SECOND REGULAR SESSION

# HOUSE BILL NO. 1904

## 95TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES WILSON (130) (Sponsor) AND HOBBS (Co-sponsor).

3805L.02I D. ADAM CRUMBLISS, Chief Clerk

## AN ACT

To repeal sections 376.717, 376.718, 376.724, 376.725, 376.732, 376.733, 376.734, 376.735, 376.737, 376.738, 376.740, 376.743, and 376.758, RSMo, and to enact in lieu thereof thirteen new sections relating to the Missouri life and health insurance guaranty association act.

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

Section A. Sections 376.717, 376.718, 376.724, 376.725, 376.732, 376.733, 376.734, 376.735, 376.737, 376.738, 376.740, 376.743, and 376.758, RSMo, are repealed and thirteen new sections enacted in lieu thereof, to be known as sections 376.717, 376.718, 376.724, 376.725, 376.732, 376.733, 376.734, 376.735, 376.737, 376.738, 376.740, 376.743, and 376.758, to read as follows:

376.717. 1. Sections 376.715 to 376.758 shall provide coverage for the policies and contracts specified in subsection 2 of this section:

(1) To persons who, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees or payees of the persons covered under subdivision (2) of this subsection; and

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

(a) Are residents of this state; or

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

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

b. **[**Such insurers never held a license or certificate of authority in the states in which such persons reside;**] The persons are not eligible for coverage by an association in any other**

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

**state due to the fact that the insurer was not licensed in such state at the time specified in such state's guaranty association law; and**

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

d. Such persons are not eligible for coverage by such associations**]**.

**(3) For structured settlement annuities specified in subsection 2 of this section, subdivisions (1) and (2) of subsection 1 of this section shall not apply, and sections 376.715 to 376.758 shall, except as provided in subdivisions (4) and (5) of this subsection, provide coverage to a person who is a payee under a structured settlement annuity, or beneficiary of a payee if the payee is deceased, if the payee:**

**(a) Is a resident, regardless of where the contract owner resides; or**

**(b) Is not a resident, but only under both of the following conditions:**

**a. (i) The contract owner of the structured settlement annuity is a resident; or**

**(ii) The contract owner of the structure settlement annuity is not a resident, but:**

**i. The insurer that issued the structured settlement annuity is domiciled in this state; and**

**ii. The state in which the contract owner resides has an association similar to the association created under sections 376.715 to 376.758; and**

**b. Neither the payee or beneficiary nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.**

**(4) Sections 376.715 to 376.758 shall not provide to a person who is a payee or beneficiary of a contract owner resident of this state, if the payee or beneficiary is afforded any coverage by such an association of another state.**

**(5) Sections 376.715 to 376.758 is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under sections 376.715 to 376.758 is provided coverage under the laws of any other state, the person shall not be provided coverage under sections 376.715 to 376.758. In determining the application of the provisions of this subdivision in situations where a person could be covered by such an association of more than one state, whether as an owner, payee, beneficiary, or assignee, sections 376.715 to 376.758 shall be construed in conjunction with the other state's laws to result in coverage by only one association.**

2. Sections 376.715 to 376.758 shall provide coverage to the persons specified in subsection 1 of this section for direct, nongroup life, health, annuity **[**and supplemental**]** policies or contracts, **and supplemental contracts to any such policies or contracts, and for** certificates under direct group policies and contracts, except as limited by the provisions of

sections 376.715 to 376.758. **Annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities, and any immediate or deferred annuity contracts.**

3. Sections 376.715 to 376.758 shall not provide coverage for:

(1) Any portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract holder;

(2) Any policy or contract of reinsurance, unless assumption certificates have been issued;

(3) Any portion of a policy or contract to the extent that the rate of interest on which it is based**, or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value**:

(a) Averaged over the period of four years prior to the date on which the association becomes obligated with respect to such policy or contract, exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four years before the association became obligated; and

(b) On and after the date on which the association becomes obligated with respect to such policy or contract exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available;

(4) Any **portion of a policy or contract issued to a** plan or program of an employer, association or **[**similar entity**] other person** to provide life, health, or annuity benefits to its employees or members to the extent that such plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association or **[**similar entity**] other person** under:

(a) A "multiple employer welfare arrangement" as defined in **[**section 514 of the Employee Retirement Income Security Act of 1974**] 29 U.S.C. Section 1144**, as amended;

(b) A minimum premium group insurance plan;

(c) A stop-loss group insurance plan; or

(d) An administrative services only contract;

(5) Any portion of a policy or contract to the extent that it provides dividends or experience rating credits, **voting rights,** or provides that any fees or allowances be paid to any person, including the policy or contract holder, in connection with the service to or administration of such policy or contract; **[**and**]**

(6) Any policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue such policy or contract in this state**;**

**(7) A portion of a policy or contract to the extent that the assessments required by section 376.735 with respect to the policy or contract are preempted by federal or state law;**

**(8) An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policy owner, including without limitation:**

**(a) Claims based on marketing materials;**

**(b) Claims based on side letters, riders, or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements;**

**(c) Misrepresentations of or regarding policy benefits;**

**(d) Extra-contractual claims;**

**(e) A claim for penalties or consequential or incidental damages;**

**(9) A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer;**

**(10) An unallocated annuity contract;**

**(11) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under sections 376.715 to 376.758, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, for purposes of determining the value that have been credited and are not subject to forfeiture under this subdivision, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture;**

**(12) A policy or contract providing any hospital, medical, prescription drug or other health care benefit under Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code, Medicare Part C & D, or any regulations issued thereunder**.

4. The benefits for which the association may become liable**, with regard to a member insurer that was first placed under an order of rehabilitation or placed under an order of liquidation if no order of rehabilitation was previously entered prior to August 28, 2010,** shall in no event exceed the lesser of:

(1) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

(2) With respect to any one life, regardless of the number of policies or contracts:

(a) Three hundred thousand dollars in life insurance death benefits, but not more than one hundred thousand dollars in net cash surrender and net cash withdrawal values for life insurance;

(b) One hundred thousand dollars in health insurance benefits, including any net cash surrender and net cash withdrawal values;

(c) One hundred thousand dollars in the present value of annuity benefits, including net cash surrender and net cash withdrawal values.

Provided, however, that in no event shall the association be liable to expend more than three hundred thousand dollars in the aggregate with respect to any one life under paragraphs (a), (b), and (c) of this subdivision.

**5. Except as otherwise provided in subdivision (2) of this subsection, the benefits for which the association may become liable with regard to a member insurer that was first placed under an order of rehabilitation or placed under an order of liquidation if no order of rehabilitation was previously entered on or after August 28, 2010, shall in no event exceed the lessor of:**

**(1) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or**

**(2) (a) With respect to any one life, regardless of the number of policies or contracts:**

**a. Three hundred thousand dollars in life insurance death benefits, but not more than one hundred thousand dollars in net cash surrender and net cash withdrawal values for life insurance;**

**b. In health insurance benefits:**

**(i) One hundred thousand dollars of coverages other than disability insurance or basic hospital, medical, and surgical insurance or major medical insurance, or long-term care insurance, including any net cash surrender and net cash withdrawal values;**

**(ii) Three hundred thousand dollars for disability insurance and three hundred thousand dollars for long-term care insurance; provided, however, that the increased maximum benefits provided herein for long-term care insurance shall apply to a member insurer that was first placed under an order of rehabilitation or placed under an order of liquidation if no order of rehabilitation was previously entered after January 1, 2009;**

**(iii) Five hundred thousand dollars for basic hospital, medical, and surgical insurance or major medical insurance;**

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

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

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

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

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

**6. The limitations set forth in subsections 4 and 5 of this section are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which such benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under sections 376.715 to 376.758 may be met by the use of assets attributable to covered policies or reimbursed to the association under its subrogation and assignment rights.**

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

(1) "Account", any of the **[**four**]** accounts created under section 376.720;

(2) **[**"Annuity or annuity contract", any annuity contract or group annuity certificate which is issued to and owned by an individual. This definition of "annuity or annuity contract" does not include any form of unallocated annuity contract;

(3)**]** "Association", the Missouri life and health insurance guaranty association created under section 376.720;

**(3) "Benefit plan", a specific employee, union, or association of natural persons benefit plan;**

(4) "Contractual obligation", any obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under the provisions of section 376.717;

(5) "Covered policy", any policy or contract **[**within the scope of sections 376.715 to 376.758**] or portion of a policy or contract for which coverage is provided** under the provisions of section 376.717;

(6) "Director", the director of the department of insurance, financial institutions and professional registration of this state;

(7) **"Extra-contractual claims", includes but is not limited to claims relating to bad faith in the payment of claims, punitive or exemplary damages, or attorneys fees and costs;**

**(8)** "Impaired insurer", a member insurer which, after August 13, 1988, is not an insolvent insurer, and is **[**deemed by the director to be potentially unable to fulfill its contractual obligations, or is**]** placed under an order of rehabilitation or conservation by a court of competent jurisdiction;

**[**(8)**] (9)** "Insolvent insurer", a member insurer which, after August 13, 1988, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency;

**[**(9)**] (10)** "Member insurer", any insurer or health services corporation licensed or which holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided under section 376.717, and includes any insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include:

(a) A health maintenance organization;

(b) A fraternal benefit society;

(c) A mandatory state pooling plan;

(d) A mutual assessment company or any entity that operates on an assessment basis;

(e) An insurance exchange; **[**or**]**

(f) **An organization that issues qualified charitable gift annuities, as defined in section 352.500, and does not hold a certificate or license to transact insurance business; or**

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

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

**(12) "Owner", "policy owner", or "contract owner", the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance**

**with the terms of the policy or contract and properly recorded as the owner on the books of the insurer. Owner, contract owner, and policy owner shall not include persons with a mere beneficial interest in a policy or contract;**

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

**[**(12)**] (14)** "Premiums", amounts received on covered policies or contracts, less premiums, considerations and deposits returned thereon, and less dividends and experience credits thereon. The term does not include any amounts received for any policies or contracts or for the portions of any policies or contracts for which coverage is not provided under subsection 3 of section 376.717, except that assessable premium shall not be reduced on account of subdivision (3) of subsection 3 of section 376.717 relating to interest limitations and subdivision (2) of subsection 4 of section 376.717 relating to limitations with respect to any one life**, any one participant,** and any one contract holder**. Premiums shall not include:**

**(a) Premiums on an unallocated annuity contract; or**

**(b) With respect to multiple nongroup policies of life insurance owned by one owner, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, premiums in excess of five million dollars with respect to such policies or contracts, regardless of the number of policies or contracts held by the owner;**

**(15) "Principal place of business", for a person other than a natural person, the single state in which the natural persons who establish policy for the direction, control, and coordination of the operations of the entity as a whole primarily exercise that function, determined by the association in its reasonable judgment by considering the following factors:**

**(a) The state in which the primary executive and administrative headquarters of the entity is located;**

**(b) The state in which the principal office of the chief executive officer of the entity is located;**

**(c) The state in which the board of directors, or similar governing person or persons, of the entity conducts the majority of its meetings;**

**(d) The state in which the executive or management committee of the board of directors, or similar governing person or persons, of the entity conducts the majority of its meetings; and**

**(e) The state from which the management of the overall operations of the entity is directed;**

**(16) "Receivership court", the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the insurer**;

**[**(13)**] (17)** "Resident", any person who resides in this state **[**at the time a member insurer is determined to be an impaired or insolvent insurer**] on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer, whichever first occurs,** and to whom a contractual obligation is owed. A person may be a resident of only one state, which in the case of a person other than a natural person shall be its principal place of business**. Citizens of the United States that are either residents of foreign countries or residents of the United States possessions, territories, or protectorates that do not have an association similar to the association created under sections 376.715 to 376.758 shall be deemed residents of the state of domicile of the insurer that issued the policies or contracts;**

**(18) "Structure settlement annuity", an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant;**

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

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

**[**(15)**] (21)** "Unallocated annuity contract", any annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity **benefits** guaranteed to an individual by an insurer under such contract or certificate.

376.724. 1. If a member insurer is an impaired **[**domestic**]** insurer, the association may, in its discretion, and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer, that are approved by the director**[**, and that are, except in cases of court ordered conservation or rehabilitation, also approved by the impaired insurer**]**:

(1) Guarantee, assume or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the policies or contracts of the impaired insurer; **or**

(2) Provide such moneys, pledges, notes, **loans,** guarantees, or other means as are proper to effectuate subdivision (1) of this subsection and assure payment of the contractual obligations of the impaired insurer pending action under subdivision (1) of this subsection**[**; or

(3) Loan money to the impaired insurer**]**.

2. **[**If a member insurer is an impaired insurer, whether domestic, foreign or alien and the insurer is not paying claims in a timely fashion, then subject to the preconditions specified in subsection 3 of this section, the association shall, in its discretion, either:

(1) Take any of the actions specified in subsection 1 of this section, subject to the conditions therein; or

(2) Provide substitute benefits in lieu of the contractual obligations of the impaired insurer solely for: health claims; periodic annuity benefit payments; death benefits; supplemental benefits; and cash withdrawals for policy or contract owners who petition therefor under claims of emergency or hardship in accordance with standards proposed by the association and approved by the director.

3. The association shall be subject to the requirements of subsection 2 of this section only if:

(1) The laws of the impaired insurer's state of domicile provide that until all payments of or on account of the impaired insurer's contractual obligations by all guaranty associations, along with all expenses thereof and interest on all such payments and expenses, shall have been repaid to the guaranty associations or a plan of repayment by the impaired insurer shall have been approved by the guaranty associations:

(a) The delinquency proceedings shall not be dismissed;

(b) Neither the impaired insurer nor its assets shall be returned to the control of its shareholders or private management; and

(c) It shall not be permitted to solicit or accept new business or have any suspended or revoked license restored; and

(2) (a) If the impaired insurer is a domestic insurer, it has been placed under an order of rehabilitation by a court of competent jurisdiction in this state; or

(b) If the impaired insurer is a foreign or alien insurer:

a. It has been prohibited from soliciting or accepting new business in this state;

b. Its certificate of authority has been suspended or revoked in this state; and

c. A petition for rehabilitation or liquidation has been filed in a court of competent jurisdiction in its state of domicile by the commissioner of that state.

4. (1)**]** If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

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

**[**(b)**] b.** Assure payment of the contractual obligations of the insolvent insurer; and

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

(2) **[**With respect only to life and health policies,**]** Provide benefits and coverages in accordance with **[**subsection 5 of this section.

5. When proceeding under subsection 2 or 4 of this section, the association shall,**] the following provisions:**

**(a)** With respect to **[**only**]** life and health insurance policies**[**:

(1)**] and annuities,** assure payment of benefits for premiums identical to the premiums and benefits, except for terms of conversion and renewability, that would have been payable under the policies of the insolvent insurer, for claims incurred:

**[**(a)**] a.** With respect to group policies **and contracts**, not later than the earlier of the next renewal date under such policies or contracts or forty-five days, but in no event less than thirty days, after the date on which the association becomes obligated with respect to such policies **and contracts**;

**[**(b)**] b.** With respect to individual policies, **contracts, and annuities,** not later than the earlier of the next renewal date, if any, under such policies **or contracts** or one year, but in no event less than thirty days, from the date on which the association becomes obligated with respect to such policies **and contracts**;

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

**[**(3)**] (c)** With respect to individual policies, make available to each known insured, **annuitant,** or owner if other than the insured **or annuitant**, and with respect to an individual formerly insured **or formerly an annuitant** under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of **[**subsection 6 of this section**] paragraph (d) of this subdivision**, if the insureds **or annuitants** had a right under law or the terminated policy to convert coverage to individual coverage or to continue an individual policy in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or had a right only to make changes in premium by class**[.] ;**

**[**6. (1)**] (d) a.** In providing the substitute coverage required under **[**subdivision (3) of subsection 5 of this section**] paragraph (c) of this subdivision**, the association may offer either to reissue the terminated coverage or to issue an alternative policy.

**[**(2)**] b.** Alternative or reissued policies shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy.

**[**(3)**] c.** The association may reinsure any alternative or reissued policy**[.] ;**

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

**[**(2)**] b.** Alternative policies shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates which it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy was last underwritten.

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

**(f) In carrying out its duties in connection with guaranteeing, assuming, or reinsuring policies or contracts under this subsection, the association may, subject to approval of the receivership court, issue substitute coverage for a policy or contract that provides an interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:**

**a. In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for a fixed interest rate, payment of dividends with minimum guarantees, or a different method for calculating interest or changes in value;**

**b. There is no requirement for evidence of insurability, waiting period, or other exclusion that would not have applied under the replaced policy or contract; and**

**c. The alternative policy or contract is substantially similar to the replaced policy or contract in all other terms**.

376.725. **1.** If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be set by the association in accordance with the amount of insurance provided and the age and class of risk of the insured, subject to approval of the director or by a court of competent jurisdiction.

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

**3. When proceeding under subdivision (2) of subsection 2 of section 376.724 with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with subdivision (3) of subsection 3 of section 376.717.**

376.732. 1. If the association fails to act within a reasonable period of time when authorized to do so, the director shall have the powers and duties of the association under sections 376.715 to 376.758 with respect to **[**impaired or**] the** insolvent insurers.

2. The association may render assistance and advice to the director, upon his request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.

3. The association shall have standing to appear **or intervene** before any court **or agency** in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under sections 376.715 to 376.758**, or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise**. Such standing shall extend to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring, modifying or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association shall have the right to appear or intervene before a court **or agency** in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over **[**a third party**] any person or property** against whom the association may have rights through subrogation **[**of the insurer's policyholders**] or otherwise**.

376.733. 1. Any person receiving benefits under sections 376.715 to 376.758 shall be deemed to have assigned the rights under, and any causes of action **against any person for losses arising under, resulting from, or otherwise** relating to, the covered policy or contract to the association to the extent of the benefits received because of the provisions of sections 376.715 to 376.758, whether the benefits are payments of or on account of contractual obligations, continuation of coverage or provision of substitute or alternative coverages. The association may require an assignment to it of such rights and cause of action by any payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any right or benefits conferred by sections 376.715 to 376.758 upon such person.

2. The subrogation rights of the association under this section have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under sections 376.715 to 376.758.

3. In addition to subsections 1 and 2 of this section, the association shall have all common law rights of subrogation and any other equitable or legal remedy which would have

been available to the impaired or insolvent insurer or **[**holder**] owner, beneficiary, or payee** of a policy or contract with respect to such policy or contracts**, including, without limitation in the case of a structured settlement annuity, any rights of the owner, beneficiary, or payee of the annuity, to the extent of benefits received under sections 376.715 to 376.758, against a person, originally or by succession, responsible for the losses arising from the personal injury relating to the annuity or payment thereof, excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under Section 130 of the Internal Revenue Code of 1986, as amended**.

376.734. 1. **In addition to any other rights and powers under sections 376.715 to 376.758,** the association may:

(1) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of sections 376.715 to 376.758;

(2) Sue or be sued, including taking any legal actions necessary or proper for recovery of any unpaid assessments under subsections 1 and 2 of section 376.735 **and to settle claims or potential claims against it**;

(3) Borrow money to effect the purposes of sections 376.715 to 376.758. Any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;

(4) Employ or retain such persons as are necessary to handle the financial transactions of the association, and to perform such other functions as become necessary or proper under sections 376.715 to 376.758;

(5) Take such legal action as may be necessary to avoid **or recover** payment of improper claims;

(6) Exercise, for the purposes of sections 376.715 to 376.758 and to the extent approved by the director, the powers of a domestic life or health insurer, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform its obligations under sections 376.715 to 376.758**;**

**(7) Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under sections 376.715 to 376.758 with respect to the person, and the person shall promptly comply with the request;**

**(8) Take other necessary or appropriate action to discharge its duties and obligations or to exercise its powers under sections 376.715 to 376.758; and**

**(9) With respect to covered policies for which the association becomes obligated after an entry of an order of liquidation or rehabilitation, elect to succeed to the rights of the insolvent insurer arising after the order of liquidation or rehabilitation under any contract of reinsurance to which the insolvent insurer was a party, to the extent that such**

**contract provides coverage for losses occurring after the date of the order of liquidation or rehabilitation. As a condition to making this election, the association shall pay all unpaid premiums due under the contract for coverage relating to periods before and after the date of the order of liquidation or rehabilitation.**

**2. The board of directors of the association may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of sections 376.715 to 376.758 in an economical and efficient manner.**

**3. Where the association has arranged for or offered to provide the benefits of sections 376.715 to 376.758 to a covered person under a plan or arrangement that fulfills the association's obligations under sections 376.715 to 376.758, the person shall not be entitled to benefits from the association in addition to or other than those provided under the plan or arrangement**.

**[**2.**] 4.** The association may join an organization of one or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association.

**[**3. Whenever it is necessary for the association to retain the services of legal counsel, the association shall retain persons licensed to practice law in this state, and whose principal place of business is in this state or who are employed by or are partners of a professional corporation, corporation, copartnership or association having its principal place of business in this state; provided however, that if, after a good faith search, such persons cannot be found, the association may retain the legal services of such other persons as it chooses.**]**

376.735. 1. For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. Assessments shall be due not less than thirty days after prior written notice to the member insurers and shall accrue interest at ten percent per annum on and after the due date.

2. There shall be two assessments, as follows:

(1) Class A assessments **[**shall**] may** be made for the purpose of meeting administrative and legal costs and other expenses **[**and examinations conducted under the authority of subsections 4 and 5 of section 376.742**]**. Class A assessments may be made whether or not related to a particular impaired or insolvent insurer;

(2) Class B assessments **[**shall**] may** be made to the extent necessary to carry out the powers and duties of the association under **[**section 376.724**] sections 376.715 to 376.758** with regard to an impaired or an insolvent insurer.

3. The amount of any class A assessment shall be determined by the board and may be made on a pro rata or nonpro rata basis. If pro rata, the board may provide that it be credited

against future class B assessments. A nonpro rata assessment shall not exceed one hundred fifty dollars per member insurer in any one calendar year. The amount of any class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

4. Class B assessments against member insurers for each account shall be in the proportion that the premiums received on business in this state by each assessed member insurer **[**or**] on** policies or contracts covered by each account for the three most recent calendar years for which information is available preceding the year in which the insurer became impaired or insolvent, as the case may be, bears to such premiums received on business in this state for such calendar years by all assessed member insurers.

5. Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be made until necessary to implement the purposes of sections 376.715 to 376.758. Classification of assessments under **[**subsections 1 and**] subdivisions (1) and (2) of subsection** 2 of this section and computation of assessments under this **[**subsection**] section** shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. In no case shall a member insurer be liable under class A or class B for assessments in any account enumerated in section 376.720, for which such insurer is not licensed by the department of insurance, financial institutions and professional registration to transact business.

376.737. 1. The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. **Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred under a repayment plan approved by the association.**

2. **(1) Subject to the provisions of subdivision (2) of this subsection,** the total of all assessments upon a member insurer for each account shall not in any one calendar year exceed two percent of such insurer's average **annual** premiums received in this state on the policies and contracts covered by the account during the three calendar years preceding the year in which the insurer became an impaired or insolvent insurer. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in **[**either**] the** account an amount sufficient to carry out the responsibilities of the association, the necessary

additional funds shall be assessed as soon thereafter as permitted by sections 376.715 to 376.758.

**(2) If two or more assessments are made in one calendar year with respect to insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in subdivision (1) of this subsection shall be equal and limited to the higher of the three-year average annual premiums for the applicable account as calculated under this section.**

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

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

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

376.738. The association shall issue to each insurer paying an assessment under the provisions of sections 376.715 to 376.758, other than class A assessment, a certificate of contribution, in a form prescribed by the director, for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution **[**issued before September 1, 1991,**]** may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the director may approve**[**, provided that a certificate issued before September 1, 1991, shall not be shown as an admitted asset for a longer period of time or greater amount than that described in subdivisions (1) to (4) of subsection 2 of section 375.774, RSMo**]**.

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

2. If the association fails to submit a suitable plan of operation within one hundred twenty days following the effective date, August 13, 1988, of sections 376.715 to 376.758 or if

at any time thereafter the association fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of sections 376.715 to 376.758. Such rules shall continue in force until modified by the director or superseded by a plan submitted by the association and approved by him.

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

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

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

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

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

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

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

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

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

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

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

5. The plan of operation may provide that any or all powers and duties of the association except those pursuant to provisions of **[**subsection 3 of section 376.733 and subsections 1 and 2 of**] subdivision (3) of subsection 1 of section 376.734 and** section 376.735 are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two or more states. Such a corporation, association, or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the director, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by sections 376.715 to 376.758.

376.743. 1. The board of directors may, upon majority vote, make reports and recommendations to the director upon any matter germane to the solvency, liquidation,

rehabilitation or conservation of any member insurer or germane to the solvency of any company seeking to do an insurance business in this state. Such reports and recommendations shall not be considered public documents.

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

**[**3. The board of directors may, upon majority vote, request that the director order an examination of any member insurer which the board in good faith believes may be an impaired or insolvent insurer. Within thirty days of the receipt of such request, he shall begin such examination. The examination may be conducted as a National Association of Insurance Commissioners examination or may be conducted by such persons as the director designates. The cost of such examination shall be paid by the association and the examination report shall be treated as are other examination reports. In no event shall such examination report be released to the board of directors prior to its release to the public, but this shall not preclude the director from complying with subsections 1 to 4 of section 376.742. The director shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the director but it shall not be open to public inspection prior to the release of the examination report to the public.

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

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

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

2. Sections 376.715 to 376.758 shall be liberally construed to effect the purpose under subsection 2 of section 376.715 which shall constitute an aid and guide to interpretation.

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

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