FIRST REGULAR SESSION

HOUSE COMMITTEE SUBSTITUTE FOR

SENATE COMMITTEE SUBSTITUTE FOR

SENATE BILL NO. 334

99TH GENERAL ASSEMBLY

1527H.03C D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 198.070, 208.690, 316.160, 376.426, 376.620, 379.160, and 379.321, RSMo, and to enact in lieu thereof eleven new sections relating to public health.

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

Section A. Sections 198.070, 208.690, 316.160, 376.426, 376.620, 379.160, and 379.321, RSMo, are repealed and eleven new sections enacted in lieu thereof, to be known as sections 198.053, 198.070, 208.690, 316.160, 374.191, 376.426, 376.620, 376.625, 376.1110, 379.160, and 379.321, to read as follows:

198.053. No later than October first of each year, in accordance with the latest recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, each assisted living facility, as such term is defined in section 198.006, shall notify residents and staff where in the facility that the latest edition of the Vaccine Informational Sheet published by the Centers for Disease Control has been posted. Nothing in this section shall be construed to require any assisted living facility to provide or pay for any vaccination against influenza, allow the department of health to promulgate any rules to implement this section, or cite any facility for acting in good faith to post the Vaccine Informational Sheet.

198.070. 1. When any adult day care worker; chiropractor; Christian Science practitioner; coroner; dentist; embalmer; employee of the departments of social services, mental health, or health and senior services; employee of a local area agency on aging or an organized area agency on aging program; funeral director; home health agency or home health agency employee; hospital and clinic personnel engaged in examination, care, or treatment of persons; in-home services owner, provider, operator, or employee; law enforcement officer; long-term

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.

care facility administrator or employee; medical examiner; medical resident or intern; mental health professional; minister; nurse; nurse practitioner; optometrist; other health practitioner; peace officer; pharmacist; physical therapist; physician; physician's assistant; podiatrist; probation or parole officer; psychologist; social worker; or other person with the care of a person sixty years of age or older or an eligible adult has reasonable cause to believe that a resident of a facility has been abused or neglected, he or she shall immediately report or cause a report to be made to the department.

2. **(1)** The report shall contain the name and address of the facility, the name of the resident, information regarding the nature of the abuse or neglect, the name of the complainant, and any other information which might be helpful in an investigation.

(2) In the event of reasonable cause to believe a suspected sexual assault of the resident has occurred, in addition to the report to be made to the department, a report shall be made to a local law enforcement entity in accordance with federal law under the provisions of 42 U.S.C. 1320b-25.

3. Any person required in subsection 1 of this section to report or cause a report to be made to the department who knowingly fails to make a report within a reasonable time after the act of abuse or neglect as required in this subsection is guilty of a class A misdemeanor.

4. In addition to the penalties imposed by this section, any administrator who knowingly conceals any act of abuse or neglect resulting in death or serious physical injury, as defined in section 556.061, is guilty of a class E felony.

5. In addition to those persons required to report pursuant to subsection 1 of this section, any other person having reasonable cause to believe that a resident has been abused or neglected may report such information to the department.

6. Upon receipt of a report, the department shall initiate an investigation within twenty-four hours and, as soon as possible during the course of the investigation, shall notify the resident's next of kin or responsible party of the report and the investigation and further notify them whether the report was substantiated or unsubstantiated unless such person is the alleged perpetrator of the abuse or neglect. As provided in section 192.2425, substantiated reports of elder abuse shall be promptly reported by the department to the appropriate law enforcement agency and prosecutor.

7. If the investigation indicates possible abuse or neglect of a resident, the investigator shall refer the complaint together with the investigator's report to the department director or the director's designee for appropriate action. If, during the investigation or at its completion, the department has reasonable cause to believe that immediate removal is necessary to protect the resident from abuse or neglect, the department or the local prosecuting attorney may, or the attorney general upon request of the department shall, file a petition for temporary care and

protection of the resident in a circuit court of competent jurisdiction. The circuit court in which the petition is filed shall have equitable jurisdiction to issue an ex parte order granting the department authority for the temporary care and protection of the resident, for a period not to exceed thirty days.

8. Reports shall be confidential, as provided pursuant to section 192.2500.

9. Anyone, except any person who has abused or neglected a resident in a facility, who makes a report pursuant to this section or who testifies in any administrative or judicial proceeding arising from the report shall be immune from any civil or criminal liability for making such a report or for testifying except for liability for perjury, unless such person acted negligently, recklessly, in bad faith or with malicious purpose. It is a crime under section 565.189 for any person to knowingly file a false report of elder abuse or neglect.

10. Within five working days after a report required to be made pursuant to this section is received, the person making the report shall be notified in writing of its receipt and of the initiation of the investigation.

11. No person who directs or exercises any authority in a facility shall evict, harass, dismiss or retaliate against a resident or employee because such resident or employee or any member of such resident's or employee's family has made a report of any violation or suspected violation of laws, ordinances or regulations applying to the facility which the resident, the resident's family or an employee has reasonable cause to believe has been committed or has occurred. Through the existing department information and referral telephone contact line, residents, their families and employees of a facility shall be able to obtain information about their rights, protections and options in cases of eviction, harassment, dismissal or retaliation due to a report being made pursuant to this section.

12. Any person who abuses or neglects a resident of a facility is subject to criminal prosecution under section 565.184.

13. The department shall maintain the employee disqualification list and place on the employee disqualification list the names of any persons who are or have been employed in any facility and who have been finally determined by the department pursuant to section 192.2490 to have knowingly or recklessly abused or neglected a resident. For purposes of this section only, "knowingly" and "recklessly" shall have the meanings that are ascribed to them in this section. A person acts "knowingly" with respect to the person's conduct when a reasonable person should be aware of the result caused by his or her conduct. A person acts "recklessly" when the person consciously disregards a substantial and unjustifiable risk that the person's conduct will result in serious physical injury and such disregard constitutes a gross deviation from the standard of care that a reasonable person would exercise in the situation.

14. The timely self-reporting of incidents to the central registry by a facility shall continue to be investigated in accordance with department policy, and shall not be counted or reported by the department as a hot-line call but rather a self-reported incident. If the self-reported incident results in a regulatory violation, such incident shall be reported as a substantiated report.

208.690. 1. Sections 208.690 to 208.698 shall be known and may be cited as the "Missouri Long-term Care Partnership Program Act".

2. As used in sections 208.690 to 208.698, the following terms shall mean:

(1) "Asset disregard", the disregard of any assets or resources in an amount equal to the insurance benefit payments that are used on behalf of the individual;

(2) "Missouri qualified long-term care partnership approved policy", a long-term care insurance policy certified by the director of the department of insurance, financial institutions and professional registration as meeting the requirements of:

(a) The National Association of Insurance Commissioners' Long-term Care Insurance Model Act and Regulation as specified in 42 U.S.C. 1917(b); and

(b) The provisions of Section 6021 of the Federal Deficit Reduction Act of 2005;

(3) "MO HealthNet", the medical assistance program established in this state under Title XIX of the federal Social Security Act;

(4) "State plan amendment", the state MO HealthNet plan amendment to the federal Department of Health and Human Services that, in determining eligibility for state MO HealthNet benefits, provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a qualified long-term care insurance partnership policy.

3. Any whole life insurance policy with long-term care riders shall qualify for the Missouri qualified long-term care partnership approval policy if such policy meets the qualifications set forth in paragraphs (a) and (b) of subdivision (2) of subsection 2 of this section.

316.160. Application for a license to operate, maintain or conduct a festival shall be made in writing to the county clerk at least sixty days prior to the time indicated for the commencement of the planned festival and shall be accompanied by a nonrefundable application fee established by the governing body of the county but not more than one hundred dollars. The application, at the discretion of the governing body of the county, shall contain the following information:

(1) The name, age, residence and mailing address of the person making the application. If the application is made by a partnership, the names and addresses of the partners must appear. Where the applicant is a corporation the application must be signed by the president, vice

president and secretary of the corporation and must contain their addresses, and a certified copy of the articles of incorporation shall be submitted with the application;

(2) Proof of financial worth of the individuals or corporation. The proof of indemnity against injury or loss to persons or property and said amount and form of the indemnity shall be prescribed by the governing body of the county**. However, members of the fair board of directors in any county of the third classification without a township form of government and with more than twenty-three thousand but fewer than twenty-six thousand inhabitants and with a city of the third classification with more than five thousand but fewer than six thousand inhabitants as the county seat, and any county of the third classification with a township form of government and with more than nine thousand but fewer than ten thousand inhabitants and with a special charter city with more than three thousand but fewer than four thousand inhabitants as the county seat shall not be required to have liability insurance**;

(3) A written statement of the kind, character, or type of festival which the applicant proposes to operate, maintain or conduct;

(4) The address or legal description of the place where the proposed festival is to be operated, maintained or conducted. Additionally, the applicant must submit proof of ownership of the place where the festival is to be operated, maintained or conducted, or a statement signed by the owner of the premises indicating his consent that the site be used for the proposed festival;

(5) The dates and hours during which the festival is to be operated, maintained or conducted;

(6) An estimate of the number of customers, spectators, participants and other persons expected to attend the festival for each day it is operated, maintained or conducted;

(7) The name and address of anyone contributing, investing or having a financial interest greater than five hundred dollars in producing the festival;

(8) A detailed written explanation of the applicant's plans to provide security and fire protection, water supply and facilities, food supply and facilities, sanitation facilities, medical facilities and services, vehicle parking space, vehicle access and onsite traffic control, and, if it is proposed or expected that spectators or participants will remain at night or overnight, the arrangements for illuminating the premises and for camping or similar facilities. The applicant's plans shall include what provisions shall be made for numbers of spectators in excess of the estimate, and what provisions shall be made for cleanup of the premises and removal of rubbish after the festival has concluded;

(9) A plot plan showing arrangement of the facilities including those for parking, egress and ingress.

374.191. 1. If an insurance company is required to pay interest on any claims, refunds, penalties, or payments under a market conduct examination, investigation, stipulation of settlement agreement, voluntary forfeiture agreement, or any other legal or remedial action ordered by the department under any law of this state, in which the interest rate is not provided for by law, such claims, refunds, penalties, or payments shall bear interest at the annual adjusted prime rate of interest as determined by section 32.065, but under no circumstance shall such interest rate exceed nine percent per annum.

2. The provisions of this section shall not apply to payments subject to the provisions of section 376.383 nor any other statute in which the interest rate is specified.

376.426. No policy of group health insurance shall be delivered in this state unless it contains in substance the following provisions, or provisions which in the opinion of the director of the department of insurance, financial institutions and professional registration are more favorable to the persons insured or at least as favorable to the persons insured and more favorable to the policyholder; except that: provisions in subdivisions (5), (7), (12), (15), and (16) of this section shall not apply to policies insuring debtors; standard provisions required for individual health insurance policies shall not apply to group health insurance policies; and if any provision of this section is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the director, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy:

(1) A provision that the policyholder is entitled to a grace period of thirty-one days for the payment of any premium due except the first, during which grace period the policy shall continue in force, unless the policyholder shall have given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such grace period;

(2) A provision that the validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue, and that no statement made by any person covered under the policy relating to insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime nor unless it is contained in a written instrument signed by the person making such statement; except that, no such provision shall preclude the assertion at any time of defenses based upon the person's ineligibility for coverage under the policy or upon other provisions in the policy;

(3) A provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or, in the event of the death or incapacity of the insured person, to the individual's beneficiary or personal representative;

(4) A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the individual's coverage;

(5) A provision specifying the additional exclusions or limitations, if any, applicable under the policy with respect to a disease or physical condition of a person, not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss, which existed prior to the effective date of the person's coverage under the policy. Any such exclusion or limitation may only apply to a disease or physical condition for which medical advice or treatment was received by the person during the twelve months prior to the effective date of the person's coverage. In no event shall such exclusion or limitation apply to loss incurred or disability commencing after the earlier of:

(a) The end of a continuous period of twelve months commencing on or after the effective date of the person's coverage during all of which the person has received no medical advice or treatment in connection with such disease or physical condition; or

(b) The end of the two-year period commencing on the effective date of the person's coverage;

(6) If the premiums or benefits vary by age, there shall be a provision specifying an equitable adjustment of premiums or of benefits, or both, to be made in the event the age of the covered person has been misstated, such provision to contain a clear statement of the method of adjustment to be used;

(7) A provision that the insurer shall issue to the policyholder, for delivery to each person insured, a certificate setting forth a statement as to the insurance protection to which that person is entitled, to whom the insurance benefits are payable, and a statement as to any family member's or dependent's coverage;

(8) A provision that written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible;

(9) A provision that the insurer shall furnish to the person making claim, or to the policyholder for delivery to such person, such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of fifteen days after the insurer receives notice of any claim under the policy, the person making such claim shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made;

(10) A provision that in the case of claim for loss of time for disability, written proof of such loss must be furnished to the insurer within ninety days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of such disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of claim for any other loss, written proof of such loss must be furnished to the insurer within ninety days after the date of such loss. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required;

(11) A provision that all benefits payable under the policy other than benefits for loss of time shall be payable not more than thirty days after receipt of proof and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time shall be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period shall be paid as soon as possible after receipt of such proof;

(12) A provision that benefits for accidental loss of life of a person insured shall be payable to the beneficiary designated by the person insured or, if the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms. In either case, payment of these benefits is subject to the provisions of the policy in the event no such designated or specified beneficiary is living at the death of the person insured. All other benefits of the policy shall be payable to the person insured. The policy may also provide that if any benefit is payable to the estate of a person, or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay such benefit, up to an amount not exceeding two thousand dollars, to any relative by blood or connection by marriage of such person who is deemed by the insurer to be equitably entitled thereto;

(13) A provision that the insurer shall have the right and opportunity, at the insurer's own expense, to examine the person of the individual for whom claim is made when and so often as it may reasonably require during the pendency of the claim under the policy and also the right

and opportunity, at the insurer's own expense, to make an autopsy in case of death where it is not prohibited by law;

(14) A provision that no action at law or in equity shall be brought to recover on the policy prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy and that no such action shall be brought at all unless brought within three years from the expiration of the time within which proof of loss is required by the policy;

(15) A provision specifying the conditions under which the policy may be terminated. Such provision shall state that except for nonpayment of the required premium or the failure to meet continued underwriting standards, the insurer may not terminate the policy prior to the first anniversary date of the effective date of the policy as specified therein, and a notice of any intention to terminate the policy by the insurer must be given to the policyholder at least thirty-one days prior to the effective date of the termination. Any termination by the insurer shall be without prejudice to any expenses originating prior to the effective date of termination. An expense will be considered incurred on the date the medical care or supply is received;

(16) A provision stating that if a policy provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in the policy, such policy, so long as it remains in force, shall be deemed to provide that attainment of such limiting age does not operate to terminate the hospital and medical coverage of such child while the child is and continues to be both incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the certificate holder for support and maintenance. Proof of such incapacity and dependency must be furnished to the insurer by the certificate holder at least thirty-one days after the child's attainment of the limiting age. The insurer may require at reasonable intervals during the two years following the child's attainment of the limiting age subsequent proof of the child's incapacity and dependency. After such two-year period, the insurer may require subsequent proof not more than once each year. This subdivision shall apply only to policies delivered or issued for delivery in this state on or after one hundred twenty days after September 28, 1985;

(17) A provision stating that if a policy provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in the policy, such policy, so long as it remains in force, until the dependent child attains the limiting age, shall remain in force at the option of the certificate holder. Eligibility for continued coverage shall be established where the dependent child is:

(a) Unmarried and no more than that twenty-five years of age; and

(b) A resident of this state; and

(c) Not provided coverage as a named subscriber, insured, enrollee, or covered person under any group or individual health benefit plan, or entitled to benefits under Title XVIII of the Social Security Act, P.L. 89-97, 42 U.S.C. Section 1395, et seq.;

(18) In the case of a policy insuring debtors, a provision that the insurer shall furnish to the policyholder for delivery to each debtor insured under the policy a certificate of insurance describing the coverage and specifying that the benefits payable shall first be applied to reduce or extinguish the indebtedness;

(19) Notwithstanding any other provision of law to the contrary, a health carrier, as defined in section 376.1350, may offer a health benefit plan that is a managed care plan that requires all health care services to be delivered by a participating provider in the health carrier's network, except for emergency services, as defined in section 376.1350, and the services described in subsection 4 of section 376.811. Such a provision shall be disclosed in clear, conspicuous, and understandable language in the enrollment application and in the policy form. Whenever a health carrier offers a health benefit plan pursuant to this subdivision to a group contract holder as an exclusive or full replacement health benefit plan the health carrier shall offer at least one additional health benefit plan option that includes an out-of-network benefit. The decision to accept or reject the offer of the option of a health benefit plan that includes an out-of-network benefit shall be made by the enrollee and not the group contract holder;

(20) A provision stating that a health benefit plan issued pursuant to subdivision (19) of this section shall have in place a procedure by which an enrollee may obtain a referral to a nonparticipating provider when the enrollee is diagnosed with a life-threatening condition or disabling degenerative disease.

~~[The provisions of subdivisions (19) and (20) of this section shall expire and be null and void at the end of the calendar year following the repeal of 42 U.S.C. Section 300gg by the United States Congress or at the end of the calendar year following a finding by a court of competent jurisdiction that such section is unconstitutional or otherwise infirm.]~~

376.620. 1. Any life insurance **policy, rider, endorsement, amendment,** or certificate issued or delivered in this state may exclude or restrict liability **under such policy, rider, endorsement, amendment, or certificate [**~~of~~**] for** death as the result of suicide in the event the insured, while sane or insane, dies as a result of suicide within one year from the date of the issue of **[**~~the~~**] such** policy**, rider, endorsement, amendment,** or certificate. **If an insured applies for additional death benefits or an increase in death benefits after initial coverage commences, the policy, rider, endorsement, amendment, or certificate may provide for an exclusion for suicide that occurs within one year after any addition or increase in death benefits only to**

the extent of the additional or increased death benefits. Any such exclusion or restriction shall be clearly stated in **[**~~the~~**] such** policy**, rider, endorsement, amendment,** or certificate.

2. Any life insurance policy**, rider, endorsement, amendment,** or certificate which contains any exclusion or restriction under subsection 1 of this section shall also provide that in the event the insured dies as a result of suicide within one year from the date of issue of **[**~~the~~**] such** policy**, rider, endorsement, amendment, or certificate** that the insurer shall promptly refund all premiums paid for **the excluded or restricted** coverage on such insured.

376.625. 1. The reinstatement of any policy of life insurance or annuity contract hereafter delivered or issued for delivery in this state may be contested on account of fraud or misrepresentation of facts material to the reinstatement only for the same period following reinstatement and with the same conditions and exceptions as the policy provides with respect to contestability after original issuance.

2. When any life insurance policy or annuity contract is reinstated, such reinstated policy or annuity contract may exclude or restrict liability to the same extent that such liability could have been or was excluded or restricted when the policy or annuity contract was originally issued, and such exclusion or restriction shall be effective from the date of reinstatement.

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

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

(1) Past and prospective loss experience;

(2) Past and prospective expenses;

(3) Adequate contingency reserves; and

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

3. If an insurance company implements a rate that the director has determined is unreasonable under subsections 1 and 2 of this section, the department shall make such determination public, in a form and manner determined by rule.

379.160. 1. Each fire insurance company doing business in the state of Missouri is hereby required to file the form of policy for use by it in the state of Missouri, covering the responsibilities of the companies as well as the duties of the assured, to be classed and known as the standard fire insurance policy. Said policy form may be approved by the director of the department of insurance, financial institutions and professional registration of the state, and no policy shall be issued in this state carrying risks by fire or lightning by any company which does not embrace the form filed and approved of, as herein provided. There may be printed upon such policy the words "Standard Fire Insurance Policy for Missouri" and there may be inserted before and after the word "Missouri" a designation of any state or states or territory in which such form is standard.

2. In order to encourage readability in insurance policy forms, the director may approve fire insurance policy forms other than the standard fire insurance policy which otherwise meet all requirements of law and are at least as favorable to the insured as the standard fire insurance policy. Any such fire insurance policy form approved by the director shall be deemed to be at least as favorable to the insured as the standard fire insurance policy, and such form is not governed by the terms of the standard fire insurance policy. This provision of this subsection shall apply to all fire insurance policy forms currently submitted for approval, approved in the future, or that have previously been approved by the director.

[~~2.~~**] 3.** All such policies shall have an address of the company in the United States fully printed thereon, to which, in case of loss, the assured may send notice of such loss, and to which notice shall be given within sixty days after the loss.

[~~3.~~**] 4.** The appearance of an adjuster of any company at the place of fire and loss in which said company is interested by reason of an insurance on such property, shall be considered evidence of notice and to be held as a waiver of the same on the part of the company; provided, that on any policies issued upon property, real or personal, or real and personal, there may be attached a coinsurance clause; and provided further, that when a coinsurance clause is attached to any policy a reduction in rate shall be given therefor, in accordance with coinsurance credits that are now or may hereafter be filed as a part of the public rating record in the office of the director of the department of insurance, financial institutions and professional registration in this state, by fire insurance companies, that have been or shall hereafter be approved by the director of the department of insurance, financial institutions and professional registration; provided further, that in all suits brought upon policies of insurance against loss or damage by fire hereafter issued or renewed, the defendant shall not be permitted to deny that the property insured thereby was worth at the time of the issuing of the policy the full amount insured therein

on said property covering both real and personal property; and provided further, that nothing in this section shall be construed to repeal or change the provisions of section 379.140.

379.321. 1. Every insurer shall file with the director, except as to commercial property or commercial casualty insurance as provided in subsection 6 of this section, every manual of classifications, rules, underwriting rules and rates, every rating plan and every modification of the foregoing which it uses and the policies and forms to which such rates are applied. Any insurer may satisfy its obligation to make any such filings by becoming a member of, or a subscriber to, a licensed rating organization which makes such filings and by authorizing the director to accept such filings on its behalf, provided that nothing contained in section 379.017 and sections 379.316 to 379.361 shall be construed as requiring any insurer to become a member of or a subscriber to any rating organization or as requiring any member or subscriber to authorize the director to accept such filings on its behalf. Filing with the director by such insurer or licensed rating organization within ten days after such manuals, rating plans or modifications thereof or policies or forms are effective shall be sufficient compliance with this section.

2. Except as to commercial property or commercial casualty insurance as provided in subsection 6 of this section, no insurer shall make or issue a policy or contract except pursuant to filings which are in effect for that insurer or pursuant to section 379.017 and sections 379.316 to 379.361. Any rates, rating plans, rules, classifications or systems, in effect on August 13, 1972, shall be continued in effect until withdrawn by the insurer or rating organization which filed them.

3. Upon the written application of the insured, stating his or her reasons therefor, filed with the insurer, a rate in excess of that provided by a filing otherwise applicable may be used on any specific risk.

4. Every insurer which is a member of or a subscriber to a rating organization shall be deemed to have authorized the director to accept on its behalf all filings made by the rating organization which are within the scope of its membership or subscribership, provided:

(1) That any subscriber may withdraw or terminate such authorization, either generally or for individual filings, by written notice to the director and to the rating organization and may then make its own independent filings for any kinds of insurance, or subdivisions, or classes of risks, or parts or combinations of any of the foregoing, with respect to which it has withdrawn or terminated such authorization, or may request the rating organization, within its discretion, to make any such filing on an agency basis solely on behalf of the requesting subscriber; and

(2) That any member may proceed in the same manner as a subscriber unless the rating organization shall have adopted a rule, with the approval of the director:

(a) Requiring a member, before making an independent filing, first to request the rating organization to make such filing on its behalf and requiring the rating organization, within thirty days after receipt of such request, either:

a. To make such filing as a rating organization filing;

b. To make such filing on an agency basis solely on behalf of the requesting member; or

c. To decline the request of such member; and

(b) Excluding from membership any insurer which elects to make any filing wholly independently of the rating organization.

5. Any change in a filing made pursuant to this section during the first six months of the date such filing becomes effective shall be approved or disapproved by the director within ten days following the director's receipt of notice of such proposed change.

6. Commercial property and commercial casualty requirements differ as follows:

(1) **[**~~All~~**]** Commercial property and commercial casualty insurance rates, rate plans, modifications, and manuals of classifications, **[**~~where appropriate~~**]** **except as specified in subdivision (2) of this subsection**, shall be filed with the director for informational purposes only **within ten days of use**. Such rates are not to be reviewed or approved by the department of insurance, financial institutions and professional registration as a condition of their use. Nothing in this subsection shall require the filing of individual rates where the original manuals, rates and rules for the insurance plan or program to which such individual policies conform have already been filed with the director;

(2) **Subject to the provisions of subdivision (4) of this subsection, commercial property and casualty underwriting rules or guidelines, rates, rate plans, modifications, and manuals of classification are exempt from filing requirements otherwise applicable under this chapter, whether the insurance coverage is endorsed to or otherwise made part of another type of insurance or sold as a stand-alone policy;**

(3) Subject to the provisions of subdivision (4) of this subsection, commercial property and casualty insurance policy forms are exempt from filing requirements otherwise applicable under this chapter when the aggregate total annual commercial insurance premiums for all property and casualty insurance purchased by a commercial policyholder, excluding premiums for the types of insurance specified in subdivision (4) of this subsection, are equal to or exceed one hundred thousand dollars and the commercial policyholder employs a full-time risk manager or has retained a licensed insurance producer to negotiate on its behalf;

(4) The filing exemptions in paragraphs (2) and (3) shall not apply to:

(a) Workers' compensation;

(b) Medical malpractice liability;

(c) Farm property and liability;

(d) Any coverage issued by an assigned risk or residual market plan pursuant to section 303.200; and

(e) Any specific policy or bond required by the division of workers' compensation of a self-insured employer or group trust, their trustees, or entities providing services to self-insured employers or group trusts;

(5) All policies exempt from filing pursuant to subdivisions (2) or (3) of this subsection shall include, at the time of policy issuance, a notice advising the policyholder that the policy may include rates or forms exempt from filing with the department. Such notice shall state that this policy may include rates and forms which may not be filed with the Missouri department of insurance;

(6) If an insurer will only renew a commercial casualty or commercial property insurance policy with an increase in premium of twenty-five percent or more, a "premium alteration requiring notification" notice must be mailed or delivered by the insurer at least sixty days prior to the expiration date of the policy, except in the case of an umbrella or excess policy the coverage of which is contingent on the coverage of an underlying policy of commercial property or casualty insurance, in which case notice of an increase in premium of twenty-five percent or more shall be mailed or delivered at least thirty days prior to the expiration date of the policy. Such notice shall be mailed or delivered to the agent of record and to the named insured at the address shown in the policy. If the insurer fails to meet this notice requirement, the insured shall have the option of continuing the policy for the remainder of the notice period plus an additional thirty days at the premium rate of the existing policy or contract. This provision does not apply if the insurer has offered to renew a policy without such an increase in premium or if the insured fails to pay a premium due or any advance premium required by the insurer for renewal. For purposes of this section, "premium alteration requiring notification" means an annual increase in premium of twenty-five percent or more, exclusive of premium increases due to a change in the operations of the insured which increases either the hazard insured against or the individual loss characteristics, or due to a change in the magnitude of the exposure basis, including, without limitation, increases in payroll or sales. For commercial multiperil policies, no "premium alteration requiring notification" shall be required unless the increase in premium for all of a policyholder's policies taken together amounts to a twenty-five percent or more annual increase in premium;

[~~(3)~~**] (7)** Commercial property and commercial casualty policy forms**, except as specified in subdivision (3) of this subsection,** shall be filed with the director **within ten days of use** as provided pursuant to subsection 1 of this section. However, if after review, it is determined that

corrective action must be taken to modify the filed forms, the director shall impose such corrective action on a prospective basis for new policies. All policies previously issued which are of a type that is subject to such corrective action shall be deemed to have been modified to conform to such corrective action retroactive to their inception date;

(8) An insurer renewing a policy issued with policy forms not filed with the director pursuant to subdivision (3) of this subsection shall provide written notice to the first named insured and producer of record, if any, at least ten days prior to the current policy's expiration date if, after renewal, there will be a material restriction or reduction in coverage not specifically requested by the insured, required by law, or based on the altered nature or extent of the risk insured. The notice may be in a printed or electronic form and shall explain what coverage will be reduced or eliminated or what condition will be restricted. It shall be a rebuttable presumption that all insureds received the notice if it was sent by e-mail or first-class mail to the first named insured's last known e-mail address or mailing address contained in the policy. If the insurer has not so notified the policyholder, the policyholder may elect to cancel the renewal policy within thirty days of delivery of the renewal policy, and the earned premium for the time the renewal policy was in force shall be calculated pro rata at the lower of the current or previous year's rate. If the insured accepts the renewal, any premium change or alteration of coverage, terms, or conditions shall be effective immediately upon the expiration of the prior policy. Nothing in this subdivision shall restrict the right of the parties to an insurance contract to amend an insurance policy if requested by the insured without the requirement for any notice;

[~~(4)~~**] (9)** For purposes of this section, "commercial casualty" means "commercial casualty insurance" as defined in section 379.882. For purposes of this section, "commercial property" means property insurance, which is for business and professional interests, whether for profit, nonprofit or public in nature which is not for personal, family or household purposes, and shall include commercial inland marine insurance, but does not include title insurance;

[~~(5)~~**] (10)** Nothing in this subsection shall limit the director's authority over excessive, inadequate or unfairly discriminatory rates **or affect the application of any laws governing unfair trade practices, unfair claims practices, or the content of policy forms;**

(11) The commercial casualty and commercial property insurance filing requirement exemptions included in this section shall apply to all property and casualty insurance policies issued or renewed on or after January 1, 2018.

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