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.

(4) Sections 376.715 to 376.758 shall not provide to a person who is a payee or beneficiary of a contract owner resident of this state, if the payee or beneficiary is afforded any coverage by such an association of another state.

(5) Sections 376.715 to 376.758 is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under sections 376.715 to 376.758 is provided coverage under the laws of any other state, the person shall not be provided coverage under sections 376.715 to 376.758. In determining the application of the provisions of this subdivision in situations where a person could be covered by such an association of more than one state, whether as an owner, payee, beneficiary, or assignee, sections 376.715 to 376.758 shall be construed in conjunction with the other state's laws to result in coverage by only one association.

2. Sections 376.715 to 376.758 shall provide coverage to the persons specified in subsection 1 of this section for direct, nongroup life, health, annuity **[**and supplemental**]** policies or contracts, **and supplemental contracts to any such policies or contracts, and for** certificates under direct group policies and contracts, except as limited by the provisions of sections 376.715 to 376.758. **Annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities, and any immediate or deferred annuity contracts.**

3. Sections 376.715 to 376.758 shall not provide coverage for:

(1) Any portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract holder;

(2) Any policy or contract of reinsurance, unless assumption certificates have been issued;

(3) Any portion of a policy or contract to the extent that the rate of interest on which it is based**, or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value**:

(a) Averaged over the period of four years prior to the date on which the association becomes obligated with respect to such policy or contract, exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four years before the association became obligated; and

(b) On and after the date on which the association becomes obligated with respect to such policy or contract exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available;

(4) Any **portion of a policy or contract issued to a** plan or program of an employer, association or **[**similar entity**]** **other person** to provide life, health, or annuity benefits to its employees or members to the extent that such plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association or **[**similar entity**]** **other person** under:

(a) A "multiple employer welfare arrangement" as defined in **[**section 514 of the Employee Retirement Income Security Act of 1974**]** **29 U.S.C. Section 1144**, as amended;

(b) A minimum premium group insurance plan;

(c) A stop-loss group insurance plan; or

(d) An administrative services only contract;

(5) Any portion of a policy or contract to the extent that it provides dividends or experience rating credits, **voting rights,** or provides that any fees or allowances be paid to any person, including the policy or contract holder, in connection with the service to or administration of such policy or contract; **[**and**]**

(6) Any policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue such policy or contract in this state**;**

(7) A portion of a policy or contract to the extent that the assessments required by section 376.735 with respect to the policy or contract are preempted by federal or state law;

(8) An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policy owner, including without limitation:

(a) Claims based on marketing materials;

(b) Claims based on side letters, riders, or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements;

(c) Misrepresentations of or regarding policy benefits;

(d) Extra-contractual claims;

(e) A claim for penalties or consequential or incidental damages;

(9) A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer;

(10) An unallocated annuity contract;

(11) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under sections 376.715 to 376.758, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, for purposes of determining the value that have been credited and are not subject to forfeiture under this subdivision, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture;

(12) A policy or contract providing any hospital, medical, prescription drug or other health care benefit under Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code, Medicare Part C & D, or any regulations issued thereunder.

4. The benefits for which the association may become liable shall in no event exceed the lesser of:

(1) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

(2) With respect to any one life, regardless of the number of policies or contracts:

(a) Three hundred thousand dollars in life insurance death benefits, but not more than one hundred thousand dollars in net cash surrender and net cash withdrawal values for life insurance;

(b) One hundred thousand dollars in health insurance benefits, including any net cash surrender and net cash withdrawal values;

(c) One hundred thousand dollars in the present value of annuity benefits, including net cash surrender and net cash withdrawal values.

Provided, however, that in no event shall the association be liable to expend more than three hundred thousand dollars in the aggregate with respect to any one life under paragraphs (a), (b), and (c) of this subdivision.

5. The limitations set forth in subsection 4 of this section are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which such benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under sections 376.715 to 376.758 may be met by the use of assets attributable to covered policies or reimbursed to the association under its subrogation and assignment rights.

376.718. As used in sections 376.715 to 376.758, the following terms shall mean:

(1) "Account", any of the **[**four**]** accounts created under section 376.720;

(2) **[**"Annuity or annuity contract", any annuity contract or group annuity certificate which is issued to and owned by an individual. This definition of "annuity or annuity contract" does not include any form of unallocated annuity contract;

(3)**]** "Association", the Missouri life and health insurance guaranty association created under section 376.720;

(3) "Benefit plan", a specific employee, union, or association of natural persons benefit plan;

(4) "Contractual obligation", any obligation under a policy or contract or

certificate under a group policy or contract, or portion thereof for which coverage is provided under the provisions of section 376.717;

(5) "Covered policy", any policy or contract **[**within the scope of sections 376.715 to 376.758**]** **or portion of a policy or contract for which coverage is provided** under the provisions of section 376.717;

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

(7) **"Extra-contractual claims", includes but is not limited to claims relating to bad faith in the payment of claims, punitive or exemplary damages, or attorneys fees and costs;**

(8) "Impaired insurer", a member insurer which, after August 13, 1988, is not an insolvent insurer, and is **[**deemed by the director to be potentially unable to fulfill its contractual obligations, or is**]** placed under an order of rehabilitation or conservation by a court of competent jurisdiction;

[(8)**]** **(9)** "Insolvent insurer", a member insurer which, after August 13, 1988, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency;

[(9)**]** **(10)** "Member insurer", any insurer or health services corporation licensed or which holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided under section 376.717, and includes any insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include:

(a) A health maintenance organization;

(b) A fraternal benefit society;

(c) A mandatory state pooling plan;

(d) A mutual assessment company or any entity that operates on an assessment basis;

(e) An insurance exchange; **[**or**]**

(f) **An organization that issues qualified charitable gift annuities, as defined in section 352.500, and does not hold a certificate or license to transact insurance business; or**

(g) Any entity similar to any of the entities listed in paragraphs (a) to **[**(e)**]** **(f)** of this subdivision;

[(10)**]** **(11)** "Moody's Corporate Bond Yield Average", the monthly average corporates as published by Moody's Investors Service, Inc., or any successor thereto;

(12) "Owner", "policy owner", or "contract owner", the person who

is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the insurer. Owner, contract owner, and policy owner shall not include persons with a mere beneficial interest in a policy or contract;

[(11)**] (13)** "Person", any individual, corporation, partnership, association or voluntary organization;

[(12)**] (14)** "Premiums", amounts received on covered policies or contracts, less premiums, considerations and deposits returned thereon, and less dividends and experience credits thereon. The term does not include any amounts received for any policies or contracts or for the portions of any policies or contracts for which coverage is not provided under subsection 3 of section 376.717, except that assessable premium shall not be reduced on account of subdivision (3) of subsection 3 of section 376.717 relating to interest limitations and subdivision (2) of subsection 4 of section 376.717 relating to limitations with respect to any one life**, any one participant,** and any one contract holder**. Premiums shall not include:**

(a) Premiums on an unallocated annuity contract; or

(b) With respect to multiple nongroup policies of life insurance owned by one owner, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, premiums in excess of five million dollars with respect to such policies or contracts, regardless of the number of policies or contracts held by the owner;

(15) "Principal place of business", for a person other than a natural person, the single state in which the natural persons who establish policy for the direction, control, and coordination of the operations of the entity as a whole primarily exercise that function, determined by the association in its reasonable judgment by considering the following factors:

(a) The state in which the primary executive and administrative headquarters of the entity is located;

(b) The state in which the principal office of the chief executive officer of the entity is located;

(c) The state in which the board of directors, or similar

governing person or persons, of the entity conducts the majority of its meetings;

(d) The state in which the executive or management committee of the board of directors, or similar governing person or persons, of the entity conducts the majority of its meetings; and

(e) The state from which the management of the overall operations of the entity is directed;

(16) "Receivership court", the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the insurer;

[(13)**] (17)** "Resident", any person who resides in this state **[**at the time a member insurer is determined to be an impaired or insolvent insurer**] on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer, whichever first occurs,** and to whom a contractual obligation is owed. A person may be a resident of only one state, which in the case of a person other than a natural person shall be its principal place of business**. Citizens of the United States that are either residents of foreign countries or residents of the United States possessions, territories, or protectorates that do not have an association similar to the association created under sections 376.715 to 376.758 shall be deemed residents of the state of domicile of the insurer that issued the policies or contracts;**

(18) "Structure settlement annuity", an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant;

(19) "State", a state, the District of Columbia, Puerto Rico, and a United States possession, territory, or protectorate;

[(14)**] (20)** "Supplemental contract", any **written** agreement entered into for the distribution of **proceeds under a life, health, or annuity** policy or contract **[**proceeds**]**;

[(15)**] (21)** "Unallocated annuity contract", any annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity **benefits** guaranteed to an individual by an insurer under such contract or certificate.

376.724. 1. If a member insurer is an impaired **[**domestic**]** insurer, the

association may, in its discretion, and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer, that are approved by the director**[**, and that are, except in cases of court ordered conservation or rehabilitation, also approved by the impaired insurer**]**:

(1) Guarantee, assume or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the policies or contracts of the impaired insurer; **or**

(2) Provide such moneys, pledges, notes, **loans,** guarantees, or other means as are proper to effectuate subdivision (1) of this subsection and assure payment of the contractual obligations of the impaired insurer pending action under subdivision (1) of this subsection**[**; or

(3) Loan money to the impaired insurer**]**.

2. **[**If a member insurer is an impaired insurer, whether domestic, foreign or alien and the insurer is not paying claims in a timely fashion, then subject to the preconditions specified in subsection 3 of this section, the association shall, in its discretion, either:

(1) Take any of the actions specified in subsection 1 of this section, subject to the conditions therein; or

(2) Provide substitute benefits in lieu of the contractual obligations of the impaired insurer solely for: health claims; periodic annuity benefit payments; death benefits; supplemental benefits; and cash withdrawals for policy or contract owners who petition therefor under claims of emergency or hardship in accordance with standards proposed by the association and approved by the director.

3. The association shall be subject to the requirements of subsection 2 of this section only if:

(1) The laws of the impaired insurer's state of domicile provide that until all payments of or on account of the impaired insurer's contractual obligations by all guaranty associations, along with all expenses thereof and interest on all such payments and expenses, shall have been repaid to the guaranty associations or a plan of repayment by the impaired insurer shall have been approved by the guaranty associations:

(a) The delinquency proceedings shall not be dismissed;

(b) Neither the impaired insurer nor its assets shall be returned to the control of its shareholders or private management; and

(c) It shall not be permitted to solicit or accept new business or have any suspended or revoked license restored; and

(2) (a) If the impaired insurer is a domestic insurer, it has been placed

under an order of rehabilitation by a court of competent jurisdiction in this state; or

(b) If the impaired insurer is a foreign or alien insurer:

a. It has been prohibited from soliciting or accepting new business in this state;

b. Its certificate of authority has been suspended or revoked in this state; and

c. A petition for rehabilitation or liquidation has been filed in a court of competent jurisdiction in its state of domicile by the commissioner of that state.

4. (1)**]** If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

(1) (a) **a.** Guarantee, assume or reinsure, or cause to be guaranteed, assumed or reinsured, the policies or contracts of the insolvent insurer; or

[(b)**]** **b.** Assure payment of the contractual obligations of the insolvent insurer; and

[(c)**]** **(b)** Provide such moneys, pledges, **loans, notes,** guarantees, or other means as are reasonably necessary to discharge such duties; or

(2) **[**With respect only to life and health policies,**]** Provide benefits and coverages in accordance with **[**subsection 5 of this section.

5. When proceeding under subsection 2 or 4 of this section, the association shall,**] the following provisions:**

(a) With respect to **[**only**]** life and health insurance policies**[**:

(1)**]** **and annuities,** assure payment of benefits for premiums identical to the premiums and benefits, except for terms of conversion and renewability, that would have been payable under the policies of the insolvent insurer, for claims incurred:

[(a)**]** **a.** With respect to group policies **and contracts**, not later than the earlier of the next renewal date under such policies or contracts or forty-five days, but in no event less than thirty days, after the date on which the association becomes obligated with respect to such policies **and contracts**;

[(b)**]** **b.** With respect to individual policies, **contracts, and annuities,** not later than the earlier of the next renewal date, if any, under such policies **or contracts** or one year, but in no event less than thirty days, from the date on which the association becomes obligated with respect to such policies **and contracts**;

[(2)**]** **(b)** Make diligent efforts to provide all known insureds **or annuitants for individual policies and contracts,** or group policyholders

with respect to group policies **or contracts**, thirty days notice of the termination**, under paragraph (a) of this subdivision,** of the benefits provided; **[**and**]**

[(3)**]** **(c)** With respect to individual policies, make available to each known insured, **annuitant,** or owner if other than the insured **or annuitant**, and with respect to an individual formerly insured **or formerly an annuitant** under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of **[**subsection 6 of this section**] paragraph (d) of this subdivision**, if the insureds **or annuitants** had a right under law or the terminated policy to convert coverage to individual coverage or to continue an individual policy in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or had a right only to make changes in premium by class**[**.**];**

[6. (1)**]** **(d) a.** In providing the substitute coverage required under **[**subdivision (3) of subsection 5 of this section**] paragraph (c) of this subdivision**, the association may offer either to reissue the terminated coverage or to issue an alternative policy.

[(2)**]** **b.** Alternative or reissued policies shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy.

[(3)**]** **c.** The association may reinsure any alternative or reissued policy**[**.**];**

[7. (1)**]** **(e) a.** Alternative policies adopted by the association shall be subject to the approval of the director. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency.

[(2)**]** **b.** Alternative policies shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates which it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy was last underwritten.

[(3)**]** **c.** Any alternative policy issued by the association shall provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association**;**

(f) In carrying out its duties in connection with guaranteeing, assuming, or reinsuring policies or contracts under this subsection, the

association may, subject to approval of the receivership court, issue substitute coverage for a policy or contract that provides an interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

a. In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for a fixed interest rate, payment of dividends with minimum guarantees, or a different method for calculating interest or changes in value;

b. There is no requirement for evidence of insurability, waiting period, or other exclusion that would not have applied under the replaced policy or contract; and

c. The alternative policy or contract is substantially similar to the replaced policy or contract in all other terms.

376.725. **1.** If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be set by the association in accordance with the amount of insurance provided and the age and class of risk of the insured, subject to approval of the director or by a court of competent jurisdiction.

2. The association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or alternative policy shall cease on the date the coverage or policy is replaced by another similar policy by the policy owner, the insured, or the association.

3. When proceeding under subdivision (2) of subsection 2 of section 376.724 with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with subdivision (3) of subsection 3 of section 376.717.

376.732. 1. If the association fails to act within a reasonable period of time when authorized to do so, the director shall have the powers and duties of the association under sections 376.715 to 376.758 with respect to **[**impaired or**]** **the** insolvent insurers.

2. The association may render assistance and advice to the director, upon his request, concerning rehabilitation, payment of claims, continuance of

coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.

3. The association shall have standing to appear **or intervene** before any court **or agency** in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under sections 376.715 to 376.758**, or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise**. Such standing shall extend to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring, modifying or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association shall have the right to appear or intervene before a court **or agency** in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over **[**a third party**]** **any person or property** against whom the association may have rights through subrogation **[**of the insurer's policyholders**]** **or otherwise**.

376.733. 1. Any person receiving benefits under sections 376.715 to 376.758 shall be deemed to have assigned the rights under, and any causes of action **against any person for losses arising under, resulting from, or otherwise** relating to, the covered policy or contract to the association to the extent of the benefits received because of the provisions of sections 376.715 to 376.758, whether the benefits are payments of or on account of contractual obligations, continuation of coverage or provision of substitute or alternative coverages. The association may require an assignment to it of such rights and cause of action by any payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any right or benefits conferred by sections 376.715 to 376.758 upon such person.

2. The subrogation rights of the association under this section have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under sections 376.715 to 376.758.

3. In addition to subsections 1 and 2 of this section, the association shall have all common law rights of subrogation and any other equitable or legal remedy which would have been available to the impaired or insolvent insurer or **[**holder**]** **owner, beneficiary, or payee** of a policy or contract with respect to such policy or contracts**, including, without limitation in the case of a**

structured settlement annuity, any rights of the owner, beneficiary, or payee of the annuity, to the extent of benefits received under sections 376.715 to 376.758, against a person, originally or by succession, responsible for the losses arising from the personal injury relating to the annuity or payment thereof, excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under Section 130 of the Internal Revenue Code of 1986, as amended.

376.734. 1. **In addition to any other rights and powers under sections 376.715 to 376.758,** the association may:

(1) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of sections 376.715 to 376.758;

(2) Sue or be sued, including taking any legal actions necessary or proper for recovery of any unpaid assessments under subsections 1 and 2 of section 376.735 **and to settle claims or potential claims against it**;

(3) Borrow money to effect the purposes of sections 376.715 to 376.758. Any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;

(4) Employ or retain such persons as are necessary to handle the financial transactions of the association, and to perform such other functions as become necessary or proper under sections 376.715 to 376.758;

(5) Take such legal action as may be necessary to avoid **or recover** payment of improper claims;

(6) Exercise, for the purposes of sections 376.715 to 376.758 and to the extent approved by the director, the powers of a domestic life or health insurer, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform its obligations under sections 376.715 to 376.758**;**

(7) Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under sections 376.715 to 376.758 with respect to the person, and the person shall promptly comply with the request;

(8) Take other necessary or appropriate action to discharge its duties and obligations or to exercise its powers under sections 376.715 to 376.758; and

(9) With respect to covered policies for which the association

becomes obligated after an entry of an order of liquidation or rehabilitation, elect to succeed to the rights of the insolvent insurer arising after the order of liquidation or rehabilitation under any contract of reinsurance to which the insolvent insurer was a party, to the extent that such contract provides coverage for losses occurring after the date of the order of liquidation or rehabilitation. As a condition to making this election, the association shall pay all unpaid premiums due under the contract for coverage relating to periods before and after the date of the order of liquidation or rehabilitation.

2. The board of directors of the association may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of sections 376.715 to 376.758 in an economical and efficient manner.

3. Where the association has arranged for or offered to provide the benefits of sections 376.715 to 376.758 to a covered person under a plan or arrangement that fulfills the association's obligations under sections 376.715 to 376.758, the person shall not be entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

[2.**]** **4.** The association may join an organization of one or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association.

[3. Whenever it is necessary for the association to retain the services of legal counsel, the association shall retain persons licensed to practice law in this state, and whose principal place of business is in this state or who are employed by or are partners of a professional corporation, corporation, copartnership or association having its principal place of business in this state; provided however, that if, after a good faith search, such persons cannot be found, the association may retain the legal services of such other persons as it chooses.**]**

376.735. 1. For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. Assessments shall be due not less than thirty days after prior written notice to the member insurers and shall accrue interest at ten percent per annum on and after the due date.

2. There shall be two assessments, as follows:

(1) Class A assessments **[**shall**]** **may** be made for the purpose of meeting

administrative and legal costs and other expenses **[**and examinations conducted under the authority of subsections 4 and 5 of section 376.742**]**. Class A assessments may be made whether or not related to a particular impaired or insolvent insurer;

(2) Class B assessments **[**shall**] may** be made to the extent necessary to carry out the powers and duties of the association under **[**section 376.724**] sections 376.715 to 376.758** with regard to an impaired or an insolvent insurer.

3. The amount of any class A assessment shall be determined by the board and may be made on a pro rata or nonpro rata basis. If pro rata, the board may provide that it be credited against future class B assessments. A nonpro rata assessment shall not exceed one hundred fifty dollars per member insurer in any one calendar year. The amount of any class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

4. Class B assessments against member insurers for each account shall be in the proportion that the premiums received on business in this state by each assessed member insurer **[**or**] on** policies or contracts covered by each account for the three most recent calendar years for which information is available preceding the year in which the insurer became impaired or insolvent, as the case may be, bears to such premiums received on business in this state for such calendar years by all assessed member insurers.

5. Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be made until necessary to implement the purposes of sections 376.715 to 376.758. Classification of assessments under **[**subsections 1 and**] subdivisions (1) and (2) of subsection** 2 of this section and computation of assessments under this **[**subsection**] section** shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. In no case shall a member insurer be liable under class A or class B for assessments in any account enumerated in section 376.720, for which such insurer is not licensed by the department of insurance, financial institutions and professional registration to transact business.

376.737. 1. The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its

contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. **Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred under a repayment plan approved by the association.**

2. **(1) Subject to the provisions of subdivision (2) of this subsection,** the total of all assessments upon a member insurer for each account shall not in any one calendar year exceed two percent of such insurer's average **annual** premiums received in this state on the policies and contracts covered by the account during the three calendar years preceding the year in which the insurer became an impaired or insolvent insurer. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in **[**either**]** **the** account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by sections 376.715 to 376.758.

(2) If two or more assessments are made in one calendar year with respect to insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in subdivision (1) of this subsection shall be equal and limited to the higher of the three-year average annual premiums for the applicable account as calculated under this section.

3. The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

4. The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation net realized gains and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses.

5. It shall be proper for any member insurer, in determining its premium

rates and policy owner dividends as to any kind of insurance within the scope of sections 376.715 to 376.758, to consider the amount reasonably necessary to meet its assessment obligations under the provisions of sections 376.715 to 376.758.

376.738. The association shall issue to each insurer paying an assessment under the provisions of sections 376.715 to 376.758, other than class A assessment, a certificate of contribution, in a form prescribed by the director, for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution **[**issued before September 1, 1991,**]** may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the director may approve**[**, provided that a certificate issued before September 1, 1991, shall not be shown as an admitted asset for a longer period of time or greater amount than that described in subdivisions (1) to (4) of subsection 2 of section 375.774, RSMo**]**.

376.740. 1. The association shall submit a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the association to the director. The plan of operation and any amendments thereto shall become effective upon the director's written approval or unless he has not disapproved it within thirty days.

2. If the association fails to submit a suitable plan of operation within one hundred twenty days following the effective date, August 13, 1988, of sections 376.715 to 376.758 or if at any time thereafter the association fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of sections 376.715 to 376.758. Such rules shall continue in force until modified by the director or superseded by a plan submitted by the association and approved by him.

3. All member insurers shall comply with the plan of operation.

4. The plan of operation shall, in addition to requirements enumerated in sections 376.715 to 376.758:

(1) Establish procedures for handling the assets of the association;

(2) Establish the amount and method of reimbursing members of the board of directors;

(3) Establish regular places and times for meetings including telephone conference calls of the board of directors;

(4) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;

(5) Establish the procedures whereby selections for the board of directors will be made and submitted to the director;

(6) Establish any additional procedures for assessments which may be necessary;

(7) Contain additional provisions necessary or proper for the execution of the powers and duties of the association**;**

(8) Establish procedures whereby a director may be removed for cause, including in the case where a member insurer director becomes an impaired or insolvent insurer;

(9) Establish procedures for the initial handling of any appeals against the actions of the board, subject to the rights of appeal in subsection 3 of section 376.742.

5. The plan of operation may provide that any or all powers and duties of the association except those pursuant to provisions of **[**subsection 3 of section 376.733 and subsections 1 and 2 of**]** **subdivision (3) of subsection 1 of section 376.734 and** section 376.735 are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two or more states. Such a corporation, association, or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the director, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by sections 376.715 to 376.758.

376.743. 1. The board of directors may, upon majority vote, make reports and recommendations to the director upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer or germane to the solvency of any company seeking to do an insurance business in this state. Such reports and recommendations shall not be considered public documents.

2. The board of directors shall, upon majority vote, notify the director of any information indicating any member insurer may be an impaired or insolvent insurer.

[3. The board of directors may, upon majority vote, request that the director order an examination of any member insurer which the board in good faith believes may be an impaired or insolvent insurer. Within thirty days of the

receipt of such request, he shall begin such examination. The examination may be conducted as a National Association of Insurance Commissioners examination or may be conducted by such persons as the director designates. The cost of such examination shall be paid by the association and the examination report shall be treated as are other examination reports. In no event shall such examination report be released to the board of directors prior to its release to the public, but this shall not preclude the director from complying with subsections 1 to 4 of section 376.742. The director shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the director but it shall not be open to public inspection prior to the release of the examination report to the public.

4.**]** The board of directors may, upon majority vote, make recommendations to the director for the detection and prevention of insurer insolvencies.

[5. The board of directors shall, at the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, prepare a report to the director containing such information as it may have in its possession bearing on the history and causes of such insolvency. The board shall cooperate with the boards of directors of guaranty associations in other states in preparing a report on the history and causes of insolvency of a particular insurer, and may adopt by reference any report prepared by such other associations.**]**

376.758. 1. Sections 376.715 to 376.758 shall not apply to any insurer which is insolvent or unable to fulfill its contractual obligations on August 13, 1988.

2. Sections 376.715 to 376.758 shall be liberally construed to effect the purpose under subsection 2 of section 376.715 which shall constitute an aid and guide to interpretation.

3. The amendments to sections 376.715 to 376.758 which become effective on August 28, 2010, shall not apply to any member insurer that is an impaired or insolvent insurer prior to August 28, 2010.

376.816. 1. No **[**individual or group insurance policy providing coverage on an expense-incurred basis, no individual or group service or indemnity contract issued by a not-for-profit health services corporation, no health maintenance organization nor any self-insured group health benefit plan of any type or description shall be offered, issued or renewed in this state on or after July 10, 1991, unless the policy, plan or contract**] health carrier or health benefit plan that offers or issues health benefit plans, other than**

Medicaid health benefit plans, shall deliver, issue for delivery, continue, or renew a health benefit plan to a Missouri resident on or after January 1, 2011, unless the health benefit plan covers adopted children of the insured, subscriber or enrollee on the same basis as other dependents.

2. The coverage required by subsection 1 of this section is effective:

(1) From the date of birth if a petition for adoption is filed within thirty days of the birth of such child; or

(2) From the date of placement for the purpose of adoption if a petition for adoption is filed within thirty days of placement of such child.

Such coverage shall continue unless the placement is disrupted prior to legal adoption and the child is removed from placement. Coverage shall include the necessary care and treatment of medical conditions existing prior to the date of placement.

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

(1) "Health benefit plan", the same meaning as such term is defined in section 376.1350;

(2) "Health carrier", the same meaning as such term is defined in section 376.1350;

(3) "Placement" **[**means**],** in the physical custody of the adoptive parent.

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 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 written, or electronic notification.

376.1450. An enrollee, as defined in section 376.1350, may **[**waive his or her right to**]** receive documents and materials from a managed care entity in printed **or electronic** form so long as such documents and materials are readily accessible **[**electronically through the entity's Internet site. An enrollee may revoke such waiver at any time by notifying the managed care entity by phone or in writing or annually. Any enrollee who does not execute such a waiver and prospective enrollees shall have documents and materials from the managed care entity provided**]** in printed form **upon request. A request by the enrollee may include written, oral, or electronic means. Such requested printed form shall be provided to the enrollee within fifteen business days**. For purposes of this section, "managed care entity" includes, but is not limited to, a health maintenance organization, preferred provider organization, point of service organization and any other managed health care delivery entity of any type or description.

Section 1. 1. For each school year beginning July 1, 2010, the department of social services shall provide all state licensed child-care providers who receive state or federal funds under section 210.027 and all public school districts in this state with written information regarding eligibility criteria and application procedures for the state children's health insurance program (SCHIP) authorized in sections 208.631 to 208.657, to be distributed by the child-care providers or school districts to parents and guardians at the time of enrollment of their children in child-care or school, as applicable.

2. The department of elementary and secondary education shall add an attachment to the application for the free and reduced lunch program for a parent or guardian to check a box indicating yes or no whether each child in the family has health care insurance. If any such child does not have health care insurance, and the parent or guardian's household income does not exceed the highest income level under 42 U.S.C. Section 1397CC, as amended, the school district shall provide a notice to such parent or guardian that the uninsured child may qualify for health insurance under SCHIP.

3. The notice described in subsection 2 shall be developed by the department of social services and shall include information on enrolling the child in the program. No notices relating to the state children's health insurance program shall be provided to a parent or guardian under this section other than the notices developed by the department of social services under this section.

4. Notwithstanding any other provision of law to the contrary, no penalty shall be assessed upon any parent or guardian who fails to provide or provides any inaccurate information required under this section.

5. The department of elementary and secondary education and the department of social services may adopt rules to implement the provisions of this section. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2010, shall be invalid and void.

6. The department of elementary and secondary education, in collaboration with the department of social services, shall report annually to the governor and the house budget committee chair and the senate appropriations committee chair on the following:

(1) The number of families in each district receiving free lunch

and reduced lunches;

(2) The number of families who indicate the absence of health care insurance on the application for free and reduced lunches;

(3) The number of families who received information on the state children's health insurance program under this section; and

(4) The number of families who received the information in subdivision (3) of this subsection and applied to the state children's health insurance program.

Section B. Because immediate action is necessary to protect the citizens of this state, the repeal and reenactment of section 452.430 and the enactment of section 1 of section A of this act is deemed necessary for the immediate preservation of the public health, welfare, peace, and safety, and is hereby declared to be an emergency act within the meaning of the constitution, and the repeal and reenactment of section 452.430 and the enactment of section 1 of section A of this act shall be in full force and effect upon its passage and approval.

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