
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.

(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 agents shall guarantee or promise to a policyholder or prospective policyholder the amount or percentage of dividends to be paid.

AUTHORITY: sections 287.310, RSMo Supp. 1992 and 374.045, RSMo 1986. 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.*

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

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 poli-

cyholder 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 possess 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**

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).

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.*

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 provide 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 ratemaking 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. Includes four rows of blank lines for data entry.

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: This rule is to formalize the plan of operation for a new Workers' Compensation residual market, known as the Alternative Residual Market Plan. The regulation also specifies the procedures for the transition to the Alternative Residual Market Plan from the Workers' Compensation Insurance Plan previously filed by the National Council on Compensation Insurance, Inc. and approved as of October 14, 1993. Pursuant to section 287.896, RSMo, Alternative Residual Market Plan will provide for the equitable apportionment among all insurers authorized to write Workers' Compensation and employers' liability insurance in Missouri of insurance which may be afforded applicants who are in good faith entitled to such insurance, but who are unable to procure such insurance through ordinary methods. The Alternative Residual Market Plan will guarantee insurance coverage and quality loss prevention and control services to employers seeking coverage through the plan. The plan will provide such insurance at actuarially sufficient premium rates agreed to by the Department of Insurance. The plan will also provide that the processing of applications, the conduct of safety engineering and other loss control services and the handling of claims for the plan shall be accomplished within the state of Missouri or adjoining states.

Under the Alternative Residual Market Plan, the Department of Insurance shall contract with an entity (the contract carrier) to issue Workers' Compensation and employer's liability policies for a one-year period to eligible employers seeking such coverage. If losses on the policies issued pursuant to this contract produce a deficit as defined herein, all insurers writing Workers' Compensation insurance in Missouri are required to reimburse the contract carrier in accordance with the Missouri Aggregate Excess of Loss Reinsurance Mechanism.

The Alternative Residual Market Plan replaces the prior WCIP. The Alternative Residual Market Plan and any future modification thereof is subject to the approval of the director of the Missouri Department of Insurance, provided, however, that such amendments shall not change the performance standards required of the contract carrier during the period of the contract, except where mutually agreed to by the contract carrier and the department.

EDITOR'S NOTE: The following material is incorporated into this rule by reference:

1) *Missouri Department of Insurance, Requests for Proposals for an Alternative Residual Market Plan for the Missouri Workers' Compensation System (Re-bid Amended) (Jefferson City, MO: Missouri Department of Insurance, January 13, 1995);*

2) *NCCI's Workers Compensation Insurance Plan (WCIP), Exhibit III, Workers Compensation and Employers Liability, National Council on Compensation Insurance (effective February 9, 1993); and*

3) *NCCI's Definition of Allocated Loss Adjust Expense (Item U-1292) Memorandum Government, Consumer and Industry Affairs, National Council on Compensation Insurance (Boca Raton, FL: National Council on Compensation Insurance, December 7, 1992).*

In accordance with section 536.031(4), RSMo. The full text of material incorporated by reference will be made available to any interested person at the Office of the Secretary of State and the headquarters of the adopting state agency.

(1) Definitions.

(A) *Affiliated insurers means an insurer that, directly or indirectly, through one (1) or more intermediaries, controls, or is controlled by, or is under common control with the insurer specified. The term control means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of an insurer whether through the ownership of voting securities, by contract, or otherwise. Control shall be deemed to exist if any person or business enterprise, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies, representing ten percent (10%) or more of the voting securities of any other insurer. Any insurer which is under the management or control of a state regulatory authority, receiver or other similar body, either pursuant to statute or the order of a court of competent jurisdiction, shall be deemed to be under the control of its former management for purposes of the Missouri Aggregate Excess of Loss Reinsurance Mechanism until such time as management or control is transferred to a successor in interest pursuant to a lawful plan, contract or order.*

(B) *Allocated Loss Adjustment Expense (ALAE), as used in this rule, shall have that meaning set forth in the National Council on Compensation Insurance, Inc. (NCCI's) Workers' Compensation Statistical Plan, as approved by the department for use in Missouri, in effect on July 1, 1995.*

(C) *Alternative Residual Market Plan (A.R.M.) means the Missouri Workers'*

Compensation residual market mechanism which shall commence insurance operations on or after July 1, 1995, replacing the residual market mechanism known as the Workers' Compensation Insurance Plan (WCIP).

(D) *Articles of agreement or articles means the mechanism authorized under the WCIP to provide reinsurance to the servicing carriers on employers assigned to them under the WCIP.*

(E) *Collected premium or premium collected means premiums for Workers' Compensation and employer's liability insurance actually received by the contract carrier for policies issued during the period of the contract under the request of proposal (RFP).*

(F) *Contract carrier means a respondent to the department's request for proposals who has been selected by the department to administer the A.R.M. Plan.*

(G) *Deficit means the determination made under the A.R.M. Plan that the amount of losses paid 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 one hundred fifteen percent (115%) for the policies issued during the one (1)-year period of the contract as periodically calculated and adjusted under the Missouri Aggregate Excess of Loss Reinsurance Mechanism set forth in Exhibit A of this rule.*

(H) *Department (or regulator) means the Missouri Department of Insurance.*

(I) *Direct assignment carrier means an insurer, other than a servicing carrier, that has been elected and authorized to receive direct assignments pursuant to Option 1 under section III of the WCIP.*

(J) *Director means the director of the Missouri Department of Insurance.*

(K) *Employer means any business organization or enterprise that is required under Chapter 287, RSMo 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.*

(L) *Employer relations consultant means the entity which has contracted to facilitate dispute resolution between the contract carrier, employers and producers, under section (8) of this rule.*

(M) *Missouri Aggregate Excess of Loss Reinsurance Mechanism means a mechanism under the A.R.M. Plan which, when approved by the director, specifies the system for distributing any residual market deficit through an assessment on insurance carriers authorized to write Workers' Compensation*

insurance in proportion to the respective share of the voluntary market premium written by such carrier. The provisions of Missouri Aggregate Excess of Loss Reinsurance Mechanism are set forth in Exhibit A.

(N) National Council on Compensation Insurance, Inc., (NCCI) means an advisory organization licensed in this state to make and file classifications, loss costs and rating plans for Workers' Compensation insurance. The NCCI is also authorized to function as the administrator of the WCIP residual market mechanism, and in this capacity shall be replaced by the contract carrier under the A.R.M. Plan. 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 the mechanism.

(O) Plan administrator means the organization designated under the WCIP to administer the affairs of the WCIP. Said plan administrator shall be replaced by the contract carrier, who shall administer the A.R.M. Plan after the transition described in this rule.

(P) Producer means a licensed insurance agent, broker or agency, as defined in section 375.012, RSMo, whose privileges under either the WCIP or the A.R.M. 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 A.R.M. Plan and not as a agent of the contract carrier or other insurer.

(Q) Reinsurance administrator means the organization identified under the A.R.M. Plan to administer the Missouri Aggregate Excess of Loss Reinsurance Mechanism and which organization is hereby appointed as the agent of each of the insurers required to participate in the A.R.M. Plan to execute the Missouri Aggregate Excess of Loss Reinsurance Mechanism with the contract carrier. In addition, the reinsurance administrator is hereby appointed as the agent of each of the insurers under the A.R.M. Plan to initiate civil prosecution, defend, submit to arbitration, settle and to propose or accept a compromise with respect to any claim existing in favor or against any participating company based on or involving any matter relating to the Missouri Aggregate Excess of Loss Reinsurance Mechanism.

(R) RFP means the amended 12/94 RFP, issued by the department on January 13, 1995, setting forth the specifications for an alternative residual market mechanism and inviting potential respondents to submit proposals by which the department could select a contractor to administer the A.R.M. Plan.

Request for proposal shall also mean any subsequent RFPs issued by the department for this purpose.

(S) Servicing carrier means an insurer, other than a direct assignment carrier, selected by the WCIP administrator pursuant to Section V, paragraph (1) of the WCIP, to receive assignments.

(T) 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.

(U) 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. By policy endorsement approved by the department, the contract carrier may specify the circumstances under which such coverage shall be defined for those employees of a Missouri employer who are temporarily engaged in employment-related activities for the employer outside the boundaries of the state of Missouri;

2. Employer's liability insurance written in connection with a Workers' Compensation policy; and

3. Such other coverages as are approved by the director, including those approved after being recommended by the advisory board of the Missouri Aggregate Excess of Loss Reinsurance Mechanism.

(V) Workers' Compensation Insurance Plan (WCIP) means the plan of operation for Missouri's Workers' Compensation residual market, submitted to the department by the NCCI under section 287.896, RSMo, and approved by the director on October 14, 1993, which shall be replaced by the A.R.M. Plan on or after July 1, 1995.

(2) Rules for Eligibility and Assignment.

(A) The A.R.M. Plan is the Missouri Workers' Compensation residual market mechanism which shall commence insurance operations on or after July 1, 1995, replacing the previous residual, market mechanism known as the WCIP. The A.R.M. Plan provides for a new residual market approved by the director to guarantee insurance coverage and quality loss prevention and control services for employers seeking coverage through the plan. Employers assigned to WCIP servicing carriers and direct assignment carriers shall be non-renewed by said carriers and

informed of their options under the A.R.M. Plan, as set forth in section (3) of this rule.

(B) The contract carrier under the A.R.M. Plan shall become responsible for losses incurred by its insured employers after the effective date of coverage under the A.R.M. Plan.

(C) The following rules will govern the insuring of employers who are in good faith entitled to Workers' Compensation insurance as defined herein, but who are unable to procure such insurance through ordinary methods. Any employer insured under the A.R.M. 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 (8) of this rule.

1. Application for insurance shall be filed with the contract carrier 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; or

- D. If the employer, or its representative and/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 A.R.M. plan, consistent with plan rules, in accordance with the following procedures:

A. The producer should forward the completed application to the contract carrier with a certified, cashier's, or agency check payable to the contract carrier for the estimated annual or deposit premium as computed by the producer, or determined by contacting the contract carrier 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 verifiable current payroll record, for example, 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 described in subsection (3)(E) of this rule to the contract carrier. 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 unless a later date is requested. Those applications hand delivered to the contract carrier will be effective as of 12:01 a.m. the date following receipt by the contract carrier 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 unless a later date is requested. Those applications hand delivered to the contract carrier will be effective 12:01 a.m. not later than sixty (60) days following the date of receipt by the contract carrier, unless a later date is requested;

C. If coverage is bound pursuant to the above, the contract carrier shall issue a binder with copies to the producer, insured, and appropriate state agency; and

D. Under performance standards approved by the department, the contract carrier may specify the circumstances under which coverage may be bound as the result of the filing of an application by facsimile.

4. Assignments shall not be made under this Plan unless all Workers' Compensation premium obligations on any previous insur-

ance 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 retains the right to cancel a policy currently in force under the A.R.M. 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 A.R.M. Plan, will be retained by the contract carrier.

6. If, after the issuance of a policy, the contract carrier 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 shall initiate cancellation by filing the reason with the employer relations consultant for approval prior to issuing a cancellation. Approval shall not be required for cancellation for nonpayment of premium. The contract carrier shall be fully informed of all cancellations and of any reestablishment of eligibility or of entitlement by an insured employer. Any insured employer so canceled must reestablish eligibility or must demonstrate entitlement before any further assignment can be made under the A.R.M. Plan.

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

8. At least sixty (60) days prior to the expiration date of insurance, the contract carrier shall send a renewal proposal or notice of impending expiration of coverage to the insured and the insured's producer. Upon receipt of the required premium, the policy shall be renewed and a copy of policy information page and all endorsements, properly stamped A.R.M. Plan, retained by the contract carrier.

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

10. Any employer desiring insurance for operations in states other than Missouri must

notify the contract carrier regarding the need for insurance in such additional states in accordance with section (6) of this rule.

11. The employer may designate a licensed producer and, with respect to any renewal of the contract carrier, may change the designated producer by notice to the contract carrier prior to the date of such renewal or, with the consent of the contract carrier, at any other time. The contract carrier shall pay a fee to the producer designated by the employer on new and renewal policies effective (July 1, 1995) and thereafter 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's RFP response.

(D) Producers through whom employers seek Workers' 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 A.R.M. Plan. At the direction of the department, a risk may be removed from the A.R.M. 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.

(E) For purposes of assisting in the placement of risks in the voluntary market, an expiration list of risks in the A.R.M. Plan, compiled and provided by the contract carrier, shall be made available by the department to producers and insurers, at the normal copying costs.

(3) Participation.

(A) All insurers licensed to write Workers' Compensation insurance in Missouri are required to participate in the A.R.M. Plan. An insurer must satisfy its participation requirement by subscribing to the Missouri Aggregate Excess of Loss Reinsurance Mechanism document. After the transition of the Missouri residual market from the WCIP to the A.R.M. Plan, carriers shall continue to be responsible for residual market assessments under the WCIP, as determined by the NCCI under the provisions of the articles of agreement, in addition to any deficits experienced under the A.R.M. Plan.

(B) After the transition of the Missouri residual market from the WCIP to the A.R.M. Plan, the WCIP's servicing carriers and direct assignment carriers shall be replaced by the contract carrier.

(C) No less than ninety (90) days before the date on which the coverage under the

A.R.M. Plan shall commence, the Department of Insurance or its designee shall, by bulletin or other notification, specify to each insurance carrier authorized to write Workers' Compensation insurance in Missouri the date upon which the responsibility for providing Workers' Compensation insurance through the residual market shall shift from the WCIP to the A.R.M. Plan.

1. Said notification shall require that, for each WCIP policy which would otherwise renew during the following year, that the policy's WCIP servicing carrier or direct assignment carrier shall provide the insured employer with no less than sixty (60) calendar day's notice that coverage under the WCIP policy will terminate and that, should the employer desire coverage under the successor A.R.M. Plan, the employer will be required to submit a new application to the A.R.M. Plan contract carrier. The director may waive the requirement of a new application for employers serviced by the contract carrier under the WCIP and may approve a shorter notification period for out-of-state employers receiving Missouri coverage under the WCIP through the WCIP's associated interstate assignment mechanism.

2. The form of the notice to employers shall be specified by the department and shall include a discussion of the availability of coverage in the voluntary market. The A.R.M. Plan contract carrier may offer voluntary market coverage to any employer.

(D) Policies issued by the A.R.M. Plan shall be issued under the presumption that payroll and classification information of an individual policy under the WCIP is accurate; employers and/or their agents or brokers shall not be permitted to modify such information as part of their application to the A.R.M. Plan without the written permission of the A.R.M. contract carrier. The contract carrier, however, is authorized to modify such information.

(E) WCIP servicing carriers and direct assignment carriers shall provide such historical policy loss run information as is reasonable, and which is not otherwise available from the NCCI, to the contract carrier, and which has been requested by the contract carrier for individually specified insureds. The NCCI shall provide experience rating, inspection reports and classifications through normal affiliation distribution channels. The NCCI shall provide status on uncollected premiums under the terms of any approved Uncollectible Status Service Agreement approved by the department.

(F) The transition from the WCIP to the A.R.M. Plan shall not change the obligations of employers insured under the WCIP to pay

premiums to that Plan. This responsibility shall include the responsibility to pay premiums owed after the WCIP policies are terminated which reflect adjustments to the employers' estimated premium made as the result of premium audits conducted within one hundred and twenty (120) days of termination. Failure to pay such audit premiums shall result in the employers' loss of its good faith entitlement to coverage under the A.R.M. Plan, absent the existence of a formal dispute. The requirement that the A.R.M. Plan contract carrier cooperate with WCIP carriers regarding unpaid premiums shall be conditioned on WCIP carriers' cooperation with the A.R.M. Plan contract carrier regarding historical account information on policies transferred to the A.R.M. Plan which is not otherwise available to the contract carrier from the NCCI.

(4) Deficit Administration.

(A) A deficit under the A.R.M. Plan shall be handled as follows:

1. Under the A.R.M. Plan, and in accordance with section 287.896, RSMo, while the plan shall be designed to provide Workers' Compensation and employer's liability insurance at premium rates which are actuarially sufficient to cover losses and reasonable operating expenses, the plan must also provide a system to distribute any deficit experienced by the plan. Under this rule, a deficit as defined under the A.R.M. Plan has occurred whenever the amount of losses and allocated loss adjustment expenses paid by the contract carrier, when divided by the amount of premium collected by the contract carrier, produces a percentage greater than or equal to one hundred fifteen percent (115%) for the policies issued during the one (1)-year period of the contract. An insurer licensed to write Workers' Compensation coverage in Missouri shall be assessed for the amount of such deficit in proportion to the share of the voluntary market premium written by such insurer, in accordance with the provisions of the Missouri Aggregate Excess of Loss Reinsurance Mechanism, set forth in Exhibit A. Failure of an insurer to pay its proper assessment shall be grounds for discipline of the insurer by the department, and for legal action by the contract carrier or the advisory board to recover such unpaid assessment owed under this rule;

2. In order to assist the determination of the existence of a deficit, the A.R.M. Plan 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 residual market

financial experience and business transactions;

3. The means for the determination of the existence of a deficit and the assessment thereof to insurers based on their Missouri voluntary Workers' Compensation insurance premium is as described in the Missouri Aggregate Excess of Loss Reinsurance Mechanism;

4. The department is to be appraised at least annually by the contract carrier as to its actuarial estimate as to the likelihood of a deficit. 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 the terms of the Missouri Aggregate Excess of Loss Reinsurance Mechanism is also to be provided to the department by the contract carrier;

5. The NCCI shall be the reinsurance administrator of the Missouri Aggregate Excess of Loss Reinsurance Mechanism, under the oversight of an advisory board appointed by the director of insurance after consultation with the NCCI and other interested parties. Subject to the direction and approval of this advisory board, the NCCI, as reinsurance administrator, shall perform as described in the Missouri Aggregate Excess of Loss Reinsurance Mechanism (Exhibit A), including the following:

A. Advising all carriers of their requirement to participate in the Missouri Aggregate Excess of Loss Reinsurance Mechanism, and informing the director of insurance of any insurer who informs the NCCI that they are unwilling to participate in said Mechanism.

B. Administering the deficit sharing mechanism;

C. Advising the department as to the oversight activities requisite to ensuring appropriate performance by the contract carrier; and

D. Acting as secretary for the advisory board; and

6. Any assessment made shall clearly distinguish the extent to which it is an A.R.M. Plan deficit assessment or a WCIP assessment.

(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 NCCI in its administration of the Missouri Aggregate Excess of Loss Reinsurance Mechanism, and to assist and advise the director regarding the execution of this mechanism by the contract carrier and the member insurers required to be reinsurers under this mechanism. The advisory board may consider any matter referred to it by the reinsurance administrator or the director which relates to the operation of the mechanism;

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; and

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.

(C) The reinsurance administrator of the Missouri Aggregate Excess of Loss Reinsurance Mechanism shall be responsible for determining expenses and fees for the operation of the deficit sharing mechanism and shall invoice, for its own account, each insurer participating in the A.R.M. Plan for these expenses and fees on an equitable basis. Such basis shall be determined by the advisory board, not later than sixty (60) days following the implementation of the filing. 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 the underlying deficit as defined herein. Additionally, it is recognized that administrative expenses may be incurred even if there is no deficit.

(D) All insurers required to participate in the A.R.M. Plan shall indemnify and hold harmless the reinsurance administrator, its officers, and/or employees from and against all judgements, fines, damages, losses,

amounts paid in settlement, reasonable costs and expenses, including attorney's fees, and any other liabilities that may be incurred as a result of any action, claim, suit, or proceeding arising out of the performance of the rights or obligations of the reinsurance administrator under the A.R.M. Plan and/or the Missouri Aggregate Excess of Loss Reinsurance Mechanism.

(5) Contract Carrier.

(A) The contract carrier shall be selected by the director after a competitive bidding process by means of an RFP.

(B) The services to be provided and performance standards to be met by the contractor under the A.R.M. Plan are those set forth in the amended 12/94 RFP or successor RFPs, as supplemented by any subsequent agreements between the director and the contract carrier regarding administrative details subsequent to the award of the contract. 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. The performance standards under which the contract carrier shall operate shall pay such commissions as are specified in the RFP or as are otherwise necessary and approved by the department to encourage the objectives of the A.R.M. Plan, such as improving workplace safety. The performance standards shall also require the use of retrospective rating plans where required under section 287.896, RSMo.

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

(6) Interstate Assignments.

(A) Any employer assigned to the contract carrier under this A.R.M. Plan and desiring coverage for Workers' Compensation benefits of states other than Missouri for its Missouri-based employees who may have business reason to travel to other states may request the contract carrier to furnish such insurance on an endorsement form approved by the department. Such form shall indicate that employees operating out of 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 to assist them in obtaining coverage in these other states. If the contract carrier does not wish to provide coverage for the additional states on a voluntary basis, the contract carrier shall advise the employer and the producer to submit an application to the appropriate administrator having jurisdiction.

(7) Assignment Formula. All employers qualifying for coverage under the A.R.M. Plan shall be assigned to the contract carrier so long as the policies commence during the contract period, including any renewals thereof.

(8) Dispute Resolution Procedure.

(A) Any person affected by the operation of the A.R.M. Plan including, but not limited to, insureds, producers, and the contract carrier, who may have a dispute with respect to any aspect of the plan, may seek a review of the matter by the employer relations consultant 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 employer relations consultant may secure such additional information as it deems necessary to make a decision.

(B) Appeals from employers and insureds 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 A.R.M. Plan, excluding individual employer disputes and those arising under the Missouri Aggregate Excess of Loss Reinsurance Mechanism (mechanism), the employer relations consultant will review the matter and render a written decision with an explanation of the reasons for the decision within thirty (30) days after receipt of all the information necessary to make the decision. Any party affected by a decision made by the employer relations consultant may seek a *de novo* review by the regulator by requesting such review, in writing, within thirty (30) days after the date of such 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 A.R.M. Plan. The regulator's decision shall be final, subject to court review.

2. Except as provided below, if the dispute arises under the mechanism, the reinsurance administrator designated under the mechanism shall first review the matter and render a written decision to the complaining party with an explanation of the reasons for the decision within thirty (30) 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 the mechanism by requesting such review, in writing, within thirty (30) days of the date of the decision by

the reinsurance administrator under the mechanism. The advisory board must then review the matter and render its written decision pursuant to the procedures set forth in the mechanism. Any party affected by a decision of the advisory board may seek a *de novo* review by the director by requesting such a review in writing within thirty (30) days of the date of the board's decision.

(9) Rate Monitoring.

(A) It is essential for maintaining the long-run viability of the A.R.M. Plan that the contract carrier and prospective contract carriers have the data necessary to determine appropriate rates. As insureds may over time move between the A.R.M. Plan and the voluntary market, data for the total market must be maintained. On behalf of the department, the NCCI shall maintain necessary loss cost data in order to permit the actuarial determination by the department and the contract carrier of rates, consistent with the NCCI-administered classification system, for the business insured through the A.R.M. Plan. The contract carrier is required to report its experience on business written under the A.R.M. 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 and the department all requested information necessary for establishing reasonable classifications, rates and enabling financial information required for the successful operation of the A.R.M. 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 shall file any rate requests for the residual market in accordance with the provisions of section 287.896, RSMo.

(10) Notice. Within sixty (60) days after this plan has been approved by the director, the NCCI shall provide notice to all insurers that are required to participate in this plan under section (3) of this rule. The notice shall include a copy of this plan, as well as the dates the plan is approved and effective and shall advise each insurer of the obligation to subscribe to the Missouri Aggregate Excess of Loss Reinsurance Mechanism. The NCCI will inform the director of any insurer refusing to subscribe to the mechanism. The NCCI shall contact the department whenever a carrier advises that they are refusing to participate, but will not be required to solicit responses from insurers on such participation. Any questions regarding the notice shall be directed to the department or the contract carrier.

(11) Confidentiality of Information.

(A) For purposes of this section, the term contract carrier shall include any reinsurers, subcontractors, vendors, or other entities or persons utilized by or associated with the contract carrier in the administration and insuring of the Missouri Workers' Compensation residual market under the A.R.M. Plan. The provisions of this section shall not apply to the contract carrier beyond the period of the carrier's contract.

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

1. The contract carrier 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 any third party, such detailed information, regardless of the form or format of the disclosure; such information shall be used by the contract carrier solely for the evaluating, underwriting and insuring of Workers' Compensation and employer's liability insurance coverage under the A.R.M. Plan, and not for any other purpose without the prior approval of the agency of record;

2. The contract carrier 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 shall not directly or indirectly request, encourage, or advise any employers who have acquired or seek to acquire coverage through the A.R.M. Plan to utilize the services of any specific insurance agent, agency, broker, insurer or group of insurers for Workers' Compensation and employer's liability insurance coverage; and

4. The contract carrier shall not give any other person, firm or entity any rights that would circumvent or violate the provisions of paragraphs (11)(B)1. 3.

(C) Notwithstanding the confidentiality provisions set forth in subsection (11)(B) of this rule, the contract carrier is expressly authorized to provide the information delineated in subsection (11)(B) to the Missouri Department of Insurance, the Missouri Division of Workers' Compensation and any other organization or entity designated by the Mis-

souri Department of Insurance 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 A.R.M. Plan.

*AUTHORITY: sections 287.896 and 374.045, RSMo (1994). *Emergency rule filed June 15, 1995, effective July 1, 1995, expired Oct. 28, 1995. Original rule filed April 3, 1995, effective Sept. 30, 1995.*

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



Exhibit A

MISSOURI
AGGREGATE EXCESS OF LOSS REINSURANCE MECHANISM

issued to

Travelers Indemnity Company of Missouri
(hereinafter referred to as the “Contract Carrier”)

by

THE SUBSCRIBING REINSURERS
(hereinafter referred to collectively as the “Reinsurers”)

WHEREAS, the Contract Carrier and each of the Reinsurers, as a requirement of being licensed to write Workers’ Compensation in Missouri, are participants in the Missouri Alternative Residual Market (A.R.M.) Plan, effective July 1, 1995; and

WHEREAS, pursuant to the A.R.M. Plan, the Missouri Aggregate Excess of Loss Reinsurance Mechanism is provided for as the means for the determination of the existence of a deficit and the assessment thereof; and

WHEREAS, pursuant to the A.R.M. Plan, The National Council on Compensation Insurance, Inc. (NCCI) is appointed as the agent for the purposes of entering into and administering the provisions of this Mechanism (“Reinsurance Administrator”), under the oversight of an Advisory Board appointed by the Director of Insurance; and

WHEREAS, pursuant to the A.R.M. Plan and the Amended 12/94 RFP related thereto, the Contract Carrier has entered into a contract (“Contract Carrier Agreement”) to provide certain policies of workers compensation, occupational disease, employers liability or other insurance (“Workers Compensation Insurance”) as defined in the A.R.M. Plan (“Policies”) to risks designated as assigned risks under the A.R.M. Plan; and

WHEREAS, the Contract Carrier is obliged to write Policies for such assigned risks provided such policies commence during a one year period specified in the Contract Carrier Agreement (“Contract Period”) and any renewals thereof; and

WHEREAS, such policies will be for durations specified by the A.R.M. Plan and the Contract Carrier Agreement (“Policy Period”); and

WHEREAS, pursuant to the Contract Carrier Agreement, the Contract Carrier has agreed to be responsible for paid losses and paid allocated loss adjustment expenses up to and including 115% of the collected premiums on the Policies (“Contract Carrier Retention”); and

WHEREAS, the Contract Carrier wishes to cede and the Reinsurers, including the Contract Carrier in its capacity as a participating company under this Aggregate Excess of Loss Reinsurance Mechanism, agree to accept aggregate excess of loss reinsurance in excess of the Contract Carrier’s Retention of 115% of collected premium; and

WHEREAS, the Reinsurers agree to share in the aggregate excess of loss reinsurance for the Contract Period pro rata according to their respective shares of voluntary Workers Compensation Insurance premium in Missouri; and

WHEREAS, the Contract Carrier Agreement may relieve the Reinsurers of other obligations for assigned risks; and

WHEREAS, “Losses” shall mean paid losses and paid allocated loss adjustment expenses under the Policies, and the terms losses and allocated loss adjustment expenses are as defined in the NCCI Workers’ Compensation Statistical Plan in effect in Missouri on July 1, 1995.

NOW THEREFORE, in consideration of and in reliance upon the premises and the mutual promises contained herein, the Contract Carrier and Reinsurers agree as follows:

ARTICLE I
REINSURERS’ PARTICIPATION

A. For the Contract Period under the Contract Carrier Agreement, the Contract Carrier shall cede and the Reinsurers shall accept all of the contract carrier’s liability for Losses under the Policies in excess of the Contract Carrier’s Retention of 115% of collected premium. Losses shall be paid to the Contract Carrier upon evidence of payment by the Contract Carrier and verification by the reinsurance administrator.

B. If the Contract Period does not run concurrently with a calendar year, each successive twelve month period in the Contract Period shall be assigned to the calendar year in which that twelve month period commenced for purposes of determining the pro rata share of paid losses and

paid allocated loss adjustment expenses in excess of the Contract Carrier's Retention for each of the Reinsurers. If the Contract Period runs concurrently with a calendar year, each successive twelve month period shall be assigned to said calendar year.

C. Each Reinsurer's proportion of liability in excess of the Contract Carrier's Retention, including Reinsurance Administrator expenses, shall be determined by the Reinsurer's Voluntary Workers Compensation Insurance written premiums in the state of Missouri in relation to the total Voluntary Workers Compensation Insurance written premiums in Missouri during the calendar year in which the Contract Period commences, subject to verification by the Reinsurance Administrator.

D. Except as otherwise provided in the A.R.M. Plan and this Mechanism, the Reinsurers shall have no obligation for Losses within Contract Carrier's Retention.

ARTICLE II OBLIGATIONS OF CONTRACT CARRIER

A. The Contract Carrier shall make available such of its own staff, office space, facilities and equipment as are necessary for the performance of its obligations under this Mechanism 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 the A.R.M. Plan, this Mechanism, the Contract Carrier Agreement, and such Performance Standards as may be established from time to time pursuant to the A.R.M. Plan.

B. The Contract Carrier shall process, adjust, settle, compromise, defend, litigate and pay claims arising out of the Policies. 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.

C. The Contract Carrier shall comply with the financial reporting requirements and procedures established from time to time by the Advisory Board and approved by the Director of Insurance pursuant to the Plan, with the advice and recommendations of the Reinsurance Administrator.

D. The Contract Carrier shall report 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.

E. The Contract Carrier agrees that it will comply with all of the terms and conditions of the A.R.M. Plan, this Mechanism, the Contract Carrier Agreement, and any rules or procedures promulgated thereunder.

ARTICLE III COMMENCEMENT AND TERMINATION

A. This Mechanism shall apply to Missouri which has adopted the Missouri Alternative Residual Market Plan and shall be effective with respect to the individual Contract Carrier Agreement and the Contract Period as provided herein. This Mechanism shall continue in force during the current contract year and subsequent contract years until terminated as provided in this Article.

B. This Mechanism may be terminated at any time by mutual agreement between the Reinsurers, acting through the Reinsurance Administrator, and the Contract Carrier with the approval of the Director of Insurance.

C. This Mechanism will be terminated at the expiration or termination of the Contract Carrier Agreement.

D. This Mechanism may be terminated by a Reinsurer only upon surrender of its authority to write workers' compensation in Missouri. The Reinsurance Administrator will inform the Director of Insurance of any reinsurer that terminates its participation in this Mechanism.

E. This Mechanism shall terminate automatically without further notice as to Contract Periods which have not yet commence upon the filing of a petition or conservation, liquidation, rehabilitation, bankruptcy or similar law for the relief of debtors of the Contract Carrier.

F. If the Reinsurance Administrator determines that the contract carrier is not in compliance with any provision of the A.R.M. Plan, this Mechanism, the Contract Carrier Agreement, or any rules or procedures promulgated thereunder, or any performance standards, it shall notify the Contract Carrier and the Director of Insurance of such noncompliance. The Director of Insurance shall have the right to take appropriate action as specified in the A.R.M. Plan or the Contract Carrier Agreement.

G. Reinsurance hereunder shall remain in full force and effect until all losses under the Policies have been settled and satisfied or otherwise resolved.



ARTICLE IV
TERRITORY

This Mechanism shall be effective only for Policies issued pursuant to the A.R.M. Plan, by the Contract Carrier.

ARTICLE V
ORIGINAL CONDITIONS

A. All reinsurance under this Mechanism shall be subject to the same rates, terms, conditions and waivers, and to the same modifications and alterations as the Policies, except as otherwise provided in the Mechanism.

B. Nothing herein shall in any manner create any obligations or establish any rights against the Reinsurers in favor of any third party or any persons not parties to this Mechanism.

C. The provisions of this Mechanism shall continue unchanged with each renewal contract period, except for revisions necessary to be consistent with the terms of each renewal contract.

ARTICLE VI
LOSS IN EXCESS OF POLICY LIMITS/EXTRA
CONTRACTUAL OBLIGATIONS

A. In the event the Contract Carrier pays an amount of loss in excess of its policy limits under the Policies, but otherwise within the terms of a 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, 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 Contract Carrier’s loss, if any, under the Policy involved, and the sum thereof shall be subject to this Mechanism.

B. 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.

C. Notwithstanding anything stated herein, this Mechanism shall not apply to any loss incurred by the Contract Carrier as a result of any willful misconduct or any fraudulent and/or criminal act by an employee, officer or director of the Contract 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 hereunder.

ARTICLE VII
PREMIUM

A. The Contract Carrier shall be solely responsible for the collection of all premiums on all risks assigned to it. Reinsurers shall have no responsibility for the Contract Carrier’s premiums, uncollected premiums, return premiums, or similar items.

B. Reinsurers shall not receive any portion of the premiums on the Policies assigned to the Contract Carrier.

ARTICLE VIII
LOSSES AND LOSS ADJUSTMENT EXPENSES

A. Loss shall be reported by the Contract Carrier in the format and manner specified in Article X below.

B. All loss settlements made by the Contract Carrier, whether under strict contract conditions or by way of compromise, shall be binding unconditionally upon the Reinsurers.

ARTICLE IX
SALVAGE AND SUBROGATION

In the event that the Contract Carrier recovers any money by way of subrogation or otherwise, other than from the Reinsurers, on a claim for which the Contract Carrier has been reimbursed by the Reinsurers, the Contract Carrier 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.

ARTICLE X
REPORTS AND REMITTANCES

A. Within 45 days after the end of each calendar quarter, the Contract Carrier shall report to the Reinsurers, through the Reinsurance Administrator, premiums, Losses, and other amounts for the Contract Period in such detail as the Advisory Board shall reasonably require.

B. Any amounts paid by the Contract Carrier and recoverable from Reinsurers shall be remitted by the Reinsurers, through the reinsurance administrator, as promptly as possible after receipt and verification of the Contract Carrier's report. Any remittance shall be paid within 30 days of the invoice mailing, or within other reasonable time periods established by the Advisory Board.

ARTICLE XI
OFFSET

The Contract Carrier 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 as Reinsurers and Contract Carrier under the terms of this Mechanism.

ARTICLE XII
CURRENCY

All limits hereunder are expressed in United States dollars and all premium and loss payments shall be made in United States currency. For the purposes of this Mechanism amounts paid or received by the Contract Carrier 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.

ARTICLE XIII
ERRORS AND OMISSIONS

Inadvertent delays, errors or omissions made in connection with this Mechanism 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.

ARTICLE XIV
PREMIUM TAXES AND ASSESSMENTS

The Contract Carrier shall be fully liable for the payment of any and all premium taxes and loss based taxes or assessments.

ARTICLE XV
ACCESS TO RECORDS

The Contract Carrier shall permit the Reinsurers, through either the Reinsurance Administrator or the Director of Insurance, 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 of Insurance. In the event of a termination of the Contract Carrier Agreement and/or this Mechanism, 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 A.R.M. 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 the policies, the Contract Carrier Agreement and/or this Mechanism.

ARTICLE XVI
INSOLVENCY

A. In the event of the insolvency of the Contract Carrier this reinsurance shall be payable directly to the Contract Carrier or its liquidator, receiver, conservator or statutory successor on the basis of the liability of the Contract Carrier without diminution because of the insolvency of the Contract Carrier or because the liquidator, receiver, conservator or statutory successor of the Contract Carrier has failed to pay all or a portion of any claim.

B. It is agreed, however, that the liquidator, receiver, conservator or statutory successor of the Contract Carrier shall give written notice to the Reinsurers of the pendency of a claim against the Contract Carrier 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 conversation 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 Contract Carrier or its liquidator, receiver, conservator or statutory successor.

C. The expense thus incurred by the Reinsurers shall be chargeable, subject to the approval of the Court, against the Contract Carrier as part of the expense of conservation or liquidation to the extent of a pro rate share of the benefit which may accrue to the Contract Carrier solely as a result of the defense undertaken by the Reinsurers.

D. The reinsurance shall be payable by the Reinsurers to the Contract Carrier or its liquidator, receiver, conservator or statutory successor, except as provided by applicable law except (a) where this Mechanism specifically provides another payee of such reinsurance, in the event of the insolvency of the Contract Carrier and (b) 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 Contract Carrier to such payees.

E. In the event any Reinsurer becomes insolvent, participation by such Reinsurer under this Mechanism 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.

ARTICLE XVII
DISPUTES AND APPEALS

In the event of any dispute with respect to this Mechanism, including without limitation, its application, scope or effect, it hereby is agreed mutually that such dispute shall be resolved pursuant to the provisions of Section (8) of the A.R.M. Plan.

ARTICLE XVIII
SECURITY

If determined by the Reinsurance Administrator, the Contract Carrier and the Reinsurers will provide such security for the benefit of the parties to this Mechanism, as determined by the Reinsurance Administrator.

ARTICLE XIX
REINSURANCE ADMINISTRATOR

The Reinsurance Administrator is recognized as the agent through whom some funds and communications relating hereto (including but not limited to notices, statements, reports of premium, losses and loss adjustment expense, salvage and loss settlements) shall be transmitted to all parties hereunder. The Reinsurers and the Contract Carrier acknowledge and agree that all administration for this Mechanism shall be performed by the Reinsurance Administrator and the Director of Insurance pursuant to the terms of this Mechanism, an Administration Agreement between the Reinsurers and the Reinsurance Administrator, the Contract Carrier Agreement, and the A.R.M. Plan.

ARTICLE XX
SUCCESSORS AND ASSIGNS

This Mechanism shall be binding upon and inure to the benefit of the respective successors and assigns of the Contract Carrier and the Reinsurance Administrator; provided, however, that the Contract Carrier shall not assign or transfer any of its rights or obligations hereunder, by operation of law or otherwise, without the prior written consent of the Missouri Director of Insurance, with the advice and recommendations of the Advisory Board and the Reinsurance Administrator.