5152S.05F

SENATE SUBSTITUTE

FOR

SENATE COMMITTEE SUBSTITUTE

FOR

HOUSE BILL NO. 2205

AN ACT

To repeal sections 208.950, 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, and 376.1109, RSMo, and to enact in lieu thereof twenty-seven new sections relating to insurance, with an expiration date for certain section.

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

Section A. Sections 208.950, 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376.732, 376.733, 376.734, 376.735, 376.737, 376.738, 376.740, 376.743, 376.758, 376.816, and 376.1109, RSMo, are repealed and twenty-seven new sections enacted in lieu thereof, to be known as sections 208.183, 208.950, 354.442, 375.024, 375.539, 375.1152, 375.1155, 375.1175, 375.1191, 375.1255, 376.717, 376.718, 376.724, 376.725, 376.732, 376.733, 376.734, 376.735, 376.737, 376.738, 376.740, 376.743, 376.758, 376.816, 376.882, 376.1109, 376.1110, to read as follows:

208.183. 1. The director of the MO HealthNet division, in collaboration with other appropriate agencies, is authorized to implement a pilot project for the purposes of creating the "Missouri Aged, Blind, Disabled Care Management Program" in order

to coordinate care and treatment of the aged, blind and disabled population. Such pilot project shall be known as the "Missouri ABD Care Management Pilot Program". Under the program:

(1) Full risk care shall be provided in which a single monthly capitation payment shall be paid to a single qualified managed care organization for all covered services to be provided to eligible Medicaid recipients;

(2) Eligibility shall be mandatory and shall include all Medicaid recipients who are identified in the aged, blind, and disabled program categories who are over the age of twenty-one, who are not enrolled in a Medicaid waiver program, who do not have eligibility for Medicare, and who do not reside in a nursing facility;

(3) The care management organization shall provide at a minimum the Medicaid mandatory, nonwaiver services as defined in the Medicaid state plan and shall include hospital, physician, ancillary, pharmacy, and behavioral health benefits. Where appropriate, the care management organization shall contract with community mental health centers at no less than the Medicaid fee-for-service reimbursement rates;

(4) The services area shall encompass a single urban area with a population of not more than two hundred fifty thousand and all contiguous counties;

(5) The capitation afforded to the care management organization shall be at least five percent less than the current historical trended fee for service costs for a similar population in the designated service area;

(6) The pilot project shall favor care management

organizations that provide for Missouri based member call centers, claims operations, and the creation of Missouri based jobs;

(7) The director shall establish an advisory council that shall include the care management organization, department of mental health, department of health and senior services representatives, advocacy groups, and provider representatives whose role shall be to develop monitoring measures and program parameters;

(8) The director of the division shall provide an annual report to the general assembly that includes cost savings, consumer satisfaction metrics, provider reimbursement timeliness, and quality measures;

(9) The care management organization provider network shall include any and all providers willing to accept current Medicaid fee for services reimbursement rates and care management contractual terms as approved by the division. Services provided to enrolled members by out-of-network providers shall be reimbursed at currently prevailing Medicaid fee-for-service reimbursement rates;

(10) The term of the pilot project shall be three years and all eligible recipients shall be enrolled in the pilot program no later than July 1, 2011, if approved by the federal Centers for Medicare and Medicaid Services.

2. The director of the division shall promulgate such rules and regulations as may be necessary 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.

3. The provisions of this section shall expire June 30, 2014.

208.950. 1. The department of social services shall, with the advice and approval of the Mo HealthNet oversight committee established under section 208.955, create health improvement plans for all participants in Mo HealthNet. Such health improvement plans shall include but not be limited to, risk-bearing coordinated care plans, administrative services organizations, and coordinated fee-for-service plans. Development of the plans and enrollment into such plans shall begin July 1, 2008, and shall be completed by July 1, 2011, and shall take into account the appropriateness of enrolling particular participants into the specific plans and the time line for enrollment. For risk-bearing care coordination plans and administrative services organization plans, the contract shall require that the contracted per diem be reduced or other financial penalty occur if the quality targets specified by the department are not met. For purposes of this section, "quality targets specified by the department" shall include, but not be

limited to, rates at which participants whose care is being managed by such plans seek to use hospital emergency department services for nonemergency medical conditions.

2. Every participant shall be enrolled in a health improvement plan and be provided a health care home. All health improvement plans are required to help participants remain in the least restrictive level of care possible, use domestic-based call centers and nurse help lines, and report on participant and provider satisfaction information annually. All health improvement plans shall use best practices that are evidence-based. The department of social services shall evaluate and compare all health improvement plans on the basis of cost, quality, health improvement, health outcomes, social and behavioral outcomes, health status, customer satisfaction, use of evidence-based medicine, and use of best practices and shall report such findings to the oversight committee.

3. When creating a health improvement plan for participants, the department shall ensure that the rules and policies are promulgated consistent with the principles of transparency, personal responsibility, prevention and wellness, performance-based assessments, and achievement of improved health outcomes, increasing access, and cost-effective delivery through the use of technology and coordination of care.

4. No provisions of any state law shall be construed as to require any aged, blind, or disabled person to enroll in a risk-bearing coordination plan <u>unless such enrollment is pursuant to a pilot project</u>.

5. The department of social services shall, by July 1,

2008, commission an independent survey to assess health and wellness outcomes of MO HealthNet participants by examining key health care delivery system indicators, including but not limited to disease-specific outcome measures, provider network demographic statistics including but not limited to the number of providers per unit population broken down by specialty, subspecialty, and multidisciplinary providers by geographic areas of the state in comparison side-by-side with like indicators of providers available to the state-wide population, and participant and provider program satisfaction surveys. In counting the number of providers available, the study design shall use a definition of provider availability such that a provider that limits the number of MO HealthNet recipients seen in a unit of time is counted as a partial provider in the determination of availability. The department may contract with another organization in order to complete the survey, and shall give preference to Missouri-based organizations. The results of the study shall be completed within six months and be submitted to the general assembly, the governor, and the oversight committee.

6. The department of social services shall engage in a public process for the design, development, and implementation of the health improvement plans and other aspects of MO HealthNet. Such public process shall allow for but not be limited to input from consumers, health advocates, disability advocates, providers, and other stakeholders.

7. By July 1, 2008, all health improvement plans shall conduct a health risk assessment for enrolled participants and develop a plan of care for each enrolled participant with health

status goals achievable through healthy lifestyles, and appropriate for the individual based on the participant's age and the results of the participant's health risk assessment.

8. For any necessary contracts related to the purchase of products or services required to administer the MO HealthNet program, there shall be competitive requests for proposals consistent with state procurement policies of chapter 34, RSMo, or through other existing state procurement processes specified in chapter 630, RSMo.

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 subdivision (14) of subsection 1 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 agreement which master agreement, together with all schedules, confirmations, definitions and addenda thereto and transactions under any thereof, shall be treated as one netting agreement, that documents one or more transactions between the parties to the agreement for or involving one or more qualified financial contracts and that provides for the netting, liquidation, setoff, termination, acceleration, or close out under or in connection with one or more qualified financial contracts or present or future payment or delivery obligations or payment or delivery entitlements thereunder, including liquidation or close-out values relating to such obligations or entitlements, among the

parties to the netting agreement;

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

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

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

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

(a) "Commodity contract", shall mean:

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

b. An agreement that is subject to regulation under Section 19 of the Commodity Exchange Act, 7 U.S.C. Section 1, et seq., and that is commonly known to the commodities trade as a margin account, margin contract, leverage account, or leverage contract;

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

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

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

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

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

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

conveyances and preferential transfers;

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

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

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

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

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

deemed necessary and proper to prevent:

(1) The transaction of further business;

(2) The transfer of property;

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

(4) Waste of the insurer's assets;

(5) Dissipation and transfer of bank accounts;

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

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

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

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

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

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

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

3. Notwithstanding anything to the contrary in this section, the commencement of a delinquency proceeding under

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

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

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

(2) That the insurer is insolvent;

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

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

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

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

(1) The director, in his or her sole discretion, approves

the articles of dissolution prior to filing such articles with the secretary of state. In determining whether to approve or disapprove the articles of dissolution, the director shall consider, among other factors, whether:

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

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

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

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

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

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

(a) The insolvency, financial condition, or default of the insurer at any time, provided that the right is enforceable under

applicable law other than sections 375.1150 to 375.1246; or

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

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

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

(4) If a counterparty to a master netting agreement or a qualified financial contract with an insurer subject to a proceeding under sections 375.1150 to 375.1246 terminates, liquidates, closes out, or accelerates the agreement or contract, damages shall be measured as of the date or dates of termination, liquidation, close out, or acceleration. The amount of a claim for damages shall be actual direct compensatory damages calculated in accordance with subsection 6 of this section.

2. Upon termination of a netting agreement or qualified financial contract, the net or settlement amount, if any, owed by a nondefaulting party to an insurer against which an application or petition has been filed under sections 375.1150 to 375.1246 shall be transferred to or on the order of the receiver for the

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

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

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

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

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

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

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

5. Notwithstanding any other provision of sections 375.1150 to 375.1246, a receiver may not avoid a transfer of money or other property arising under or in connection with a netting agreement or qualified financial contract, or any pledge, security, collateral or guarantee agreement or any other similar security arrangement or credit support document relating to a netting agreement or qualified financial contract, that is made before the commencement of a formal delinquency proceeding under sections 375.1150 to 375.1246. However, a transfer may be avoided pursuant to section 375.1192 if the transfer was made

with actual intent to hinder, delay or defraud the insurer, a receiver appointed for the insurer, or existing or future creditors.

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

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

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

(2) Notwithstanding any other provision of sections 375.1150 to 375.1246, any claim of a counterparty against the estate arising from the receiver's disaffirmance or repudiation of a netting agreement or qualified financial contract that has not been previously affirmed in the liquidation or immediately preceding conservation or rehabilitation case shall be determined and shall be allowed or disallowed as if the claim had arisen before the date of the filing of the petition for liquidation or, if a conservation or rehabilitation proceeding is converted to a liquidation proceeding, as if the claim had arisen before the date of the filing of the petition for conservation or rehabilitation. The amount of the claim shall be the actual direct compensatory damages determined as of the date of the

disaffirmance or repudiation of the netting agreement or qualified financial contract. The term "actual direct compensatory damages" does not include punitive or exemplary damages, damages for lost profit or lost opportunity or damages for pain and suffering, but does include normal and reasonable costs of cover or other reasonable measures of damages utilized in the derivatives, securities or other market for the contract and agreement claims.

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

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

9. All rights of counterparties under sections 375.1150 to 375.1246 shall apply to netting agreements and qualified financial contracts entered into on behalf of the general account

or separate accounts if the assets of each separate account are available only to counterparties to netting agreements and qualified financial contracts entered into on behalf of that separate account.

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

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

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

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

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

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

(3) If pursuant to section 375.1265 the insurer challenges an adjusted RBC report that indicates the event described in

subdivision (1) of this subsection, the notification by the director to the insurer that the director has, after a hearing, rejected the insurer's challenge.

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

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

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

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

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

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

3. The RBC plan shall be submitted:

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

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

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

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

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

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

375.1265, specify in the notification that the notification constitutes a regulatory action level event.

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

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

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

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

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

376.717. 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**]**<u>, other than structured settlement annuities,</u> 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 on insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in subdivision (1) of this subsection shall be equal

and limited to the higher of the three-year average annual premiums for the applicable account as calculated under this section.

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

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

5. It shall be proper for any member insurer, in determining its premium rates and policy owner dividends as to any kind of insurance within the scope of sections 376.715 to 376.758, to consider the amount reasonably necessary to meet its assessment obligations under the provisions of sections 376.715 to 376.758.

376.738. The association shall issue to each insurer paying an assessment under the provisions of sections 376.715 to 376.758, other than class A assessment, a certificate of contribution, in a form prescribed by the director, for the amount of the assessment so paid. All outstanding certificates

shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution **[**issued before September 1, 1991,**]** may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the director may approve**[**, provided that a certificate issued before September 1, 1991, shall not be shown as an admitted asset for a longer period of time or greater amount than that described in subdivisions (1) to (4) of subsection 2 of section 375.774, RSMo**]**.

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

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

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

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

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

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

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

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

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

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

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

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

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

5. The plan of operation may provide that any or all powers and duties of the association except those pursuant to provisions of **[**subsection 3 of section 376.733 and subsections 1 and 2 of**]** subdivision (3) of subsection 1 of section 376.734 and section 376.735 are delegated to a corporation, association, or other

organization which performs or will perform functions similar to those of this association, or its equivalent, in two or more states. Such a corporation, association, or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the director, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by sections 376.715 to 376.758.

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

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

[3. The board of directors may, upon majority vote, request that the director order an examination of any member insurer which the board in good faith believes may be an impaired or insolvent insurer. Within thirty days of the receipt of such request, he shall begin such examination. The examination may be conducted as a National Association of Insurance Commissioners examination or may be conducted by such persons as the director

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

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

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

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

2. Sections 376.715 to 376.758 shall be liberally construed to effect the purpose under subsection 2 of section 376.715 which

shall constitute an aid and guide to interpretation.

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

376.816. 1. No [individual or group insurance policy providing coverage on an expense-incurred basis, no individual or group service or indemnity contract issued by a not-for-profit health services corporation, no health maintenance organization nor any self-insured group health benefit plan of any type or description shall be offered, issued or renewed in this state on or after July 10, 1991, unless the policy, plan or contract] health carrier or health benefit plan that offers or issues health benefit plans, other than Medicaid health benefit plans, shall deliver, issue for delivery, continue, or renew a health benefit plan to a Missouri resident on or after January 1, 2011, unless the health benefit plan covers adopted children of the insured, subscriber or enrollee on the same basis as other dependents.

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

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

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

Such coverage shall continue unless the placement is disrupted prior to legal adoption and the child is removed from placement.

Coverage shall include the necessary care and treatment of medical conditions existing prior to the date of placement.

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

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

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

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

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

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

376.1109. 1. The director may adopt regulations that include standards for full and fair disclosure setting forth the manner, content and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent

conditions and definitions of terms. Regulations adopted pursuant to sections 376.1100 to 376.1130 shall be in accordance with the provisions of chapter 536, RSMo.

2. No long-term care insurance policy may:

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

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

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

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

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

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

of coverage of an insured person.

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

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

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

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

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

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

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

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

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

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

11. Long-term care insurance applicants shall have the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and

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

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

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

376.1110. 1. No insurance company licensed to transact business in this state shall deliver or issue for delivery in this state any policy or certificate of long-term care insurance, unless the classification of risks and the premium rates

pertaining to such policy or certificate have been filed with and approved by the director.

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

(1) Past and prospective loss experience;

(2) Past and prospective expenses;

(3) Adequate contingency reserves; and

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

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