SECOND REGULAR SESSION

[CORRECTED]

HOUSE COMMITTEE SUBSTITUTE FOR

SENATE COMMITTEE SUBSTITUTE FOR

SENATE BILL NO. 583

95TH GENERAL ASSEMBLY

3574L.07C D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 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, 376.1450, 452.430, 454.515, and 525.233, RSMo, and to enact in lieu thereof forty-two 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 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376.737, 376.738, 376.740, 376.743, 376.758, 376.816, 376.1109, 376.1450, 452.430, 454.515, and 525.233, RSMo, are repealed and forty-two new sections enacted in lieu thereof, to be known as sections 301.560, 303.025, 303.040, 337.300, 337.305, 337.310, 337.315, 337.320, 337.325, 337.330, 337.335, 337.340, 337.345, 354.442, 375.024, 375.539, 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, 376.882, 376.1109, 376.1224, 376.1450, 452.430, 454.515, 525.233, and 1, to read as follows:

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.

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

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.

337.300. As used in sections 337.300 to 337.340, the following terms shall mean:

(1) "Applied behavior analysis", the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior;

(2) "Board", the behavior analyst advisory board within the state committee of psychologists;

(3) "Certifying entity", the nationally accredited Behavior Analyst Certification Board, or other equivalent nationally accredited nongovernmental agency approved by the committee which certifies individuals who have completed academic, examination, training, and supervision requirements in applied behavior analysis;

(4) "Committee", the state committee of psychologists;

(5) "Division", the division of professional registration within the department of insurance, financial institutions and professional registration;

(6) "Licensed assistant behavior analyst" or "LaBA", an individual who is certified by the certifying entity as a certified assistant behavior analyst and meets the criteria in section 337.315 and as established by committee rule;

(7) "Licensed behavior analyst" or "LBA", an individual who is certified by the certifying entity as a certified behavior analyst and meets the criteria in section 337.315 and as established by committee rule;

(8) "Line therapist", an individual who provides supervision of an individual diagnosed with an autism diagnosis and other neurodevelopmental disorders pursuant to the prescribed treatment plan, and implements specific behavioral interventions as outlined in the behavior plan under the direct supervision of a licensed behavior analyst and meets the criteria in section 337.315 and as established by committee rule;

(9) "Practice of applied behavior analysis", the application of the principles, methods, and procedures of the experimental analysis of behavior and applied behavior analysis (including principles of operant and respondent learning) to assess and improve socially important human behaviors. It includes, but is not limited to, applications of those principles, methods, and procedures to:

(a) The design, implementation, evaluation, and modification of treatment programs to change behavior of individuals;

(b) The design, implementation, evaluation, and modification of treatment programs to change behavior of groups; and

(c) Consultation to individuals and organizations.

Applied behavior analysis does not include cognitive therapies or psychological testing, personality assessment, intellectual assessment, neuropsychological assessment, psychotherapy, cognitive therapy, sex therapy, psychoanalysis, hypnotherapy, family therapy, and long-term counseling as treatment modalities.

337.305. 1. There is hereby created under the state committee of psychologists within the division of professional registration the "Behavior Analyst Advisory Board". The behavior analyst advisory board shall consist of the following seven members: three licensed behavior analysts, one licensed behavior analyst holding a doctoral degree, one licensed assistant behavior analyst, one professional member of the committee, and one public member.

2. Appointments to the board shall be made by the governor upon the recommendations of the director of the division, upon the advice and consent of the senate. The division, prior to submitting nominations, shall solicit nominees from professional associations and licensed behavior analysts or licensed assistant behavior analysts in the state.

3. The term of office for board members shall be five years. In making initial appointments to the board, the governor shall stagger the terms of the appointees so that one member serves an initial term of two years, three members shall serve an initial term of three years, and three members serve initial terms of four years. Each member of the board shall hold office until his or her successor has been qualified. A vacancy in the membership of the board shall be filled for the unexpired term in the manner provided for the original appointment. A member appointed for less than a full term may serve two full terms in addition to such part of a full term.

4. Each board member shall be a resident of this state for a period of one year and a registered voter, shall be a United States citizen, and shall, other than the public member, have been a licensed behavior analyst or licensed assistant behavior analyst in this state for at least three years prior to appointment except for the original members of the board who shall have experience in the practice of applied behavior analysis.

5. The public member shall be a person who is not and never was a member of any profession licensed or regulated under sections 337.300 to 337.340 or the spouse of such person; and a person who does not have and never has had a material financial interest in either the providing of the professional services regulated by sections 337.300 to 337.340, or an activity or organization directly related to any profession licensed or regulated under sections 337.300 to 337.340.

6. The board shall meet at least quarterly. At one of its regular meetings, the board shall select from among its members a chairperson and a vice chairperson. A quorum of the committee shall consist of a majority of its members. In the absence of the chairperson, the vice chairperson shall conduct the office of the chairperson.

7. Each member of the board shall receive as compensation an amount set by the division not to exceed fifty dollars for each day devoted to the affairs of the board and shall be entitled to reimbursement for necessary and actual expenses incurred in the performance of the member's official duties.

8. Staff for the board shall be provided by the director of the division of professional registration.

9. The governor may remove any member of the board for misconduct, inefficiency, incompetency, or neglect of office. All vacancies shall be filled by appointment of the governor with the advice and consent of the senate, and the member so appointed shall serve for the unexpired term.

337.310. 1. The behavior analyst advisory board is authorized to:

(1) Review all applications for licensure and temporary licensure for behavior analysts and assistant behavior analysts and any supporting documentation submitted with the application to the committee and make recommendations to the committee regarding the resolution of the application;

(2) Review all applications for registration and temporary permits for line therapists and any supporting documentation submitted with the application to the committee and make recommendations to the committee regarding the resolution of the application;

(3) Review all complaints made relating to the practice of behavior analysis and make recommendations to the committee regarding investigation of the complaint, referral for discipline or other resolution of the complaint; and

(4) Review any entities responsible for certifying behavior analysts and make recommendations to the committee as to approval or disapproval of the certifying entity based on qualifications established by the committee.

2. The board may recommend to the committee rules to be promulgated pertaining to:

(1) The form and content of license and registration applications required and the procedures for filing an application for an initial, temporary or renewal license, temporary permit, and registration in this state;

(2) The establishment of fees;

(3) The educational and training requirements for licensed behavior analysts, licensed assistant behavior analysts, and line therapists;

(4) The roles, responsibilities and duties of licensed behavior analysts, licensed assistant behavior analysts, and line therapists;

(5) The characteristics of supervision and supervised clinical practicum experience for the licensed behavior analyst and the licensed assistant behavior analyst;

(6) The supervision of licensed assistant behavior analysts and line therapists;

(7) The requirements for continuing education for licensed behavior analysts and licensed assistant behavior analysts;

(8) Establishment and promulgation of procedures for investigating, hearing and determining grievances and violations occurring under sections 337.300 to 337.340;

(9) Development of an appeal procedure for the review of decisions and rules of administrative agencies existing pursuant to the constitution or laws of this state;

(10) A code of conduct; and

(11) Any other policies or procedures necessary to the fulfillment of the requirements of sections 337.300 to 337.340.

3. The committee shall make all final decisions, and only upon the board's recommendation related to licensing, registration, complaint resolution, approval of certifying entities, and rules unless otherwise authorized by sections 337.300 to 337.340.

4. Notwithstanding the provisions of subsection 3 of this section, until such time as the governor appoints the board and the board has a quorum, the committee shall review and resolve all applications for licensure as a licensed behavior analyst or licensed assistant behavior analyst and line therapists.

5. 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.

337.315. 1. An applied behavior analysis intervention shall produce socially significant improvements in human behavior through skill acquisition, increase or decrease in behaviors under specific environmental conditions and the reduction of problematic behavior. An applied behavior analysis intervention shall:

(1) Be based on empirical research and the identification of functional relations between behavior and environment, contextual factors, antecedent stimuli and reinforcement operations through the direct observation and measurement of behavior, arrangement of events and observation of effects on behavior, as well as other information gathering methods such as record review and interviews; and

(2) Utilize changes and arrangements of contextual factors, antecedent stimuli, positive reinforcement, and other consequences to produce behavior change.

2. Each person wishing to practice as a licensed behavior analyst shall:

(1) Submit a complete application on a form approved by the committee;

(2) Pay all necessary fees as set by the committee;

(3) Submit a two-inch or three-inch photograph or passport photograph taken no more than six months prior to the application date;

(4) Provide two classified sets of fingerprints for processing by the Missouri state highway patrol under section 43.543. One set of fingerprints shall be used by the highway patrol to search the criminal history repository and the second set shall be forwarded to the Federal Bureau of Investigation for searching the federal criminal history files;

(5) Have passed an examination and been certified as a board certified behavior analyst by a certifying entity, as defined in section 337.300;

(6) Provide evidence of active status as a board certified behavior analyst; and

(7) If the applicant holds a license as a behavior analyst in another state, a statement from all issuing states verifying licensure and identifying any disciplinary action taken against the license holder by that state.

3. Each person wishing to practice as a licensed assistant behavior analyst shall:

(1) Submit a complete application on a form approved by the committee;

(2) Pay all necessary fees as set by the committee;

(3) Submit a two-inch or three-inch photograph or passport photograph taken no more than six months prior to the application date;

(4) Submit to a background check and/or provide fingerprints;

(5) Have passed an examination and been certified as a board certified assistant behavior analyst by a certifying entity, as defined in section 337.300;

(6) Provide evidence of active status as a board certified assistant behavior analyst;

(7) If the applicant holds a license as an assistant behavior analyst in another state, a statement from all issuing states verifying licensure and identifying any disciplinary action taken against the license holder by that state; and

(8) Submit documentation satisfactory to the committee that the applicant will be directly supervised by a licensed behavior analyst in a manner consistent with the certifying entity.

4. Each person wishing to practice as a line therapist shall:

(1) Submit a complete application on a form approved by the committee;

(2) Pay all necessary fees as set by the committee;

(3) Submit a two-inch or three-inch photograph or passport photograph taken no more than six months prior to the application date;

(4) Submit evidence satisfactory to the committee that the applicant is eighteen years of age or older;

(5) Submit a copy of a high school diploma, or its equivalent;

(6) Submit documentation of successful passage of a background check through the Missouri family care safety registry; and

(7) Submit documentation satisfactory to the committee that the applicant will be directly supervised by a licensed behavior analyst.

5. The committee shall be authorized to issue a temporary license to an applicant for a behavior analyst license or assistant behavior analyst license upon receipt of a complete application for behavior analyst or assistant behavior analyst or a showing of valid licensure as a behavior analyst in another state, only if the applicant has submitted fingerprints and no disqualifying criminal history appears on the family care safety registry.

6. The committee is authorized to issue a temporary permit to an applicant as a line therapist upon receipt of a complete application for a line therapist only if the applicant is awaiting documentation of successful passage of a background check through the Missouri family care safety registry. The temporary license and temporary permit shall expire upon issuance of a license or denial of the application but no later than ninety days from issuance of the temporary license or temporary permit. Upon written request to the committee, the holder of a temporary license or temporary permit shall be entitled to one extension of ninety days of the temporary license or temporary permit.

7. No person shall hold himself or herself out to be licensed behavior analysts or LBA, licensed assistant behavior analysts or LaBA, or registered line therapist in the state of Missouri unless they meet the applicable requirements.

8. No persons shall engage in the practice of applied behavior analysis when provided under section 376.1224 unless they are:

(1) Licensed behavior analysts;

(2) Licensed assistant behavior analysts working under the supervision of a licensed behavior analyst;

(3) An individual who has a bachelor's or graduate degree and completed course work for licensure as a behavior analyst and is obtaining supervised field experience under a licensed behavior analyst pursuant to required supervised work experience for licensure at the behavior analyst or assistant behavior analyst level; or

(4) Licensed psychologists practicing within the rules and standards of practice for psychologists in the state of Missouri and whose practice is commensurate with their level of training and experience.

9. Notwithstanding the provisions in subsection 7 of this section:

(1) A registered line therapist, under the direct supervision of a licensed behavior analyst, may:

(a) Provide general supervision of an individual diagnosed with a autism spectrum disorder diagnosis and other neurodevelopmental disorders, or serve as a line therapist under the supervision of a licensed behavior analyst;

(b) Provide protective oversight of the individual; and

(c) Implement specific behavioral interventions, including applied behavior analysis, as outlined in the behavior plan;

(2) Any licensed or certified professional may practice components of applied behavior analysis, if he or she is acting within his or her applicable scope of practice and ethical guidelines.

10. All licensed behavior analysts and licensed assistant behavior analysts and line therapists shall be bound by the code of conduct adopted by the committee by rule.

11. Licensed assistant behavior analysts and line therapists shall work under the direct supervision of a licensed behavior analyst as established by committee rule.

12. No line therapist may conduct behavior evaluations or establish or alter the behavior plan or the intervention.

13. Persons who provide services under the Individuals with Disabilities Education Act (IDEA), 20 U.S.C. Section 1400 et seq. or Section 504 of the federal Rehabilitation Act of 1973, 20 U.S.C. Section 794, or are enrolled in a course of study at a recognized educational institution through which the person provides applied behavior analysis as part of supervised clinical experience shall be exempt from the requirements of this section.

14. The individual's immediate family, including natural, half, or step relationships with parent, child, sibling, or spouse or as otherwise defined by rule, providing services defined in section 337.300 shall not be considered as a line therapist and exempt from registration as a line therapist.

15. A violation of this section shall be punishable by probation, suspension, or loss of any license or registration held by the violator.

337.320. 1. The division shall mail a renewal notice to the last known address of each licensee or registrant prior to the renewal date.

2. Each person wishing to renew the behavior analyst license or the assistant behavior analyst license shall:

(1) Submit a complete application on a form approved by the committee;

(2) Pay all necessary fees as set by the committee; and

(3) Submit proof of active certification and fulfillment of all requirements for renewal and recertification with the certifying entity.

3. Each person wishing to renew the line therapist registration shall:

(1) Submit a complete application on a form approved by the committee;

(2) Pay all necessary fees as set by the committee; and

(3) Submit documentation satisfactory to the committee that the applicant is not on the Missouri family care safety registry.

4. Failure to provide the division with documentation required by subsection 2 or 3 of this section or other information required for renewal shall effect a revocation of the license or registration after a period of sixty days from the renewal date.

5. Each person wishing to restore the license, within two years of the renewal date, shall:

(1) Submit a complete application on a form approved by the committee;

(2) Pay the renewal fee and a delinquency fee as set by the committee; and

(3) Submit proof of current certification from a certifying body approved by the committee.

6. Each person wishing to restore the registration, within two years of the renewal date, shall:

(1) Submit a complete application on a form approved by the committee;

(2) Pay the renewal fee and a delinquency fee as set by the committee; and

(3) Submit documentation satisfactory to the committee that the applicant has no disqualifying information on the Missouri family care safety registry.

7. A new license or registration to replace any certificate lost, destroyed, or mutilated may be issued subject to the rules of the committee, upon payment of a fee established by the committee.

8. The committee shall set the amount of the fees authorized by sections 337.300 to 337.340 and required by rules promulgated under section 536.021. The fees shall be set at

a level to produce revenue which shall not substantially exceed the cost and expense of administering sections 337.300 to 337.340.

9. The committee is authorized to issue an inactive license or registration to any licensee or registrant who makes written application for such license or registration on a form provided by the committee and remits the fee for an inactive license or registration established by the committee. An inactive license or registration may be issued only to a person who has previously been issued a license to practice as a licensed behavior analyst, licensed assistant behavior analyst, or registration to practice as a line therapist, who is no longer regularly engaged in such practice and who does not hold himself or herself out to the public as being professionally engaged in such practice in this state. Each inactive license or registration shall be subject to all provisions of this chapter, except as otherwise specifically provided. Each inactive license or registration may be renewed by the committee subject to all provisions of this section and all other provisions of this chapter. The inactive licensee or registrant shall not be required to submit evidence of completion of continuing education as required by this chapter.

10. An inactive licensee or registrant may apply for a license or registration to regularly engage in the practice of behavioral analysis by:

(1) Submitting a complete application on a form approved by the committee;

(2) Paying the reactivation fee as set by the committee; and

(3) Submitting proof of current certification from a certifying body approved by the committee.

11. An inactive registrant may apply for a line therapist registration by:

(1) Submitting a complete application on a form approved by the committee;

(2) Paying the reactivation fee as set by the committee; and

(3) Submitting documentation satisfactory to the committee that the applicant is not on the Missouri family care safety registry.

337.325. 1. A licensed behavior analyst and licensed assistant behavior analyst shall limit his or her practice to demonstrated areas of competence as documented by relevant professional education, training, and experience. A licensed behavior analyst, licensed assistant behavior analyst and line therapist trained in one area shall not practice in another area without obtaining additional relevant professional education, training, and experience.

2. A line therapist shall limit his or her practice as defined in section 337.300 and as established by the committee by rule. A line therapist trained in one area shall not practice in another area without obtaining professional education or additional relevant training as established in section 337.315 and by the committee by rule.

337.330. 1. The committee may refuse to issue any license or registration required under this chapter for one or any combination of causes stated in subsection 2 of this section. The committee shall notify the applicant in writing of the reasons for the refusal and shall advise the applicant of the applicant's right to file a complaint with the administrative hearing commission as provided by chapter 621.

2. The committee may cause a complaint to be filed with the administrative hearing commission, as provided by chapter 621, against any holder of any license or registration required by this chapter or any person who has failed to renew or has surrendered the person's license or registration for any one or any combination of the following causes:

(1) Use of any controlled substance, as defined in chapter 195, or alcoholic beverage to an extent that such use impairs a person's ability to perform the work of any profession licensed or regulated by this chapter;

(2) The person has been finally adjudicated and found guilty, or entered a plea of guilty or nolo contendere, in a criminal prosecution under the laws of any state or of the United States, for any offense reasonably related to the qualifications, functions, or duties of any profession licensed or regulated under this chapter, for any offense an essential element of which is fraud, dishonesty or an act of violence, or for any offense involving moral turpitude, whether or not sentence is imposed;

(3) Use of fraud, deception, misrepresentation or bribery in securing any certificate of registration or authority, permit or license issued under this chapter or in obtaining permission to take any examination given or required under sections 337.300 to 337.340;

(4) Obtaining or attempting to obtain any fee, charge, tuition, or other compensation by fraud, deception or misrepresentation;

(5) Incompetency, misconduct, gross negligence, fraud, misrepresentation, or dishonesty in the performance of the functions or duties of any profession licensed or regulated by sections 337.300 to 337.340;

(6) Violation of, or assisting or enabling any person to violate, any provision of sections 337.300 to 337.340, or of any lawful rule adopted thereunder;

(7) Impersonation of any person holding a certificate of registration or authority, permit or license or allowing any person to use his or her certificate of registration or authority, permit, license, or diploma from any school;

(8) Disciplinary action against the holder of a license or other right to practice any profession regulated by sections 337.300 to 337.340 granted by another state, territory, federal agency, or country upon grounds for which revocation or suspension is authorized in this state;

(9) A person is finally adjudged insane or incapacitated by a court of competent jurisdiction;

(10) Assisting or enabling any person to practice or offer to practice any profession licensed or regulated by sections 337.300 to 337.340 who is not registered and currently eligible to practice as provided in sections 337.300 to 337.340;

(11) Issuance of a certificate of registration or authority, permit, or license based upon a material mistake of fact;

(12) Failure to display a valid certificate or license if so required by sections 337.300 to 337.340 or any rule promulgated thereunder;

(13) Violation of any professional trust or confidence;

(14) Use of any advertisement or solicitation which is false, misleading, or deceptive to the general public or persons to whom the advertisement or solicitation is primarily directed;

(15) Being guilty of unethical conduct as defined in "Ethical Rules of Conduct" as adopted by the committee and filed with the secretary of state.

3. After the filing of such complaint, the proceedings shall be conducted in accordance with the provisions of chapter 621. Upon a finding by the administrative hearing commission that the grounds, provided in subsection 2 of this section, for disciplinary action are met, the committee may, singly or in combination, censure or place the person named in the complaint on probation on such terms and conditions as the department deems appropriate for a period not to exceed five years, or may suspend, for a period not to exceed three years, or revoke the license, certificate, or permit.

337.335. 1. Any person found guilty of violating any provision of sections 337.300 to 337.340 is guilty of a class A misdemeanor and upon conviction thereof shall be punished as provided by law.

2. All fees or other compensation received for services rendered in violation of sections 337.300 to 337.340 shall be refunded.

3. The committee shall inquire as to any violation of any provision of sections 337.300 to 337.340 and may institute actions for penalties herein prescribed, and shall enforce generally the provisions of sections 337.300 to 337.340.

4. Any person, organization, association or corporation who reports or provides information to the committee or the division under sections 337.300 to 337.380 and who does so in good faith shall not be subject to an action for civil damages as a result thereof.

5. Upon application by the committee the attorney general may on behalf of the committee request that a court of competent jurisdiction grant an injunction, restraining order, or other order as may be appropriate to enjoin a person from:

(1) Offering to engage or engaging in the performance of any acts or practices for which a certificate of registration or authority, permit, or license is required upon a showing that such acts or practices were performed or offered to be performed without a certificate of registration or authority, permit or license; or

(2) Engaging in any practice or business authorized by a certificate of registration or authority, permit, or license issued under sections 337.300 to 337.340 upon a showing that the holder presents a substantial probability of serious harm to the health, safety, or welfare of any resident of this state or client or patient of the licensee.

6. Any action brought under the provisions of this section shall be commenced either in the county in which such conduct occurred or in the county in which the defendant resides.

7. Any action brought under this section may be in addition to or in lieu of any penalty provided by sections 337.300 to 337.380 and may be brought concurrently with other actions to enforce sections 337.300 to 337.340.

337.340. All fees authorized under sections 337.300 to 337.340 shall be collected by the director of the division of professional registration and shall be transmitted to the department of revenue for deposit in the state treasury to the credit of the state committee of psychologists fund.

337.345. 1. Prior to August 28, 2012, each person desiring to obtain a provisional license shall make application to the committee upon such forms and in such manner as may be prescribed by the committee and shall pay the required application fee. The application fee shall not be refundable. Each application shall contain a statement that it is made under oath or affirmation and that its representations are true and correct to the best knowledge and belief of the person signing the application, subject to the penalties of making a false affidavit or declaration.

2. For a provisional behavioral analyst license, the applicant shall:

(1) Submit a two-inch or three-inch photograph or passport photograph taken no more than six months prior to the application date, and only if the applicant has submitted fingerprints and no disqualifying criminal history appears on the family care safety registry;

(2) Have passed an examination and been certified as a board certified behavior analyst by the Behavior Analyst Certification Board or a certifying entity listed in subdivision (3) of section 337.300; and

(3) Provide evidence of active status as a board certified behavior analyst.

3. For a provisional assistant behavioral analyst license, the applicant shall:

(1) Submit a two-inch or three-inch photograph or passport photograph taken no more than six months prior to the application date, and only if the applicant has submitted fingerprints and no disqualifying criminal history appears on the family care safety registry;

(2) Have passed an examination and been certified as a board certified assistant behavior analyst by a certifying entity listed in subdivision (3) of section 337.300;

(3) Provide evidence of active status as a board certified assistant behavior analyst; and

(4) Submit documentation satisfactory to the board that the applicant will be directly supervised by a licensed behavior analyst in a manner consistent with the certifying entity.

4. Each applicant for provisional licensure or registration shall meet the applicable requirements of section 337.315 within three months of the date of issuance of the provisional license or registration.

5. The provisional license or registration shall be effective only until the board shall have had the opportunity to investigate the qualifications for licensure or registration under subsection 5 of this section and to notify the applicant that his or her application for a license or registration has been either granted or rejected. In no event shall such provisional license or registration be in effect for more than three months after the date of its issuance nor shall a provisional license or registration be reissued to the same applicant. The holder of a provisional license or registration which has not expired, been suspended, or revoked, shall be deemed to be the holder of a license or registration issued under section 337.315 until such provisional license or registration expires, is suspended, or revoked.

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.

375.1255. 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 verbal, written, or electronic notification.

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

2. No long-term care insurance policy may:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11. Long-term care insurance applicants shall have the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in paragraph (a) of subdivision (4) of subsection 2 of section 376.1100, the applicant is not satisfied for any reason. This subsection shall also apply to denials of applications and any refund must be made within thirty days of the return or denial.

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

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

376.1224. 1. For purposes of this section, the following terms shall mean:

(1) "Applied behavior analysis", the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior;

(2) "Autism service provider":

(a) Any person, entity or group that provides diagnostic or treatment services for autism spectrum disorders who is licensed or certified by the state of Missouri;

(b) Any person who is certified as a board certified behavior analyst by the behavior analyst certification board; or

(c) Any person, if not licensed or certified, who is supervised by a person who is certified as a board certified behavior analyst by the Behavior Analyst Certification Board, whether such board certified behavior analyst supervises as an individual or as an employee of or in association with an entity or group; provided however, the definition of autism service provider shall specifically exclude parents and siblings of autistic children to the extent such parents or siblings are providing diagnostic or treatment services to their child or sibling;

(3) "Autism spectrum disorder" or "ASD", a neurobiological disorder, an illness of the nervous system, which includes:

(a) "Autistic Disorder", which is:

a. Six or more items from items (i), (ii), and (iii), of this subparagraph with at least two items from item (i) of this subparagraph, and one item each from items (ii) and (iii) of this subparagraph:

(i) Qualitative impairment in social interaction, as manifested by at least two of the following:

i. Marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction;

ii. Failure to develop peer relationships appropriate to developmental level;

iii. A lack of spontaneous seeking to share enjoyment, interests, or achievements with other people;

iv. Lack of social or emotional reciprocity;

(ii) Qualitative impairments in communication as manifested by at least one of the following:

i. Delay in, or total lack of, the development of spoken language;

ii. In individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others;

iii. Stereotyped and repetitive use of language or idiosyncratic language;

iv. Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level;

(iii) Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

i. Encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus;

ii. Apparently inflexible adherence to specific, nonfunctional routines or rituals;

iii. Stereotyped and repetitive motor mannerisms;

iv. Persistent preoccupation with parts of objects;

b. Delays or abnormal functioning in at least one of the following areas, with onset prior to age three years including social interaction, language as used in social communication, or symbolic or imaginative play;

c. The disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder;

(b) "Asperger's Disorder":

a. Qualitative impairment in social interaction, as manifested by at least two of the following:

(i) Marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction;

(ii) Failure to develop peer relationships appropriate to developmental level;

(iii) A lack of spontaneous seeking to share enjoyment, interests, or achievements with other people; and

(iv) Lack of social or emotional reciprocity;

b. Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

(i) Encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus;

(ii) Apparently inflexible adherence to specific, nonfunctional routines or rituals;

(iii) Stereotyped and repetitive motor mannerisms; and

(iv) Persistent preoccupation with parts of objects;

c. The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning;

d. There is no clinically significant general delay in language;

e. There is no clinically significant delay in cognitive development or in the development of age-appropriate self-help skills, adaptive behavior (other than in social interaction), and curiosity about the environment in childhood;

f. Criteria are not met for another specific Pervasive Developmental Disorder or Schizophrenia;

(c) "Pervasive Developmental Disorder Not Otherwise Specified", a severe and pervasive impairment in the development of reciprocal social interaction associated with impairment in either verbal or nonverbal communication skills or with the presence of stereotyped behavior, interests, and activities, but the criteria are not met for a specific

Pervasive Developmental Disorder, Schizophrenia, Schizotypal Personality Disorder, or Avoidant Personality Disorder;

(d) "Rett's Disorder", includes:

a. All of the following:

(i) Apparently normal prenatal and perinatal development;

(ii) Apparently normal psychomotor development through the first five months after birth;

(iii) Normal head circumference at birth;

b. Onset of all of the following after the period of normal development:

(i) Deceleration of head growth between ages five and forty-eight months;

(ii) Loss of previously acquired purposeful hand skills between ages five and thirty months with the subsequent development of stereotyped hand movements;

(iii) Loss of social engagement early in the course;

(iv) Appearance of poorly coordinated gait or trunk movements;

(v) Severely impaired expressive and receptive language development with severe psychomotor retardation; or

(e) "Childhood Disintegrative Disorder", is:

a. Apparently normal development for at least the first two years after birth as manifested by the presence of age-appropriate verbal and nonverbal communication, social relationships, play, and adaptive behavior;

b. Clinically significant loss of previously acquired skills in at least two of the following areas: expressive or receptive language, social skills or adaptive behavior, bowel or bladder control, play, and motor skills;

c. Abnormalities of functioning in at least two of the following areas: qualitative impairment in social interaction, qualitative impairments in communication, restricted, repetitive, and stereotyped patterns of behavior, interests, and activities, including motor stereotypies and mannerisms; and

d. The disturbance is not better accounted for by another specific Pervasive Developmental Disorder or by Schizophrenia;

(4) "Diagnosis of autism spectrum disorders", medically necessary assessments, evaluations, or tests in order to diagnose whether an individual has an autism spectrum disorder;

(5) "Habilitative or rehabilitative care", professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are necessary to develop the functioning of an individual;

(6) "Health benefit plan", shall have the same meaning ascribed to it as in section 376.1350;

(7) "Health carrier", shall have the same meaning ascribed to it as in section 376.1350;

(8) "Pharmacy care", medications used to address symptoms of an autism spectrum disorder prescribed by a licensed physician, and any health-related services deemed medically necessary to determine the need or effectiveness of the medications only to the extent that such medications are included in the insured's health benefit plan;

(9) "Psychiatric care", direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices;

(10) "Psychological care", direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices;

(11) "Therapeutic care", services provided by licensed speech therapists, occupational therapists, or physical therapists;

(12) "Treatment for autism spectrum disorders", care prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist, provided by an autism service provider, and pursuant to the powers granted under such licensed physician's or licensed psychologist's license, including, but not limited to:

(a) Psychiatric care;

(b) Psychological care;

(c) Habilitative or rehabilitative care, including applied behavior analysis therapy;

(d) Therapeutic care; or

(e) Pharmacy care.

2. All group health benefit plans that are delivered, issued for delivery, continued, or renewed on or after January 1, 2011, if written inside the state of Missouri, or written outside the state of Missouri but insuring Missouri residents, shall provide coverage for the diagnosis and treatment of autism spectrum disorders to the extent that such diagnosis and treatment is not already covered by the health benefit plan.

3. The director of the department of insurance, financial institutions and professional registration shall grant a small employer with a group health plan, as that term is defined in section 379.930, a waiver from the provisions of this section if the small employer demonstrates to the director by actual experience over any consecutive twelve month period that compliance with this section has increased the cost of the health insurance plan by an amount that results in at least a two and one-half percent increase over the period of a calendar year in premium costs to the small employer.

4. With regards to a health benefit plan, a health carrier shall not deny or refuse to issue coverage on, refuse to contract with, or refuse to renew or refuse to reissue or otherwise terminate or restrict coverage on an individual or their dependent because the individual is diagnosed with autism spectrum disorder.

5. (1) Coverage provided under this section is limited to medically necessary treatment that is ordered by the insured's treating licensed physician or licensed psychologist, pursuant to the powers granted under such licensed physician's or licensed psychologist's license, in accordance with a treatment plan.

(2) The treatment plan upon request by the health benefit plan or health carrier shall include all elements necessary for the health benefit plan or health carrier to pay claims. Such elements include, but are not limited to, a diagnosis, proposed treatment by type, frequency and duration of treatment, and goals.

(3) Except for inpatient services, if an individual is receiving treatment for an autism spectrum disorder, a health carrier shall have the right to review the treatment plan not more than once every three months unless the health carrier and the individual's treating physician or psychologist agree that a more frequent review is necessary. The cost of obtaining any review shall be borne by the health benefit plan or health carrier, as applicable.

6. Coverage provided under this section for applied behavior analysis shall be subject to a maximum total benefit of thirty-six thousand dollars per year for individuals through eighteen years of age. No coverage for applied behavior analysis shall be required for individuals older than eighteen years of age. Payments made by a health carrier on behalf of a covered individual for any care, treatment, intervention, service or item, the provision of which was for the treatment of a health condition unrelated to the covered individual's autism spectrum disorder, shall not be applied toward any maximum benefit established under this subsection.

7. Subject to the provisions set forth in subdivision (3) of subsection 5 of this section, coverage provided under this section shall not be subject to any limits on the number of visits an individual may make to a ASD service provider; except that, the maximum benefit total benefit for applied behavior analysis set forth in subsection 6 of this section shall apply to this subsection.

8. This section shall not be construed as limiting benefits which are otherwise available to an individual under a health benefit plan. The health care services required by this section shall not be subject to any greater deductible, coinsurance or co-payment than other physical health care services provided by a health benefit plan. Coverage of services may be subject to other general exclusions and limitations of the contract or

benefit plan, such as coordination of benefits, services provided by family or household members, and utilization review of health care services, including review of medical necessity and care management; however, coverage for treatment under this section shall not be denied on the basis that it is educational or habilitative in nature.

9. To the extent any payments or reimbursements are being made for applied behavior analysis, such payments or reimbursements shall be made to the autism service providers except for line therapists as defined in section 337.300; the person who is supervising an autism service provider who is also certified as a board certified behavior analyst and licensed by the state of Missouri; or any entity or group for whom such supervising person, who is certified as a board certified behavior analyst by the Behavior Analyst Certification Board, works or is associated.

10. If a request for qualifications is made by a health carrier of a person who is not licensed as an autism service provider, such person shall provide documented evidence of education and professional training, if any, in applied behavior analysis.

11. The provisions of this section shall apply to any health care plans issued to employees and their dependents under the Missouri consolidated health care plan established under chapter 103, that are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2011. The terms "employees" and "health care plans" shall have the same meaning ascribed to them in section 103.003.

12. The provisions of this section shall also apply to the following types of plans that are established, extended, modified, or renewed on or after January 1, 2011:

(1) All self-insured governmental plans, as that term is defined in 29 U.S.C. Section 1002(32);

(2) All self-insured group arrangements, to the extent not preempted by federal law;

(3) All plans provided through a multiple employer welfare arrangement, or plans provided through another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, or any waiver or exception to that act provided under federal law or regulation; and

(4) All self-insured school district health plans.

13. The provisions of this section shall not apply:

(1) To the MO HealthNet program as described in chapter 208; or

(2) To a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policy of six months or less duration, or any other supplemental policy.

14. Any health carrier or other entity subject to the provisions of this section shall not be required to provide reimbursement for the services delivered by any school-based service.

15. The provisions of sections 376.1350 to 376.1399, 376.383, and 376.384 shall apply to this section.

16. The provisions of this section shall not automatically apply to an individually underwritten health benefit plan, but shall be offered as an option to any such plan.

17. (1) By February 1, 2012, and every February first thereafter, the department of insurance, financial institutions and professional registration shall submit a report to the general assembly regarding the implementation of the coverage required under this section. The report shall include, but shall not be limited to, the following:

(a) The total number of insureds diagnosed with autism spectrum disorder;

(b) The total cost of all claims paid out in the immediately preceding calendar year for PDD;

(c) The cost of such coverage per insured per month; and

(d) The average cost per insured for coverage of applied behavior analysis.

(2) All health carriers and health benefit plans subject to the provisions of this section shall provide the department with the data requested by the department for inclusion in the annual report.

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.

452.430. Any pleadings, other than the interlocutory or final judgment **or any modification thereof**, in a dissolution of marriage **[**or**] ,** legal separation**, or modification proceeding** filed prior to August 28, 2009, shall be subject to inspection only by the parties **[**or**] ,** an attorney of record **[**or upon order of the court for good cause shown, or by**] ,** the family support division within the department of social services when services are being provided under

section 454.400, **[**RSMo.**] a person or designee of a person licensed and acting under chapter 381 who shall keep any information obtained confidential except as necessary to the performance of functions required by chapter 381, or upon order of the court for good cause shown. Such persons may receive or make copies of documents without the clerk being required to redact the Social Security number, unless the court specifically orders the clerk to do otherwise.** The clerk shall redact the Social Security number from any **copy of a** judgment **[**or pleading**] or satisfaction of judgment** before releasing the **copy of the** interlocutory or final judgment **or satisfaction of judgment** to the public.

454.515. 1. A judgment or order for child support or maintenance payable in periodic installments shall not be a lien on the real estate of the person against whom the judgment or order is rendered until the person entitled to receive payments pursuant to the judgment or order, the division or IV-D agency files a lien and the lien is recorded in the office of the circuit clerk of any county in this state in which such real estate is situated in the manner provided for by the supreme court and chapter 511, RSMo. Thereafter, the judgment shall become a lien on all real property of the obligor in such county, owned by the obligor at the time, or which the obligor may acquire afterwards and before the lien expires.

2. Liens pursuant to this section shall commence on the day filed and shall continue for a period of three years. A judgment creditor, the division or IV-D agency may revive a lien by filing another lien on or before each three-year anniversary of the original judgment. At the time each lien is revived, all unpaid installments shall remain a lien for the subsequent three-year period.

3. The lien shall state the name, last known address of the obligor, the **last four digits of the** obligor's Social Security number, the obligor's date of birth, if known, and the amount of support or maintenance due and unpaid.

4. A copy of the lien shall be mailed by the person entitled to receive payments under the judgment or order, the division or IV-D agency to the last known address of the obligor.

5. The person entitled to receive payments pursuant to the judgment or order, the division or IV-D agency may execute a partial or total release of the liens created by this section, either generally or as to specific property.

525.233. The notice of garnishment and the writ of sequestration shall contain **only the last four digits of** the federal taxpayer identification number, when available, on the judgment debtor. When the **last four digits of the** federal taxpayer identification number is omitted from the notice of garnishment or the writ of sequestration the garnishee shall not be held liable for withholding from the incorrect debtor by the creditor garnishing the funds. The creditor shall not have any action against the garnishee, when the federal taxpayer identification number is

omitted from the notice of garnishment or the writ of sequestration or does not match the **last four digits of the** federal taxpayer identification, for failure to withhold from any person the amount stated in the notice of garnishment or the writ of sequestration, except to serve a notice of garnishment or writ of sequestration for the original amount to the garnishee with the correct **last four digits of the** federal taxpayer identification number.

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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