SECOND REGULAR SESSION

HOUSE COMMITTEE SUBSTITUTE FOR

SENATE SUBSTITUTE FOR

SENATE BILL NO. 597

99TH GENERAL ASSEMBLY

4177H.04C D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 208.152, 354.150, 354.495, 374.115, 374.150, 374.230, 375.1218, 376.715, 376.717, 376.718, 376.720, 376.722, 376.724, 376.725, 376.726, 376.733, 376.734, 376.735, 376.737, 376.738, 376.742, 376.743, 376.746, 376.747, 376.748, 376.755, 376.756, and 376.758, RSMo, and to enact in lieu thereof twenty-seven new sections relating to fees for insurance services, with a delayed effective date for certain sections.

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

Section A. Sections 208.152, 354.150, 354.495, 374.115, 374.150, 374.230, 375.1218, 376.715, 376.717, 376.718, 376.720, 376.722, 376.724, 376.725, 376.726, 376.733, 376.734, 376.735, 376.737, 376.738, 376.742, 376.743, 376.746, 376.747, 376.748, 376.755, 376.756, and 376.758, RSMo, are repealed and twenty-seven new sections enacted in lieu thereof, to be known as sections 208.152, 354.150, 354.495, 374.150, 374.230, 375.1218, 376.715, 376.717, 376.718, 376.720, 376.722, 376.724, 376.725, 376.726, 376.733, 376.734, 376.735, 376.737, 376.738, 376.742, 376.743, 376.746, 376.747, 376.748, 376.755, 376.756, and 376.758, to read as follows:

208.152. 1. MO HealthNet payments shall be made on behalf of those eligible needy persons as described in section 208.151 who are unable to provide for it in whole or in part, with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the MO HealthNet division, unless otherwise hereinafter provided, for the following:

(1) Inpatient hospital services, except to persons in an institution for mental diseases who are under the age of sixty-five years and over the age of twenty-one years; provided that the MO HealthNet division shall provide through rule and regulation an exception process for coverage

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

of inpatient costs in those cases requiring treatment beyond the seventy-fifth percentile professional activities study (PAS) or the MO HealthNet children's diagnosis length-of-stay schedule; and provided further that the MO HealthNet division shall take into account through its payment system for hospital services the situation of hospitals which serve a disproportionate number of low-income patients;

(2) All outpatient hospital services, payments therefor to be in amounts which represent no more than eighty percent of the lesser of reasonable costs or customary charges for such services, determined in accordance with the principles set forth in Title XVIII A and B, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. Section 301, et seq.), but the MO HealthNet division may evaluate outpatient hospital services rendered under this section and deny payment for services which are determined by the MO HealthNet division not to be medically necessary, in accordance with federal law and regulations;

(3) Laboratory and X-ray services;

(4) Nursing home services for participants, except to persons with more than five hundred thousand dollars equity in their home or except for persons in an institution for mental diseases who are under the age of sixty-five years, when residing in a hospital licensed by the department of health and senior services or a nursing home licensed by the department of health and senior services or appropriate licensing authority of other states or government-owned and -operated institutions which are determined to conform to standards equivalent to licensing requirements in Title XIX of the federal Social Security Act (42 U.S.C. Section 301, et seq.), as amended, for nursing facilities. The MO HealthNet division may recognize through its payment methodology for nursing facilities those nursing facilities which serve a high volume of MO HealthNet patients. The MO HealthNet division when determining the amount of the benefit payments to be made on behalf of persons under the age of twenty-one in a nursing facility may consider nursing facilities furnishing care to persons under the age of twenty-one as a classification separate from other nursing facilities;

(5) Nursing home costs for participants receiving benefit payments under subdivision (4) of this subsection for those days, which shall not exceed twelve per any period of six consecutive months, during which the participant is on a temporary leave of absence from the hospital or nursing home, provided that no such participant shall be allowed a temporary leave of absence unless it is specifically provided for in his plan of care. As used in this subdivision, the term "temporary leave of absence" shall include all periods of time during which a participant is away from the hospital or nursing home overnight because he is visiting a friend or relative;

(6) Physicians' services, whether furnished in the office, home, hospital, nursing home, or elsewhere;

(7) **Up to twenty visits per year for services limited to examinations, diagnoses, adjustments, and manipulations and treatments of malpositioned articulations and structures of the body provided by licensed chiropractic physicians practicing within their scope of practice. Nothing in this subdivision shall be interpreted to otherwise expand MO HealthNet services;**

(8) Drugs and medicines when prescribed by a licensed physician, dentist, podiatrist, or an advanced practice registered nurse; except that no payment for drugs and medicines prescribed on and after January 1, 2006, by a licensed physician, dentist, podiatrist, or an advanced practice registered nurse may be made on behalf of any person who qualifies for prescription drug coverage under the provisions of P.L. 108-173;

[~~(8)~~**] (9)** Emergency ambulance services and, effective January 1, 1990, medically necessary transportation to scheduled, physician-prescribed nonelective treatments;

[~~(9)~~**] (10)** Early and periodic screening and diagnosis of individuals who are under the age of twenty-one to ascertain their physical or mental defects, and health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby. Such services shall be provided in accordance with the provisions of Section 6403 of P.L. 101-239 and federal regulations promulgated thereunder;

[~~(10)~~**] (11)** Home health care services;

[~~(11)~~**] (12)** Family planning as defined by federal rules and regulations; provided, however, that such family planning services shall not include abortions unless such abortions are certified in writing by a physician to the MO HealthNet agency that, in the physician's professional judgment, the life of the mother would be endangered if the fetus were carried to term;

[~~(12)~~**] (13)** Inpatient psychiatric hospital services for individuals under age twenty-one as defined in Title XIX of the federal Social Security Act (42 U.S.C. Section 1396d, et seq.);

[~~(13)~~**] (14)** Outpatient surgical procedures, including presurgical diagnostic services performed in ambulatory surgical facilities which are licensed by the department of health and senior services of the state of Missouri; except, that such outpatient surgical services shall not include persons who are eligible for coverage under Part B of Title XVIII, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended, if exclusion of such persons is permitted under Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended;

[~~(14)~~**] (15)** Personal care services which are medically oriented tasks having to do with a person's physical requirements, as opposed to housekeeping requirements, which enable a person to be treated by his or her physician on an outpatient rather than on an inpatient or residential basis in a hospital, intermediate care facility, or skilled nursing facility. Personal care

services shall be rendered by an individual not a member of the participant's family who is qualified to provide such services where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a licensed nurse. Persons eligible to receive personal care services shall be those persons who would otherwise require placement in a hospital, intermediate care facility, or skilled nursing facility. Benefits payable for personal care services shall not exceed for any one participant one hundred percent of the average statewide charge for care and treatment in an intermediate care facility for a comparable period of time. Such services, when delivered in a residential care facility or assisted living facility licensed under chapter 198 shall be authorized on a tier level based on the services the resident requires and the frequency of the services. A resident of such facility who qualifies for assistance under section 208.030 shall, at a minimum, if prescribed by a physician, qualify for the tier level with the fewest services. The rate paid to providers for each tier of service shall be set subject to appropriations. Subject to appropriations, each resident of such facility who qualifies for assistance under section 208.030 and meets the level of care required in this section shall, at a minimum, if prescribed by a physician, be authorized up to one hour of personal care services per day. Authorized units of personal care services shall not be reduced or tier level lowered unless an order approving such reduction or lowering is obtained from the resident's personal physician. Such authorized units of personal care services or tier level shall be transferred with such resident if he or she transfers to another such facility. Such provision shall terminate upon receipt of relevant waivers from the federal Department of Health and Human Services. If the Centers for Medicare and Medicaid Services determines that such provision does not comply with the state plan, this provision shall be null and void. The MO HealthNet division shall notify the revisor of statutes as to whether the relevant waivers are approved or a determination of noncompliance is made;

[~~(15)~~**]** **(16)** Mental health services. The state plan for providing medical assistance under Title XIX of the Social Security Act, 42 U.S.C. Section 301, as amended, shall include the following mental health services when such services are provided by community mental health facilities operated by the department of mental health or designated by the department of mental health as a community mental health facility or as an alcohol and drug abuse facility or as a child-serving agency within the comprehensive children's mental health service system established in section 630.097. The department of mental health shall establish by administrative rule the definition and criteria for designation as a community mental health facility and for designation as an alcohol and drug abuse facility. Such mental health services shall include:

(a) Outpatient mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately

established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

(b) Clinic mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

(c) Rehabilitative mental health and alcohol and drug abuse services including home and community-based preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health or alcohol and drug abuse professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management. As used in this section, mental health professional and alcohol and drug abuse professional shall be defined by the department of mental health pursuant to duly promulgated rules. With respect to services established by this subdivision, the department of social services, MO HealthNet division, shall enter into an agreement with the department of mental health. Matching funds for outpatient mental health services, clinic mental health services, and rehabilitation services for mental health and alcohol and drug abuse shall be certified by the department of mental health to the MO HealthNet division. The agreement shall establish a mechanism for the joint implementation of the provisions of this subdivision. In addition, the agreement shall establish a mechanism by which rates for services may be jointly developed;

[~~(16)~~**]** **(17)** Such additional services as defined by the MO HealthNet division to be furnished under waivers of federal statutory requirements as provided for and authorized by the federal Social Security Act (42 U.S.C. Section 301, et seq.) subject to appropriation by the general assembly;

[~~(17)~~**]** **(18)** The services of an advanced practice registered nurse with a collaborative practice agreement to the extent that such services are provided in accordance with chapters 334 and 335, and regulations promulgated thereunder;

[~~(18)~~**]** **(19)** Nursing home costs for participants receiving benefit payments under subdivision (4) of this subsection to reserve a bed for the participant in the nursing home during the time that the participant is absent due to admission to a hospital for services which cannot be performed on an outpatient basis, subject to the provisions of this subdivision:

(a) The provisions of this subdivision shall apply only if:

a. The occupancy rate of the nursing home is at or above ninety-seven percent of MO HealthNet certified licensed beds, according to the most recent quarterly census provided to the

department of health and senior services which was taken prior to when the participant is admitted to the hospital; and

b. The patient is admitted to a hospital for a medical condition with an anticipated stay of three days or less;

(b) The payment to be made under this subdivision shall be provided for a maximum of three days per hospital stay;

(c) For each day that nursing home costs are paid on behalf of a participant under this subdivision during any period of six consecutive months such participant shall, during the same period of six consecutive months, be ineligible for payment of nursing home costs of two otherwise available temporary leave of absence days provided under subdivision (5) of this subsection; and

(d) The provisions of this subdivision shall not apply unless the nursing home receives notice from the participant or the participant's responsible party that the participant intends to return to the nursing home following the hospital stay. If the nursing home receives such notification and all other provisions of this subsection have been satisfied, the nursing home shall provide notice to the participant or the participant's responsible party prior to release of the reserved bed;

[~~(19)~~**]** **(20)** Prescribed medically necessary durable medical equipment. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

[~~(20)~~**]** **(21)** Hospice care. As used in this subdivision, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO HealthNet division to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

[~~(21)~~**]** **(22)** Prescribed medically necessary dental services. Such services shall be subject to appropriations. An electronic web-based prior authorization system using best medical

evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

[~~(22)~~**] (23)** Prescribed medically necessary optometric services. Such services shall be subject to appropriations. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

[~~(23)~~**] (24)** Blood clotting products-related services. For persons diagnosed with a bleeding disorder, as defined in section 338.400, reliant on blood clotting products, as defined in section 338.400, such services include:

(a) Home delivery of blood clotting products and ancillary infusion equipment and supplies, including the emergency deliveries of the product when medically necessary;

(b) Medically necessary ancillary infusion equipment and supplies required to administer the blood clotting products; and

(c) Assessments conducted in the participant's home by a pharmacist, nurse, or local home health care agency trained in bleeding disorders when deemed necessary by the participant's treating physician;

[~~(24)~~**] (25)** The MO HealthNet division shall, by January 1, 2008, and annually thereafter, report the status of MO HealthNet provider reimbursement rates as compared to one hundred percent of the Medicare reimbursement rates and compared to the average dental reimbursement rates paid by third-party payors licensed by the state. The MO HealthNet division shall, by July 1, 2008, provide to the general assembly a four-year plan to achieve parity with Medicare reimbursement rates and for third-party payor average dental reimbursement rates. Such plan shall be subject to appropriation and the division shall include in its annual budget request to the governor the necessary funding needed to complete the four-year plan developed under this subdivision.

2. Additional benefit payments for medical assistance shall be made on behalf of those eligible needy children, pregnant women and blind persons with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the MO HealthNet division, unless otherwise hereinafter provided, for the following:

(1) Dental services;

(2) Services of podiatrists as defined in section 330.010;

(3) Optometric services as described in section 336.010;

(4) Orthopedic devices or other prosthetics, including eye glasses, dentures, hearing aids, and wheelchairs;

(5) Hospice care. As used in this subdivision, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO HealthNet division to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

(6) Comprehensive day rehabilitation services beginning early posttrauma as part of a coordinated system of care for individuals with disabling impairments. Rehabilitation services must be based on an individualized, goal-oriented, comprehensive and coordinated treatment plan developed, implemented, and monitored through an interdisciplinary assessment designed to restore an individual to optimal level of physical, cognitive, and behavioral function. The MO HealthNet division shall establish by administrative rule the definition and criteria for designation of a comprehensive day rehabilitation service facility, benefit limitations and payment mechanism. 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 subdivision 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, 2005, shall be invalid and void.

3. The MO HealthNet division may require any participant receiving MO HealthNet benefits to pay part of the charge or cost until July 1, 2008, and an additional payment after July 1, 2008, as defined by rule duly promulgated by the MO HealthNet division, for all covered services except for those services covered under subdivisions **[**~~(14)~~**]** **(15)** and **[**~~(15)~~**]** **(16)** of subsection 1 of this section and sections 208.631 to 208.657 to the extent and in the manner authorized by Title XIX of the federal Social Security Act (42 U.S.C. Section 1396, et seq.) and regulations thereunder. When substitution of a generic drug is permitted by the prescriber according to section 338.056, and a generic drug is substituted for a name-brand drug, the MO HealthNet division may not lower or delete the requirement to make a co-payment pursuant to

regulations of Title XIX of the federal Social Security Act. A provider of goods or services described under this section must collect from all participants the additional payment that may be required by the MO HealthNet division under authority granted herein, if the division exercises that authority, to remain eligible as a provider. Any payments made by participants under this section shall be in addition to and not in lieu of payments made by the state for goods or services described herein except the participant portion of the pharmacy professional dispensing fee shall be in addition to and not in lieu of payments to pharmacists. A provider may collect the co-payment at the time a service is provided or at a later date. A provider shall not refuse to provide a service if a participant is unable to pay a required payment. If it is the routine business practice of a provider to terminate future services to an individual with an unclaimed debt, the provider may include uncollected co-payments under this practice. Providers who elect not to undertake the provision of services based on a history of bad debt shall give participants advance notice and a reasonable opportunity for payment. A provider, representative, employee, independent contractor, or agent of a pharmaceutical manufacturer shall not make co-payment for a participant. This subsection shall not apply to other qualified children, pregnant women, or blind persons. If the Centers for Medicare and Medicaid Services does not approve the MO HealthNet state plan amendment submitted by the department of social services that would allow a provider to deny future services to an individual with uncollected co-payments, the denial of services shall not be allowed. The department of social services shall inform providers regarding the acceptability of denying services as the result of unpaid co-payments.

4. The MO HealthNet division shall have the right to collect medication samples from participants in order to maintain program integrity.

5. Reimbursement for obstetrical and pediatric services under subdivision (6) of subsection 1 of this section shall be timely and sufficient to enlist enough health care providers so that care and services are available under the state plan for MO HealthNet benefits at least to the extent that such care and services are available to the general population in the geographic area, as required under subparagraph (a)(30)(A) of 42 U.S.C. Section 1396a and federal regulations promulgated thereunder.

6. Beginning July 1, 1990, reimbursement for services rendered in federally funded health centers shall be in accordance with the provisions of subsection 6402(c) and Section 6404 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989) and federal regulations promulgated thereunder.

7. Beginning July 1, 1990, the department of social services shall provide notification and referral of children below age five, and pregnant, breast-feeding, or postpartum women who are determined to be eligible for MO HealthNet benefits under section 208.151 to the special supplemental food programs for women, infants and children administered by the department

of health and senior services. Such notification and referral shall conform to the requirements of Section 6406 of P.L. 101-239 and regulations promulgated thereunder.

8. Providers of long-term care services shall be reimbursed for their costs in accordance with the provisions of Section 1902 (a)(13)(A) of the Social Security Act, 42 U.S.C. Section 1396a, as amended, and regulations promulgated thereunder.

9. Reimbursement rates to long-term care providers with respect to a total change in ownership, at arm's length, for any facility previously licensed and certified for participation in the MO HealthNet program shall not increase payments in excess of the increase that would result from the application of Section 1902 (a)(13)(C) of the Social Security Act, 42 U.S.C. Section 1396a (a)(13)(C).

10. The MO HealthNet division may enroll qualified residential care facilities and assisted living facilities, as defined in chapter 198, as MO HealthNet personal care providers.

11. Any income earned by individuals eligible for certified extended employment at a sheltered workshop under chapter 178 shall not be considered as income for purposes of determining eligibility under this section.

12. If the Missouri Medicaid audit and compliance unit changes any interpretation or application of the requirements for reimbursement for MO HealthNet services from the interpretation or application that has been applied previously by the state in any audit of a MO HealthNet provider, the Missouri Medicaid audit and compliance unit shall notify all affected MO HealthNet providers five business days before such change shall take effect. Failure of the Missouri Medicaid audit and compliance unit to notify a provider of such change shall entitle the provider to continue to receive and retain reimbursement until such notification is provided and shall waive any liability of such provider for recoupment or other loss of any payments previously made prior to the five business days after such notice has been sent. Each provider shall provide the Missouri Medicaid audit and compliance unit a valid email address and shall agree to receive communications electronically. The notification required under this section shall be delivered in writing by the United States Postal Service or electronic mail to each provider.

13. Nothing in this section shall be construed to abrogate or limit the department's statutory requirement to promulgate rules under chapter 536.

14. Beginning July 1, 2016, and subject to appropriations, providers of behavioral, social, and psychophysiological services for the prevention, treatment, or management of physical health problems shall be reimbursed utilizing the behavior assessment and intervention reimbursement codes 96150 to 96154 or their successor codes under the Current Procedural Terminology (CPT) coding system. Providers eligible for such reimbursement shall include psychologists.

354.150. 1. Every health services corporation subject to the provisions of sections 354.010 to 354.380 shall pay **[**~~the following fees~~**]** to the director **[**~~for the administration and enforcement of the provisions of this chapter:~~

~~(1) For filing the declaration required on organization of each domestic company, two hundred fifty dollars;~~

~~(2) For filing statement and certified copy of charter required of foreign companies, two hundred fifty dollars;~~

~~(3) For filing application to renew certificate of authority, along with all required annual reports, including the annual statement, actuarial statement, risk-based capital report, report of valuation of policies or other obligations of assurance, and audited financial report of any company doing business in this state, one thousand five hundred dollars;~~

~~(4) For filing any paper, document, or report not filed under subdivision (1), (2), or (3) of this section but required to be filed in the office of the director, fifty dollars each;~~

~~(5) For affixing the seal of office of the director, ten dollars;~~

~~(6) For accepting each service of process upon the company, ten dollars~~**] the fees specified in section 374.230**.

2. Fees mandated in subdivision (1) of **[**~~subsection 1 of this section~~**] section 374.230** shall be waived if a majority shareholder, officer, or director of the organizing corporation is a member of the Missouri National Guard or any other active duty military, resides in the state of Missouri, and provides proof of such service to the secretary of state.

354.495. Every health maintenance organization subject to sections 354.400 to 354.636 shall pay to the director the **[**~~following fees:~~

~~(1) For filing the declaration required on organization of each domestic company, two hundred fifty dollars;~~

~~(2) For filing statement and certified copy of charter required of foreign companies, two hundred fifty dollars;~~

~~(3) For filing application to renew certificate of authority, along with all required annual reports, including the annual statement, actuarial statement, risk based capital report, report of valuation of policies or other obligations of assurance, and audited financial report of any company doing business in this state, one thousand five hundred dollars;~~

~~(4) For filing any paper, document, or report not filed under subdivision (1), (2), or (3) of this section but required to be filed in the office of the director, fifty dollars each;~~

~~(5) For affixing the seal of office of the director, ten dollars;~~

~~(6) For accepting each service of process upon the company, ten dollars~~**] fees specified in section 374.230**.

374.150. 1. All fees due the state under the provisions of the insurance laws of this state shall be paid to the director **[**~~of revenue~~**]** and deposited in the state treasury to the credit of the insurance dedicated fund unless otherwise provided for in subsection 2 of this section.

2. There is hereby established in the state treasury a special fund to be known as the "Insurance Dedicated Fund". The fund shall be subject to appropriation of the general assembly and shall be devoted solely to the payment of expenditures incurred by the department attributable to duties performed by the department for the regulation of the business of insurance, regulation of health maintenance organizations and the operation of the division of consumer affairs as required by law which are not paid for by another source of funds. Other provisions of law to the contrary notwithstanding, beginning on January 1, 1991, all fees charged under any provision of chapter 325, 354, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384 or 385 due the state shall be paid into this fund. The state treasurer shall invest moneys in this fund in the same manner as other state funds and any interest or earnings on such moneys shall be credited to the insurance dedicated fund. The provisions of section 33.080 notwithstanding, moneys in the fund shall not lapse, be transferred to or placed to the credit of the general revenue fund unless and then only to the extent to which the unencumbered balance at the close of the biennium year exceeds two times the total amount appropriated, paid, or transferred to the fund during such fiscal year.

[~~3. Notwithstanding provisions of this section to the contrary, five hundred thousand dollars of the insurance dedicated fund shall annually be transferred and placed to the credit of the state general revenue fund on July first beginning with fiscal year 2014.~~**]**

374.230. Every **[**~~insurance company doing business in this state~~**] individual or entity making a filing with the department described below** shall pay to the director **[**~~of revenue~~**]** the following fees **and charges, to be paid into the insurance dedicated fund established under section 374.150**:

(1) For filing the declaration required on organization of each domestic company, **[**~~two hundred fifty~~**] one thousand** dollars;

(2) For filing statement and certified copy of charter required of foreign companies, **[**~~two hundred fifty~~**] one thousand** dollars;

(3) For filing application to renew certificate of authority, along with all required annual reports, including the annual statement, actuarial statement, risk-based capital report, report of valuation of policies or other obligations of assurance, and audited financial report annual statement of any company doing business in this state, **[**~~one thousand five hundred~~**] two thousand** dollars;

(4) **[**~~For filing supplementary annual statement of any company doing business in this state, fifty dollars~~**] For filing the ORSA summary report required by sections 382.500 to**

382.550, or a preacquisition notification required by sections 382.040 through 382.060, or section 382.095, five hundred dollars;

(5) **Unless otherwise specified in subdivision (4) or another section of law, for any filings required under chapter 382, two hundred fifty dollars;**

(6) For filing any paper, document, or report **for which a filing fee is not otherwise provided for in another section of law that is** not filed under subdivision (1), (2), **[**~~or~~**]** (3), **(4), or (5),** but required to be filed in the office of the director, **[**~~fifty~~**] one hundred fifty** dollars each**[**~~;~~**]**

[~~(6) For a copy of a company's certificate of authority or producer or agent license, ten dollars;~~

~~(7) For affixing the seal of office of the director, ten dollars;~~

~~(8) For accepting each service of process upon the company, ten dollars~~**]**.

375.1218. The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is herein set forth. Every claim in each class shall be paid in full or adequate funds retained for such payment before the members of the next class receive any payment. No subclasses shall be established within any class. No claim by a shareholder, policyholder or other creditor shall be permitted to circumvent the priority class through the use of equitable remedies. The order of distribution of claims shall be:

(1) Class 1. The costs and expenses of administration during rehabilitation and liquidation, including but not limited to the following:

(a) The actual and necessary costs of preserving or recovering the assets of the insurer, and costs necessary to store records required to be preserved pursuant to section 375.1228;

(b) Compensation for all authorized services rendered in the rehabilitation and liquidation;

(c) Any necessary filing fees;

(d) The fees and mileage payable to witnesses;

(e) Authorized reasonable attorney's fees and other professional services rendered in the rehabilitation and liquidation**; and**

(f) The reasonable expenses of the Missouri property and casualty insurance guaranty association, the Missouri life and health insurance guaranty association, and any similar organization in any other state, including overhead, salaries, and other general administrative expenses allocable to the receivership. These expenses shall be subordinate to all other costs and expenses of administration under paragraphs (a) to (e) of this subdivision. The provisions of this paragraph shall apply to the distribution of claims from an insurer's estate if such insurer was first placed under an order of rehabilitation or an order of liquidation if no order of rehabilitation was entered on or after August 28, 2018.

(2) Class 2. All claims under policies including such claims of the federal or any state or local government for losses incurred ("loss claims") including third party claims and all claims of a guaranty association or foreign guaranty association including reasonable allocated loss adjustment expenses and all claims of a life and health insurance guaranty association or foreign guaranty association which covers claims of life and health insurance policies, relating to the handling of such claims. All claims under life insurance and annuity policies and funding agreements, whether for death proceeds, annuity proceeds or investment values shall be treated as loss claims. That portion of any loss, indemnification for which is provided by other benefits or advantages recovered by the claimant, shall not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligation of support or by way of succession at death or as proceeds of life insurance, or as gratuities. No payment by an employer to his employee shall be treated as a gratuity. Early distributions to guaranty associations and foreign guaranty associations may be made in the manner provided in section 375.1205, provided that such guaranty associations and foreign guaranty associations agree to indemnify the liquidator if a shortage occurs in the insurer's estate of property necessary to settle claims as provided by this section. Any early distributions shall not increase the proportionate share of such guaranty associations and foreign guaranty associations, of distributions of the insurer's estate. The liquidator shall have authority to inquire into the reasonableness of any allocated loss adjustment expenses claimed by a guaranty association or foreign guaranty association and such claim shall not be allowed if it is found to be unreasonable.

(3) Class 3. Claims of the United States government other than those claims included in class 2.

(4) Class 4. Reasonable compensation to employees for services performed to the extent that they do not exceed two months of monetary compensation and represent payment for services performed within one year before the filing of the petition for liquidation or, if rehabilitation preceded liquidation, within one year before the filing of the petition for rehabilitation. Principal officers and directors shall not be entitled to the benefit of this priority except as otherwise approved by the liquidator and the court. Such priority shall be in lieu of any other similar priority which may be authorized by law as to wages or compensation of employees.

(5) Class 5. Claims under nonassessable policies for unearned premiums or other premium refunds and claims of general creditors including claims of ceding and assuming companies in their capacity as such.

(6) Class 6. Claims of any state or local government except those under class 2 of this section. Claims, including those of any governmental body for a penalty or forfeiture, shall be allowed in this class only to the extent of the pecuniary loss sustained from the act, transaction,

or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of such claims shall be postponed as class 9 claims.

(7) Class 7. Claims filed late or any other claims other than class 8 or 9 claims.

(8) Class 8. Surplus or contribution notes, or similar obligations, and premium refunds on assessable policies. Payments to members of domestic mutual insurance companies shall be limited in accordance with law.

(9) Class 9. The claims of shareholders or other owners in their capacity as shareholders.

376.715. 1. Sections 376.715 to 376.758 shall be known and may be cited as the "Missouri Life and Health Insurance Guaranty Association Act".

2. The purpose of sections 376.715 to 376.758 is to protect, subject to certain limitations, the persons specified in subsection 1 of section 376.717 against failure in the performance of contractual obligations, under life**, [**~~and~~**]** health**, [**~~insurance policies~~**]** and annuity **policies, plans, or** contracts specified in subsection 2 of section 376.717, because of the impairment or insolvency of the member insurer that issued the policies or contracts.

3. To provide this protection, an association of **member** insurers is created to pay benefits and to continue coverages as limited herein, and members of the association are subject to assessment to provide funds to carry out the purpose of sections 376.715 to 376.758.

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**, including health care providers rendering services covered under health insurance policies or certificates,** of the persons covered under subdivision (2) of this subsection; and

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

(a) Are residents of this state; or

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

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

b. The persons are not eligible for coverage by an association in any other state due to the fact that the insurer **or health maintenance organization** was not licensed in such state at the time specified in such state's guaranty association law; and

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

(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 are 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, **enrollee,** 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 **policies or contracts of** direct, nongroup life **insurance**, health**[**~~, annuity policies or contracts,~~**] insurance, which for the purposes of sections 376.715 to 376.758 includes health maintenance organizations' subscriber contracts and certificates, or annuities** 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. **Except as otherwise provided in paragraph (c) of subdivision (3) of this subsection,** sections 376.715 to 376.758 shall not provide coverage for:

(1) Any portion of a policy or contract not guaranteed by the **member** 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; **and**

(c) The exclusion from coverage referenced in this subdivision shall not apply to any portion of a policy or contract, including a rider, that provides long-term care or any other health insurance benefits;

(4) Any portion of a policy or contract issued to a plan or program of an employer, association or 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 other person under:

(a) A multiple employer welfare arrangement as defined in 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;

(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 **member** insurer to the **enrollee, certificate holder,** 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 **member** insurer without meeting applicable policy **or contract** form filing or approval requirements;

(c) Misrepresentations of or regarding policy **or contract** 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 Parts C & D, **Subchapter XIX, Chapter 7 of Title 42 of the United States Code, Medicaid,** or any regulations issued thereunder.

4. The benefits for which the association may become liable, with regard to a member insurer that was first placed under an order of rehabilitation or under an order of liquidation if no order of rehabilitation was entered prior to August 28, 2013, shall in no event exceed the lesser of:

(1) The contractual obligations for which the **member** 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. Except as otherwise provided in subdivision (2) of this subsection, the benefits for which the association may become liable with regard to a member insurer that was first placed under an order of rehabilitation or under an order of liquidation if no order of rehabilitation was entered on or after August 28, 2013, 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) (a) 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. **[**~~In~~**] For** health insurance benefits:

(i) One hundred thousand dollars of coverage**s** other than disability **income** insurance **[**~~or basic hospital, medical, and surgical insurance or major medical insurance~~**]**, **health benefit plans,** or long-term care insurance, including any net cash surrender and net cash withdrawal values;

(ii) Three hundred thousand dollars for disability **income** insurance and three hundred thousand dollars for long-term care insurance;

(iii) Five hundred thousand dollars for **[**~~basic hospital, medical, and surgical insurance or major medical insurance~~**] health benefit plans**;

c. Two hundred fifty thousand dollars in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; or

(b) With respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, two hundred fifty thousand dollars in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any;

(c) Except that, in no event shall the association be obligated to cover more than:

a. An aggregate of three hundred thousand dollars in benefits with respect to any one life under paragraphs (a) and (b) of this subdivision, except with respect to benefits for **[**~~basic hospital, medical, and surgical insurance and major medical insurance~~**] health benefit plans** under item (iii) of subparagraph b. of paragraph (a) of this subdivision, in which case the aggregate liability of the association shall not exceed five hundred thousand dollars with respect to any one individual; or

b. With respect to one owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, more than five million dollars in benefits, regardless of the number of policies and contracts held by the owner.

6. The limitations set forth in subsections 4 and 5 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.

7. For the purposes of sections 376.715 to 376.758, benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the basic life insurance policy or annuity contract to which it relates.

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

(1) "Account", any of the accounts created under section 376.720;

(2) "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 **contract" or "covered policy**", any policy or contract 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) **"Health benefit plan", any hospital or medical expense policy or certificate, health maintenance organization subscriber contract, or any other similar health contract. "Health benefit plan" does not include:**

(a) Accident only insurance;

(b) Credit insurance;

(c) Dental only insurance;

(d) Vision only insurance;

(e) Medicare supplement insurance;

(f) Benefits for long-term care, home health care, community-based care, or any combination thereof;

(g) Disability income insurance;

(h) Coverage for on-site medical clinics; or

(i) Specified disease, hospital confinement indemnity, or limited benefit health insurance if the types of coverage do not provide coordination of benefits and are provided under separate policies or certificates;

(9) "Impaired insurer", a member insurer which, after August 13, 1988, is not an insolvent insurer, and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction;

[~~(9)~~**] (10)** "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;

[~~(10)~~**] (11)** "Member insurer", any insurer**, health maintenance organization,** or health services corporation licensed or which holds a certificate of authority to transact in this state any kind of insurance **or health maintenance organization business** for which coverage is provided under section 376.717, and includes any insurer **or health maintenance organization** 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)~~**] (b)** A mandatory state pooling plan;

[~~(d)~~**] (c)** A mutual assessment company or any entity that operates on an assessment basis;

[~~(e)~~**] (d)** An insurance exchange;

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

[~~(11)~~**] (12)** "Moody's Corporate Bond Yield Average", the monthly average corporates as published by Moody's Investors Service, Inc., or any successor thereto;

[~~(12)~~**] (13)** "Owner", **"policyholder",** "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 **member** insurer. Owner, contract owner, **policyholder,** and policy owner shall not include persons with a mere beneficial interest in a policy or contract;

[~~(13)~~**] (14)** "Person", any individual, corporation, partnership, association or voluntary organization;

[~~(14)~~**] (15)** "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 **policy or** 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 **or contract** 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)~~**] (16)** "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)~~**] (17)** "Receivership court", the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the insurer;

[~~(17)~~**] (18)** "Resident", any person who resides in this state 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 **member** insurer that issued the policies or contracts;

[~~(18)~~**] (19)** "State", a state, the District of Columbia, Puerto Rico, and a United States possession, territory, or protectorate;

[~~(19)~~**] (20)** "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;

[~~(20)~~**] (21)** "Supplemental contract", any written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or contract;

[~~(21)~~**] (22)** "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.

376.720. 1. There is created a nonprofit legal entity to be known as the "Missouri Life and Health Insurance Guaranty Association". All member insurers shall be and remain members of the association as a condition of their authority to transact insurance **or a health maintenance organization business** in this state. The association shall perform its functions under the plan of operation established and approved under subsections 1 to 3 of section 376.740 and shall exercise its powers through a board of directors established pursuant to section 376.722. For purposes of administration and assessment the association shall maintain three accounts:

(1) The health **[**~~insurance~~**]** account;

(2) The life insurance account;

(3) The annuity account, excluding unallocated annuity contracts.

2. The association shall come under the immediate supervision of the director and shall be subject to the applicable provisions of the insurance laws of this state. Meetings or records

of the association may be opened to the public upon majority vote of the board of directors of the association.

376.722. 1. The board of directors of the association shall consist of not less than **[**~~five~~**]** **seven** nor more than **[**~~nine~~**]** **eleven** member insurers serving terms as established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the director. Each class of member insurer, as defined in section 376.718, shall be represented on the board. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the director. **[**~~To select the initial board of directors, and initially organize the association, the director shall give notice to all member insurers of the time and place of the organizational meeting.~~**]** In determining voting rights at the organizational meeting each member insurer shall be entitled to one vote in person or by proxy. **[**~~If the board of directors is not selected within sixty days after notice of the organizational meeting, the director may appoint the initial members.~~**]**

2. In approving selections or in appointing members to the board, the director shall consider, among other things, whether all member insurers are fairly represented.

3. Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors but members of the board shall not otherwise be compensated by the association for their services.

376.724. 1. If a member insurer is an impaired 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:

(1) Guarantee, assume**, reissue,** or reinsure, or cause to be guaranteed, assumed, **reissued,** 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.

2. If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

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

b. Assure payment of the contractual obligations of the insolvent insurer; and

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

(2) Provide benefits and coverages in accordance with the following provisions:

(a) With respect to **[**~~life and health insurance policies and annuities~~**]** **policies and contracts**, 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. 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. 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;

(b) Make diligent efforts to provide all known insureds**, enrollees,** or annuitants for individual policies and contracts, or group **[**~~policyholders~~**] policy or contract owners** with respect to group policies or contracts, thirty days notice of the termination, under paragraph (a) of this subdivision, of the benefits provided;

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

(d) a. In providing the substitute coverage required under paragraph (c) of this subdivision, the association may offer either to reissue the terminated coverage or to issue an alternative policy **or contract at actuarially justified rates**;

b. Alternative or reissued policies **or contracts** 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 **or contract**;

c. The association may reinsure any alternative or reissued policy **or contract**;

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

b. Alternative policies **or contracts** 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 **or contract** was last underwritten;

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

(f) In carrying out its duties in connection with guaranteeing, assuming, **reissuing,** 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 **or contract**, the premium shall be **actuarially justified and** set by the association in accordance with the amount of insurance **or coverage** provided and the age and class of risk of the insured, subject to **prior** approval of the director **[**~~or by a court of competent jurisdiction~~**]**.

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

376.726. 1. Nonpayment of premiums within thirty-one days after the date required under the terms of any guaranteed, assumed, alternative or reissued policy or contract or substitute coverage shall terminate the association's obligations under such policy**, contract,** or coverage under sections 376.715 to 376.758 with respect to such policy**, contract,** or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of sections 376.715 to 376.758.

2. Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association, and the association shall be liable for unearned premiums due to policy or contract owners arising after the entry of such order.

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 **policies, contracts, or** coverages. The association may require an assignment to it of such rights and cause of action by any **enrollee,** 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 owner, beneficiary, **enrollee,** 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 **member** 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, **health insurer, or health maintenance organization** 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) **Unless prohibited by law, in accordance with the terms and conditions of the policy or contract, file an actuarially justified rate or premium increase for any policy or contract for which it provides coverage under sections 376.715 to 376.758;**

(9) 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)~~**] (10)** 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.

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.

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 may be made for the purpose of meeting administrative and legal costs and other expenses. Class A assessments may be made whether or not related to a particular impaired or insolvent insurer;

(2) Class B assessments may be made to the extent necessary to carry out the powers and duties of the association under 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.~~**]**

4. **(1)** The amount of any class B assessment**, except for assessments related to long-term care insurance,** shall be allocated for assessment purposes **[**~~among~~**] between** 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.

(2) The amount of the class B assessment for long-term care insurance written by the impaired or insolvent insurer shall be allocated according to methodology included in the plan of operation and approved by the director. The methodology shall provide for fifty percent of the assessment to be allocated to accident and health member insurers and fifty percent to be allocated to life and annuity member insurers.

5. 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 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 **member** 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.~~**] 6.** 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 subdivisions (1) and (2) of subsection 2 of this section and computation of assessments under this 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 **member** 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 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 **member** insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in subdivision (1) of this subsection shall be equal and limited to the higher of the three-year average annual premiums for the applicable account as calculated under this section.

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

4. The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each **member** 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 **or health maintenance organization business** 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 **member** 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 may be shown by the **member** 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.

376.742. 1. In addition to the duties and powers enumerated elsewhere in sections 376.715 to 376.758, the director shall:

(1) Upon request of the board of directors, provide the association with a statement of the premiums in this and any other appropriate states for each member insurer;

(2) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer shall constitute notice to its shareholders, if any. The failure of the **impaired** insurer to promptly comply with such demand shall not excuse the association from the performance of its powers and duties under the provisions of sections 376.715 to 376.758;

(3) In any liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator or rehabilitator.

2. The director may suspend or revoke, after notice and hearing, the certificate of authority to transact **[**~~insurance~~**] business** in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative the

director may levy a forfeiture on any member insurer which fails to pay an assessment when due. Such forfeiture shall not exceed five percent of the unpaid assessment per month, but no forfeiture shall be less than one hundred dollars per month.

3. Any action of the board of directors or the association may be appealed to the director by any member insurer if such appeal is taken within sixty days of the action being appealed. If a member company is appealing an assessment, the amount assessed shall be paid to the association and available to meet association obligations during the pendency of an appeal. If the appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member company. Any final action or order of the director shall be subject to judicial review in a court of competent jurisdiction.

4. The liquidator, rehabilitator, or conservator of any impaired insurer may notify all interested persons of the effect of sections 376.715 to 376.758.

5. To aid in the detection and prevention of **member** insurer insolvencies or impairments, the director shall:

(1) Notify the commissioners of all the other states, territories of the United States and the District of Columbia when he takes any of the following actions against a member insurer:

(a) Revocation of license;

(b) Suspension of license; or

(c) Makes any formal order that such **[**~~company~~**]** **member insurer** restricts its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of **[**~~policyholders~~**]** **policy owners, contract owners, certificate holders,** or creditors.

Such notice shall be mailed to all commissions within thirty days following the action taken or the date on which such action occurs;

(2) Report to the board of directors when he has taken any of the actions set forth in subdivision (1) of this subsection or has received a report from any other commissioner indicating that any such action has been taken in another state. Such report to the board of directors shall contain all significant details of the action taken or the report received from another commissioner;

(3) Report to the board of directors when he has reasonable cause to believe from any examination, whether completed or in process, of any member company that such company may be an impaired or insolvent insurer;

(4) Furnish to the board of directors the NAIC Insurer Regulatory Information Service (IRIS) ratios and listings of companies not included in the ratios developed by the National Association of Insurance Commissioners, and the board may use the information contained

therein in carrying out its duties and responsibilities under this section. Such report and the information contained therein shall be kept confidential by the board of directors until such time as made public by the director or other lawful authority.

6. The director may seek the advice and recommendations of the board of directors concerning any matter affecting his duties and responsibilities regarding the financial condition of member insurers and **[**~~companies~~**] health maintenance organizations** seeking admission to transact insurance business in this state.

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~~**] insurer or health maintenance organization** 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. The board of directors may, upon majority vote, make recommendations to the director for the detection and prevention of **member** insurer insolvencies.

376.746. 1. Nothing in sections 376.715 to 376.758 shall be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

2. Records shall be kept of all negotiations and meetings in which the association or its representatives are involved to discuss the activities of the association in carrying out its powers and duties under the provisions of sections 376.715 to 376.758. Records of such negotiations or meetings shall be made public only upon the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. Nothing in this subsection shall limit the duty of the association to render a report of its activities under subsection 1 of section 376.750.

3. For the purpose of carrying out its obligations under the provisions of sections 376.715 to 376.758, the association is deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee under the provisions of sections 376.715 to 376.758. Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by sections 376.715 to 376.758. Assets attributable to covered policies **or contracts**, as used in this subsection, are that proportion of the assets which the reserves that should have been established for such policies **or contracts** bear to the reserves that should have

been established for all policies of insurance **or health benefit plans** written by the impaired or insolvent insurer.

376.747. 1. Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, **contract owners, certificate holders, enrollees,** and policy owners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of such insolvent insurer. In such a determination consideration shall be given to the welfare of the **policy owners, contract owners, certificate holders, enrollees, and** policyholders of the continuing or successor **member** insurer.

2. No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims of the association with interest thereon for funds expended in carrying out its powers and duties under the provisions of sections 376.715 to 376.758 with respect to such **member** insurer have been fully recovered by the association.

376.748. 1. If an order for liquidation or rehabilitation of **[**~~an~~**] a member** insurer domiciled in this state has been entered, the receiver appointed under such order shall have a right to recover on behalf of the **member** insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the **member** insurer on its capital stock, made at any time during the five years preceding the petition for liquidation or rehabilitation subject to the limitations of subsections 2 through 4 of this section.

2. No such distribution shall be recoverable if the **member** insurer shows that when paid the distribution was lawful and reasonable, and that the **member** insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the **member** insurer to fulfill its contractual obligations.

3. Any person who was an affiliate that controlled the **member** insurer at the time the distributions were paid shall be liable up to the amount of distributions he received. Any person who was an affiliate that controlled the **member** insurer at the time the distributions were declared shall be liable up to the amount of distributions he would have received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

4. The maximum amount recoverable under this section shall be the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

5. If any person liable under subsection 3 of this section is insolvent, all its affiliates that controlled it at the time the distribution was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

376.755. No person, including **[**~~an~~**] a member** insurer, agent or affiliate of an insurer shall make, publish, disseminate, circulate, or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in any newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio station or television station, or in any other way, any advertisement, announcement or statement, written or oral, which uses the existence of the insurance guaranty association of this state for the purpose of sales, solicitation, or inducement to purchase any form of insurance **or other coverage** covered by sections 376.715 to 376.758. If a policy exceeds the limitations of coverage under sections 376.715 to 376.758, the insurer shall prominently inscribe on an endorsement to the insurance contract the limitations of coverage provided by the guaranty association. This section shall not apply to the Missouri Life and Health Insurance Guaranty Association or any other entity which does not sell or solicit insurance **or coverage by a health maintenance organization**.

376.756. 1. **[**~~Within one hundred eighty days of August 13, 1988,~~**]** The association shall prepare a summary document describing the general purposes and current limitations of the act and complying with subsection 2 of this section. This document should be submitted to the director for approval. Sixty days after receiving such approval, no insurer may deliver a policy or contract described in subsection 2 of section 376.717 to a policy **[**~~or~~**] owner** contract holder**, certificate holder, or enrollee** unless the document is delivered to the policy or contract holder prior to or at the time of delivery of the policy or contract except if subsection 3 of this section applies. The document should also be available upon request by a policyholder**, contract owner, certificate holder, or enrollee**. The distribution, delivery, or contents or interpretation of this document shall not mean that either the policy or the contract or the **policy owner, contract owner, certificate** holder**, or enrollee** thereof would be covered in the event of the impairment or insolvency of a member insurer. The description document shall be revised by the association as amendments to the act may require. Failure to receive this document does not give the policyholder, contract holder, certificate holder, **enrollee,** or insured any greater rights than those stated in sections 376.715 to 376.758.

2. The document prepared under subsection 1 of this section shall contain a clear and conspicuous disclaimer on its face. The director shall promulgate a rule establishing the form and content of the disclaimer. The disclaimer shall:

(1) State the name and address of the life and health insurance guaranty association and department of insurance, financial institutions and professional registration;

(2) Prominently warn the policy **[**~~or contract holder~~**] owner, contract owner, certificate holder, or enrollee** that the Missouri life and health insurance guaranty association may not

cover the policy **or contract** or, if coverage is available, it will be subject to substantial limitations, exclusions and conditioned on continued residence in the state;

(3) State that the **member** insurer and its agents are prohibited by law from using the existence of the life and health insurance guaranty association for the purpose of sales, solicitation or inducement to purchase any form of insurance **or health maintenance organization coverage**;

(4) Emphasize that the policy **[**~~or contract holder~~**] owner, contract owner, certificate holder, or enrollee** should not rely on coverage under the Missouri life and health insurance guaranty association when selecting an insurer **or health maintenance organization**;

(5) Provide other information as directed by the director.

3. No insurer or agent may deliver a policy or contract described in subsection 2 of section 376.717 and excluded under subsection 3 of section 376.717 from coverage under the provisions of sections 376.715 to 376.758 unless the insurer or agent, prior to or at the time of delivery, gives the policy or contract holder a separate written notice which clearly and conspicuously discloses that the policy or contract is not covered by the Missouri life and health insurance guaranty association. The director shall by rule specify the form and content of the notice.

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.

4. The amendments to sections 376.715 to 376.758, which become effective on August 28, 2018, shall not apply to any member insurer that is an impaired or insolvent insurer prior to August 28, 2018.

[~~374.115. Insurance examiners appointed or employed by the director of the department of insurance, financial institutions and professional registration shall be compensated according to the applicable levels established and published by the National Association of Insurance Commissioners.~~**]**

Section B. The repeal of section 374.115 and the repeal and reenactment of sections 354.150, 354.495, 374.150 and 374.230 of this act shall become effective on January 1, 2019.

✓