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**Rules of  
Department of Insurance  
Division 500—Property and Casualty  
Chapter 6—Workers’ Compensation and Employer’s  
Liability**

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## Title 20—DEPARTMENT OF INSURANCE

### Division 500—Property and Casualty Chapter 6—Workers' Compensation and Employer's Liability

#### 20 CSR 500-6.100 Policy and Endorsement Forms

*PURPOSE: This rule specifies policy provisions to be found in all Workers' Compensation policies. In addition, there are specifications for approval or disapproval by the director. This rule was adopted pursuant to the provisions of section 374.045, RSMo and implements section 287.310, RSMo.*

*PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. Therefore, the material which is so incorporated is on file with the agency who filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency's headquarters or the same will be made available at the Office of the Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.*

(1) All Workers' Compensation and employers' liability policy forms must be submitted to the Department of Insurance for specific approval. All endorsements attached to or made a part of the basic policy which have not been submitted by a filing agency on behalf of its members and subscribers must be submitted by each company. The policy and endorsement forms are incorporated by reference herein.

(2) All companies are required to employ the use of the standard provisions for Workers' Compensation and employers' liability policies.

(3) All provisions of Workers' Compensation and employers' liability policies which have not been approved under a uniform filing program must be submitted in duplicate by each company for specific approval. This shall include all mutual and the participating provisions and any special provisions pertaining to subscribers' agreements of reciprocal companies.

(4) An approved form entitled "Application of Limits of Liability Endorsement—Missouri"

must be attached to all policies of Workers' Compensation and employers' liability insurance issued in Missouri.

(5) All policies issued must comply with the counter-signature requirements of this state.

(6) All policies shall exclude any agreement, warranty or representation by the insured pertaining to prior cancellation or refusal to renew coverage by a previous carrier.

(7) It is not permissible for a company to issue group Workers' Compensation and employers' liability policies.

(8) It is not permissible for a company to issue both participating and nonparticipating policies of Workers' Compensation insurance.

(9) For those companies issuing participating policies, neither the company nor its insurance producers shall guarantee or promise to a policyholder or prospective policyholder the amount or percentage of dividends to be paid.

*AUTHORITY: sections 287.310 and 374.045, RSMo 2000.\* This rule was previously filed as 4 CSR 190-18.010. This version of rule filed July 27, 1964, effective Aug. 6, 1964. Amended: Filed Dec. 5, 1969, effective Dec. 15, 1969. Amended: Filed Oct. 30, 1974, effective Nov. 9, 1974. Amended: Filed July 12, 2002, effective Jan. 30, 2003.*

*\*Original authority: 287.310, RSMo 1939, amended 1992 and 374.045, RSMo 1967, amended 1993, 1995.*

#### 20 CSR 500-6.200 Premium Charges (Rescinded September 30, 1995)

*AUTHORITY: sections 287.320, RSMo Supp. 1992 and 374.045, RSMo 1986. This rule was previously filed as 4 CSR 190-18.020. This version of rule filed July 27, 1964, effective Aug. 6, 1964. Amended: Filed Dec. 5, 1969, effective Dec. 15, 1969. Amended: Filed Oct. 30, 1974, effective Nov. 9, 1974. Rescinded: Filed April 3, 1995, effective Sept. 30, 1995.*

#### 20 CSR 500-6.300 Self-Insurance

*PURPOSE: This rule outlines the requirements for employers that choose to self-insure their Workers' Compensation claims on a group basis.*

(1) This rule is intended to implement section 287.280, RSMo governing employers' group self-insurance of Workers' Compensation. The payroll, the experience and the premium of individual employers within a group are so diverse that they require the calculation of the premium applicable to individual employers within a group in order to determine the individual employer's tax and Second Injury Fund surcharge liability.

(2) Employers that choose to self-insure as a group and qualify to do so shall be liable, either individually or as a group, for the payment of the Workers' Compensation self-insurance premium tax and Second Injury Fund surcharge certified by the director of the Missouri Department of Insurance (MDI).

(3) Qualified employers that choose to self-insure as a group shall be responsible, either individually or as a group, for maintaining and reporting to the director of the Department of Insurance employer payroll records, medical and compensation paid and losses incurred, including reserves to or on behalf of injured employees.

(4) Qualified employers, either individually or as a group, shall compile, compute and submit premium tax and Second Injury Fund surcharge information in a prescribed manner on forms furnished by the director of the MDI.

(5) All records, reports, premium tax base and Second Injury Fund surcharge computations shall be submitted to the director of insurance by duly appointed administrators or elected officers who shall sign these records.

(6) The self-insurer shall collect and timely transfer to the director of revenue the surcharge required for the Second Injury Fund. The calculation for the Second Injury Fund surcharge shall be based upon premiums adjusted for experience modification, if any.

(7) An insurer may issue excess Workers' Compensation insurance to self-insured employers upon such terms, conditions, benefits and premiums as permitted by law. Any insurer issuing such insurance may give the self-insured employer a credit against the premiums payable to such insurer to the extent of any premium taxes paid by the self-insured employer with respect to premium imputed for losses covered under the excess insurance.

(8) All payroll records, loss records, insurance rating and premium computations, and reserves are pertinent to the tax liability and



Second Injury Fund surcharge liability of qualified self-insured employers. Consequently, they shall be subject to audit and examination by the director of insurance or his/her duly appointed representative.

(9) The reasonable expense for auditing the self-insurer's records shall be charged to the self-insurer being audited; however, the self-insurer shall be entitled to credit for these charges against the self-insurer's compensation premium tax, provided that no credit shall be allowed if the self-insurer's tax liability and Second Injury Fund surcharge liability have not been determined.

*AUTHORITY: sections 287.280 and 374.045, RSMo Supp. 1997.\* This rule was previously filed as 4 CSR 190-18.030. Original rule filed March 9, 1982, effective Aug. 12, 1982. Amended: Filed July 2, 1990, effective Dec. 31, 1990. Amended: Filed Sept. 11, 1997, effective March 30, 1998.*

*\*Original authority: 287.280, RSMo 1939, amended 1957, 1965, 1974, 1980, 1981, 1993, 1995 and 374.045, RSMo 1967, amended 1993, 1995.*

**20 CSR 500-6.400 Rate Deviation**  
(Rescinded September 30, 1995)

*AUTHORITY: sections 287.320, RSMo Supp. 1992 and 374.045, RSMo 1986. This rule was previously filed as 4 CSR 190-18.040. Original rule filed July 13, 1982, effective Nov. 11, 1982. Rescinded: Filed April 3, 1995, effective Sept. 30, 1995.*

**20 CSR 500-6.500 Performance Standards for Workers' Compensation Carriers**

*PURPOSE: This rule establishes minimum standards of performance for carriers writing Workers' Compensation coverage with regard to the writing of policies, auditing and billing accounts and servicing. This rule was adopted pursuant to the provisions of section 374.045, RSMo and implements section 287.310, RSMo.*

(1) Policy Service Standards.

(A) The policy shall be issued within sixty (60) days of the receipt of the application. The renewal policy shall be issued within sixty (60) days of receipt of the deposit premium. This subsection is not applicable if there exists a mutual agreement between the policyholder and the insurance company to delay the issuance of the policy provided the agreement is adequately documented.

(B) Endorsements are to be issued within sixty (60) days of the receipt of the request. This subsection is not applicable if there exists a mutual agreement between the policyholder and the insurance company to delay the issuance of the endorsement provided the agreement is adequately documented.

(C) Reinstatement notices must be issued within thirty (30) days after the request for reinstatement has been received and the premium due has been paid.

(D) Certificates of insurance must be mailed within five (5) working days of receipt of the request.

(2) Audit Standards.

(A) Audits shall be completed, billed and premiums returned within one hundred twenty (120) days of policy expiration or cancellation. This standard of one hundred twenty (120) days shall not be applicable—1) if a delay is caused by the policyholder's failure to respond to reasonable audit requests provided that the requests are timely and adequately documented or 2) if a delay is by the mutual agreement of the policyholder and insurance company provided that the agreement is adequately documented.

(B) If the policyholder or insurance company has any objection to the results of any audit, the policyholder or insurance company shall have up to three (3) years from the date of expiration or cancellation of that policy in which to send a written notice demanding a reconsideration of the audit. The written notice shall be based upon sufficiently clear and specific facts as to why the audit should be reconsidered.

*AUTHORITY: sections 287.310, RSMo Supp. 1992 and 374.045, RSMo 1986.\* This rule was previously filed as 4 CSR 190-18.060. Original rule filed Dec. 1, 1989, effective May 1, 1990.*

*\*Original authority: 287.310, RSMo 1939, amended 1992 and 374.045, RSMo 1967.*

**20 CSR 500-6.600 Effective Date of Experience Rating Modification**

*PURPOSE: This rule sets standards for the use of experience rating modification and other similar modifications applicable to Workers' Compensation insurance policies.*

(1) An insurer shall not implement an increase in premiums through the application of an experience rating modification factor, assigned risk adjustment program (ARAP) factor, or other surcharge authorized by the Department of Insurance after the effective

date of the policy (or at the anniversary date of the policy, if different), unless the insured is issued an endorsement describing the potential of the pending increase when the policy is issued.

(2) An insurer shall not apply an increase specified in section (1) of this rule retroactively.

(3) Any factor or other surcharge specified in section (1) applied after the policy effective date (or anniversary rating date, if different) which increases premiums shall not become effective until sixty (60) days after the date the insurer provides written notification to the insured of the increase.

(4) Any modification of a type specified in section (1) of this rule but which results in a premium reduction shall not be subject to the restrictions in sections (2) and (3) and shall be retroactive to the policy inception date.

(5) For the purposes of the rates filed in compliance with section 287.320, RSMo, it shall be considered unreasonable and inadequate to develop rates based on data which excludes premiums that would have been collected except for the restrictions set forth in this rule. Actuarial estimates would be acceptable to demonstrate the impact of this rule.

(6) Sections (2) and (3) shall not apply when any delay in the application of the modification factor increase or surcharge increase is due to the policyholder's failure in providing necessary data for the development of the factor or surcharge, provided that requests for data are timely and adequately documented.

(7) This rule is applicable only to portions of an insurance policy which provide coverage for risks principally localized in Missouri.

*AUTHORITY: sections 287.320, RSMo Supp. 1992 and 374.045, RSMo 1986.\* This rule was previously filed as 4 CSR 190-18.070. Original rule filed Dec. 1, 1989, effective May 1, 1990. Amended: Filed Nov. 14, 1991, effective June 25, 1992.*

*\*Original authority: 287.320, RSMo 1939, amended 1982, 1992 and 374.045, RSMo 1967.*

**20 CSR 500-6.700 Workers' Compensation Managed Care Organizations**

*PURPOSE: This rule specifies the conditions under which the use of a managed care plan certified by the department will justify a*

*premium discount on Workers' Compensation insurance.*

(1) Definitions.

(A) Access fee means the percentage of savings off usual and customary health care provider charges that is often charged by a managed care organization (MCO) as reimbursement for access to its network of providers.

(B) Bill re-pricing means a system for re-pricing charges for medical services to conform to levels contractually agreed to by health care providers, facilities and hospitals and through which discounted medical services are obtained.

(C) Case management means a collaborative process by which appropriately licensed and trained health care providers coordinate, monitor and evaluate the delivery of that level of health care treatment which is necessary to assist an injured employee in reaching prompt maximum medical improvement, following prescribed medical treatment plans, and, achieving, where possible, the prompt and appropriate return to work. Case management includes "on-site case management" and "telephonic case management."

(D) Certified MCO means a workers' compensation managed care organization certified by the department.

(E) Cost savings analysis means a documentation of savings achieved through reduction of medical fees, through the use of utilization review techniques, through early employee return to work, or all of the above.

(F) Department means the Missouri Department of Insurance.

(G) Hospital bill auditing means a service designed to review the accuracy and applicability of hospital charges as well as to evaluate the medical necessity of all services and treatment rendered, which shall be considered distinct from utilization review.

(H) Insurer means any person or entity defined under section 375.932 or 375.1002, RSMo, authorized to provide workers' compensation insurance in Missouri. The term shall include any employees, agents, third party administrators (TPAs) or others acting on behalf of such insurers.

(I) Managed care organization (MCO) means an organization, such as a preferred provider organization (PPO), a health maintenance organization (HMO) or other, direct employer/provider arrangements, designed to provide the appropriate procedures and incentives to medical providers necessary to manage the cost and utilization of care associated with claims covered by workers' compensation insurance. Unless the context clearly requires otherwise, when the term

MCO is used in this rule it will mean an MCO certified under the provisions of this rule.

(J) MCO administrative fee or administrative fee means any fee or charge for the reimbursement of the administrative services of an MCO, as opposed to any fee or charge for the reimbursement of a health care provider for the rendition of health care services, treatment or supplies. Such fees reimburse the MCO for the cost of organizing a network of health care providers, negotiating provider reimbursement rates, re-pricing bills, hospital bill auditing, provider bill auditing, tracking and coordinating care, pre-certification, utilization review, cost savings analysis and other MCO administrative functions. An MCO administrative fee may be in the form of an access fee, a percentage of savings off a provider's billed charges, a percentage of savings off average usual and customary fees as defined in an identified database, a dollar amount per hour, or some other method.

(K) On-site case management means case management performed in person by the case manager as the location requires.

(L) Payor means an insurer or TPA responsible for paying workers' compensation-related claim, including a bill for the fees of an MCO required to be reimbursed under this rule.

(M) Pre-certification means the process of reviewing planned nonemergency medical care to assure said care is reasonably required to cure and relieve the injured worker from the effects of the injury, as required under the Missouri Workers' Compensation Law.

(N) Provider bill auditing means a computer-assisted retrospective service which verifies the accuracy and applicability of provider charges, their conformity with usual and customary charges and their conformity with any discounts from usual and customary charges or other adjustments negotiated between the provider and the MCO. Provider bill auditing also verifies causal relationships between injury and treatment, the necessity of treatment and the accuracy of medical bills prior to recommending payment.

(O) Telephonic case management means case management conducted by telephone, e-mail, or facsimile machine.

(P) TPA means a third party administrator as defined under sections 376.1075 to 376.1095, RSMo.

(Q) Utilization review means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, pre-certification, concurrent review, discharge planning or retrospective review. For purposes of this rule, utilization review shall not include case management.

(2) Employer's Right to Select an MCO or Health Care Provider.

(A) A Missouri employer shall have the right to select an MCO for the purpose of providing the employer with managed care services in relation to the health care required to be provided under the Missouri Workers' Compensation Law. The employer shall have the right to select such an MCO regardless of whether that selection is approved by the employer's insurer or the selection differs from that made by the employer's insurer. Although the insurer may not require the employer to select a particular MCO, it may discuss that selection with the employer. While an employer may voluntarily agree to use an MCO under contract with the insurer if the employer so chooses, the employer may also select another MCO.

(B) An employer may select an MCO at any time during the period of the employer's insurance policy. An insurer will be deemed to have been notified of that selection whenever the insurer receives an administrative fee invoice from the MCO as defined in subsection (3)(E), attached to the bill of a health care provider for health care services provided to an injured employee of the insured employer.

(C) Nothing in this section shall limit an employer's right to select the health care provider as authorized under subsection 10 of section 287.140, RSMo. Although the insurer may not require the employer to use a particular health care provider, it may discuss that selection with the employer. While an employer may voluntarily agree to use the providers in an MCO network under contract with the insurer if the employer so chooses, the employer may also select a provider outside a particular MCO network.

(3) Coordination and Integration of Insurer and MCO Systems.

(A) A managed care organization and an insurer shall coordinate and integrate their internal operational systems relating to claim reporting, claim handling, medical case management and billings as required under this section, unless alternative arrangements are agreed to by the MCO and the insurer.

(B) Regarding claim reporting, an employer shall report all claims to the employer's insurance company. The employer may also report any such claims to the employer's MCO.



(C) The fact that the employer has selected an MCO shall not require the employer's insurer to modify its internal claims handling procedures beyond the requirements that the insurer shall cooperate with and reimburse the providers in the MCO network selected by the employer, and shall also reimburse the MCOs for its reasonable administrative fees. The insurer shall use whatever procedures the insurer ordinarily uses for dealing with non-network providers to accomplish such cooperation and reimbursement.

(D) The employer's right to select a health care provider under subsection 10 of section 287.140, RSMo extends to the employer's right to select a case management nurse, so long as the nurse is operating within the scope of his or her license.

(E) An MCO shall use a standard administrative fee invoice when billing an insurer for reimbursement. An administrative fee invoice should contain the information listed below, but shall not be deemed insufficient due to the lack of any particular pieces of information so long as the document is sufficiently clear so that an insurer can determine that the document is from an MCO and that the MCO is requesting payment for MCO services, so long as the document also provides a reasonable method for the insurer to contact the MCO for further explanation:

1. The MCO name, address, telephone number, facsimile number, federal employer identification number (FEIN); e-mail address (if available) and department MCO certification number;
2. The employer's name;
3. The injured employee's name and Social Security number;
4. The medical provider's name and FEIN;
5. The date of the medical service;
6. The provider's usual and customary charge for the service, treatment or supplies;
7. The discounted charge negotiated by the MCO for those same services, treatment or supplies;
8. The savings resulting from the MCOs discounts;
9. The administrative fee of the MCO to be paid by the insurer relating to the service, treatment or supplies in question.

(4) Criteria for Determining the Reasonableness of MCO Fees.

(A) An employer's insurer shall reimburse the reasonable administrative fees of an MCO selected by a Missouri employer if the department has certified that MCO. However, no insurer shall be required to reimburse an administrative fee charged by a department-certified MCO unless the fee is reasonable in

relation to both the managed care services provided and to the savings which result from those services.

(B) Where the type of MCO administrative fee is an access fee, there shall be a rebuttable presumption that the access fee is reasonable under subsection (A) above if it is less than or equal to twenty-five percent ( $\leq 25\%$ ) of the difference between the health care provider's usual and customary charge for the service, treatment or supplies in question and the amount the provider has agreed to accept under his contract with the MCO.

(C) Where the type of MCO fee is not an access fee, there shall be a rebuttable presumption that the fee is reasonable under subsection (4)(A) above if it is the standard fee charged by the MCO to other payors, when those other payors include insurers with which the MCO has formal reimbursement agreements. Where the MCO charges different payors different amounts for the fee in question under its formal reimbursement agreements with said payors, there shall be a rebuttable presumption that the lowest of these fees is reasonable under subsection (4)(A) above.

(D) Where a particular MCO fee charged by the MCO exceeds an amount deemed reasonable under subsections (B) or (C) above, an insurer may satisfy its reimbursement obligations under this section by paying an amount which does in fact conform to the appropriate subsection.

(5) Preconditions for an Insurer's Reimbursement of an MCO's Fees.

(A) An MCO fee must meet the following preconditions, which shall be presumed to be true unless proven otherwise by the insurer:

1. Relate to an injury or illness that is compensable under Chapter 287, RSMo;
2. Relate to a medically necessary procedure or a determination of medical necessity;
3. Relate to a medical claim that has previously been reported to the insurer by the employer;
4. Relate to an employer who has a contract with the insurer for workers' compensation insurance that covers the injury or illness;
5. Be from an MCO which, on the date of the bill charge, was certified by the department;
6. Be from an MCO with which the employer has a written contract to provide MCO services;
7. Be the MCO's standard reimbursement fee for the service in question;
8. Be by means of an administrative fee invoice as required under subsection (3)(E),

submitted to the insurer in connection with the underlying health care provider bill; and

9. Be reasonable under section (4) above.

(B) If an MCO administrative fee meets the requirements of subsection (A) above, an insurer shall be required to pay the MCO fee stated on the MCO administrative fee invoice.

(C) MCOs seeking reimbursement from insurers should maintain a listing of their standard administrative fees for the periods for which reimbursements are sought. Such lists should disclose the terms of the MCO's standard discounting arrangement with its health care providers and also list any administrative fees of the MCO for specific administrative functions, which may include but which are not necessarily limited to the following activities:

1. Pre-certification;
2. Prospective utilization review;
3. Concurrent utilization review;
4. Telephonic case management;
5. On-site case management;
6. Retrospective utilization review;
7. Provider bill auditing;
8. Hospital bill auditing;
9. Bill re-pricing; and
10. Cost savings analysis.

(D) Individual insurers and MCOs are authorized to enter into alternative reimbursement arrangements under subsection 3 of section 287.135, RSMo. Any such alternative arrangements will take precedence over the provisions of this section for the MCO and the insurer that are parties to the agreement.

(6) Procedure for Reimbursement by Insurers of MCO Fees.

(A) An MCO seeking reimbursement from an employer's insurer for its MCO services shall submit an administrative fee invoice to the insurer documenting the MCO services provided and the reimbursement requested.

(B) The insurer shall pay an MCO fee which is reasonable under section (4) above and which meets the preconditions of section (5) above.

(C) To the degree there is a dispute between an MCO and an insurer under this section, said dispute may be submitted in writing to the department for its review. The dispute shall be handled in an advisory manner by the department, after providing the parties written notice of the dispute and notice of the opposing party's allegations.

(D) An MCO may accept partial payment of an amount tendered by an insurer without prejudice to the MCO's right to the full reimbursement authorized under this rule.

(E) Where a dispute between an insurer and an MCO regarding an access fee is based on a question regarding the amount of the health care provider's underlying usual and customary charge for the service, treatment or supplies in question, the MCO may establish the provider's usual and customary charge by means of an affidavit from the provider, or a duly authorized agent of the provider, attesting to the provider's usual and customary charge for the period and for the service, treatment or supplies in question, supported by contemporaneous bills to other payors from that period for the same service, treatment or supplies in question.

(F) An insurer may produce evidence to rebut the presumptions of sections (4) and (5) above, including evidence showing that the MCO fee in question is unreasonable in relation to either the managed care services provided or to the savings which result from those services. An MCO may produce evidence in support of said presumptions. Such evidence from either party may include information regarding:

1. The extent to which the medical case involved or required oversight and coordination by the MCO;
2. The fees normally paid by the insurer to other MCOs;
3. The fees normally charged by the MCO to other insurers, and to TPAs, self-insurers and individual employers;
4. The fees normally paid by other insurers to MCOs;
5. The fees normally charged by other MCOs to insurers, TPAs, self-insurers and individual employers;
6. What the health care provider has agreed to accept from the insurer under any agreements other than the MCO agreement in question;
7. The dollar amount of the MCO fee being sought compared to the dollar amount of the underlying usual and customary charge for the service of the health care provider;
8. What an independent database indicates is a usual and customary charge for the health care service, treatment or supplies in question;
9. What a governmental database indicates is a usual and customary charge for the service, treatment or supplies;
10. The charges allowed for the treatment, service, or supplies when the government is the payor;
11. What has been determined to be a reasonable provider fee by the Division of Workers' Compensation under Section 287.140.3, RSMo and regulation 8 CSR 50-2.030 for the medical procedure upon which

the MCO fee dispute is based, where such a determination has been made;

12. What the department has determined to be a reasonable fee in prior disputes of a similar nature; or

13. Any other information considered relevant by the department.

(G) In order to expedite its review of disputes under this rule, the department may, in its discretion or at the request of either an insurer or an MCO, consolidate separate disputes between a particular MCO and a particular insurer or insurance company holding group into a single dispute where the separate disputes concern common issues or elements.

(H) After both sides have been afforded the opportunity to present their evidence and comment on the evidence presented by the other party, the department shall review said evidence. After its review, the department shall provide the parties with a written advisory opinion of its conclusions as to the reasonableness of the fees under section 287.135, RSMo. The department's advisory opinion on its conclusions as to the reasonableness of the MCO fee shall be subject to *de novo* review by a court of competent jurisdiction pursuant to section 536.150, RSMo.

(7) Department Certification of MCOs. In order to be certified, an MCO shall meet the following requirements:

(A) The MCO shall contract with member health care providers who are authorized to provide health care services in this state by the appropriate licensing authorities;

(B) Regarding contract requirements for medical and rehabilitative services, the MCO shall—

1. Provide for convenient access to the following types of providers in one (1) or more Missouri counties or cities not within a county:

- A. Primary care physicians;
- B. Subspecialty physicians;
- C. Rehabilitation centers; and
- D. Hospitals;

2. Provide for convenient access to primary care clinics which are specialized in providing occupational medical services;

3. Employ a medical director who is board-certified in occupational medicine or who possesses considerable experience with Missouri's workers' compensation system; and

4. Possess the capability for progressive rehabilitation services, including, but not limited to:

- A. Functional, objective capacity evaluations;
- B. Psychological testing; and
- C. Work hardening;

(C) Regarding additional MCO contract requirements, the MCO shall—

1. Provide employers with job-site presentations or other presentations regarding how to make proper use of the managed care services of the organization;

2. Base charges on negotiated rates of reimbursement to providers for the services specified in paragraph (7)(B)1. comparable to the best group medical plans in the geographic market area served, including provisions for basing inpatient services charges on diagnosis-related group (DRG) rates;

3. Include the prepricing of claims;

4. Provide monthly reports, on a claim-by-claim basis, specifying customary charges, charges allowed under the MCO contract and the resulting savings, if any; and

5. Provide for the external management and oversight from the initial date of injury by a nonhealth care provider of the health care provider's rendition of medical care in all cases; and

6. Provide for an internal dispute resolution procedure that meets the requirements of subsection 2 of section 287.135, RSMo;

(D) Be in addition, under the management and control of officers and directors who are competent to manage the MCO-managed health care operations, its finances, its compliance with agreements between itself and insurers or employers, or both, and its compliance with any applicable laws of Missouri.

(8) Certification Procedure.

(A) For purposes of obtaining the department's certification of a MCO, the organization shall provide the department with the following materials:

1. Copies of any MCO/employer and MCO/insurer contracts to be used;

2. A general diagram of the MCO's organizational structure;

3. A listing of the MCO's officers and directors;

4. The MCO's most recently audited financial report;

5. A thorough description of the MCO's experience with the management of health care costs associated with Workers' Compensation claims and with other health care claims;

6. The geographic area, by county, the MCO plans to serve;

7. A copy of the licenses and any certificates of the medical director;

8. A complete list of all primary care physicians, subspecialist physicians, rehabilitation centers, hospitals and work hardening centers to be employed by the organization;

9. The estimated savings to employers and insurers from the use of the organization;



10. The outline of the operation of the MCO to be provided to employers explaining their rights and responsibilities;

11. The MCO's dispute resolution procedures; and

12. Any other materials requested by the director.

(B) The materials specified in subsection (8)(A) shall be retained by the department. Any significant changes to the nature of the MCO's operations as reflected in these materials shall be reported to the department, but these reports need not be made more than twice a year, as measured from the date of the granting of any certification.

(C) The department shall review these documents and grant certification, on the form contained in Exhibit I of this rule, included herein, to those MCOs deemed to meet the criteria set forth in this rule. Any departmental decision to deny certification shall be accompanied by a written explanation by the department of the reasons for denial.

(D) The department may suspend or revoke the certification of a MCO at any time it establishes that the criteria set forth in this rule are no longer being met. Any such organization may request a hearing before the director on that suspension or revocation.

(E) MCOs previously certified need not be re-certified during the period of this code.

(9) Termination Date. This rule shall terminate December 31, 2002.



**Exhibit I**

**Certificate of Authority**

**Managed Care System for Workers' Compensation**

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**It is Hereby Certified That**

**(Enter name of Managed Care Organization)**

**meets the certification requirements of Section 287.135 of the Revised Statutes of Missouri and Regulation 20 CSR 500-6.700. (Enter name of MCO) has been assigned the following departmental identification number: MCO No. XX.**

**This certificate shall remain in full force and effect until suspended or revoked by the Director.**

**IN WITNESS WHEREOF, I have hereto set my hand and caused to be hereto affixed the Seal of said Department. Done in my office in the City of Jefferson, this ( Enter date ).**

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**Director of Insurance**





*AUTHORITY: sections 287.135 and 374.045, RSMo 2000.\* Emergency rule filed Aug. 31, 1992, effective Nov. 1, 1992, expired Feb. 28, 1993. Original rule filed April 14, 1992, effective Feb. 26, 1993. Emergency amendment filed Sept. 16, 2002, effective Sept. 26, 2002, expired Dec. 31, 2002. Amended: Filed May 3, 2002, effective Nov. 30, 2002.*

*\*Original authority: 287.135, RSMo 1993, and 374.045, RSMo 1967, amended 1993, 1995.*

*On September 26, 2002, the Circuit Court of Cole County, State of Missouri, issued a temporary restraining order enjoining the enforcement of the rule 20 CSR 500-6.700. On December 3, 2003, the Circuit Court of Cole County subsequently issued a permanent injunction prohibiting the Missouri Department of Insurance from taking any action to enforce or implement the foregoing regulation. See, *Alliance of American Insurers, et al. v. Missouri Department of Insurance and Scott B. Lakin, Director, Case No. 02-CV-325517.**

## 20 CSR 500-6.800 Employee Leasing Arrangements

*PURPOSE: This rule ensures that an employer who leases some or all of its employees properly obtains Workers' Compensation insurance coverage for all of these employees, including those leased from another entity, and that premium is paid commensurate with exposure and anticipated claim experience. The rule is promulgated pursuant to section 374.045, RSMo in order to implement section 287.282, RSMo.*

### (1) Definitions.

(A) Employee leasing arrangement means any arrangement, under contract or otherwise, where one (1) business or other entity leases any of its workers from another business. Employee leasing arrangements include, but are not limited to, full service employee leasing arrangements, long-term temporary arrangements and any other arrangement which involves the allocation of employment responsibilities among two (2) or more entities. For purposes of this rule, the phrase employee leasing arrangements does not include arrangements to provide temporary help service.

(B) Temporary help service means any service where an organization hires its own employees and assigns them to clients for a finite time period to support or supplement the client's work force in special work situations such as employee absences, temporary skill shortages and seasonal workloads.

(C) Client (or lessee) means any entity which obtains all or part of its work force from another entity through an employee leasing arrangement or which employs the services of an entity through an employee leasing arrangement.

(D) Employee leasing company (or lessor) means any entity that grants a written lease to a client through an employee leasing arrangement.

(E) Leased worker (or leased employee) means any person performing services for a client under an employee leasing arrangement.

(F) Multiple coordinated policies basis means—

1. A system of policies where a client's leased and nonleased employees are treated as follows:

A. Each client shall have its own standard Workers' Compensation insurance policy covering its leased workers who are required to be covered pursuant to the Workers' Compensation laws of the state; and

B. Nonleased workers of a client shall not be included on the policy required by subparagraph (1)(F)1.A.;

2. All policies for clients of the same employee leasing company shall be assigned to one (1) insurer in the state;

3. The insurer shall arrange to have the same renewal dates for all the policies;

4. The insurer shall arrange to have all notices sent to the employee leasing company and to have a single master invoice sent to the employee leasing company for all policies covering the clients of the employee leasing company;

5. If a client leases employees from more than one (1) employee leasing company, there shall be a separate policy for the leased employees for each employee leasing company.

6. The insurer also shall issue a policy covering the internal employees of the employee leasing company; and

7. Appropriate endorsements shall be used to restrict the coverage to specific employees and to coordinate coverage between clients and employee leasing company.

(G) Premium subject to dispute shall mean those premiums for which the insured has provided a written notice of dispute to the insurer or service carrier, has initiated any applicable proceeding for resolving such disputes as prescribed by law or rating organization rule, or has initiated litigation regarding the premium dispute. The insured must have detailed the specific areas of dispute and provided an estimate of the premium the insured

believes to be correct. The insured must have paid any undisputed portion of the bill.

(2) Eligibility for Policy Issuance and Continuance.

(A) Basic Rules. Except as provided in subsection (2)(B), a client shall fulfill its statutory responsibility to secure benefits under Chapter 287, RSMo, by purchasing and maintaining a standard Workers' Compensation policy approved by the director. The exposure and experience of the client shall be used in determining the premium for policy.

(B) Exceptions. An employee leasing company which obtains coverage in the voluntary Workers' Compensation market and is registered with the director may elect, with the voluntary market insurer's knowledge and consent, to secure the coverage on leased employees through a standard Workers' Compensation policy issued to the employee leasing company. The insurer of the employee leasing company may take all reasonable steps to ascertain exposure under the policy and collect the appropriate premium through the following procedures:

1. Complete description of employee leasing company's operations;

2. Periodic reporting of covered client's payroll, classifications, experience rating modification factors and jurisdictions with exposure. This reporting may be supplemented by a requirement to submit to the carrier Internal Revenue Service Form 941 or its equivalent on a quarterly basis;

3. Audit of employee leasing company's operations; and

4. Any other reasonable measures to determine the appropriate premium.

(C) Residual Market Coverage. An employee leasing company which obtains coverage through the residual market, established pursuant to section 287.330, RSMo, for leased employees, must secure coverage on a multiple coordinated policies basis. To qualify for coverage on a multiple coordinated policies basis, the employee leasing company shall meet each of the following requirements at application and annual renewal:

1. Its officers or directors, or any person with a five percent (5%) or greater interest, do not owe any premium to the current or prior insurers, except premium subject to dispute;

2. It shall provide information as is otherwise required by this rule; and

3. It shall be registered as an employee leasing arrangement with the Department of Insurance.

(D) Application Data Required for Residual Market. An employee leasing company



which applies for coverage through the residual market shall furnish the following information with the application for coverage:

1. A list by jurisdiction of every name that the employee leasing company has operated under in the preceding five (5) years (including any alternative names and names of predecessors, and successor business entities) along with the policy number and carrier for each Workers' Compensation insurance policy issued to the employee leasing company under every name in the preceding five (5) years and a copy of the most recent Form 941 or its equivalent filed with the United States Internal Revenue Service by the employee leasing company;

2. A list of every person or entity who owns a five percent (5%) or greater interest in the employee leasing company at the time of application and a list of every person or entity who formerly owned a five percent (5%) or greater interest in the employee leasing company or its predecessors, successors or alter egos in the preceding five (5) years;

3. For each person or entity identified in the preceding subsection, a list of all other employee leasing companies in which each person or entity owns or owned a five percent (5%) or greater interest and a list of all other businesses in which each person or entity or combination of two (2) or more persons or entities owns or owned a fifty percent (50%) or greater interest at the time application is made and in the preceding twelve (12) months;

4. A list of jurisdiction for each client, along with any other name(s) a client has operated under in the preceding (5) years and the Internal Revenue Service Form 941 or its equivalent most recently filed with the service with respect to each client and a copy of the most recent Form 941 or its equivalent filed with the United States Internal Revenue Service by each client;

5. A sworn written statement signed by the owner, partner or officer authorized to bind the client legally, that states the policy number and carrier for each Workers' Compensation insurance policy issued to the client under every name in the preceding five (5) years;

6. The employee leasing company must also furnish for each client at the time of application or renewal, a listing of all leased employees along with their Social Security numbers, classification codes and wages; and

7. A sworn written statement signed by the owner, partner or officer authorized to bind the client legally that states that all of the client's nonleased employees are covered by a Workers' Compensation insurance policy. In addition, the sworn written statement

must provide the policy number, carrier, a listing of the number of nonleased employees, and the aggregate payroll applicable to each classification code.

(E) Other Data Required. An employee leasing company which applies for coverage or is covered through either the voluntary market or the residual market mechanism also shall maintain and furnish to the insurer or to the principal rating organization through the residual market servicing carrier, sufficient information to permit the calculation of an experience modification factor for each client. This information shall include:

1. The client's corporate name;
2. The client's taxpayer or employer identification number;
3. The client's risk identification number;
4. A listing of all leased employees associated with each client, the applicable classification code and payroll; and
5. Claims information grouped by client and any other information necessary to permit the calculation of an experience modification factor for each client.

(3) Premium for Leased Workers. Premium shall be charged on the policy of the party to an employee leasing arrangement which is securing coverage for the leased workers as indicated in this section. The party to an employee leasing arrangement which is not securing coverage for the leased workers shall furnish satisfactory evidence that the other party to the employee leasing arrangement had Workers' Compensation insurance in force covering the leased workers. For each employee leasing arrangement for which the evidence is not furnished, additional premium shall be charged on the policy of the party to the employee leasing arrangement which originally did not intend to secure coverage for the leased workers as follows:

(A) The risk shall provide a complete payroll record of the leased workers. Premium on this payroll shall be based on the classifications and rates which would have applied if the leased workers had been direct employees of the client;

(B) If the payroll records of the leased workers are not provided, ten percent (10%) of the full employee leasing arrangement price shall be established as the payroll of the leased workers. The premium shall be charged on that amount as payroll. However, if investigation on a specific employee leasing arrangement contract discloses that a definite amount of the contract price represents payroll, this amount, if deemed reasonable, shall be the payroll for the premium computation; and

(C) If an experience modification has been established for the risk, this experience modification shall be applied to the premium developed for the leased workers.

(4) Multiple Coordinated Policies.

(A) Eligibility. The employee leasing company shall meet each of the following requirements at application and after that to qualify for securing coverage on a multiple coordinated policies basis:

1. It is in good faith entitled to insurance required under the Workers' Compensation laws, state and federal, and has been unable to secure this insurance in a regular manner.

2. Its officers, directors, and any person with a five percent (5%) or greater interest do not owe any undisputed Workers' Compensation premium to the current or prior insurers;

3. It provides all information required under each policy in accordance with this rule; and

4. It is in compliance with all state laws applicable to employee leasing arrangements.

(B) In order for the employee leasing company to secure the coverage for the workers leased to a client, the client must be in good faith eligible to receive the insurance. The client is not in good faith entitled to insurance if any of the following circumstances exist, at the time of the application or after that, or other evidence exists that the client is not in good faith entitled to insurance:

1. If, at the time of application, a self-insured client is aware of pending bankruptcy proceedings, insolvency, cessation of operations or conditions that would probably result in occupational disease or cumulative injury claims from exposures incurred while the client was self-insured;

2. If the client, while insurance is in force, knowingly refuses to meet reasonable health and safety requirements; or

3. If the client, or an enterprise with a common managing interest, has an outstanding obligation for Workers' Compensation premium on previous insurance which is not the subject of a bona fide dispute.

(C) Policy Issuance. Each policy issued to cover the leased workers of a specific employee leasing arrangement on a multiple coordinated policies basis shall be issued in the name of the client and in accordance with this rule and all other rules governing the issuance of a standard Workers' Compensation insurance policy for assigned risk business. A policy issued to cover the direct employees of the employee leasing company under a multiple coordinated policies basis shall be issued in the name of the employee leasing company and in accordance with this rule and all other rules governing the issuance



of a standard Workers' Compensation insurance policy for assigned risk business.

(D) Deposit Premium. The multiple coordinated policies of a single employee leasing company may be combined for the purpose of computing deposit premiums. A deposit premium is payable at the time of application and at the time of renewal.

(E) Endorsements.

1. Employee leasing company policy. The Employee Leasing Company Exclusion Endorsement (Exhibit A) shall be attached to the employee leasing company's policy to exclude coverage for workers leased to specified clients.

2. Client policy. To each client's policy, the Multiple Coordinated Policy Endorsement (Exhibit B) shall be attached to provide coverage for workers leased from the specified employee leasing company and the Employee Leasing Company Endorsement (Exhibit C) shall be attached to extend coverage to the employee leasing company.

(5) Policy Cancellation or Nonrenewal.

(A) Grounds for Cancellation and Nonrenewal. In addition to any statutory grounds that may exist, any violation of this rule is grounds for cancellation or nonrenewal provided that the employee leasing company has been provided a reasonable opportunity to cure the violation.

(B) Notice to Clients. If an employee leasing company has received notice that its Workers' Compensation insurance policy will be canceled or nonrenewed, the leasing company shall notify by certified mail, within fifteen (15) days of the receipt of the notice, all of the clients for which there is an employee leasing arrangement covered under the to-be-canceled policy.

(C) Experience Modification Factor Following Termination.

1. Client covered by multiple coordinated policies basis. In the event that the employee leasing arrangement with a client is terminated, the client shall be assigned an experience modification factor which reflects its experience during the experience period specified by the approved experience rating plan, including, if applicable, experience incurred for leased employees under the employee leasing arrangements.

2. Client covered by master policy. In the event that the employee leasing arrangement with the client is terminated and the experience of the client is commingled with that of other clients on the employee leasing company's master policy, then the experience of the client shall be developed and reported by the insurer, to the extent possible, for use in development of an experience modification

for the client. If suitable payroll and loss experience is not reported, then the employee leasing company's experience modification factor will apply to the client for up to three (3) years or until the client qualifies for development of its own experience modification. The employee leasing company shall notify the insurer or the service carrier thirty (30) days prior to the effective date of termination or immediately upon notification of cancellation by the client of an employee leasing arrangement with a client in order to allow sufficient time to calculate an experience modification factor for the client.

(6) Client's Obligation.

(A) Nothing in this rule shall have any effect on the statutory obligation, if any, of a client to secure Workers' Compensation coverage for employees not provided, supplied or maintained by an employee leasing company pursuant to an employee leasing arrangement.

(B) A client shall not be eligible for coverage pursuant to a Workers' Compensation insurance—

1. Issued to a client in the voluntary market if the employee leasing company in the voluntary market if the client owes its current or prior insurer any premium for Workers' Compensation insurance, except premium subject to dispute.

2. Under a multiple coordinated policy basis in the residual market if the client owes its current or a prior insurer any premium for Workers' Compensation insurance, except premium subject to dispute.

Exhibit A

WORKERS' COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

Original Printing Effective

EMPLOYEE LEASING COMPANY EXCLUSION ENDORSEMENT

As used in this endorsement, employee leasing shall mean an arrangement where an entity utilizes the services of a third party to provide its workers for a fee or other compensation. The third party providing employee leasing services shall be referred to as an employee leasing company. The entity receiving the services shall be referred to as a client.

This endorsement applies only with respect to workers provided by you to a client under an employee leasing arrangement to engage in work for the client. Your policy does not pro-

vide coverage for workers you lease to the clients listed as follows.

Schedule

Client Address Exhibit B

WORKERS' COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

Original Printing Effective

MULTIPLE COORDINATED POLICY ENDORSEMENT

The multiple coordinated policy to which this endorsement is attached provides coverage for the workers you lease from the employee leasing company listed below and does not provide coverage for any other workers leased or nonleased.

This endorsement may be used in jurisdictions where not prohibited by single policy statutes or regulations, or both.

Schedule

- 1. Employee Leasing Company Address
2. State Where Work Performed
3. Contract or Project
4. Employee Leasing Company Policy Number

Exhibit C

WORKERS' COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

1st Reprint Effective

EMPLOYEE LEASING COMPANY ENDORSEMENT

This endorsement applies only with respect to bodily injury to your leased employees in the state named in Item 2 of the Schedule when provided by an employee leasing company named in Item 1 of the Schedule. This endorsement does not apply with respect to bodily injury to workers provided to you on a temporary basis.

Certain words and phrases in this endorsement are defined as follows:



Employee leasing company means the entity furnishing some or all of the workers to another entity.

Client means the entity using the services of an employee leasing company to obtain some or all of its workers.

Temporary worker means a worker who is furnished to an entity to substitute for a permanent employee on leave or to meet seasonal or short-term workload conditions.

Part One (Workers' Compensation Insurance) and Part Two (Employer's Liability Insurance) will apply as though the employee leasing company is an insured. If an entry is shown in Item 3 of the Schedule, the insurance afforded by this endorsement applies only to work you perform under the contract or at the project named in the Schedule.

Under Part One we will reimburse the employee leasing company named in the Schedule for the benefits required by the Workers' Compensation law if we are not permitted to pay the benefits directly to the persons entitled to them.

The insurance afforded by this endorsement is not intended to satisfy the employee leasing company's duty to secure its obligations under the Workers' Compensation law. We will not file evidence of this insurance on behalf of the employee leasing company with any government agency.

We will not ask any other insurer of the employee leasing company to share with us a loss covered by this endorsement.

Premium will be charged for your leased employees while provided by the employee leasing company. You must obtain from the employee leasing company and furnish to us a complete payroll record of your leased employees provided by the employee leasing company to satisfy your obligations under Part Five (Premium), C.2.

The policy may be canceled according to its terms or for violation of rules applicable to employee leasing operations provided that the employee leasing company has been provided a reasonable opportunity to cure the violation. If the policy is canceled, we will send notice of the cancellation to the employee leasing company.

Part Four (Your Duties If Injury Occurs) applies to you and the employee leasing company. The employee leasing company will recognize our right to defend under Parts One

and Two and our right to inspect under Part Six (Conditions).

This endorsement may be used in jurisdictions where not prohibited by single policy statutes or regulations, or both.

#### Schedule

- | 1. Employee Leasing Company   | Address |
|-------------------------------|---------|
| 2. State Where Work Performed |         |
| 3. Contract or Project        |         |

*AUTHORITY: sections 287.282, RSMo (Cum. Supp. 1992) and 374.045, RSMo (1986). \*Original rule filed Dec. 1, 1992, effective Aug. 9, 1993.*

*\*Original authority: 287.282, RSMo (1992) and 374.045, RSMo (1967).*

#### 20 CSR 500-6.950 Workers' Compensation Rate and Supplementary Rate Information Filings

*PURPOSE: This rule sets forth the rules and procedures which the director of the Department of Insurance deems necessary to carry out the provisions for individual insurance companies making Workers' Compensation insurance rate filings pursuant to sections 287.930-287.975, RSMo. When making rate filings, individual insurers may utilize historical rate-making data, as defined in this rule, and developed and tended as follows: 1) by the Missouri Department of Insurance, 2) by the designated advisory organization or 3) by the insurer itself.*

(1) Applicability and Scope. This rule applies to statutory Workers' Compensation insurance as described in sections 287.090, 287.280 and 287.310, RSMo and to insurers making filings under section 287.947, RSMo.

(2) Definitions.

(A) Accepted actuarial standards means the standards adopted by the Casualty Actuarial Society in its Statement of Principles Regarding Property and Casualty Insurance Rate-making, and the Standards of Practice adopted by the Actuarial Standards Board.

(B) Advisory organization means any entity which has two (2) or more member insurers or is controlled either directly or indirectly by two (2) or more insurers, and which assists insurers in ratemaking related activities and is licensed pursuant to section 287.967, RSMo. Two (2) or more insurers

which have a common ownership or operate in this state under common management or control constitute a single insurer for the purposes of this definition. Advisory organization does not include a joint underwriting association, any actuarial or legal consultant, any employee of an insurer or insurers under common control or management or their employees or manager.

(C) Director means the director of the Missouri Department of Insurance.

(D) Expenses means that portion of any rate attributable to acquisition and field supervision; collection expenses and general expenses; and taxes, licenses and fees.

(E) Historical ratemaking data means information respecting Workers' Compensation insurance exposures, premiums and claims paid or reserves held for claims reported, including actual loss adjustment expenses paid or reserved for claims paid or reported but excluding all other expenses or profit, without judgmental adjustments such as loss development and projections through loss trending to a future point in time.

(F) Loss trending means any procedure projecting developed losses to the average date of loss for the period during which the policies are to be effective.

(G) Pure premium rate means that portion of the rate which represents the loss cost per unit of exposure including loss adjustment expense.

(H) Rate means the costs of insurance per exposure base unit, prior to any application of individual risk modifications based on loss or expense considerations, and does not include minimum premiums.

(I) Supplementary rate information means any manual or plan of rates, classification system, rating schedule, minimum premium, policy fee, rating rule, rating plan and any other similar information needed to determine the applicable premium for an insured.

(J) Supporting information means the experience and judgment of the filer and the experience or data of other insurers or organizations relied on by the filer, the interpretation of any statistical data relied on by the filer, descriptions of methods used in making the rates and any other similar information required to be filed by the director.

(3) Reference Filings—Advisory Historical Loss Costs.

(A) The advisory organization shall make reference filings and distribute historical rate-making data in the following manner adjusted for:

1. Development and loss trending by the advisory organization;



2. Development and loss trending by the director; and

3. Loss development without any trend factor.

(B) An insurer shall satisfy its rate filing obligation by submitting—

1. Final rates for each classification in which the insurer writes any voluntary market insurance;

2. The information required in section (4); and

3. All supplementary rate information used in developing the final premium of any insured.

(4) Required Filing Documents. All insurer rate filings shall include the following documents:

(A) Independent Rate Filing Form (Exhibit A);

(B) Rate Development Summary Form (Exhibit B);

(C) A TD-2 filing form and filing fee; and

(D) The final rate pages, including supplementary rate information, indicating the rate for each classification that the insurer chooses to market. Insurers shall file these rates using an electronically readable format. The director will outline the format for making the filings.

(5) Supplementary Rate Information.

(A) Advisory organizations may not develop and make filings of supplementary rating information except as provided in section 287.972.1, RSMo.

(B) Each insurer shall file all supplementary rate information it uses to determine the final premium of any insured employer.

(6) Filing of Rates Effective January 1, 1994. All insurers writing Workers' Compensation insurance in this state shall file their rates in effect on January 1, 1994, along with all supplementary rate information. Insurers shall file these rates and supplementary rate information not later than thirty (30) days after their effective date.

(7) Filing of Rates Effective After January 1, 1994. All insurers filing rates after January 1, 1994, shall file these rates, along with all supplementary rate information, not later than thirty (30) days after their effective date. Nothing in this provision shall prevent insurers from making these filings at any time prior to the effective date of the filings.

**Exhibit A**  
**Independent Rate Filing Form**

Date: \_\_\_\_\_

1. Insurer Name & Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Person Responsible For Filing

\_\_\_\_\_

Title

\_\_\_\_\_

Telephone Number

2. Insurer NAIC # \_\_\_\_\_

3. Advisory Organization Reference Filing # \_\_\_\_\_

4. Proposed Rate Level Change \_\_\_\_\_ %

Proposed Premium Level Change \_\_\_\_\_ %

5. Effective Date \_\_\_\_\_

6. Attach "Rate Development Summary Form (Exhibit B)."

7. Attach TD-2 filing form and \$50.00 filing fee (section 374.230(6), RSMo).



Exhibit B

RATE DEVELOPMENT SUMMARY FORM

Date: \_\_\_\_\_

Insurer Name: \_\_\_\_\_ NAIC Number: \_\_\_\_\_

1. This form is applicable only to the following employer classification(s), as approved in the uniform classification manual:
(Please attach list)

2. Loss Cost Determination:

A. The insurer hereby declares that it used the following historical ratemaking data to determine its final rates:
(Please mark one)

- Own Experience (only)
Advisory Organization's
Combination of Above

If the insured used a combination of historical rate-making data, the insurer hereby declares that the proportional weight given to such data is as follows:

- % Own Experience
% Advisory Organization

B. The insurer declares it used the following loss development factor(s) (LDF) in developing its loss costs:
(Please mark one)

- The advisory organization's loss development factors.
The insurer's own loss development factors.

If the insurer independently developed its own loss development factors, the insurer hereby declares that it used the following factors for each year of loss development:

Table with 2 columns: Policy Year/Accident Year, LDF

C. The insurer hereby declares that it used the following trend factor, combined for MEDICAL AND INDEMNITY, to trend the historical rate-making data:
(Please mark one)

- The advisory organization's trend
The insurer's own trend

If the insurer developed its own trend, the insurer hereby declares that it used the following trend factor:

Annual Trend Factor Used \_\_\_\_\_

3. Development of Expected Loss Ratio. Please attach an exhibit detailing actual insurer expense data or other supporting information, or both. If selected and actual expense provisions differ, please explain.

	Selected	Actual
A. Commission Expense	_____ %	_____ %
B. Other Acquisition Expense	_____ %	_____ %
C. General Expense	_____ %	_____ %
D. Taxes, License & Fees	_____ %	_____ %
E. Underwriting Profit (Loss) & Contingencies	_____ %	_____ %
F. Other Expenses		
(a) premium discount	_____ %	_____ %
(b) dividends	_____ %	_____ %
(c) _____	_____ %	_____ %
(d) _____	_____ %	_____ %
G. TOTAL	_____ %	_____ %
4. Rate level change for the indicated classifications _____ %		

*AUTHORITY: sections 287.947 and 374.045, RSMo Supp. 1993.\* Emergency rule filed Nov. 2, 1993, effective Jan. 1, 1994, expired April 1, 1994. Original rule filed Nov. 2, 1993, effective June 6, 1994.*

*\*Original authority: 287.947, RSMo 1993 and 374.045, RSMo 1967, amended 1993.*



**20 CSR 500-6.960 Plan of Operation for the Workers' Compensation Residual Market**

*PURPOSE: The purpose of this proposed rule is to modify Missouri's Alternative Residual Market (ARM) Plan to allow the Director of Insurance greater flexibility in selecting an entity to administer the state's residual market for worker's compensation insurance. In addition to the current arrangement, which requires the selection of a "contract carrier" to be on the risk for a loss ratio of one hundred fifteen percent (115%) of collected premium, the proposal allows for loss ratios down to one hundred percent (100%), it allows for "plan administrators" who would not be on the risk, and it allows for an appointment process if a bid process is not feasible. The current rule is extensively reorganized to accommodate these additional options.*

*PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. Therefore, the material which is so incorporated is on file with the agency who filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency's headquarters or the same will be made available at the Office of the Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.*

(1) Definitions. For purposes of this rule, unless the context clearly requires otherwise, the terms below are defined as follows:

(A) Allocated Loss Adjustment Expense (ALAE) shall mean ALAE as that term is defined in the National Council on Compensation Insurance, Inc. (NCCI)'s *URE Workers Compensation Statistical Plan*, as approved by the department for use in Missouri, in effect on January 1, 2002, and any subsequently approved amendments thereto;

(B) Alternative Residual Market Plan (ARM Plan) means the Missouri workers' compensation residual market plan set forth in this rule, and its predecessor rule, established under section 287.896, RSMo and in effect since July 1, 1995;

(C) Assessment means the amount owed by and assessed against reinsurers under the ARM Plan because the amount of losses and allocated loss adjustment expense paid by the plan administrator and any servicing carriers,

plus the plan administrator's percentage of the premium, exceed the amount of premium collected by the plan administrator and any servicing carriers, for the period in question;

(D) Collected premium or premium collected means premiums for workers' compensation insurance actually received by a contract carrier, plan administrator or servicing carrier for policies issued during the period of the contract under the request for proposal (RFP) for the ARM Plan;

(E) Contract carrier means an insurer selected by the department to administer the ARM Plan under the "contract carrier option" or "emergency option" of the ARM Plan, and to thereby be at risk for the losses of the plan up to the retention level set by the director, for the term of the contract carrier agreement and any extensions thereof;

(F) Contract carrier agreement means the terms of the RFP issued by the department, the proposed response to that RFP submitted by the insurer ultimately selected to be the contract carrier by the department, and the performance standards and any modifications thereto agreed to by the contract carrier and the department to implement the RFP under the ARM Plan;

(G) Contract carrier option means that alternative under the ARM Plan whereby the director selects a contract carrier to administer the Missouri residual market for workers' compensation insurance, after a formal public bidding process, under which always the contract carrier will be at risk for the losses of the Missouri residual market up to the retention level set by the director. Losses in excess of that retention level shall be reimbursed to the contract carrier by Missouri's voluntary workers' compensation market insurance companies, which are participating as reinsurers under this rule;

(H) Day means calendar day as opposed to business day;

(I) Deficit means the determination made under the ARM Plan that the amount of losses and allocated loss adjustment expense paid by the contract carrier which, when divided by the amount of premium collected by the contract carrier, is greater than or equal to the retention level selected for the contract carrier for the policies issued during the one (1)-year period of the contract carrier agreement and any extensions thereof;

(J) Department (or regulator) means the Missouri Department of Insurance;

(K) Direct assignment carrier means an insurer, other than a servicing carrier, that has elected and been authorized by the department to receive direct assignments pursuant to the servicing carrier option under the ARM Plan. Whether or not to allow insurers

the option of functioning as a direct assignment carrier as opposed to functioning as a servicing carrier is up to the director;

(L) Direct assignment means the act of a plan administrator of assigning a particular employer seeking coverage under the ARM Plan to an insurer authorized by the director to function as a direct assignment carrier. The direct assignment carrier will be at risk for all of the insured losses of an employer so assigned, for period of the policy. The direct assignment carrier shall be entitled to all of the premium generated by an employer so assigned, but in return it shall forego the benefit of the reinsurance normally afforded servicing carriers for losses under the servicing carrier option of the ARM Plan;

(M) Director means the director of the Missouri Department of Insurance;

(N) Emergency option means that alternative under the ARM Plan whereby the director selects either a contract carrier or a plan administrator to administer the Missouri residual market for workers' compensation insurance without using a formal public bidding process;

(O) Employer means any business organization or enterprise that is required under Chapter 287 of the *Revised Statutes of Missouri* to maintain workers' compensation insurance in Missouri, or which has voluntarily decided to elect to be covered by such laws. The term shall include any business organizations or enterprises that are affiliated as a result of common management or common ownership;

(P) Losses means losses and allocated loss adjustment expenses as those terms are defined in the *URE Workers Compensation Statistical Plan* of the NCCI, and any other losses in excess of policy limits or extra-contractual obligations authorized under this rule;

(Q) National Council on Compensation Insurance, Inc., (NCCI) means a particular advisory organization licensed in this state to make and file classifications, loss costs and rating plans for workers' compensation insurance. The NCCI functions as the administrator of the Workers' Compensation Insurance Plan (WCIP) plan residual market mechanism. The NCCI is also the organization named in the Missouri Aggregate Excess of Loss Reinsurance Mechanism to administer insurance carrier participation, deficit assessments and other components of that mechanism under the ARM Plan from July 1, 1995 until the effective date of this rule, and to function as a reinsurance administrator as defined under this rule;

(R) Performance standards are the standards to be met by a contract carrier or plan

administrator in administering the ARM Plan;

(S) Plan administrator means an entity selected by the department to administer the ARM Plan under the "servicing carrier option" or "emergency option" of the ARM Plan, for the term of the plan administrator agreement and any extensions thereof;

(T) Plan administrator agreement means the terms of the RFP issued by the department, the proposed response to that RFP submitted by the entity ultimately selected to be the plan administrator by the department, and the performance standards and any modifications thereto agreed to by the plan administrator and the department to implement the RFP under the ARM Plan;

(U) Plan administrator's percentage of premium means that percentage of the premium collected under the servicing carrier option of the ARM Plan which, per the plan administrator agreement, the plan administrator is allowed to retain to cover the expenses of the plan administrator and any servicing carriers used by the plan administrator. The plan administrator's percentage of premium shall be an amount sufficient to cover the expenses of the plan administrator in administering the ARM Plan, plus an additional amount for profit and contingencies;

(V) Policy or policies means a policy or policies of workers' compensation insurance as defined under this rule issued to risks insured under the ARM Plan;

(W) Producer means an insurance producer as defined in section 375.012, RSMo, whose privileges under either the WCIP or the ARM Plan have not been suspended or revoked, provided, however, that such producer shall, for purposes of this rule, be considered to be acting on behalf of the employer when placing coverage through the ARM Plan and not as an agent of the contract carrier, the plan administrator, or any other insurer;

(X) Reinsurance administrator means the organization identified under this rule to administer the reinsurance provisions of this rule. The reinsurance administrator shall be the NCCI unless another entity is appointed by the director;

(Y) Reinsurer means a Missouri voluntary market workers' compensation insurer in its capacity as a reinsurer for any deficits under the contract carrier option of this rule or for any losses under the servicing carrier option of this rule. The term does not include any direct assignment carriers authorized under the servicing carrier option of this rule;

(Z) Retention level means the level of losses, specified by the director as part of a contract carrier agreement, for which the con-

tract carrier will be responsible, prior to any responsibility of the reinsurers;

(AA) Request for proposal (RFP) means an RFP issued by the department setting forth the specifications for the ARM Plan and inviting potential respondents to submit proposals by which the department can select a contract carrier under the contract carrier option, or plan administrator under the servicing carrier option, to administer the ARM Plan. The department may specify in a single RFP specifications for both a contract carrier option and a servicing carrier option, and may decide as part of its bid evaluation process which option to select;

(BB) Servicing carrier means an insurer, other than a direct assignment carrier, selected by the plan administrator under the servicing carrier option of the ARM Plan to provide insurance services to insured employers and injured employees covered under the ARM Plan;

(CC) Servicing carrier option means that alternative under the ARM Plan whereby the director selects a plan administrator to administer the Missouri residual market for workers' compensation insurance, after a formal public bidding process. The plan administrator will provide any necessary insurance services itself, if it is a licensed and admitted Missouri workers' compensation insurer, or through other insurers functioning as servicing carriers or direct assignment carriers. Losses paid under the servicing carrier option by or on behalf of the plan administrator shall be reimbursed to the plan administrator by Missouri's voluntary workers' compensation market insurance companies, which are participating as reinsurers under this rule;

(DD) Standard premium means the state premium determined on the basis of authorized rates, any experience modification, any applicable schedule rating modification, loss constants and minimum premiums. The expense constant shall be excluded from determination of the standard premium;

(EE) Workers' compensation insurance means:

1. Statutory workers' compensation and occupational disease including liability under the Longshore and Harbor Workers' Compensation Act, as amended, and the Federal Coal Mine Health and Safety Act of 1969, as amended;

2. Employers liability insurance written in connection with a workers' compensation policy;

3. Such other coverages as are approved by the director, including those approved after being recommended by the advisory

board authorized under section (3) of this rule;

(FF) Workers' Compensation Insurance Plan (WCIP) means the NCCI's plan of operation for administering workers' compensation residual markets. The WCIP was the plan used to administer Missouri's residual market prior to the commencement of the ARM Plan on July 1, 1995, and may be used in the future if selected by the director under the servicing carrier option or emergency option of the ARM Plan.

(2) Director's Options for Administering the ARM Plan. The director may select one (1) of the following options for administering the ARM Plan.

(A) The Contract Carrier Option. Under this option, by means of a formal bid process, the director may select a contract carrier to administer the Missouri residual market. The contract carrier will then be on the risk for the losses of the residual market, up to a retention level selected by the director.

1. In its capacity as the contract carrier, the insurer so selected, and any duly-licensed and approved subcontractors of that insurer, shall perform all of the functions required of a workers' compensation insurer, such as employee classification, underwriting, policy issuance, safety engineering, loss control, premium collection, claims handling, claims reserving, auditing and benefits payment, all under performance standards agreed to by the director, for those insured employers and their injured employees covered under the ARM Plan.

2. If losses exceed the selected retention level and thereby result in a deficit, each insurer licensed to write workers' compensation insurance in Missouri (including the contract carrier if it is also a voluntary market insurer) will participate in any such deficit in a proportional manner based upon the insurer's *pro rata* share of voluntary market premium. The deficit collection function shall be administered by the reinsurance administrator under the oversight of an advisory board appointed by the director under section (6) of this rule.

3. In its bid process, the department shall invite each bidding insurer to specify one (1) or more loss retention levels for losses, as defined in this rule, that the insurer is willing to retain in its capacity as contract carrier, provided the levels shall not be lower than one hundred percent (100%) of collected premium for a given contract year or greater than one hundred fifteen percent (115%) of collected premium for a given contract year. The reinsurance administrator shall determine whether or not the retention

level selected by the director is exceeded for any given year, based on data supplied to it by the contract carrier.

4. The premium rates charged to an insured employer under the contract carrier option of this rule shall be based on rates and rating plans recommended by the contract carrier and approved by the director. Premium rates under the ARM Plan shall be actuarially sufficient to cover the losses and the reasonable operating expenses of the plan, plus a reasonable amount to cover profits and contingencies.

(B) The Servicing Carrier Option. Under this option, by means of a formal bid process, the director may select a plan administrator to administer the Missouri residual market. The plan administrator shall not be on the risk for the losses of the residual market, but shall instead cede those losses to the insurers in the state's voluntary workers' compensation market, who shall act as reinsurers under this rule, in return for the premium collected by the plan administrator less the plan administrator's percentage of that premium, as provided for below. The same shall be true of any servicing carriers employed by the plan administrator, provided, however, that a servicing carrier's reimbursement shall be paid out of the plan administrator's percentage of the premium.

1. If the plan administrator is a licensed and admitted workers' compensation insurer, the plan administrator, and any duly-licensed and approved subcontractors of the plan administrator, may perform all of the functions required of a workers' compensation insurer, such as employee classification, underwriting, policy issuance, safety engineering, loss control, premium collection, claims handling, claims reserving, auditing and benefits payment, all under performance standards agreed to by the director, for those insured employers and injured employees covered under the ARM Plan.

2. If the plan administrator is not itself an insurer, it may delegate any insurance functions to one (1) or more licensed and admitted servicing carriers selected or designated by the plan administrator and approved by the director, and, at the option of the director, one (1) or more licensed and admitted direct assignment carriers. The plan administrator shall assign risks covered by the ARM Plan to any such servicing carrier(s) and direct assignment carrier(s) in a manner specified by the plan administrator in its bid, or any subsequent modifications thereto agreed to by the director.

3. The plan administrator, and the servicing carrier(s), if any, shall perform their services in return for a percentage of premi-

um authorized by the director as part of the bid process to reimburse the plan administrator and any servicing carriers. The remaining premium shall be transferred to the insurers licensed to write workers' compensation insurance in Missouri (including the plan administrator and any servicing carriers) in a manner specified by the plan administrator in its bid.

4. In return for a share of the ARM Plan's premiums (less the plan administrator's percentage of premium) which share shall be based on the insurer's *pro rata* share of the Missouri voluntary workers' compensation market premium, each insurer licensed to write workers' compensation insurance in Missouri (including the plan administrator or any servicing carriers if they are also voluntary market insurers) shall participate under this rule by accepting its share of the plan administrator's liabilities for losses under policies insured by the ARM Plan, in a proportional manner based on the insurer's *pro rata* share of the voluntary market's premium.

5. The plan administrator shall account for all premiums collected and losses paid under the ARM Plan in a manner specified under subsection (7)(H) of this rule.

6. If the director authorizes the use of direct assignment carriers, such carriers shall be assigned employers by the plan administrator. A direct assignment carrier shall thereafter provide to such employers all the services required to be provided by the plan administrator and servicing carrier(s). A direct assignment carrier shall receive the premiums of such an assigned insured employer and shall accept all the liability for the losses of such an employer under the policy, but shall be exempt from participating further under this rule on a *pro rata* basis as to either collected premiums or paid losses. The direct assignment carrier's portion of the state's voluntary market premium shall be subtracted from the total voluntary market premium for purposes of calculating the *pro rata* shares of the remaining voluntary market carriers who are functioning as reinsurers for the losses of the ARM Plan.

7. The premium rates charged to an insured employer under the serving carrier option of this rule shall be based on rates and rating plans recommended by the plan administrator and approved by the director. Premium rates under the ARM Plan shall be actuarially sufficient to cover the losses and the reasonable operating expenses of the plan.

(C) The Emergency Option. Under this option, based on unusual market conditions, exigent circumstances or other events deemed by the director to constitute a threat to the

life, property, public health or public safety of Missouri citizens entitled to coverage under the ARM Plan or which threatens to disrupt services under the plan, the director may appoint a duly-qualified and willing entity to function as either a contract carrier or as a plan administrator, as defined above, until such time as it is practical to conduct a formal bid process under the ARM Plan. Any contract carrier or plan administrator so appointed shall have the same rights and responsibilities under this rule as a contract carrier or plan administrator selected after a bid process. Each insurer licensed to write workers' compensation insurance in the voluntary workers' compensation market shall participate in the reinsurance for such an appointed entity under this rule to the same extent as if the entity had been selected after a formal bid process. Under this option, the director and the entity so selected may agree in advance on the premium rates to be charged to insured employers under the ARM Plan for the period during which the emergency option is in effect.

(3) Contract Carrier.

(A) Under the contract carrier option for administering the ARM Plan, a contract carrier shall be selected by the director to administer the plan after a formal bid process conducted by means of a request for proposals (RFP) issued by the department. However, a contract carrier may also be selected by the director without a formal bid process under the emergency option for administering the ARM Plan.

(B) The services to be provided and performance standards to be met by the contract carrier under the ARM Plan are those set forth in the RFP issued by the director, as supplemented by any subsequent performance standards agreed to between the director and the contract carrier following the award of the contract carrier agreement. If a contract carrier is appointed by the director under the emergency option, the contract carrier will operate under the most recently issued RFP of the director, as supplemented by any subsequent performance standards agreed to between the director and the contract carrier following appointment of the contract carrier. In no event shall the performance standards to be met by the contract carrier be less rigorous than those required of a servicing carrier under the WCIP, except as authorized by the director.

(C) The amended 12/94 RFP shall be considered incorporated into this regulation by reference.

(D) The contract carrier shall make available its own staff, office space, facilities and

equipment to the extent necessary to perform its obligations under this rule and the contract carrier agreement. The contract carrier shall perform its services, exercise its powers, and perform all of its duties in accordance with the terms of this rule, the contract carrier agreement, and such performance standards as may be established from time to time pursuant to this rule.

(E) The services to be provided by the contract carrier shall include employee classification, policy underwriting, policy issuance, safety engineering, loss control, premium collection, claims handling, claims reserving, auditing, and benefits payment, all under performance standards agreed to by the director, for those insured employers and injured employees covered under the ARM Plan.

(F) The contract carrier shall process, adjust, settle, compromise, defend, litigate and pay claims arising out of workers' compensation policies issued by the contract carrier under the ARM Plan. The contract carrier shall establish and maintain such claim reserves as are reasonable and proper. It shall also maintain complete, orderly and accurate claim files, records and accounts in accordance with generally accepted insurance principles and the laws of the state of Missouri.

(G) The contract carrier shall comply with the financial and data reporting requirements and procedures established from time to time by the advisory board and approved by the director pursuant to the ARM Plan, with the advice and recommendations of the reinsurance administrator regarding such requirements and procedures.

(H) The contract carrier shall report to the director, and to the reinsurers through the reinsurance administrator, as soon as possible, and, in any event, within ten (10) calendar days, any change in its ability to perform its obligations as a contract carrier hereunder.

(I) The contract carrier shall be fully liable for the payment of any and all workers' compensation administrative taxes and loss-based assessments under state or federal law.

(J) The contract carrier shall permit the director, the reinsurance administrator, or the reinsurers acting through either the director or the reinsurance administrator, full and free access during normal business hours to the contract carrier's premises, records and personnel for the purposes of auditing and reviewing the contract carrier's performance hereunder upon ten (10) calendar days written notice to the contract carrier by either the reinsurance administrator or the director. In the event of a termination of the contract carrier agreement or this rule, this provision shall survive such termination and remain in

full force and effect until all losses under the policies issued by the contract carrier pursuant to the ARM Plan have been satisfied or otherwise resolved. Further, the survival of this provision shall not alter, modify, diminish, or extinguish any outstanding rights or obligations of the parties that otherwise may exist upon such termination under such policies, the contract carrier agreement or this rule.

(K) In its capacity as the contract carrier, the insurer so selected may perform its functions under this rule through duly-licensed subcontractors, subject to the approval of the director.

(L) Nothing in this rule shall relieve the contract carrier of any other obligations imposed on a workers' compensation insurer by Missouri law.

#### (4) Plan Administrator and Servicing Carriers.

(A) Under the servicing carrier option for administering the ARM Plan, a plan administrator may be selected by the director to administer the plan after a formal bid process conducted by means of a request for proposals (RFP) issued by the department. However, a plan administrator may also be selected by the director without a formal bid process under the emergency option for administering the ARM Plan.

(B) The services to be provided and performance standards to be met by the plan administrator under the ARM Plan are those set forth in the RFP issued by the director, as supplemented by any subsequent performance standards agreed to by the director and the plan administrator following the award of the plan administrator agreement. If a plan administrator is appointed by the director under the emergency option, the plan administrator will operate under the most recently issued RFP of the director, as supplemented by any subsequent performance standards agreed to between the director and the plan administrator following the appointment of the plan administrator. In no event shall the performance standards to be met by the plan administrator be less rigorous than those required of a servicing carrier under the WCIP except as authorized by the director.

(C) The amended 12/94 RFP shall be considered incorporated into this regulation by reference.

(D) The plan administrator shall make available its own staff, office space, facilities and equipment to the extent necessary to perform its obligations under this rule and the plan administrator agreement. The plan administrator shall perform its services, exercise its powers, and perform all of its duties

in accordance with the terms of this rule, the plan administrator agreement, and such performance standards as may be established from time to time pursuant to this rule.

(E) The services to be provided by the plan administrator shall include employee classification, policy underwriting, policy issuance, safety engineering, loss control, premium collection, claims handling, claims reserving, auditing and benefits payment, all under performance standards agreed to by the director, for those insured employers and injured employees covered under the ARM Plan. If the plan administrator is a licensed and admitted workers' compensation insurer, the plan administrator shall perform these services.

(F) If the plan administrator is not itself a licensed and admitted insurer, it shall not directly accept any insurance risk, but rather, shall assign such insurance risk and may delegate normal insurance functions required under this rule to one (1) or more licensed and admitted servicing carriers, selected or designated by the plan administrator and approved by the director, and, at the option of the director, one (1) or more direct assignment carriers. The plan administrator shall assign risks covered by the ARM Plan to any such servicing carrier(s) and direct assignment carrier(s) in a manner specified by the plan administrator in its bid, or any subsequent modifications thereto agreed to by the director. If servicing carriers or direct assignment carriers are utilized, the plan administrator shall monitor the performance of the servicing carrier or direct assignment carriers to assure they are meeting the performance standards agreed to by the plan administrator and the director.

(G) The plan administrator or servicing carriers shall process, adjust, settle, compromise, defend, litigate and pay claims arising out of workers' compensation policies issued by the plan administrator or any servicing carrier under the ARM Plan. The plan administrator or any servicing carriers shall establish and maintain such claim reserves as are reasonable and proper. They shall also maintain complete, orderly and accurate claim files, records and accounts in accordance with generally accepted insurance principles and the laws of the state of Missouri.

(H) The plan administrator and any servicing carriers shall comply with the financial and data reporting requirements and procedures established from time to time by the advisory board and approved by the director pursuant to the ARM Plan, with the advice and recommendations of the reinsurance administrator.

(I) The plan administrator shall report to the director, and to the reinsurers through the reinsurance administrator, as soon as possible, and, in any event, within ten (10) days, any change in its ability to perform its obligations as a plan administrator hereunder. Any servicing carrier shall report to the plan administrator, who shall in turn report to the director and the reinsurance administrator, as soon as possible, and, in any event, within ten (10) days, any change in its ability to perform its obligations as a servicing carrier hereunder.

(J) The plan administrator or any servicing carriers shall be fully liable for the payment of any and all workers' compensation taxes and premium or loss-based assessments under state or federal law.

(K) The plan administrator and any servicing carriers shall permit the director, the reinsurance administrator, or the reinsurers acting through either the director or the reinsurance administrator, full and free access during normal business hours to the entity's premises, records and personnel for the purposes of auditing and reviewing the entity's performance hereunder upon ten (10) days written notice to the entity by either the reinsurance administrator or the director. In the event of a termination of the plan administrator agreement and/or this rule, this provision shall survive such termination and remain in full force and effect until all losses under the policies issued by the plan administrator or any servicing carriers pursuant to the ARM Plan have been satisfied or otherwise resolved. Further, the survival of this provision shall not alter, modify, diminish, or extinguish any outstanding rights or obligations of the parties that otherwise may exist upon such termination under such policies, the contract carrier agreement or this rule.

(L) Nothing in this rule shall relieve the plan administrator, if the plan administrator is an insurer, of any other obligations imposed on a licensed workers' compensation insurer by Missouri law.

(5) Participation of Reinsurers.

(A) Under the contract carrier option for the administration of the ARM Plan, reinsurance shall be handled as follows:

1. For the period of the contract carrier agreement, the contract carrier shall cede to the reinsurers and the reinsurers shall accept only that portion of the contract carrier's liability for losses under the policies issued under the ARM Plan in excess of the contract carrier's retention level. Such deficit losses shall be paid to the contract carrier upon evidence of payment by the contract carrier of

such losses and verification of such payment by the reinsurance administrator;

2. In addition to their liability for the losses specified in paragraph (5)(A)1. above, the reinsurers shall also be liable for the expenses of the reinsurance administrator to the extent these expenses are approved from time-to-time by the advisory board;

3. If the period of the contract carrier agreement does not run concurrently with a calendar year, each successive twelve (12)-month period in the agreement shall be assigned to the calendar year in which that twelve (12)-month period commenced for purposes of determining the *pro rata* share of losses in excess of the contract carrier's retention for each of the reinsurers. If the period runs concurrently with a calendar year, each successive twelve (12)-month period shall be assigned to said calendar year;

4. Each reinsurer's proportion of liability in excess of the contract carrier's retention level, or any reinsurance administrator expenses, shall be based on that percentage of the total written premium in Missouri's voluntary workers' compensation market during the calendar year in which the contract carrier agreement commences that is represented by the reinsurer's total written voluntary market premium for that same period, subject to verification by the reinsurance administrator;

5. Each reinsurer's participation shall become effective and shall terminate on the dates specified in subsection (7)(N). Each reinsurer's share of the losses under this subsection shall be calculated with respect to each calendar year for which its participation is effective and shall be based upon the total amount of the participation of all the reinsurers in Missouri for that calendar year;

6. Each reinsurer's liability for its *pro rata* share of the losses under this subsection shall be separate and apart from the liability for the *pro rata* shares of the other reinsurers so that each reinsurer shall be liable solely for its own *pro rata* share of said losses and not the *pro rata* shares of any other reinsurer, except as otherwise provided in this rule, such as under paragraph (7)(L)5.;

7. A reinsurer shall be assessed for its *pro rata* share of any deficit by the reinsurance administrator after verification by the reinsurance administrator of payment of the losses by the contract carrier. Failure of a reinsurer to pay its assessment shall be grounds for discipline of the reinsurer by the department, and legal action by the contract carrier or the advisory board to recover such unpaid assessments;

8. At least annually, the contract carrier, in conjunction with the reinsurance administrator, shall provide an actuarial estimate as

to the likelihood of a deficit to the department and the advisory board. Such estimates shall include a valuation of the probability of any future deficits based on amounts already incurred, determined by an evaluation procedure approved by the department. Such an evaluation procedure may be recommended to the department by the advisory board. Should a deficit be indicated by the actuarial estimate, a projection as to when assessments are expected to begin under this rule shall also be provided to the department;

9. In order to assist the determination of the existence of a deficit, the contract carrier and its affiliated insurers shall, at a minimum, segregate their Missouri voluntary market workers' compensation financial experience and business transactions from their Missouri workers' compensation residual market financial experience and business transactions;

10. The liability for losses of the reinsurers with respect to each cession under this rule shall commence simultaneously with that of the contract carrier, except as otherwise provided in this rule;

11. Except as otherwise provided under this rule, such as subsection (7)(L), the reinsurers shall have no obligation for losses within the contract carrier's retention level.

(B) Under the servicing carrier option for the administration of the ARM Plan, reinsurance shall be handled as follows:

1. For the period of the plan administration agreement, the plan administrator, itself or through its duly-appointed servicing carriers, if any, shall cede to the reinsurers and the reinsurers shall accept, each for its own part and not for the others, quota share reinsurance of the plan administrator's or servicing carrier's liability for all losses under policies issued through the ARM Plan. Losses shall be paid to the plan administrator or servicing carrier upon evidence of payment by the plan administrator or servicing carrier and verification by the reinsurance administrator;

2. In addition to their liability for the losses specified in paragraph (5)(B)1. above, the reinsurers shall also be liable for the expenses of the reinsurance administrator to the extent these expenses are approved from time to time by the advisory board;

3. If the period of the plan administrator agreement does not run concurrently with a calendar year, each successive twelve (12)-month period in the period shall be assigned to the calendar year in which that twelve (12)-month period commenced for purposes of determining the *pro rata* share for each of the reinsurers. If the period runs concurrently with a calendar year, each successive

twelve (12)-month period shall be assigned to said calendar year;

4. Each reinsurer's proportion of liability for losses, or any reinsurance administrator expenses, shall be based on that percentage of the total written premium in Missouri's voluntary workers' compensation market during the calendar year in which the contract carrier agreement commences that is represented by the reinsurer's total written voluntary market premium for that same period, subject to verification by the reinsurance administrator, but not including the premiums of any direct assignment carriers;

5. Each reinsurer's participation shall become effective and shall terminate on the dates specified in subsection (7)(N). Each reinsurer's share of the losses under this subsection shall be calculated with respect to each calendar year for which its participation is effective and shall be based upon the total amount of the participation of all the reinsurers in Missouri for that calendar year;

6. Each reinsurer's liability for its *pro rata* share of the losses under this subsection shall be separate and apart from the liability for the *pro rata* shares of the other reinsurers so that each reinsurer shall be liable solely for its own *pro rata* share of said losses and not the *pro rata* shares of any other reinsurer, except as otherwise provided in this rule, such as paragraph (7)(L)5.;

7. A reinsurer shall be assessed for its *pro rata* share of any losses by the reinsurance administrator after verification by the reinsurance administrator of payment of the losses by the plan administrator or servicing carriers. Failure of a reinsurer to pay its assessment shall be grounds for discipline of the reinsurer by the department, and legal action by the plan administrator, servicing carriers or the advisory board to recover such unpaid assessments;

8. In order to assist in the payment of assessments, the plan administrator and any servicing carriers shall, at a minimum, segregate their Missouri voluntary market workers' compensation financial experience and business transactions from their Missouri workers' compensation residual market financial experience and business transactions;

9. The liability for losses of the reinsurers with respect to each cession under this rule shall commence simultaneously with that of the plan administrator, except as otherwise provided in this rule.

(C) Under the emergency option for the administration of the ARM Plan, the handling of any reinsurance shall depend upon whether the director has selected a contract carrier or a plan administrator to administer

the ARM Plan. If the director has selected a contract carrier, any reinsurance shall be handled as provided under subsection (5)(A) above. If the director has selected a plan administrator, reinsurance will be handled as provided under subsection (5)(B) above.

(6) Reinsurance Administrator and Advisory Board.

(A) Subject to the direction and approval of the advisory board, the reinsurance administrator, shall perform the functions set forth in this rule, including the following:

1. Informing the director as to any insurance carrier not participating as a reinsurer as required under this rule;

2. Administering the deficit sharing mechanism under the contract carrier option of this rule or the premium and loss distribution and assessment mechanism under the servicing carrier option of this rule;

3. Advising the department as to the oversight activities requisite to ensuring appropriate performance by the contract carrier or the plan administrator and any servicing carriers;

4. Acting as secretary for the advisory board;

5. Analyzing a contract carrier's estimate of whether and when a deficit will occur; and

6. Determining expenses and fees for the operation of the deficit sharing and assessment provisions of this rule, and assessing each insurer participating in the ARM Plan for these expenses and fees, on an equitable basis determined by the advisory board. Such administrative expenses and fees shall be labeled as such on any assessments to clearly distinguish them as being in addition to the amount of any underlying deficit under the contract carrier option or any assessment under the servicing carrier option.

(B) Advisory Board.

1. The advisory board shall be composed of at least nine (9) but no more than thirteen (13) members, appointed by the director as follows:

A. No fewer than nine (9) insurers who write workers' compensation insurance in Missouri's voluntary market, and who are representative of the interests of such carriers;

B. Other members as determined by the director, with consideration given to members recommended by the advisory board.

2. The function of the advisory board is to oversee the reinsurance administrator, and to assist and advise the director regarding the execution of the ARM Plan by a contract carrier, a plan administrator and any servicing

carriers, and the member insurers required to be reinsurers under the ARM Plan. The advisory board may consider any matter referred to it by the reinsurance administrator or the director which relates to the operation of the ARM Plan.

3. Each advisory board member shall serve a term of two (2) years, but may serve additional terms.

4. No advisory board member shall fill more than one (1) position on the board. All advisory board members shall serve until their successors are designated by the director. Any vacancy on the advisory board, by resignation or otherwise, shall be filled by a representative of the member's insurer or organization, until a replacement is appointed.

5. The advisory board members, in person or by proxy, shall hold an annual meeting at which it shall elect a chairperson. The advisory board shall hold such additional meetings as necessary whenever requested by the chairperson, the director or upon petition of three (3) advisory board members. Meetings of the advisory board may be held or attended, and votes taken, by means of a teleconference.

6. The advisory board shall review any expenses or fees recommended by the reinsurance administrator to reimburse the reinsurance administrator, the members of the advisory board and any duly appointed subcontractors thereof, for their services on behalf of the ARM Plan. The advisory board shall, on behalf of the reinsurers, approve such recommendations to the extent the board finds such recommendations fair and reasonable.

7. The advisory board shall also approve any amounts needed to indemnify the board or the reinsurance administrator.

(7) Additional Reinsurance Provisions.

(A) Original Conditions.

1. All reinsurance under this rule shall be subject to the same rates, terms, conditions and waivers, and to the same modifications and alterations as the underlying workers' compensation policies, except as otherwise provided in this rule.

2. Nothing herein shall in any manner create any obligations or establish any rights against the reinsurers in favor of any third party unless authorized under this rule.

3. A reinsurer's rights and responsibilities under this rule shall continue unchanged for the period of each extension of the contract carrier agreement or plan administrator agreement, except for revisions necessary to be consistent with the terms of each such extension.

(B) Indemnification. Notwithstanding anything stated herein, this rule shall not apply to any loss incurred by a contract carrier, plan administrator or any servicing carrier as a result of any willful misconduct or any fraudulent or criminal act by an employee, officer or director of the contract carrier, plan administrator or servicing carrier acting individually or collectively or in collusion with any individual or corporation or any other organization or party involved in the presentation, defense or settlement of any loss covered under this rule.

(C) The Reinsurance Administrator. The reinsurance administrator is recognized as the agent through whom funds and communications relating to this rule (including but not limited to notices, statements, reports of premium, losses and loss adjustment expense, salvage and loss settlements) shall be transmitted.

(D) Premium.

1. The contract carrier or the plan administrator and any servicing carriers shall be responsible for the collection of all premiums on all risks assigned to them under the ARM Plan. The reinsurers shall have no responsibility for the premiums, uncollected premiums, return premiums, or similar items under this rule.

2. Reinsurers shall not receive any portion of the premiums on the policies issued by the contract carrier.

(E) Salvage and Subrogation. In the event that the contract carrier or plan administrator and any servicing carrier recover any money by way of subrogation or otherwise, other than from the reinsurers, on a claim for which the contract carrier or plan administrator and any servicing carriers has been reimbursed by the reinsurers, the contract carrier or plan administrator and any servicing carriers shall reimburse the reinsurers for amounts paid by the reinsurers on account of such claim, but not more than the total amount so recovered less expenses incurred in securing such recovery.

(F) Losses.

1. Losses shall be reported by the contract carrier or plan administrator and any servicing carriers in the format and manner specified in subsection (7)(H) below.

2. All loss settlements made by the contract carrier or plan administrator and any servicing carriers, whether under strict contract conditions or by way of compromise, shall be binding unconditionally upon the reinsurers.

(G) Losses in Excess of Policy Limits or Extra-Contractual Losses.

1. In the event the contract carrier or plan administrator and any servicing carrier

pays an amount of loss in excess of its policy limits under a workers' compensation policy issued under the ARM Plan, but otherwise within the terms of the policy (hereinafter called "loss in excess of policy limits") including but not limited to any punitive, exemplary, compensatory or consequential damages, resulting from the alleged improper conduct of the insured, one hundred percent (100%) of the loss in excess of the policy limits as well as the loss adjustment expense incurred in connection therewith shall be added to the losses of the contract carrier or plan administrator and any servicing carriers, under this rule.

2. Any loss in excess of policy limits shall be deemed to have occurred on the same date as the loss covered or alleged to be covered under the policy.

(H) Reports and Remittances.

1. Within forty-five (45) days after the end of each calendar quarter, the contract carrier or the plan administrator shall report to the reinsurers, through the reinsurance administrator, premiums, losses, and other amounts for the quarter, in such detail as the advisory board shall reasonably require.

2. Any amounts paid by the contract carrier or plan administrator and any servicing carriers and recoverable from reinsurers shall be remitted by the reinsurers, through the reinsurance administrator, as promptly as possible after receipt and verification of the report of the contract carrier or plan administrator. Any remittance shall be paid within thirty (30) days of the invoice mailing, or within other reasonable time periods established by the advisory board.

(I) Offsets. The contract carrier or plan administrator and any servicing carriers, or the reinsurers shall have and may exercise at any time, and from time to time, the right to offset any balance or balances whether on account of premiums or on account of losses or obligations otherwise due from one party to the other or any affiliate thereof in their capacities under the terms of this rule.

(J) Currency. All limits under this rule are expressed in United States dollars and all premium and loss payments shall be made in United States currency. For the purposes of this rule amounts paid or received by the contract carrier or plan administrator and any servicing carriers in any other currency shall be converted into United States dollars at the rates of exchange at which such transactions are converted on the books of the contract carrier, plan administrator or servicing carrier.

(K) Inadvertent Delays, Errors or Omissions in Performance. Inadvertent delays, errors or omissions made in connection with

this rule or any transaction hereunder shall not relieve either party from any liability which would have attached had such delay, error or omission not occurred, provided that such error or omission will be rectified as soon as possible after discovery.

(L) Insolvency.

1. In the event of the insolvency of the contract carrier, the plan administrator or a servicing carrier, reinsurance owed under this rule shall be payable directly to the insolvent entity or its liquidator, receiver, conservator or statutory successor on the basis of the liability of the insolvent entity without diminution because of the insolvency of the entity or because the liquidator, receiver, conservator or statutory successor of the entity has failed to pay all or a portion of any claim.

2. The liquidator, receiver, conservator or statutory successor of the insolvent contract carrier, plan administrator or servicing carrier shall give written notice to the reinsurers of the pendency of a claim against the insolvent entity indicating the contract or bond reinsured which claim would involve a possible liability on the part of the reinsurers within a reasonable time after such claim is filed in the conservation or liquidation proceeding or in the receivership, and that during the pendency of such claim, the reinsurers may investigate such claim and interpose at their own expense, in the proceeding where such claim is to be adjudicated, any defense or defenses that they may deem available to the insolvent entity or its liquidator, receiver, conservator or statutory successor.

3. The expense thus incurred by the reinsurers shall be chargeable, subject to the approval of the court, against the insolvent entity as part of the expense of conservation or liquidation to the extent of a *pro rata* share of the benefit which may accrue to the insolvent entity solely as a result of the defense undertaken by the reinsurers.

4. The reinsurance shall be payable by the reinsurers to the contract carrier or the plan administrator and any servicing carriers or their liquidator, receiver, conservator or statutory successor, except as provided by applicable law except where this rule specifically provides another payee of such reinsurance, in the event of the insolvency of such entity and where the reinsurers, with the consent of the direct insureds, have assumed such policy obligations of the reinsurers to the payees under such policies and in substitution for the obligations of the insolvent entity to such payees.

5. In the event any reinsurer becomes insolvent, participation by such reinsurer under this rule shall be deemed terminated at the time such reinsurer becomes insolvent.

The outstanding liability of an insolvent reinsurer shall be assumed by and apportioned among the remaining reinsurers in the same manner for which other liabilities are apportioned.

(M) Security. If determined by the director or the reinsurance administrator, the contract carrier, plan administrator, servicing carriers or the reinsurers will provide such security for the benefit of the parties to this rule as determined by the director or the reinsurance administrator.

(N) Commencement and Termination.

1. This rule shall apply to the individual contract carrier agreement or plan administrator agreement for the period of said agreement and any extensions thereto.

2. A reinsurer's responsibility under this rule may be terminated by the reinsurer only upon surrender of its authority to write workers' compensation in Missouri. The reinsurance administrator shall inform the director of any reinsurer that terminates its participation under this rule.

3. If the reinsurance administrator determines that the contract carrier, plan administrator or servicing carrier is not in compliance with any provision of this rule, the contract carrier or plan administrator agreement, or any performance standards, it shall notify the director, the contract carrier, plan administrator or servicing carrier of such noncompliance. The director shall have the right to take appropriate action as specified in the ARM Plan or the contract carrier agreement or plan administrator agreement.

4. Reinsurance under this rule shall remain in full force and effect until all losses under the workers' compensation policies for the time period in question have been settled and satisfied or otherwise resolved.

(8) Rules for Eligibility and Assignment.

(A) The provision of this section shall govern the insuring of employers who are required to carry workers' compensation insurance, but who are unable to procure such insurance through ordinary methods. Any employer insured under the ARM Plan shall receive at least the same quality of service as is available to those employers who are voluntarily insured. This includes, but is not limited to, safety engineering, loss control, claims handling, employee classification and reserving practices. Any dispute arising hereunder shall be subject to section (10) of this rule.

1. Application for insurance shall be filed with the contract carrier or plan administrator by the employer or its representative on a form approved by the department.

2. Good faith will be presumed in the absence of clear and convincing evidence to the contrary. An employer is not, in good faith, entitled to insurance if any of the following circumstances exist, at the time of application or thereafter, or other evidence exists that such employer is not in good faith entitled to insurance:

A. If, at the time of application, a self-insured employer is aware of pending bankruptcy proceedings, insolvency, cessation of operations, or conditions that would probably result in occupational disease or cumulative injury claims from exposure incurred while the employer was self-insured;

B. If the employer, while insurance is in force, knowingly refuses to meet reasonable health and safety requirements designed to remove an imminent threat of serious bodily harm;

C. If the employer has an outstanding obligation for workers' compensation premium on previous insurance about which there is no formal dispute;

D. If the employer, or its representative or the producer knowingly makes a material misrepresentation on the application by omission or otherwise, including any of the following: estimated annual premium, estimated payroll, offers of workers' compensation insurance, nature of business, name or ownership of business, previous insurance history, or outstanding premium obligation of the employer.

3. Coverage may be bound under the ARM Plan, in accordance with the following procedures:

A. The producer should forward the completed application to the contract carrier or plan administrator with a certified, cashier's, or producer check payable to the contract carrier or plan administrator for the estimated annual or deposit premium as computed by the producer, or determined by contacting the contract carrier or plan administrator prior to submission of the application. The employer or its representative shall also include with and as a part of the application a copy of the employer's latest filed federal employer 941, 941E, 942 or 943 form or equivalent federal- or state-required verifiable current payroll record, such as an unemployment wage report. The application form, as approved by the department, shall indicate the employer's agreement to authorize its current carrier to release any safety and loss information to the contract carrier or plan administrator. For all employers other than those formerly self-insured, coverage will be bound at 12:01 a.m. on the first day following the postmark time and date on the envelope in which the application is mailed,

including the estimated annual or deposit premium, or the expiration of existing coverage, whichever is later. If there should be no postmark, coverage will be effective 12:01 a.m. of the date of receipt by the contract carrier or plan administrator unless a later date is requested. Those applications hand delivered to the contract carrier or plan administrator will be effective as of 12:01 a.m. the date following receipt by the contract carrier or plan administrator unless a later date is requested;

B. For employers formerly self-insured, coverage will be bound at 12:01 a.m. not later than sixty (60) days following the postmark time and date on the envelope in which the application is mailed including the estimated annual or deposit premium, or the expiration of existing coverage, whichever is later. If there should be no postmark, coverage will be effective 12:01 a.m. not later than sixty (60) days following the date of receipt by the contract carrier or plan administrator unless a later date is requested. Those applications hand delivered to the contract carrier or plan administrator will be effective 12:01 a.m. not later than sixty (60) days following the date of receipt by the contract carrier or plan administrator, unless a later date is requested;

C. If coverage is bound pursuant to the above, the contract carrier or plan administrator shall issue a binder with copies to the producer, the insured, and the Missouri Division of Workers' Compensation.

4. Assignments shall not be made under this rule unless all workers' compensation premium obligations on any previous insurance have been met by the employer, unless a formal dispute regarding such payments has been made. If, subsequent to policy issuance, the insured employer does not meet all workers' compensation insurance premium obligations under a previous policy or under a present policy, the contract carrier or plan administrator shall have the right to cancel the policy currently in force under the ARM Plan.

5. The policy shall be issued for a term of one (1) year, unless insurance for a shorter term has been requested or unless a longer period is authorized by the department. A copy of the policy declarations and all endorsements, properly stamped ARM Plan, will be retained by the contract carrier or plan administrator.

6. If, after the issuance of a policy, the contract carrier or plan administrator determines that an employer is not entitled to insurance, or has failed to comply with reasonable safety requirements, or has violated any of the terms and conditions under which the insurance was issued, and after providing



opportunity for cure, the contract carrier or plan administrator shall initiate cancellation. Any insured employer so canceled must reestablish eligibility or must demonstrate entitlement before any further coverage will be provided under the ARM Plan.

7. All policies issued pursuant to the ARM Plan shall be written utilizing the classifications, forms, rates and rating data set forth in the contract carrier or plan administrator's RFP response or as otherwise approved by the director.

8. Unless otherwise authorized by the director, at least sixty (60) days prior to the expiration date of insurance, the contract carrier or plan administrator shall send a renewal proposal or notice of impending expiration of coverage to the named insured at his last known address and the insured's producer. Upon receipt of the required premium, the policy shall be renewed and a copy of the policy information page and all endorsements, properly stamped ARM Plan, shall be retained by the contract carrier or plan administrator.

9. Any otherwise eligible employer who agrees to have its workers' compensation insurance provided by an insurer other than the contract carrier or plan administrator on a voluntary basis may do so at any time. The contract carrier or plan administrator shall cancel its coverage on a *pro rata* basis as of the effective date of the voluntary insurer's policy.

10. Any employer desiring insurance for operations in states other than Missouri must notify the contract carrier or plan administrator regarding the need for insurance in such additional states in accordance with section (9) of this rule.

11. The employer may designate a licensed producer and, with respect to any renewal of the contract carrier or plan administrator, may change the designated producer by notice to the contract carrier or plan administrator prior to the date of such renewal or, with the consent of the contract carrier or plan administrator, at any other time. The contract carrier or plan administrator shall pay a fee to the producer designated by the employer on new and renewal policies after July 1, 1995, upon payment of all premium due under the policy. The fee shall be based on the state standard premium and paid at the rate as set forth in the contract carrier or plan administrator's RFP response.

(B) Producers through whom employers seek worker's compensation coverage shall endeavor to place such coverage through the voluntary market; only where the producer certifies on an application approved by the department that the producer has been unable

to obtain such coverage at comparable cost and service through the voluntary market shall such coverage be placed in the ARM Plan. At the direction of the department, a risk may be removed from the ARM Plan if the department subsequently determines coverage was available through the voluntary market at comparable cost and service and this fact was known to the producer.

(C) For purposes of assisting in the placement of risks in the voluntary market, an expiration list of risks in the ARM Plan shall be made available, by the contract carrier or plan administrator and through the department, to producers and insurers, at the normal copying costs.

(D) Notwithstanding the above provisions of this section, an approved plan administrator may file a plan of operation for approval by the director which incorporates its own rules of eligibility and assignment, which, upon approval, shall supercede the rules of eligibility and assignment of this section.

(9) Interstate Assignments.

(A) Any employer seeking coverage under this ARM Plan and desiring coverage for workers' compensation benefits of states other than Missouri for its Missouri-based employees who may have business reasons to travel to other states may request the contract carrier or plan administrator to furnish such insurance on an endorsement form approved by the department. Such form may indicate that employees based in states other than Missouri are not covered by this endorsement.

(B) Employers with known exposures in states other than Missouri may request the contract carrier or plan administrator to assist them in obtaining coverage in these other states. If the contract carrier or plan administrator does not wish to provide coverage for the additional states on a voluntary basis, the contract carrier or plan administrator shall advise the employer and the producer to submit an application to the appropriate administrator having jurisdiction.

(10) Dispute Resolution Procedure.

(A) Any person affected by the operation of the ARM Plan including, but not limited to, insured employers, covered employees, producers, the contract carrier, the plan administrator, a servicing carrier or a direct assignment carrier who may have a dispute with respect to any aspect of the plan, may seek a review of the matter by the department by setting forth in writing with particularity the nature of the dispute, the parties to the dispute, the relief sought and the basis thereof. The department may secure such addi-

tional information as it deems necessary to make a decision.

(B) Appeals from insured employers and covered employees on plan matters regarding individual employer disputes shall be within the jurisdiction of the mechanism established to handle such appeals under the applicable insurance laws, including section 287.335, RSMo. All other disputes shall be handled as follows:

1. If the dispute relates to the general operation of the ARM Plan, excluding individual employer disputes and those arising under this rule, the department shall review the matter and render a written decision with an explanation of the reasons for the decision within sixty (60) days after receipt of all the information necessary to make the decision. In reviewing any such matter, the department shall decide the dispute in accordance with the state law, regulation and policy and in the interests of the reasonable and proper administration of the ARM Plan. The department's decision shall be final, subject to court review;

2. Except as provided below, if the dispute arises under the reinsurance provisions of this rule, the reinsurance administrator shall first review the matter and render a written decision to the complaining party with an explanation of the reasons for the decision within sixty (60) days after receipt of all the information necessary to make the decision. Any party affected by the decision may seek a review by the advisory board established under this rule by requesting such review, in writing, within thirty (30) days of the date of the decision by the reinsurance administrator. The advisory board must then review the matter and render its written decision pursuant to the bylaws adopted by the board. Any party affected by a decision of the advisory board may seek a *de novo* review by the department by requesting such a review in writing within thirty (30) days of the date of the board's decision.

(11) Rate Monitoring.

(A) It is essential for maintaining the long-run viability of the ARM Plan that the contract carrier, plan administrator or prospective contract carriers or plan administrators have the data necessary to determine appropriate rates. As insureds may, over time, move between the ARM Plan and the voluntary market, data for the total market must be maintained. On behalf of the department, the NCCI shall maintain necessary ratemaking data in order to permit the actuarial determination by the department and the contract carrier or plan administrator of rates, consistent with the NCCI-administered

classification system, for the business insured through the ARM Plan. The contract carrier or plan administrator is required to report its experience on business written under the ARM Plan to the NCCI in the same format required by the NCCI for carriers writing voluntary market business. The NCCI shall provide to the contract carrier or plan administrator and the department all requested information necessary for establishing reasonable classifications, rates and enabling financial information required for the successful operation of the ARM Plan and the total market, and for whatever other purposes the department from time to time may require for said data.

(B) The contract carrier or plan administrator shall file any rate requests for the residual market in accordance with the provisions of section 287.896, RSMo.

(12) Notice. Within sixty (60) days of the effective date of this rule, the reinsurance administrator shall provide notice to all insurers that are required to participate as reinsurers under this rule. The notice shall include a copy of this rule or a reference to the department's website, as well as the dates the rule was effective and shall advise each insurer of the obligation to participate as reinsurers. The reinsurance administrator shall inform the Director of any insurer refusing to participate as a reinsurer, as required under this rule.

(13) Confidentiality of Information.

(A) For purposes of this section, the phrase "contract carrier or plan administrator" shall include any reinsurance market reinsurers, or any subcontractors, vendors, servicing carriers or other entities or persons utilized by or associated with the contract carrier or plan administrator in the administration of and the insuring of the Missouri workers' compensation residual market under the ARM Plan.

(B) Detailed information, whether provided orally, in writing, via computer media, or by other means, given to producers, insurers, or their clients, required to properly evaluate, underwrite and insure risks under the ARM Plan, shall be provided by such persons and entities to the contract carrier or plan administrator for evaluation, underwriting and insurance purposes. In consideration of the disclosure of such information, the contract carrier or plan administrator agrees to and shall comply with the following provisions:

1. The contract carrier plan or administrator shall keep in confidence and shall not, except as directed by the insured, disclose to any third party, or use for the benefit of any

third party, such detailed information, regardless of the form or format of the disclosure; such information shall be used by the contract carrier or plan administrator solely for the evaluating, underwriting and insuring of workers' compensation and employer's liability insurance coverage under the ARM Plan, and not for any other purpose without the prior approval of the insured.

2. The contract carrier or plan administrator shall take all reasonable measures necessary to protect the confidentiality of such information in its possession from disclosure to any other third party, except as directed by the insured.

3. The contract carrier or plan administrator shall not directly or indirectly request, encourage, or advise any employers who have acquired or seek to acquire coverage through the ARM Plan to utilize the services of any specific insurance producer, insurer or group of insurers for workers' compensation insurance coverage.

4. The contract carrier or plan administrator shall not give any other person, firm or entity any rights that would circumvent or violate the provisions of paragraphs 1. through 3., above.

(C) Notwithstanding the confidentiality provisions set forth in subsection (B) of this section, the contract carrier or plan administrator is expressly authorized to provide the information delineated in subsection (B) of this section to the department, the Missouri Division of Workers' Compensation and any other organization or entity designated by the department to gather and analyze data for the purpose of establishing rate or loss cost information, or in conjunction with the issuance of reports concerning the Missouri workers' compensation market.

(D) In addition to any other remedies available to the department regarding any violation of the provisions of this section, including those contained in section 374.280, RSMo, the department shall consider the nature and severity of any violations of the provisions of this section during its consideration of the letting of or renewal of any contract for the administration of and insurance of the Missouri workers' compensation residual market under the ARM Plan.

*AUTHORITY: sections 287.896 and 374.045, RSMo 2000.\* Emergency rule filed June 15, 1995, effective July 1, 1995, expired Oct. 28, 1995. Original rule filed April 3, 1995, effective Sept. 30, 1995. Emergency rule filed April 26, 2002, effective May 6, 2002, expired Feb. 6, 2003. Emergency rescission filed May 7, 2002, effective May 17, 2002, expired Feb. 18, 2003. Rescinded: Filed Nov.*

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*\*Original authority: 287.896, RSMo 1993 and 374.045, RSMo 1967, amended 1993, 1995.*