Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 1—Organization and Administration

PROPOSED AMENDMENT

11 CSR 45-1.090 Definitions. The commission proposes to amend subsection (20)(G).

PURPOSE: This amendment gives the commission the discretion to approve various representations of value as tokens for use in gambling games.

(20) Definitions beginning with T—

(G) Token—A metal object *[representative]* **or other representation** of value*[,]* **that is authorized by statute and/or approved by the commission, which is** redeemable for cash only at the issuing riverboat gaming operation, and issued and sold by a holder of a Class A license for use in electronic gaming devices; and

AUTHORITY: sections 313.004, [and] 313.805 ***and 313.817,*** *RSMo 1994. Emergency rule filed Sept. 1, 1993, effective Sept. 20, 1993, expired Jan. 17, 1994. Emergency rule filed Jan. 5, 1994, effective Jan. 18, 1994, expired Jan. 30, 1994. Original rule filed Sept. 1, 1993, effective Jan 31, 1994. For intervening history, please consult the* ***Code of State of Regulations****. Amended: Filed March 30, 2000.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, P.O. Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. A public hearing is scheduled for 10:00 a.m. on June 8, 2000, at the Missouri Gaming Commission, 3417 Knipp Drive, Jefferson City, Missouri.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 24—Drivers License Bureau Rules

PROPOSED RULE

12 CSR 10-24.450 Staggering Expiration Dates of Driver/Nondriver Licenses

PURPOSE: This rule outlines the procedures for staggering the expiration date of driver/nondriver licenses being issued or renewed over a six (6)-year period as outlined in section 302.177, RSMo.

(1) From July 1, 2000 through June 30, 2003, the director of revenue shall issue driver licenses with expiration dates as outlined below to applicants that are at least twenty-one (21) years of age and less than seventy (70) years of age.

(A) All new driver license transactions completed shall produce a driver license expiring on the applicant's date of birth in the sixth year after issuance.

(B) All mail-in transactions completed shall produce a driver license expiring on the applicant's date of birth in the sixth year after issuance.

(C) All renewal driver license transactions shall be staggered based on the applicant's year of birth. All applicants born in an odd-numbered year shall receive a driver license expiring on the applicant's date of birth in the third year after issuance. All applicants born in an even-numbered year shall receive a driver license expiring on the applicant's date of birth in the sixth year after issuance.

(2) From July 1, 2000 through June 30, 2003, the director of revenue shall issue nondriver licenses with expiration dates as outlined below to applicants that are less than seventy (70) years of age.

(A) All new nondriver license transactions completed shall produce a nondriver license expiring on the applicant's date of birth in the sixth year after issuance.

(B) All renewal nondriver license transactions shall be staggered based on the applicant's year of birth. All applicants born in an odd-numbered year shall receive a nondriver license expiring on the applicant's date of birth in the third year after issuance. All applicants born in an even-numbered year shall receive a nondriver license expiring on the applicant's date of birth in the sixth year after issuance.

(3) The fees for driver/nondriver license renewals that are staggered from July 1, 2000 through June 30, 2003, are as follows:

(A) Class A, B or C three (3)-year renewal is twenty dollars ($20);

(B) Class A, B or C six (6)-year renewal is forty dollars ($40);

(C) Class E three (3)-year renewal is fifteen dollars ($15);

(D) Class E six (6)-year renewal is thirty dollars ($30);

(E) Class F or M three (3)-year renewal is seven dollars and fifty cents ($7.50);

(F) Class F or M six (6)-year renewal is fifteen dollars ($15);

(G) Nondriver license three (3)-year renewal is three dollars ($3); and

(H) Nondriver license six (6)-year renewal is six dollars ($6).

AUTHORITY: section 302.177, RSMo Supp. 1999. Original rule filed March 27, 2000.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Department of Revenue, Office of Legislation and Regulations, P.O. Box 629, Jefferson City, MO 65105. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 24—Drivers License Bureau Rules

PROPOSED RULE

12 CSR 10-24.452 Highway Sign Recognition Test

PURPOSE: This rule establishes the passing score for the highway sign recognition test as outlined in section 302.173, RSMo.

(1) The director shall require any person applying for a new or renewal driver license to submit to an examination that tests his/her ability to understand highway signs regulating, warning or directing traffic.

(2) The person shall be presented with six (6) highway signs and must successfully identify four (4) out of the six (6) signs to pass the examination.

AUTHORITY: section 302.173, RSMo Supp. 1999. Original rule filed March 27, 2000.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Department of Revenue, Office of Legislation and Regulations, P.O. Box 629, Jefferson City, MO 65105. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 30—Child Support Enforcement
Chapter 8—Cooperation Requirement

PROPOSED RULE

13 CSR 30-8.010 Cooperation Requirement

P*URPOSE. This rule sets forth the requirement for individuals who are applicants for or recipients of public assistance benefits (applicants/recipients) to cooperate with the Division of Child Support Enforcement in its efforts to establish paternity and establish, modify and enforce child support orders.*

(1) Definition. For the purposes of this rule the following definitions are applicable:

(A) Division means the Division of Child Support Enforcement;

(B) Good cause means the circumstances under which cooperation is not in the best interest of the child or custodian who has applied for or is receiving public assistance benefits;

(C) Cooperation means the duty of applicants/recipients to provide within their ability to do so, all requested information and assistance to the division to enable it to establish paternity and establish, modify, and enforce child support and medical support orders;

(D) Public assistance means any benefits from a program funded pursuant to Part A or Part E of Title IV of the Social Security Act, Title XIX of the Social Security Act or the Food Stamp Act;

(E) Applicant/recipient is a person who has applied for or is receiving public assistance;

(F) NCP means noncustodial parent;

(G) AF means alleged father.

(2) Cooperation Requirements. If it is determined by the division that an applicant/recipient is not cooperating in establishing paternity or establishing a medical support order with respect to a child, and the applicant/recipient does not qualify for a good cause or other exceptions established by the division, the division shall notify the Division of Family Services, who shall impose sanctions. Cooperation requirements include, but are not limited to providing to the division the following information pertaining to the noncustodial parent (NCP) or alleged father (AF) and assistance to establish paternity and establish, modify, and enforce support orders:

(A) Information relating to the NCP or AF includes, but is not limited to the following:

1.The name;

2. Date of birth or approximate age;

3. Social Security number;

4. Known address or last known address;

5. Past or present employer and usual occupation;

6. Name of high school, college, university, vocational school/expected graduation date;

7. Names of friends or relatives who may have information;

8. Names of clubs or union memberships;

9. Drivers license information;

10. Physical description;

11. Make, model or license plate of any vehicles owned;

12. Any information regarding any other property owned; and

13. Any other pertinent information relevant to locating the NCP/AF.

(B) Assistance required from the applicant/recipient—

1. Providing financial and income information, education and work history of the applicant/recipient;

2. Providing and updating the street and mailing address of the applicant/recipient;

3. Appearing at and cooperating with the division, or prosecuting attorney's offices and supplying written documentary evidence;

4. Appearing as a witness at judicial or administrative hearings;

5. Completing a notarized affidavit, attesting to a lack of relevant requested information regarding the NCP or AF; and

6. All other assistance requested by the division to establish paternity including, but not limited to, keeping appointments for genetic testing, participating in genetic testing.

(3) Good Cause for Noncooperation.

(A) An applicant/recipient may refuse to cooperate with the division based upon good cause. Each applicant/recipient will be informed by the division or Division of Family Services caseworker about the duty to cooperate and the right to claim good cause. Each applicant/recipient will also be provided information regarding good cause, including its definition and how good cause can be claimed and what evidence is needed to support such a claim.

(B) If the applicant/recipient claims good cause to the Division of Family Services caseworker, the Division of Family Services may make the good cause determination in compliance with this regulation.

(C) The applicant/recipient shall be provided a written copy of the requirement to cooperate and the right to claim good cause for refusal to cooperate with the division. It is the responsibility of the applicant/recipient to specify the circumstances under which good cause is claimed and provide corroborative evidence. Good cause for refusing to cooperate is deemed to exist in one or more of the following circumstances, but may not be limited to these circumstances:

1. Physical or emotional harm to a child;

2. Physical or emotional harm to the applicant/recipient of sufficient severity that it would reduce the applicant/recipient's capacity to adequately care for a child;

3. Physical or emotional harm to the applicant/recipient as a result of domestic violence;

4. The child for whom support is sought was conceived as a result of incest or rape; or

5. Legal proceeding for the adoption of the child is pending before a court.

(4) The documentation will be submitted to the caseworker who will review it to determine if there is sufficient evidence to establish a claim of good cause. A claim of good cause may be verified by one of the following:

(A) Birth certificate or medical or law enforcement records that indicate that a child was conceived as the result of incest or forcible rape. Acceptable medical records shall include records reflecting the judgment of a disinterested third party including, but not limited to, counselors, therapists, or any other medical or psychological health professional that conception is the result of rape;

(B) Court documents or other records that indicate that legal proceedings for adoption are pending before a court of competent jurisdiction;

(C) Court, medical, criminal, child protective services, social service, psychological, or law enforcement records that indicate the NCP/AF might inflict physical or emotional harm on the child or applicant/recipient;

(D) Medical records regarding the emotional health history and present emotional health status of the applicant/recipient or the child for whom support would be sought that indicate emotional harm would result from cooperation, or written statements from a mental health professional indicating such results;

(E) A written statement from a public or licensed private social agency that the applicant/recipient is being assisted by the agency to resolve the issue of whether to keep the child or relinquish him or her for adoption; or

(F) When none of the items listed above is present or conclusive, a sworn statement from the applicant/recipient, and at least one other individual with knowledge of the circumstances that provide the basis for the claim of good cause may be submitted.

(5) Due Process Rights.

(A) Upon application, the applicant/recipient will be given in writing, notice of the cooperation requirements. These requirements will be explained along with what sanctions can be applied when the applicant/recipient fails to cooperate with the division. If the applicant/recipient claims good cause, he/she will have twenty (20) calendar days to provide evidence to support the claim of good cause. The twenty (20) days may be extended in case of difficulty in obtaining the evidence for a period of time not to exceed forty-five (45) days as determined by the caseworker.

(B) Review and Determination. If the applicant/recipient claims good cause, the division or Division of Family Services caseworker will review the information provided and make a recommendation as to whether or not good cause exists. The recommendation must—

1. Be in written form and contain the worker's recommendation, the basis for the recommendation, the documentation provided by the applicant/recipient; and

2. Be forwarded to the designated division or Division of Family Services personnel, who will make the final determination as to whether there is good cause for noncooperation.

(C) Notification of Final Determination. The applicant/recipient must be notified in writing of the findings and basis for determination. If there is a finding of good cause for noncooperation, the applicant/recipient will be given the opportunity to have child support services stopped or be continued. If no good cause is found, the applicant/recipient will be afforded an opportunity to cooperate, withdraw the request for assistance or terminate assistance. The notification must be made a part of either the division or Division of Family Services case record.

AUTHORITY: section 454.400.2(5), RSMo Supp. 1999. Original rule filed March 30, 2000.

PUBLIC COST: This proposed rule will cost state agencies or political subdivisions less than $500 in the aggregate.

PRIVATE COST: This proposed rule is not estimated to cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Division of Child Support Enforcement, Lynn F. Fallen, 3418 Knipp Drive, Suite F, Jefferson City, MO 65109. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 1—Organization and Operation of Board of Directors

PROPOSED AMENDMENT

16 CSR 50-1.010 General Organization. The board is amending sections (1)–(5).

PURPOSE: This amendment clarifies the contacts, including their addresses, of individuals whom the public may contact to obtain information. This amendment also incorporates changes made by the General Assembly to sections 50.1000 to 50.1300, RSMo.

(1) Description of the Board. The board of directors consists of *[nine (9) persons]* **eleven directors, two (2) of whom shall be appointed by the governor, with the advice and consent of the Senate, but who shall have no beneficiary interest in the system. The remaining nine (9) directors shall be** elected by the membership of the County Employees' Retirement Fund (CERF). *[The board shall consist of]* **These remaining nine (9) directors shall include** an elected official or an employee of an elected official representing the elective county offices*[. None]***, but none** of these offices may have more than one (1) elected official or representative serving at a given time.

(2) Meetings of the Board. The board of directors of the County Employees' Retirement Fund, hereafter "board," shall hold regular **quarterly** meetings at a location to be designated by the board *[in February, May, August and November of each calendar year]* and special meetings at times as may be necessary on call of the chairman or by three (3) members acting jointly and notifying the chair, in writing, of their desire to meet, upon due and reasonable notice. In the event three (3) members act to request a meeting, their written notification to the chair may be served by either United States mail or facsimile transmission. The chairman shall publicize through appropriate channels the time and place of the meetings of the board. All meetings of the board of directors shall comply with Chapter 610, RSMo. Information concerning meetings or rules may be obtained by contacting *[Brydon, Swearengen & England P.C., 312 East Capitol Avenue, Jefferson City, MO 65101]* **the County Employees' Retirement Fund Administrative Office, P.O. Box 2271, Jefferson City, MO 65102**. Information concerning operations of the system may be obtained by writing or calling the CERF plan administrator. The contact person for the plan administrator is *[Terry Seboldt, Employee Benefits Officer]* **Sarah J. Maxwell, Executive Director**. *[Mr. Seboldt]* **Ms. Maxwell** may be reached by mail at *[P.O. Box 577, Columbia, MO 65205]* **P.O. Box 2271, Jefferson City, MO 65102,** or by telephone at *[1 (800) 357-8557]* **(573) 632-9203**.

(3) Election of Officers. The board of directors, at the **first** regular meeting *[in February]* of each year, or at a special meeting, shall elect a chairman *[and]***,** vice-chairman**, and secretary** to serve for a period of one (1) year commencing upon their election to office. The chairman shall preside at all meetings of the board; except that in the absence of the chairman, the vice-chairman shall preside. In the event of a vacancy in one (1) of the officers' positions, that vacancy will be filled at the next regular meeting by election.

(4) Quorum. A quorum required for a meeting of the board of directors shall consist of *[five (5)]* **six (6)** members. Each director shall be entitled to one (1) vote on any matter requiring a decision by the board and majority of concurring votes among the directors present shall be necessary for a decision.

(5) The custodian of records for the County Employees' Retirement Fund is its plan administrator. Anyone wishing to obtain information or make submissions or requests may do so by contacting *[Boone County National Bank]* **the County Employees' Retirement Fund**, Plan Administrator, *[P.O. Box 577, Columbia, MO 65205]* **P.O. Box 2271, Jefferson City, MO 65102,** or by calling *[1 (800) 357-8557]* **(573) 632-9203**.

*AUTHORITY: section 50.1032, RSMo Supp. [1997] **1999**. Original rule filed Oct. 11, 1995, effective May 30, 1996. Amended: Filed March 22, 1996, effective Oct. 30, 1996. Amended: Filed Sept. 9, 1997, effective Feb. 28, 1998. Amended: Filed Sept. 17, 1998, effective March 30, 1999. Amended: Filed March 17, 2000.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than $500 in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 1—Organization and Operation of Board of Directors

PROPOSED AMENDMENT

16 CSR 50-1.020 Appeal Process. The board is amending sections (2) and (4).

PURPOSE: This amendment clarifies administrative procedures for handling appeals.

(2) Requests.

(A) The request for review must be stated in writing, addressed to the *[legal counsel of the board]* **plan administrator**. The request must state what decision the board is being asked to review, and what action the board is being asked to take.

(3) The review will be conducted at the next regularly scheduled meeting of the board of directors which is at least thirty (30) days after the request for review is received. The party requesting review (the appellant) will be notified in writing of the date the board will conduct the review. All reviews will be conducted in Jefferson City, Missouri.

(4) The plan administrator*[, in conjunction with legal counsel,]* will prepare background material for the board, which will include documentation necessary for the board to review the decision. The background material will be provided to the appellant at the same time that it is provided to the board. Any requirements of law prohibiting reproduction or distribution of material will be observed.

*AUTHORITY: section 50.1032, RSMo Supp. [1997] **1999**. Original rule filed Oct. 11, 1995, effective May 30, 1996. Amended: Filed Sept. 9, 1997, effective Feb. 28, 1998. Amended: Filed March 17, 2000.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than $500 in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 1—Organization and Operation of Board of Directors

PROPOSED AMENDMENT

16 CSR 50-1.030 Open Records Policy. The board is adding section (4).

PURPOSE: This amendment clarifies the procedure for determining costs for certain open records requests.

(4) Individuals requesting member records for purposes of seeking election to the board of directors shall be charged a reasonable cost established by a schedule promulgated by the board of directors to cover the administrative costs of providing such information.

*AUTHORITY: section 50.1032, RSMo Supp. [1996] **1999**. Original rule filed July 29, 1997, effective Jan. 30, 1998. Amended: Filed March 17, 2000.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than $500 in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 2—Membership

PROPOSED RESCISSION

16 CSR 50-2.010 Definitions. This rule expanded on definitions found in section 50.1000, RSMo.

PURPOSE: There were significant legislative changes to sections 50.1000 to 50.1300, RSMo, which sets forth the statutory framework for the County Employees' Retirement Fund, in the 1999 legislative session. The Board of the County Employees' Retirement Fund wishes to rescind this rule and adopt a new rule in its place in order to define terms in accordance with the new law and to add other defined terms in light of the new law.

AUTHORITY: section 50.1032, RSMo Supp. 1997. Original rule filed Oct. 11, 1995, effective May 30, 1996. Amended: Filed July 16, 1998, effective Jan. 30, 1999. Rescinded: Filed March 17, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 2—Membership *and Benefits*

PROPOSED RULE

16 CSR 50-2.010 Definitions

PURPOSE: This rule sets forth the defined terms necessary to describe the provisions of the Missouri County Employees' Retirement Fund.

(1) When used in these regulations or in sections 50.1000 to 50.1300, RSMo, the words and phrases defined hereinafter shall have the following meanings unless a different meaning is clearly required by the context of the plan:

(A) Accrued benefit means the amount that would be payable at normal retirement date, considering the participant's average final compensation, primary Social Security benefit, target replacement ratio, and creditable service at the date of termination. Notwithstanding the foregoing, a participant's accrued benefit under the plan shall not be less than his or her accrued benefit as of December 31, 1999, determined under the prior plan;

(B) Active member or active participant means an employee who does not currently have an election in effect to opt-out of the plan, who has not incurred a separation from service, and who otherwise meets the criteria necessary to participate in the plan;

(C) Actuarial equivalence means equality in value of the aggregate amounts expected to be received under different forms of payment. Such equality in value shall be based on assumptions as to the occurrence of future events. The future events to be taken into account are mortality for participants, mortality for a beneficiary, and an interest discount for the time value of money. For this plan, the actuarial assumptions are as follows:

1. Mortality: the 1983 Group Annuity Mortality Table, weighted sixty-six and two-thirds percent (66 2/3%) male and thirty-three and one-third percent (33 1/3%) female;

2. Interest discount assumption: eight percent (8%), compounded annually;

(D) Actuary means an individual who is enrolled as an actuary by the Joint Board for the Enrollment of Actuaries pursuant to 29 U.S.C. 1242, or firm of actuaries, which has on its staff such an enrolled actuary, which enrolled actuary or firm of actuaries is selected by the board to provide actuarial services for the plan;

(E) Annuity means a form of payment under which monthly installments are made to a retired participant in accordance with the terms of this plan;

(F) Annuity starting date means:

1. The first day of the first period for which an amount is payable as an annuity;

2. In the case of a benefit not payable in the form of an annuity, the first day on which all events have occurred which entitle the participant to such benefit; or

3. In the case of a deferred annuity, the annuity starting date is the date for which the annuity payments are to commence, not the date that the deferred annuity is elected;

(G) Average final compensation means the monthly average of the two highest years of compensation received by the participant;

(H) Beneficiary means the person, persons, or legal entity entitled to receive benefits under this plan which become payable in the event of the participant's death;

(I) Board means the Board of Directors of the County Employees' Retirement Fund;

(J) Code means the *Internal Revenue Code* of 1986, as amended, and includes any regulations thereunder;

(K) Compensation means, for all periods on or after January 1, 2000, all salary and other compensation paid by an employer to an employee for personal services rendered as an employee as shown on the employee's Form W-2, plus amounts paid by an employer but excluded from W-2 compensation by reason of *Internal Revenue Code* sections 125, 402(g)(3), 414(h)(2), or 457, but not including travel and mileage reimbursement, and not including compensation in excess of the limit imposed by section 401(a)(17) of the Code. Compensation received from sources other than an employer and compensation received pursuant to independent contracting relationships shall not be included in calculating the retirement benefit. In the case of a participant who left the employer to join a uniformed service (as defined in the Uniformed Services Employment and Reemployment Rights Act of 1994), and returns to the employ of an employer before his or her reemployment rights under the statute expire, compensation, with respect to the plan years in which the participant was in the uniformed service, shall mean the compensation the participant would have earned had he remained in the employ of the employer. The board has the discretionary authority to make a reasonable estimate of this amount. For periods before January 1, 2000, compensation shall be determined under the terms of the prior plan;

(L) Employee means any county elective or appointive officer or employee who is hired and fired by an employer and whose work and responsibilities are directed and controlled by the employer and who is compensated directly from county funds and whose position requires the actual performance of duties during not less than one thousand (1,000) hours per year, except county prosecuting attorneys covered pursuant to sections 56.800 to 56.840, RSMo, circuit clerks and deputy circuit clerks covered under the Missouri State Retirement System and county sheriffs covered pursuant to sections 57.949 to 57.997, RSMo; provided that individuals who receive some pay from a county but who are subject to hiring, supervision, promotion, or termination by an entity other than the employer, including but not limited to an extension council or the circuit court, are not employees of the employer for purposes of the plan;

(M) Employer means each county in the state, except any city not within a county and counties of the first classification with a charter form of government;

(N) The entry date of a full-time employee is the hire date unless the employee opted out of the prior plan. The entry date of a part-time employee shall be the first semiannual entry date (January 1 or July 1) after the part-time employee satisfies the one thousand (1,000) hour requirement during the calendar year;

(O) Former employee means a person who ceases to be an employee but who is entitled to a benefit from this plan;

(P) Full-time employee means an elective or appointive official or employee regularly employed by an employer who is under the direct control and supervision of the employer or an elected or appointed county official and who is subject to continued employ-

ment, promotion, salary review or termination by an employer or an elected or appointed county official and who is compensated directly from county funds and whose position requires the actual performance of duties during not less than one thousand (1,000) hours per calendar year, except county prosecuting attorneys covered under sections 56.800–56.840, RSMo, circuit clerks and deputy circuit clerks covered under the Missouri State Retirement System and county sheriffs covered under sections 57.949 to 57.997, RSMo, and employees who receive some compensation from an employer but who are subject to hiring, supervision, promotion or termination by an entity other than the employer such as an extension council or the circuit court;

(Q) Hire date means the date that an employee begins actual employment with an employer;

(R) Hour of service means each hour for which an employee is paid or entitled to payment for the performance of duties for the employer;

(S) LAGERS means the Local Government Employees' Retirement System presently codified at sections 70.600 to 70.755, RSMo;

(T) Normal form of benefit means an annuity paid in equal monthly installments on the first day of each calendar month in which the participant shall have lived the entire preceding calendar month;

(U) Part-time employee means an employee regularly employed by an employer or an elected or appointed county official who is under the direct control and supervision of an employer or an elected or appointed county official and who is subject to continued employment, promotion, salary review or termination by an employer or an elected or appointed county official and who is compensated directly from county funds and whose position is not anticipated to require the actual performance of duties during one thousand (1,000) hours or more per calendar year;

(V) Participant means an employee covered by this plan and a former employee with a vested accrued benefit remaining in the plan;

(W) Plan, or CERF, means the County Employees' Retirement Fund, as described in sections 50.1000–50.1300, RSMo;

(X) Plan year means the calendar year;

(Y) Primary Social Security amount means the old age insurance benefit pursuant to section 202 of the Social Security Act (42 U.S.C. 402) payable to a participant at age sixty-two (62). Such determination shall be at the time that creditable service ends without assuming any future increases in compensation, any future increases in the taxable wage base, any changes in the formulas used pursuant to the Social Security Act, or any future increases in the Consumer Price Index; provided, however, that if the participant's creditable service ends after age sixty-two (62), the primary Social Security amount shall be determined pursuant to the Social Security Act as in effect at the time the participant reached age sixty-two (62). However, it shall be assumed that the employee will continue to receive compensation at the same rate as that received at the time the determination is being made, until the participant reaches age sixty-two (62). The first year of compensation as an employee shall be regressed at three percent (3%) per year with respect to years prior to the period of creditable service. For this purpose, the "first year of compensation" shall be the first complete calendar year in which the plan has documented information regarding the participant's compensation. If the board does not have records of a participant's compensation for a plan year, the board may make reasonable estimates of compensation, if the participant does not supply the records described in 16 CSR 50-2.050;

(Z) Prime rate means the prime rate at any given time as listed in the Historical Chart of Prime Rates at www.nfsn.com/library/prime/htm, or any other source which the board in its discretion deems to be reliable;

(AA) Prior plan means the County Employees' Retirement System as in effect on December 31, 1999;

(BB) Prior service means a participant's service rendered prior to August 28, 1994;

(CC) Required beginning date means the April first of the calendar year following the later of the calendar year in which the participant reaches age seventy and one-half (70 1/2), or the calendar year in which the participant separates from service;

(DD) Separation from service means the severance of a participant's employment with an employer for any reason, including retirement; provided that a participant shall not be deemed to have incurred a separation from service if the participant resumes employment with an employer within thirty (30) days after terminating employment with an employer;

(EE) Survivor annuitant means the individual other than a beneficiary eligible to receive an annuity following the death of a participant who is receiving an annuity;

(FF) Target replacement ratio means:

1. Eighty percent (80%), if a participant's average final compensation is thirty thousand dollars ($30,000) or less;

2. Seventy-seven percent (77%), if a participant's average final compensation is forty thousand dollars ($40,000) or less, but greater than thirty thousand dollars ($30,000);

3. Seventy-two percent (72%), if a participant's average final compensation is fifty thousand dollars ($50,000) or less, but greater than forty thousand dollars ($40,000); and

4. Seventy percent (70%), if a participant's average final compensation is greater than fifty thousand dollars ($50,000);

(GG) Trust fund means the custodial account established to fund benefits under the plan; and

(HH) Trustee means the entity, or individuals, or committee that is responsible for holding and managing the trust fund that is appointed by the board.

(2) The masculine gender shall be deemed to include the feminine and the singular shall include the plural unless otherwise clearly required by the context.

AUTHORITY: section 50.1032, RSMo Supp. 1999. Original rule filed Oct. 11, 1995, effective May 30, 1996. Amended: Filed July 16, 1998, effective Jan. 30, 1999. Rescinded and readopted: March 17, 2000.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 2—Membership

PROPOSED RESCISSION

16 CSR 50-2.020 Payroll Contributions. This rule set forth what payroll contributions were required from employees in counties that either are or are not members of the Local Government Employees' Retirement System.

PURPOSE: There were significant legislative changes to sections 50.1000 to 50.1300, RSMo, which sets forth the statutory framework for the County Employees' Retirement Fund, in the 1999 legislative session. The Board of the County Employees' Retirement Fund wishes to rescind this rule and adopt a new rule in its place in order to ensure compliance with the applicable law.

AUTHORITY: section 50.1032, RSMo Supp. 1998. Original rule filed Oct. 11, 1995, effective May 30, 1996. Amended: Filed July 29, 1997, effective Jan. 30, 1998. Amended: Filed June 1, 1999, effective Nov. 30, 1999. Rescinded: Filed March 17, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 2—Membership *and Benefits*

PROPOSED RULE

16 CSR 50-2.020 Employee Contributions

PURPOSE: This rule clarifies the nature of payroll contributions required from employees both in counties which are members of the Local Government Employees' Retirement System and those counties which are not members of the Local Government Employees' Retirement System.

(1) A participant who is not a member of Local Government Employees' Retirement System (LAGERS) is subject to a two percent (2%) monthly payroll deduction beginning with the first payroll period after the participant's entry date. This payroll deduction shall constitute the participant's required contribution to the plan and after January 1, 2000, shall be designated as an employer "pick-up" contribution, as described in section 414(h)(2) of the *Internal Revenue Code*. A participant may not waive this contribution, or terminate this contribution requirement by opting out of the plan.

(2) Participants who are members of LAGERS are not subject to any payroll deductions in connection with their participation in the plan.

(3) Contributions Required from Part-Time Employees in Non-LAGERS Counties. Participants in non-LAGERS counties have two (2) options with regard to the prior service earned while they are still qualifying for entry into the plan. A participant must make his or her election to either forego or purchase this prior service as outlined in subsections (A) and (B) upon their entry into the plan at the first available entry date. Such participant may either—

(A) Forego those months of prior service and accrue eight (8) years of service from their entry into the plan; or

(B) Purchase the prior service at the rate of two percent (2%) times the total compensation earned during this prior service period. Participants selecting this option may purchase the prior service with a lump-sum contribution or through monthly payroll deductions in addition to the regular monthly payroll deduction. If the participant elects to purchase the prior service with an additional payroll deduction, then the deduction shall not extend longer than the period of prior service being purchased.

(4) A participant shall not be eligible for a benefit under this plan until all contributions and other payments required by law have been received on behalf of a participant.

(5) When a participant receives a refund of contributions from LAGERS, pursuant to section 70.690, RSMo, the county clerk shall forward a copy of the LAGERS report of the refund to the plan administrator of County Employees' Retirement Fund (CERF) to notify CERF of the change in the participant's LAGERS status. The participant's service for the period refunded shall become non-LAGERS service and shall be calculated as such for purposes of the participant's retirement annuity and any purchase of prior service related thereto. The participant is responsible for notifying CERF of his or her intention to apply for a section 70.690 refund and for verifying that the information on any retirement information received from CERF is correct with respect to the participant's LAGERS or non-LAGERS status. If the participant fails to notify CERF of an incorrect LAGERS status on his or her retirement paperwork, the participant will be subject to the provisions of sections 50.1034 and 50.1036, RSMo.

AUTHORITY: section 50.1032, RSMo Supp. 1999. Original rule filed Oct. 11, 1995, effective May 30, 1996. Amended: Filed July 29, 1997, effective Jan. 30, 1998. Amended: Filed June 1, 1999, effective Nov. 30, 1999. Rescinded and readopted: Filed March 17, 2000.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 2—Membership

PROPOSED RESCISSION

16 CSR 50-2.030 Eligibility for Benefits. This rule clarified who was eligible for membership in the County Employees' Retirement Fund.

PURPOSE: There were significant legislative changes to sections 50.1000 to 50.1300, RSMo, which sets forth the statutory framework for the County Employees' Retirement Fund, in the 1999 legislative session. The Board of the County Employees' Retirement Fund wishes to rescind this rule and adopt a new rule in its place in order to ensure compliance with the applicable law.

AUTHORITY: section 50.1032, RSMo Supp. 1997. Original rule filed Oct. 11, 1995, effective May 30, 1996. Amended: Filed Dec. 9, 1997, effective June 30, 1998. Rescinded: Filed March 17, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 2—Membership *and Benefits*

PROPOSED RULE

16 CSR 50-2.030 Eligibility and Participation

PURPOSE: This rule describes when employees may become plan participants.

(1) General Rule. An employee shall become a participant in the plan upon his or her entry date. Effective on and after January 1, 2000, an employee shall not be permitted to opt out of the plan.

(2) Prior Plan Opt Outs. Before January 1, 2000, an employee had the right to opt out of the plan. Employees who exercised this opt-out option must wait three (3) years from the date the opt-out decision was made before becoming a participant. After this three (3)-year period has elapsed, the employee shall have a three (3)-month period to opt in to the plan. If the employee fails to opt in during an applicable three (3)-month period which begins on or after January 1, 2000, the employee shall be forever ineligible to participate in the plan.

(3) Membership service for part-time employees and service toward vesting in the plan for all participants will be calculated as follows:

(A) A participant must work one thousand (1,000) hours of service in a plan year to be enrolled in the plan;

(B) A participant must work one thousand (1,000) hours of service in a plan year to receive a year of vested service;

(C) A participant must have at least eight (8) years of service with at least one thousand (1,000) hours of service worked per plan year to be vested in the plan. A participant shall receive vesting service credit for a year only if he or she has received creditable service credit for the months in such plan year during which he earned hours of service.

AUTHORITY: section 50.1032, RSMo Supp. 1999. Original rule filed Oct. 11, 1995, effective May 30, 1996. Amended: Filed Dec. 9, 1997, effective June 30, 1998. Rescinded and readopted: Filed March 17, 2000.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 2—Membership

PROPOSED RESCISSION

16 CSR 50-2.035 Timing of Applications and Benefit Start Date. This rule clarified when a member's benefits would begin.

PURPOSE: There were significant legislative changes to sections 50.1000 to 50.1300, RSMo, which sets forth the statutory framework for the County Employees' Retirement Fund, in the 1999 legislative session. The Board of the County Employees' Retirement Fund wishes to rescind this rule and adopt a new rule in its place in order to ensure compliance with the applicable law.

AUTHORITY: section 50.1032, RSMo Supp. 1996. Original rule filed July 29, 1997, effective Jan. 30, 1998. Rescinded: Filed March 17, 2000,

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 2—Membership *and Benefits*

PROPOSED RULE

16 CSR 50-2.035 Payment of Benefits

PURPOSE: This rule clarifies options of benefit payments available to members of the County Employees' Retirement Fund, the procedure for selecting such options, and the timing of benefit payments.

(1) Method of Payment. Prior to his or her annuity starting date, each participant shall be offered the following optional methods of payment, in addition to the normal form of benefit. Any benefits payable under such optional methods of payment shall be the actuarial equivalent of the normal form of benefit:

(A) Joint and One Hundred Percent (100%) Survivor Annuity. An annuity whereby a monthly installment shall be paid to the participant during his or her lifetime and thereafter in the same monthly amount to his or her survivor annuitant during his or her lifetime, on the first day of each calendar month in which the participant or his or her survivor annuitant shall have lived the entire preceding calendar month;

(B) Joint and Seventy-Five Percent (75%) Survivor Annuity. An annuity whereby a monthly installment shall be paid to the participant during his or her lifetime and thereafter in three-quarters (3/4) of such monthly amount to his or her survivor annuitant during his or her lifetime, on the first day of each calendar month in

which the participant or his or her survivor annuitant shall have lived the entire preceding calendar month;

(C) Joint and Fifty Percent (50%) Survivor Annuity. An annuity, whereby a monthly installment shall be paid to the participant during his or her lifetime and thereafter in one-half (1/2) of such monthly amount to his or her survivor annuitant during his or her lifetime, on the first day of each calendar month in which the participant or his or her survivor annuitant shall have lived the entire preceding calendar month;

(D) Ten (10) Year Certain and Life Annuity. An annuity whereby a monthly installment shall be paid to the participant during his or her lifetime. If the participant dies after receiving one hundred twenty (120) monthly payments, the annuity shall end with the calendar month immediately preceding the participant's death. If the participant dies before one hundred twenty (120) monthly payments have been made, then the remaining payments under the form shall be made to the participant's beneficiary (if surviving), or in a single sum to the participant's estate, if the beneficiary predeceases the participant. If the beneficiary survives the participant, but dies before one hundred twenty (120) monthly payments have been made, then the remaining payments under the form shall be made to the beneficiary's estate in a single sum. In the case where the beneficiary and the participant die simultaneously before one hundred twenty (120) monthly payments have been made, then the remaining payments under the form shall be made in a single sum to the participant's estate;

(E) Level Income Option—Life Only. An annuity that is adjusted so that the monthly annuity payable for the months ending before the participant attains age sixty-two (62) is approximately equal to the sum of i) the monthly adjusted annuity payable for the month coinciding with and subsequent to the month in which the participant reaches age sixty-two (62) and ii) the monthly Social Security benefit payable to the participant at age sixty-two (62); or

(F) Level Income Option—Joint and Survivor.

1. An annuity, whereby a monthly installment shall be paid to the participant during his or her lifetime and thereafter in the percentage (either fifty (50), seventy-five (75), or one hundred (100)) of such monthly amount, as elected by the participant, to his or her survivor annuitant during his or her lifetime, on the last day of each calendar month in which the participant or his or her survivor annuitant shall have lived the entire month. The annuity shall be adjusted so that the monthly annuity payable for the months ending before the participant attains age sixty-two (62) is approximately equal to the sum of i) the monthly adjusted annuity payable for the month coinciding with and subsequent to the month in which the participant reaches age sixty-two (62) and ii) the monthly Social Security benefit payable to the participant at age sixty-two (62). If the participant dies before he or she reaches age sixty-two (62), the survivor annuitant's benefit shall be adjusted on the date the participant would have reached age sixty-two (62) in the manner that the participant's annuity would have been adjusted on such date.

2. Notwithstanding anything in the preceding paragraph to the contrary, if the monthly benefit payable to the participant under this form after the participant's sixty-second birthday is zero, then the monthly adjusted annuity before age sixty-two (62) shall be a period-certain annuity, commencing on the participant's annuity starting date, and ending on the date the participant attains (or would have attained) age sixty-two (62). If the participant dies before attaining age sixty-two (62), then the remaining payments under the form shall be made to the participant's survivor annuitant (if surviving), or in a single sum to the participant's estate, if the survivor annuitant predeceases the participant. If the survivor annuitant survives the participant, but dies before the participant's sixty-second birthday, then the remaining payments under the form shall be made to the survivor annuitant's estate.

(2) Election of Payment Method. A payment option shall be elected, changed or revoked by the participant, his or her guardian, or attorney-in-fact, by written notice filed with the board during the election period specified in section (3) below; provided, however:

(A) A survivor annuitant under an option may not be changed after an election has been received by the board (or by its designee);

(B) A participant shall be deemed to have elected the normal form of benefit unless he or she makes an affirmative election not to take such an annuity in accordance with this section. Such annuity shall commence as soon as administratively feasible following the participant's required beginning date.

(3) Election Period. Generally, a participant must complete an application for benefits at least thirty (30), but not more than ninety (90), days prior to the date he or she wishes benefits to commence. The annuity starting date for such a participant shall be the first of the month coincident with or following the date specified by the participant, or, if earlier, the participant's required beginning date. If the participant does not submit an application at least thirty (30) days prior to his or her separation from service, the payments will not be retroactive to the date of separation from service. Once a participant has submitted an application, if supporting documentation has been requested but has not been obtained by the annuity starting date selected by the participant and the application has not been completely processed, the participant will not receive the first benefit payment until the additional documentation has been received and the application has been completely processed. The payments will, however, be retroactive to the annuity starting date designated by the participant in his or her application. If a participant has not submitted an application upon his or her separation from service, his or her benefits will start on the first of the month following a thirty (30)-day period from the date of the application.

(4) Payments after Death of Survivor Annuitant. In the event a participant has chosen an optional form of payment which provides for a continuing payment to a survivor annuitant after the death of the participant in which the participant received a reduced annuity during his or her lifetime and the participant's survivor annuitant precedes the participant in death, the participant's benefit shall revert, effective the next month following the death of the participant's survivor annuitant, to an amount equal to his or her normal annuity at the time of the annuity starting date plus any cost-of-living or other increases that the participant may have received prior to the survivor annuitant's death. Notwithstanding the preceding sentence, if the participant elected the Level Income Option—Joint and Survivor, the participant's benefit shall revert to the benefit he or she would have received had he or she elected the Level Income Option—Life Only. It shall be the participant's duty to inform the board or its designee of the death of such a survivor annuitant.

(5) 401(a)(9) Requirements. Regardless of any contrary provision in the plan, any distribution shall be determined in accordance with *Internal Revenue Code* section 401(a)(9) and the proposed regulations thereunder, including the "minimum distribution incidental benefit requirement" of Prop. Reg. section 1.401(a)(9)-2 (62 Fed. Reg. 67,780 (Dec. 30, 1997)). Accordingly, distribution of a participant's accrued benefit shall begin no later than his or her required beginning date.

(6) Non-Assignability of Benefits. A participant's right to an annuity or other benefits under the plan shall not be subject to execution, garnishment, attachment, writ of sequestration, the operation of bankruptcy or insolvency laws, a qualified domestic relations order (as defined in 26 U.S.C. section 414(p) or 29 U.S.C. section 1056(d)), or to any other claim or process of law whatsoever, and shall be unassignable.

(7) Return of Mistaken Payments. Notwithstanding anything to the contrary, a participant or beneficiary is entitled to only those benefits provided by the plan and promptly shall return any payment, or portion thereof, made by mistake of fact or law. The board may offset the future benefits of any recipient who refuses to return an erroneous payment, in addition to pursuing any other remedies provided by law.

(8) Correction of Underpayments. Should any error result in any participant or beneficiary receiving less than he or she should have been entitled, then such error shall be corrected by paying the participant or beneficiary a lump-sum amount equal to the underpayment, without interest.

(9) In the case of special consultants, as provided for in section 50.1090.2, RSMo, who do not return buyback invoices or requested supporting documentation, the benefit will begin on the first of the month following payment of the initial fifty percent (50%) buyback amount.

AUTHORITY: section 50.1032, RSMo Supp. 1999. Original rule filed July 29, 1997, effective Jan. 30, 1998. Rescinded and readopted: Filed March 17, 2000.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 2—Membership

PROPOSED RESCISSION

16 CSR 50-2.040 Refund of Contributions. This rule clarified eligibility for a refund of employee payroll contributions upon cessation of membership in the County Employees' Retirement Fund.

PURPOSE: There were significant legislative changes to sections 50.1000 to 50.1300, RSMo, which sets forth the statutory framework for the County Employees' Retirement Fund, in the 1999 legislative session. The Board of the County Employees' Retirement Fund wishes to rescind this rule and adopt a new rule in its place in order to ensure compliance with the applicable law.

AUTHORITY: section 50.1032, RSMo Supp. 1997. Original rule filed Oct. 11, 1995, effective May 30, 1996. Amended: Filed Sept. 17, 1998, effective March 30, 1999. Rescinded: Filed March 17, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 2—Membership *and Benefits*

PROPOSED RULE

16 CSR 50-2.040 Separation from Service Before Retirement

PURPOSE: This rule describes the effect of a separation from service on a participant's benefit.

(1) Upon separation from service, any participant with less than eight (8) vested years of service shall forfeit all rights under the plan, including the participant's creditable service as of the date of the participant's separation from service. This forfeiture shall be applied to reduce the board's obligation to contribute to the plan. Such a participant will receive a refund of any of his or her contributions upon the receipt by the board or its designee of a termination notice. Such refund shall be made to the participant in a single sum as soon as administratively feasible following receipt of the termination notice by the board (or its designee). For purposes of this section, it shall not be administratively feasible for the board or its designee to disburse a refund until the board or its designee also receives proper verification and reconciled contribution information from the employer.

(2) A participant who has a separation from service, before reaching the age of sixty-two (62), after having earned at least eight (8) vested years of service shall be entitled to a deferred vested benefit, determined in accordance with the formula described in 16 CSR 50-2.090. The participant may elect to defer the receipt of his or her deferred vested benefit, until the participant's attainment of age sixty-two (62), or the participant may elect to begin receiving his or her deferred vested benefit on the first day of any month following the later of the date of separation from service or age fifty-five (55). The amount of the benefit, if paid before the participant's sixty-second birthday, shall be the actuarial equivalent of the participant's accrued benefit.

(3) Members who terminate employment and then resume employment with an employer within thirty (30) days will not forfeit their prior service and will not be required to receive a refund of their payroll contributions.

AUTHORITY: section 50.1032, RSMo Supp. 1999. Original rule filed Oct. 11, 1995, effective May 30, 1996. Amended: Filed Sept. 17, 1998, effective March 30, 1999. Rescinded and readopted: Filed March 17, 2000.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 2—Membership

PROPOSED RESCISSION

16 CSR 50-2.050 Certification of Employment and Salary. This rule clarified the process for certifying employment and salary figures upon termination of employment for purposes of calculating retirement benefits in the future.

PURPOSE: There were significant legislative changes to sections 50.1000 to 50.1300, RSMo, which sets forth the statutory framework for the County Employees' Retirement Fund, in the 1999 legislative session. The Board of the County Employees' Retirement Fund wishes to rescind this rule and adopt a new rule in its place in order to ensure compliance with the applicable law.

AUTHORITY: section 50.1032, RSMo Supp. 1998. Original rule filed Oct. 11, 1995, effective May 30, 1996. Amended: Filed Dec. 9, 1997, effective June 30, 1998. Amended: Filed July 16, 1998, effective Jan. 30, 1999. Amended: Filed Sept. 17, 1998, effective March 30, 1999. Amended: Filed April 16, 1999, effective Sept. 30, 1999. Rescinded: Filed March 17, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 2—Membership *and Benefits*

PROPOSED RULE

16 CSR 50-2.050 Certifying Service and Compensation

PURPOSE: This rule clarifies the process for certifying employment and salary figures upon separation from service for purposes of calculating retirement benefits in the future.

(1) Upon separation from service, a participant shall request that the county clerk complete a certification form on a form to be provided by the board or its designee which verifies the length of employment and the two (2) highest years of compensation received by the participant. The participant must provide documentation to support the compensation figures which must be attached to the certification including W-2 forms, 1099 forms, canceled checks and other supporting documentation reflecting compensation received. In determining average final compensation, County Employees' Retirement Fund (CERF) will use the cash receipts and disbursements method as defined by the *Internal Revenue Code*. Lump sum payments of benefits, back pay, or compensation for unused vacation days or sick leave will not be included in calculating average final compensation if the payments are attributable to a prior year or prior years than the year being claimed as a high year.

(2) The participant shall forward the completed certification to the board where it shall be maintained until needed to calculate the participant's retirement benefit.

(3) Any certification submitted without supporting documentation will be reviewed by the board.

(4) Fee-Based or Fee/Salary-Based Officials.

(A) Any participant whose compensation is collected partly or wholly from fees or a combination of fees and salary must submit, by March 1 of each year, proof of all fees and/or salary received, less operating and other expenses.

(B) Two percent (2%) of the net amount of all fees and/or salary collected as compensation by such participants who are not members of the Local Government Employees' Retirement System (LAGERS) must be submitted to the plan administrator not less than annually and no later than March 1 of each year for the preceding calendar year.

(C) Any unpaid balance of the required fee or salary contributions due to the fund must be paid in full prior to distribution of any retirement benefit amount or death benefit amount.

(D) Prior to January 1, 2000, some officials received partial or full compensation through various fees for personal services performed in their capacity as an elected official. If a member has such compensation which was not processed through county payroll prior to January 1, 2000, and the member chooses to use as a high year for retirement calculations a year including such fees, the member must make the required contributions on all of these fees collected between August 27, 1994, and December 31, 1999, prior to his or her retirement commencement.

(E) Beginning January 1, 2000, officials whose compensation is collected partly or wholly from fees or a combination of fees and salary may only include these fees if they are processed through county payroll and in accordance with the definition of compensation included in 16 CSR 50-2.010(1)(K).

(F) Compensation received from sources other than an employer and compensation received pursuant to independent contracting relationships shall not be included in calculating the retirement benefit.

AUTHORITY: section 50.1032, RSMo Supp. 1999. Original rule filed Oct. 11, 1995, effective May 30, 1996. Amended: Filed Dec. 9, 1997, effective June 30, 1998. Amended: Filed July 16, 1998, effective Jan. 30, 1999. Amended: Filed Sept. 17, 1998, effective March 30, 1999. Amended: Filed April 16, 1999, effective Sept. 30, 1999. Rescinded and readopted: Filed March 17, 2000.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 2—Membership

PROPOSED RESCISSION

16 CSR 50-2.060 Survivorship Rights and Service Requirements. This rule clarified a prohibition on the eligibility

for death benefits and also clarified the eligibility and enrollment of part-time employees.

PURPOSE: This rule is being rescinded because it is superseded by other rules.

AUTHORITY: section 50.1032, RSMo Supp. 1997. Original rule filed Nov. 26, 1996, effective June 30, 1997. Amended: Filed Dec. 9, 1997, effective June 30, 1998. Amended: Filed March 2, 1998, effective Aug. 30, 1998. Rescinded: Filed March 17, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 2—Membership *and Benefits*

PROPOSED RULE

16 CSR 50-2.080 Source of Pension Funds

PURPOSE: This rule describes the source of funds available to the plan.

(1) The source of contributions to this plan (if required) for a plan year shall be the funds described in sections 50.1020, 50.1190, 50.1200 and 150.150, RSMo that have been accumulated during the plan year. Such funds shall be held in a separate account until the board determines, in accordance with the advice of the actuary, the amount of such funds that must be contributed to this plan for a plan year to maintain its actuarial sufficiency. The board shall ensure that sufficient amounts shall be contributed so that this plan is funded in a manner consistent with the provisions of the *Internal Revenue Code* and such other laws and regulations as shall be applicable. The remainder of funds accumulated in the separate account during a plan year shall be contributed to the defined contribution plan established in sections 50.1210 to 50.1260, RSMo.

(2) Any gains arising from the death of participants prior to retirement or forfeiture upon separation from service shall not be utilized to increase the benefits to the remaining participants, but shall be retained in the trust fund.

(3) Notwithstanding anything to the contrary, any contribution made to the plan by the board as result of a mistake of fact shall be returned to the separate account as soon as practicably possible following discovery of the mistake, but not later than one year after the payment of the contribution. The maximum amount that may be returned is the excess of the amount contributed, over the amount that would have been contributed had no mistake of fact occurred. Earnings attributable to the excess contribution may not be returned, but losses attributable thereto must reduce the amount to be so returned.

AUTHORITY: section 50.1032, RSMo Supp. 1999. Original rule filed March 17, 2000.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 2—Membership *and Benefits*

PROPOSED RULE

16 CSR 50-2.090 Normal Retirement Benefit

PURPOSE: This rule describes when a participant is eligible for unreduced retirement benefits under the plan.

(1) Eligibility for Normal Retirement Benefit. To be eligible to receive a normal retirement benefit from the plan, a participant must:

(A) Have attained the age of sixty-two (62);

(B) Applied for retirement benefits as provided by applicable laws and regulations; and

(C) Earned eight (8) or more vested years of service.

(2) Benefit to Non-LAGERS Participants. The normal retirement benefit of a participant who is not a member of the Local Government Employees' Retirement System (LAGERS) shall be a monthly benefit in the normal form of benefit equal to the greater of:

(A) Twenty-four dollars ($24) multiplied by years of creditable service, up to a maximum of twenty-five (25) years; or

(B) An amount determined according to the following formula:

$$((TRR \times AFC) - PSSA) \times (CS/25)$$

Where:

TRR is the participant's target replacement ratio;

AFC is the participant's average final compensation;

PSSA is the participant's primary Social Security amount, on a monthly basis; and

CS is the participant's creditable service (up to a maximum of twenty-five (25) years).

(3) Benefit to LAGERS Participant. The normal retirement benefit of a participant who is also a member of LAGERS shall be sixty-six and two-thirds percent (66 2/3%) of the normal retirement benefit determined pursuant to section (2).

(4) LAGERS Participant Defined. Generally, a participant is considered a member of LAGERS with respect to a period of creditable service (including prior service) if he or she has been exempt from making the mandatory two percent (2%) contribution on account of his or her membership in LAGERS. Accordingly, the formula set forth in section (3) shall be used to determine a participant's benefit for such period of creditable service. If a participant ceases to qualify for active membership or ceases to be an active member in LAGERS, the formula described in section (2) shall be used to determine the participant's benefit for the creditable service earned during periods when the participant ceased to so qualify or ceased to be an active member in

LAGERS. If a participant receives a refund of contributions from LAGERS, pursuant to section 70.690, RSMo, then the formula described in section (3) shall be used to determine the participant's benefit, if the participant makes an additional contribution to the Plan. The amount of such additional contribution shall be equal to two percent (2%) of the participant's compensation for the period in which he or she was a LAGERS participant (plus any interest and penalties assessed by the board). The amount may be paid in one lump sum, or by payroll deduction.

(5) Minimum Benefit. The normal retirement benefit of a participant shall not be less than the annuity the participant had earned as of the day before January 1, 2000, under the prior plan. This minimum benefit shall be determined without regard to any exclusion of prior service mandated by the terms of the prior plan.

(6) Maximum Benefit. No benefit payable from the plan shall exceed the maximum benefit permitted under section 415(b) of the *Internal Revenue Code* (Code). If a participant's membership in another retirement plan results in the violation of the limits of Code section 415, the participant's benefit in this plan shall be reduced in order to ensure compliance with such Code section.

AUTHORITY: section 50.1032, RSMo Supp. 1999. Original rule filed March 17, 2000.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 2—Membership *and Benefits*

PROPOSED RULE

16 CSR 50-2.100 Early Retirement Benefit

PURPOSE: This rule describes when a participant may receive early retirement benefits from the plan.

A participant who has not attained age sixty-two (62) but has both attained at least his or her fifty-fifth birthday and has eight (8) or more vested years of service may elect to retire as of the first day of any calendar month following written notice to the board (or its delegatee). At the option of the participant, benefits may begin as of any calendar month following his or her early retirement and preceding the participant's sixty-second birthday. Such early retirement benefit of a participant shall be payable to him/her as the normal form of benefit, and shall equal the greater of the actuarial equivalent of his or her accrued benefit or his or her accrued benefit as of his or her annuity starting date, reduced by four-tenths of one percent (0.4%) for each month by which the annuity starting date precedes the participant's sixty-second birthday, and by an additional three-tenths of one percent (0.3%) for each month by which the annuity starting date precedes the participant's sixtieth birthday.

AUTHORITY: section 50.1032, RSMo Supp. 1999. Original rule filed March 17, 2000.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 2—Membership *and Benefits*

PROPOSED RULE

16 CSR 50-2.110 Rehires

PURPOSE: This rule clarifies the treatment of a former employee who returns to covered employment.

(1) Suspension of Benefits. If a participant returns to employment after a separation from service, benefit payments to the individual will be suspended, pending the termination of employment and completion of a new retirement application. All elections made in the original retirement application will be revoked upon completion of an enrollment form indicating a return to county employment. While employed, the individual will accrue creditable service, which, upon termination of employment and submission of a new retirement application, will be used to recalculate the benefit in accordance with the provisions of this chapter. If the individual had started a buyback of prior service during the first benefit payment period, the total paid toward the buyback will be subtracted from the new buyback figure. Benefits less any remaining buyback will recommence upon termination of employment. The buyback will extend for a maximum of forty-eight (48) months less the total number of months during which the individual had already made a buyback.

(2) Rejoining the Plan. Notwithstanding the provisions of section (1), a participant may work as a part-time employee, and continue to receive benefit payments. Such service as a part-time employee shall not increase or change the participant's benefit, unless the participant has an entry date, and again becomes an active participant in the plan. In such case, a participant shall not receive creditable service for any period of employment preceding his or her entry date unless i) the participant purchases such service in accordance with section 16 CSR 50-3.010(3) or ii) such creditable service was used in calculating the participant's accrued benefit as of the date of his or her separation from service.

(3) Nonvested Participants. A participant who has a separation from service with less than eight (8) years of creditable service forfeits creditable service at the time of his or her separation from service. Accordingly, if such an individual is rehired as an employee, that individual is treated as a new employee for all purposes under the plan. However, such a rehired individual may be able to repurchase his or her forfeited creditable service under section 16 CSR 50-3.010(3).

AUTHORITY: section 50.1032, RSMo Supp. 1999. Original rule filed March 17, 2000.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 2—Membership *and Benefits*

PROPOSED RULE

16 CSR 50-2.120 Benefits Upon Participant's Death

PURPOSE: This rule describes the benefits available to the beneficiaries of participants who die before receiving a retirement benefit.

(1) Lump Sum Death Benefit. A death benefit of ten thousand dollars ($10,000) shall be paid to the beneficiary of every active participant upon his or her death or, if the participant fails to designate a beneficiary, then to the participant's surviving spouse or, if there is no spouse, then in equal shares to the participant's surviving children. If there is neither a surviving spouse nor surviving children, then the benefit shall be paid to the active participant's estate.

(A) Designation of Beneficiary. Each participant may name a beneficiary on a form provided by the board and delivered to the board. Such designation may include more than one (1) person with one (1) or more secondary or contingent beneficiaries and shall be subject to change upon written request of such participant in the same manner as the original designation.

(B) If the participant executes a beneficiary designation form and lists more than one (1) beneficiary but fails to list the percentage of benefit that each beneficiary should receive, then the benefit shall be divided equally among the named beneficiaries.

(2) Spousal Death Benefit. If a participant dies before his or her annuity starting date but after completing eight (8) or more years of creditable service, the surviving spouse shall be entitled to survivorship benefits under the fifty percent (50%) annuity option as set forth in subsection 16 CSR 50-2.035(1)(C). If the participant was age sixty-two (62) or older at death, the surviving spouse's benefit shall begin to accrue on the first day of the month following the participant's death. If the participant was under age sixty-two (62) at death, the surviving spouse's benefits shall begin to accrue on the first day of the month following the date the participant would have attained age sixty-two (62) had the participant lived. In the event that a delay in the submission or processing of paperwork or some other delay results in the first payment of survivorship benefits commencing after the month in which the survivorship benefits began to accrue, such survivorship benefits shall be retroactive to the date on which the survivorship benefits began to accrue. Alternatively, the surviving spouse may elect to receive the reduced actuarially equivalent benefit payable on the first day of any month following the date of the participant's death and prior to the date the participant would have attained age sixty-two (62).

(3) No Benefits Payable to Beneficiary Who Intentionally Kills Participant. The board shall cease paying benefits to any survivor annuitant or beneficiary who is charged with the intentional killing of a participant without legal excuse or justification. A survivor annuitant or beneficiary who is convicted of such charge shall no longer be entitled to receive benefits. If the survivor annuitant or beneficiary is not convicted of such charge, the board shall resume payment of benefits and shall pay the survivor annuitant or beneficiary any benefits that were suspended pending resolution of such charge.

(4) The death benefit will only be extended to part-time and seasonal employees in months for which they receive pay.

AUTHORITY: section 50.1032, RSMo Supp. 1999. Original rule filed March 17, 2000.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 2—Membership *and Benefits*

PROPOSED RULE

16 CSR 50-2.130 Direct Rollover Option

PURPOSE: This rule describes the direct rollover option authorized by section 50.1260, RSMo.

(1) A distributee may elect to have an eligible rollover distribution paid directly to a single eligible retirement plan specified by the distributee. However, this election may not be made if the total eligible rollover distributions paid to the distributee will be less than two hundred dollars ($200).

(2) A distributee may elect to divide an eligible rollover distribution so that part is paid directly to an eligible retirement plan and part is paid to the distributee. However, the part paid directly to the eligible retirement plan must total at least five hundred dollars ($500).

(3) A distributee may elect a direct rollover after having received a written notice which complies with the rules of *Internal Revenue Code* (Code) section 402(f). In general, payment to a distributee shall not begin until thirty (30) days after the notice is given. However, payment may be made sooner if the notice clearly informs the distributee of the right to a period of at least thirty (30) days to consider the decision of whether or not to make a direct rollover, and the distributee, after receiving the notice, makes an affirmative election to receive an immediate distribution. A distributee who fails to make an election in the thirty (30)-day period shall receive the eligible rollover distribution immediately after the thirty (30)-day period expires.

(4) For purposes of this regulation, the following terms have the meanings set forth below:

(A) An "eligible rollover distribution" is any distribution or withdrawal payable under the terms of this plan to a participant, which is described in Code section 402(c)(4). In general, this term includes any single-sum distribution, and any distribution which is one in a series of substantially equal periodic payments made over a period of less than ten (10) years, and is less than the distributee's life expectancy. However, an eligible rollover distribution does not include the portion of any distribution that constitutes a

minimum required distribution under Code section 401(a)(9). Such term also does not include a distribution to the participant's beneficiary, unless the beneficiary is the participant's spouse.

(B) "Eligible retirement plan" means:

1. An individual retirement account described in Code section 408(a);

2. An individual retirement annuity described in Code section 408(b);

3. An annuity plan described in Code section 403(a); and

4. A retirement plan qualified under Code section 401(a), but only if the terms of the plan permit the acceptance of rollover distributions.

However, in the case of an eligible rollover distribution to a beneficiary who is a surviving spouse, an "eligible retirement plan" is an individual retirement account or an individual retirement annuity.

(C) "Distributee" means a participant or the spouse of a deceased participant.

AUTHORITY: section 50.1032, RSMo Supp. 1999. Original rule filed March 17, 2000.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 2—Membership *and Benefits*

PROPOSED RULE

16 CSR 50-2.140 Cost-of-Living Adjustment

PURPOSE: This rule describes the eligibility and amount of any cost-of-living adjustment.

(1) Eligibility for Annual Cost-of-Living Adjustment. To be eligible to receive any cost-of-living adjustment (COLA), adopted by the board pursuant to section 50.1070, RSMo, a retired participant must meet the following criteria:

(A) Is presently receiving an annuity, even if the annuity is payable in accordance with the prior plan, and has been receiving such annuity since at least July 1 of the previous year; and

(B) Has not waived his or her right to receive the COLA increase.

(2) The amount of the COLA increase for a year shall be determined by the board in February of each year, based on the excess of the consumer price index for the preceding calendar year over the consumer price index for the calendar year immediately prior thereto. Notwithstanding the preceding sentence, this automatic increase shall not exceed one percent (1%) per year. The total increase in the amount of benefits received pursuant to the provisions of this section shall not exceed fifty percent (50%) of the participant's accrued benefit determined as of his or her most recent separation from service.

(3) Any COLA approved by the board will be payable to eligible retirees monthly, including those who retired under the terms of the prior plan, commencing on July 1 of any given year, following the board's determination of the appropriate increase. The application of any COLA with regard to retired and rehired members is shown in Table 1 to 16 CSR 50-2.150.

AUTHORITY: section 50.1032, RSMo Supp. 1999. Original rule filed March 17, 2000.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 2—Membership *and Benefits*

PROPOSED RULE

16 CSR 50-2.150 Transition Rules and Effective Date

PURPOSE: This rule sets forth the effective date of the rules of this chapter and describes the classes of participants to whom the 1999 legislative changes to the plan apply.

(1) Classes of Participants Affected by Amendment. The following matrix, which is shown in Table 1, sets forth different classes of participants who are affected by the amendments to sections 50.1000 to 50.1300, RSMo, which became effective January 1, 2000.

(2) USERRA. A participant who incurs a separation from service before January 1, 2000, on account of his or her stint in a uniformed service shall be treated as eligible for benefits determined under the new plan formula that is effective January 1, 2000, if such treatment would be required under the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994.

(3) Consequences of Treatment as a Former Employee. To the extent a participant is treated as a former employee under this section:

(A) Creditable service shall be determined in accordance with the provisions of the prior plan; and

(B) The participant's retirement benefit shall be determined in accordance with the benefit formula set forth in the prior plan.

(4) Continued Application of Forfeiture Rules. Nothing in this section shall reinstate amounts previously forfeited in accordance with section 50.1140, RSMo. Accordingly, a participant who had a separation from service before January 1, 2000, but was not vested in his or her accrued benefit before January 1, 2000, shall be treated as a new employee.

AUTHORITY: section 50.1032, RSMo Supp. 1999. Original rule filed March 17, 2000.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

TABLE 1

County Employees' Retirement Fund
Treatment of Service After Rehire, Membership Service, and Prior Service for Purposes of Benefit Determination at Ultimate Retirement Date
Depending Upon Employment Status on June 10, 1999, and When Return to Work

	In County Employment on June 10, 1999 — Ultimately Terminates After December 31, 1999						In County Employment on June 10, 1999, Terminates Before December 31, 1999 — Ultimately Terminates Before January 1, 2000					
	Had Returned to Work <2000			Had Returned to Work >=2000			Had Returned to Work <2000			Had Returned to Work >=2000		
	Future Service	Previous Membership Service	Prior Service	Future Service	Previous Membership Service	Prior Service	Future Service	Previous Membership Service	Prior Service	Future Service	Previous Membership Service	Prior Service
Past Retiree	NP	OP	OP Subject to Purchase**	NP	OP**	OP Subject to Purchase**	OP	OP	OP Subject to Purchase	NA	NA	NA
Vested Termination	NP	NP	NP	NP	NP	NP	OP	OP	OP Subject to Purchase	NA	NA	NA
Non-vested Termination	NP*	NP*	NP*	NP*	NP*	NP*	OP*	OP*	OP* Subject to Purchase	NA	NA	NA

	Not in County Employment on June 10, 1999 — Ultimately Terminates After December 31, 1999						Not in Employment on June 10, 1999, Back to Work and Terminates Before 12/31/99 — Ultimately Terminates Before January 1, 2000					
	Had Returned to Work <2000			Had Returned to Work >=2000			Had Returned to Work <2000			Had Returned to Work >=2000		
	Future Service	Previous Membership Service	Prior Service	Future Service	Previous Membership Service	Prior Service	Future Service	Previous Membership Service	Prior Service	Future Service	Previous Membership Service	Prior Service
Past Retiree	NP	OP	OP Subject to Purchase**	NP	OP	OP Subject to Purchase**	OP	OP	OP Subject to Purchase	NA	NA	NA
Vested Termination	NP	OP	OP Subject to Purchase	NP	OP	OP Subject to Purchase	OP	OP	OP Subject to Purchase	NA	NA	NA
Non-vested Termination	NP*	NP*	NP* Subject to Purchase	NP*	NP*	NP* Subject to Purchase	OP*	OP*	OP* Subject to Purchase	NA	NA	NA

Key to Abbreviations and Terminology
NP: New Plan formula effective January 1, 2000
OP: Old Plan formula in effect on December 31, 1999
Future Service is service on and after January 1, 2000
Previous Membership Service is service between August 28, 1994, and December 31, 1999
Prior Service is service before August 28, 1994

*Subject to Completion of 8 Years of Vesting Service
**With COLAs (cost of living increases) granted since the time of rehire

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 2—Membership *and Benefits*

PROPOSED RULE

16 CSR 50-2.160 Administration of Fund

PURPOSE: This rule sets forth general rules regarding the administration of the Plan.

(1) Plan Administration. The board shall have sole discretionary responsibility for the operation, interpretation, and administration of the plan and for determining eligibility for plan benefits. Any action taken on any matter within the discretion of the board shall be final, conclusive, and binding on all parties. In order to discharge its duties hereunder, the board shall have the power and authority to delegate ministerial duties and to employ such outside professionals as may be required for prudent administration of the plan. The board shall also have authority to enter into agreements as may be necessary to implement this plan. Any individual member of the board who is otherwise eligible may participate in the plan, but shall not be entitled to make decisions solely with respect to his or her own participation and benefits under the plan.

(2) To implement the plan, the board shall enter into a trust agreement, so that plan funds shall be segregated from an employer's own assets and held in trust by the trustee for the exclusive benefit of participants and their beneficiaries. Any or all benefits that may accrue to any participant or beneficiary under this plan shall be subject to the terms and conditions of said trust agreement. Except as provided in section (5), it shall be impossible under any circumstances at any time for any part of the corpus or income of the trust fund to be used for, or diverted to purposes other than the exclusive benefit of participants and their beneficiaries.

(3) Plan Expenses. All expenses of plan administration, including (by way of illustration and not limitation) those incurred by the board and the fees of the trustee shall be paid from the trust fund.

(4) Claims for Benefits. A claim for a benefit under this plan shall be reviewed by the board (or by its designee) in accordance with the procedure outlined in section 16 CSR 50-2.035. An appeal of an adverse claim decision shall be processed in accordance with section 16 CSR 50-1.020.

(5) Facility of Payments. If any participant shall be physically, mentally or legally incapable of receiving or acknowledging receipt of any payment under the plan to which he or she is entitled, the board, upon the receipt of satisfactory evidence of his or her incapacity and satisfactory evidence that another person or institution is maintaining him/her and that no guardian or committee has been appointed for him/her, may cause any payment otherwise payable to him/her to be made to such person or institution so maintaining him/her.

AUTHORITY: section 50.1032, RSMo Supp. 1999. Original rule filed March 17, 2000.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 3—Creditable Service

PROPOSED RESCISSION

16 CSR 50-3.010 Calculation of Creditable Service. This rule clarified the process for calculating creditable service of a member.

PURPOSE: There were significant legislative changes to sections 50.1000 to 50.1300, RSMo, which sets forth the statutory framework for the County Employees' Retirement Fund, in the 1999 legislative session. The Board of the County Employees' Retirement Fund wishes to rescind this rule and adopt a new rule in its place in order to ensure compliance with the applicable law.

AUTHORITY: section 50.1032, RSMo 1994. Original rule filed Oct. 11, 1995, effective May 30, 1996. Rescinded: Filed March 17, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 3—Creditable Service

PROPOSED RULE

16 CSR 50-3.010 Creditable Service

PURPOSE: This rule describes what constitutes creditable service under the plan, and describes how such service may be purchased.

(1) General Rule. Creditable service means a participant's period of employment as an employee, including the participant's prior service, except as provided in section (2). In addition, absences for sickness and injury of less than twelve (12) months shall be counted as creditable service, and any periods of service in a uniformed service (as defined in section 414(u) of the *Internal Revenue Code* (Code)), shall be included in creditable service to the extent required by the Uniformed Service Employment and Reemployment Rights Act of 1994. A participant (other than a part-time employee) shall receive credit for one-twelfth (1/12) of a year for each month in which the participant earns an hour of service. Elective or appointive county officials receive one (1) year of service for each year in office. A person may not earn more than one (1) year of creditable service in any plan year.

(2) Excluded Service. Unless the participant purchases such service in accordance with section (3), a participant's creditable service shall not include:

(A) A period of employment during which the participant opted out of the plan, and any prior service excluded under the terms of the prior plan as a result of the opt out;

(B) Prior service by a former employee, unless purchased in accordance with the terms of the prior plan or unless purchased by a special consultant as provided for in section 50.1090.2, RSMo and in 16 CSR 50-3.060;

(C) Service prior to a separation from service, if the participant was not vested at the time of the separation from service;

(D) If the participant is a part-time employee, service prior to the participant's entry date, unless the participant purchases service (up to a maximum of one (1) year) pursuant to section (3) of this regulation;

(E) Service after a participant's entry date, if the required two percent (2%) contribution is not withheld from the participant's pay for any reason; or

(F) A participant's stint in a uniformed service (within the meaning of section 414(u) of the Code), if the participant was not a member of Local Government Employees' Retirement System (LAGERS) before such stint.

(3) Purchase of Service. A participant described in subsections (2)(A), (2)(B), (2)(D), (2)(E) or 2(F) may purchase his or her service excluded under such paragraphs by notifying the board, in writing, of his or her election to buy back such service within sixty (60) days following the date the employee becomes a plan participant. A participant described in subsection (2)(C) who purchases excluded service as described in the preceding sentence will become vested in his or her accrued benefit only if the participant completes eight (8) years of uninterrupted creditable service after his or her return to county employment. The written election shall include a statement indicating the portion of the excluded service he or she elects to purchase. If a participant makes a request in accordance with this section to purchase service, the board, or its designee, will calculate the cost of buying back the service including interest and penalties provided by statute. The participant shall be notified of the cost to buy back service. After receiving this notice, the participant may elect to buy back service either through a lump-sum payment due at the time of the election or a payroll deduction beginning with the first pay period after the participant makes the election. The participant may request that the payroll deduction be made in equal monthly installments over a period not to exceed the period of prior service being purchased or four (4) years, whichever is shorter. If the participant elects to buy back excluded service through an installment plan of payroll deductions and either dies or separates from service prior to completing the installment plan, then the participant or his or her spouse may pay the remaining amount due under the installment plan within sixty (60) days following the participant's death or separation from service in a manner acceptable to the board or its designee. If such payment is not made, the participant shall not receive credit towards his or her retirement benefits for any unpaid portion of the service which is the subject of the installment plan.

(4) Part-Time Employees.

(A) Working More Than One Thousand (1,000) Hours. If a part-time employee works more than one thousand (1,000) hours of service in a plan year, he or she will receive one (1) full year (or twelve (12) months) of creditable service.

(B) Working Less Than One Thousand (1,000) Hours. If a part-time employee works less than one thousand (1,000) hours of service in a plan year, his or her creditable service shall be calculated by dividing the total number of hours worked by ninety-one (91) to arrive at the number of months of creditable service. This number shall be rounded to the next nearest whole number of months. If a part-time employee started or terminated employment within the calendar year, he or she may not receive more months of creditable service than the actual number of months worked.

AUTHORITY: section 50.1032, RSMo Supp. 1999. Original rule filed Oct. 11, 1995, effective May 30, 1996. Rescinded and readopted: Filed March 17, 2000.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 3—Creditable Service

PROPOSED RESCISSION

16 CSR 50-3.020 Purchase of Prior Creditable Service. This rule clarified situations in which a member is entitled to purchase prior service as prior creditable service.

PURPOSE: There were significant legislative changes to sections 50.1000 to 50.1300, RSMo, which sets forth the statutory framework for the County Employees' Retirement Fund, in the 1999 legislative session. This rule is being rescinded because it is superseded by other rules and because, with certain exceptions, members are no longer required to purchase prior service.

AUTHORITY: section 50.1032, RSMo 1994. Original rule filed Oct. 11, 1995, effective May 30, 1996. Rescinded: Filed March 17, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 3—Creditable Service

PROPOSED RESCISSION

16 CSR 50-3.030 Buyback of Prior Creditable Service Following Opt-Out by Member. This rule clarified the procedures for buying back prior creditable service when a member has opted out of membership in the County Employees' Retirement Fund for a period of time.

PURPOSE: There were significant legislative changes to sections 50.1000 to 50.1300, RSMo, which sets forth the statutory framework for the County Employees' Retirement Fund, in the 1999 legislative session. This rule is being rescinded because it is superseded by

other rules, because, with certain exceptions, members are no longer required to purchase prior service, and because, after January 1, 2000, members are no longer permitted to opt-out of the County Employees' Retirement Fund.

AUTHORITY: section 50.1032, RSMo 1994. Original rule filed Oct. 11, 1995, effective May 30, 1996. Rescinded: Filed March 17, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 3—Creditable Service

PROPOSED RESCISSION

16 CSR 50-3.040 Buyback of Prior Creditable Service Earned Before Creation of Retirement System. This rule clarified the procedure by which county employees could purchase prior service accrued before August 28, 1994, as prior creditable service.

PURPOSE: There were significant legislative changes to sections 50.1000 to 50.1300, RSMo, which sets forth the statutory framework for the County Employees' Retirement Fund, in the 1999 legislative session. This rule is being rescinded because it is superseded by other rules and because, with certain exceptions, members are no longer required to purchase prior service.

AUTHORITY: section 50.1032, RSMo 1994. Original rule filed Oct. 11, 1995, effective May 30, 1996. Rescinded: Filed March 17, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 3—Creditable Service

PROPOSED RESCISSION

16 CSR 50-3.050 Buyback of Prior Creditable Service Following Forfeiture of Creditable Service. This rule clarified procedures for buying back prior service following forfeiture of creditable service.

PURPOSE: There were significant legislative changes to sections 50.1000 to 50.1300, RSMo, which sets forth the statutory framework for the County Employees' Retirement Fund, in the 1999 legislative session. This rule is being rescinded because it is superseded by other rules and because, with certain exceptions, members are no longer required to purchase prior service.

AUTHORITY: section 50.1032, RSMo Supp. 1997. Original rule filed Oct. 11, 1995, effective May 30, 1996. Amended: Filed Sept. 17, 1998, effective March 30, 1999. Rescinded: Filed March 17, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 3—Creditable Service

PROPOSED AMENDMENT

16 CSR 50-3.060 Buyback by a Special Consultant to the Board. The board is amending section (1) and deleting section (2).

PURPOSE: This amendment clarifies the language is section (1) to comply with terminology used in other regulations promulgated by the Board of the County Employees' Retirement Fund. This amendment also removes the language in section (2) because it is superseded by other regulations.

(1) Former county employees who were employed between January 1, 1990 and August 27, 1994, and who worked for *[the county]* **an employer** for at least eight (8) years may apply to the board to serve as a special consultant on the problems of retirement. Calculation of the amount required to purchase the prior service shall be in accordance with applicable statutes. The former employee must submit at least fifty percent (50%) of the purchase price with *[his/her]* **his or her** application to serve as a special consultant. If the former employee submits less than one hundred percent (100%) of the purchase price with *[his/her]* **his or her** application, then the remainder of the purchase price shall be deducted from the consultant's retirement benefits in equal monthly installments as agreed by the board and the consultant. Such payments shall not extend over more than four (4) years.

[(2) The County Employees' Retirement Fund will follow Missouri's common law which prohibits a spouse from receiving survivorship benefits if the spouse intentionally killed the member.]

*AUTHORITY: section 50.1032, RSMo Supp. [1998] **1999**. Original rule filed Oct. 11, 1995, effective May 30, 1996. Amended: Filed Nov. 26, 1996, effective June 30, 1997. Amended: Filed Sept. 17, 1998, effective March 30, 1999. Amended: Filed March 17, 2000.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 3—Creditable Service

PROPOSED AMENDMENT

16 CSR 50-3.070 Refund of Buybacks. The board is amending sections (1) and (2).

PURPOSE: This amendment clarifies the regulation to comply with terminology used in other regulations promulgated by the Board of the County Employees' Retirement Fund.

(1) *[Individuals]* **Former county employees** who have tendered their fifty percent (50%) buyback to County Employees' Retirement Fund **(CERF) as provided in 16 CSR 50-3.060**, but have not received a benefit, may request a refund of their buyback. To receive a refund, the *[individual]* **former county employee** must submit a written request to the plan administrator **of CERF**. Upon executing the refund request, the *[individual]* **former county employee** will forfeit the spousal survivorship benefit.

(2) *[Any individual]* **A former county employee** who receives a refund of his or her buyback may reapply to serve as a special consultant in the future.

*AUTHORITY: section 50.1032, RSMo Supp. [1997] **1999**. Original rule filed Nov. 26, 1996, effective June 30, 1997. Amended: Filed Sept. 17, 1998, effective March 30, 1999. Amended: Filed March 17, 2000.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 3—Creditable Service

PROPOSED RESCISSION

16 CSR 50-3.080 Changes in Buyback When a Retiree Returns to Employment with the County. This rule clarified benefit payments when a retired person returned to employment.

PURPOSE: There were significant legislative changes to sections 50.1000 to 50.1300, RSMo, which sets forth the statutory framework for the County Employees' Retirement Fund, in the 1999 legislative session. This rule is being rescinded because it is superseded by other rules and because, with certain exceptions, members are no longer required to purchase prior service.

AUTHORITY: section 50.1032, RSMo Supp. 1997. Original rule filed July 29, 1997, effective Jan. 30, 1998. Amended: Filed Sept. 17, 1998, effective March 30, 1999. Rescinded: Filed March 17, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 16—RETIREMENT SYSTEMS
Division 50—The County Employees' Retirement Fund
Chapter 3—Creditable Service

PROPOSED RESCISSION

16 CSR 50-3.090 Early Buyback of Prior Creditable Service. This rule explained the process for handling early buyback of prior service.

PURPOSE: There were significant legislative changes to sections 50.1000 to 50.1300, RSMo, which sets forth the statutory framework for the County Employees' Retirement Fund, in the 1999 legislative session. This rule is being rescinded because, with certain exceptions, members are no longer required to buy back prior creditable service.

AUTHORITY: section 50.1032, RSMo Supp. 1997. Original rule filed Sept. 17, 1998, effective March 30, 1999. Rescinded: Filed March 17, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the County Employees' Retirement Fund, P.O. Box 2271, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 20—DEPARTMENT OF INSURANCE
Division 500—Property and Casualty
Chapter 6—Workers' Compensation and Employer's Liability

PROPOSED AMENDMENT

20 CSR 500-6.700 *[Premium Discounts for Using Managed Care Programs]* ***Procedures Associated With Workers' Compensation Managed Care Organizations***. The department is

amending the title of the rule, deleting section (1)–(9), adding sections (1)–(23) and replacing the exhibits that follow this rule.

PURPOSE: The proposed amendment updates this regulation to implement section 287.135, RSMo.

[(1) Upon issuance or renewal of a Workers' Compensation insurance policy, there shall be a reduction in the total premium charged to an employer for the policy for the first three (3) years during which the employer contracts with a managed health care system which has met the certification requirements of this rule and which serves the geographic area in which the employer is located. The premium reduction shall be five percent (5%) of the total premium which would otherwise be charged to the employer for each of the three (3) initial policy years under the certified managed care system. An insurer may require the employer to notify it of the employer's intent to contract with certified managed care system and to execute any such contract, prior to the issue date or renewal date of the policy, before granting the reduction. This arrangement shall be evidenced by the following documents:

(A) An endorsement to the Workers' Compensation policy setting forth the use of the certified managed care system and the extension of the five percent (5%) reduction in premium. The endorsement may include provisions on the effect of the employer's use of providers outside the terms of the managed care agreement;

(B) A contract between the certified managed care system and the employer specifying the terms and conditions associated with the use of the managed care system, including the employer's agreement that the use of the organization is the free exercise of the employer's right to choose a health care provider under section 287.140, RSMo;

(C) A certification of a managed care utilization form to be given to the employer's insurer documenting the existence of the contract specified in subsection (1)(B), as set forth in Exhibit II of this rule; and

(D) A Workers' Compensation insurer and a certified managed care system may also enter into an agreement specifying the terms and conditions associated with the use of the managed care system.

(2) For purposes of this rule, the term certified managed care system or system shall mean medical care cost containment arrangements such as preferred provider organizations (PPOs), health maintenance organizations (HMOs) and other direct employer/provider arrangements designed to provide incentives to medical care providers to manage the cost and utilization of care associated with claims covered by Workers' Compensation insurance, which have been approved by the department. The approval criteria for PPO arrangements are set forth in section (3) of this rule. The approval criteria for non-PPO arrangements shall be developed under section (8) of this rule.

(3) For purposes of this rule, the term Workers' Compensation preferred provider organization (WC/PPO) shall mean a health care plan designed to coordinate employee care and control and contain costs for medical and rehabilitative services associated with Missouri Workers' Compensation claims through the use of special provider networks, utilization review and case management procedures. In order to be certified, a WC/PPO shall meet the following requirements:

(A) The WC/PPO 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 WC/PPO 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; 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 WC/PPO contract requirements, the WC/PPO 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 (3)(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 WC/PPO 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

(D) Be in addition, under the management and control of officers and directors who are competent to manage the WC/PPO-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.

(4) Certification Procedure.

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

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

2. A general diagram of the WC/PPO's organizational structure;

3. A listing of the WC/PPO's officers and directors;

4. The WC/PPO's most recently audited financial report;

5. A thorough description of the WC/PPO'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 WC/PPO plans to serve;

7. A copy of the certificate of the board-certified 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 WC/PPO to be provided to employers explaining their rights and responsibilities; and

11. Any other materials requested by the director.

(B) The materials specified in subsection (4)(A) shall be retained by the department. Any significant changes to the nature of the WC/PPO'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, to those WC/PPOs 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 WC/PPO 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.

(5) Insurers writing Workers' Compensation insurance in Missouri may contract with a certified managed care system. This contract may cover all employers insured by the insurer in the state, any class or subclass of employers, any employers located in a particular geographic region, or on any other basis which does not result in unfair discrimination under section 375.936(11), RSMo. Any employers who participate in this arrangement shall execute the contract required in subsection (1)(B) of this rule. For purposes of encouraging its insured employers to use a managed care system with which it has contracted, an insurer may offer premium reductions in excess of those required in section (1) of this rule. Nothing shall preclude an insurer from discussing the relative merits of different managed care systems with its insureds.

(6) Where an insurer has not contracted with a certified managed care system in a given geographic region, but that a system does operate in that region, upon a request by an insured employer, the insurer shall provide the insured the premium reduction specified in section (1) of this rule so long as the certified system is willing to provide health care services to the employer. The insurer, however, may apply the five percent (5%) premium reduction specified in section (1) only to that portion of the employer's operations occurring in the geographic regions served by the certified system.

(7) Nothing contained in this rule shall be interpreted as precluding an employer from taking advantage of other noncertified managed care options at his/her own expense, particularly where the employer's operations are located outside the geographic territory of a certified managed care system. The use of this system, however, shall not entitle the employer to a premium reduction by its insurer.

(8) The director shall establish an informal task force for fostering the widest possible use of managed care systems in Missouri in relation to Workers' Compensation insurance. The task force may consist of volunteers representing insurers, managed care providers, employers and other interested parties. The task force will assist the department in developing approval criteria for approving additional managed care systems in Missouri. The panel will assist the director in developing approval criteria for PPOs that do not meet the criteria of section (3) of this rule, and of other managed care systems such as HMOs and direct employer/provider contracts, and the appropriate level of premium discount to be associated with these systems. They also may assist in the development of performance standards to measure the effectiveness of all managed care systems associated with Workers' Compensation insurance. All meetings of the advisory panel will be subject to the state's open meetings law.

(9) An insurer need provide a premium discount to an insured employer only for a three (3)-year period, after which time any reduction in the employer's premium as a result of the use of managed care services shall be reflected in the employer's experience modification factor. An employer shall not be entitled to more than three (3) years of specified premium reductions by reason of changing insurers, changing managed care systems or changing the ownership of the employer. Change of ownership rules regarding employers approved by the department concerning Workers' Compensation shall apply to these cases.]

(1) Definitions. Under this regulation, unless the context clearly requires otherwise:

(A) Access fee means the percentage of savings off the usual and customary charges for medical or rehabilitative services charged by a managed care organization (MCO) as reimbursement for access to its discounted provider network;

(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 licensed nurses experienced in the delivery of medical care under the workers' compensation system plan, 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) Cost savings analysis means a documentation of savings achieved through reduction of medical fees and/or coordination of utilization review management techniques and/or savings achieved from an early return to work;

(E) CPT-4 Code means a code contained in the *Current Procedural Terminology* published by the American Medical Association;

(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;

(H) Insurer means any person or entity defined under sections 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 to manage the cost and utilization of care associated with claims covered by workers' compensation insurance;

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

(K) 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 regulation;

(L) Precertification means the process of reviewing planned non-emergency medical care to assure said care conforms with an MCO's current managed care procedures;

(M) 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;

(N) Qualified actuary means a fellow or member of the Casualty Actuarial Society;

(O) Telephonic case management means case management conducted by telephone or facsimile machine;

(P) TPA means an administrator as defined under sections 376.1075 to 376.1095, RSMo;

(Q) Utilization review (UR) 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, precertification, concurrent review, discharge planning or retrospective review. For purposes of this regulation, utilization review shall not include case management;

(R) Usual and customary fee receipt, as required under subsection 3 of section 287.140, RSMo, means a charge by a health care provider for a treatment or service compensable under the Workers' Compensation Law which is no greater than the fee received by the provider when the payor for such service is a private individual or a private health insurance carrier.

(2) The Role of MCOs in Managing the Cost and Utilization of Medical Care.

(A) Section 287.135, RSMo provides for the certification by the department of MCOs designed to provide incentives to medical care providers to manage the cost and use of care associated with claims covered by workers' compensation insurance. In addition to assisting in the management and use of medical care, MCOs should also be able to render the following benefits to the workers' compensation system:

1. To injured employees, prompt and appropriate medical care through a system which coordinates and delivers that care so that the employee fully understands the process;

2. To employers, cost-effective medical care to their injured employees which helps reduce workers' compensation losses in the aggregate as well as the experience modifications of experience-rated employers in particular, which helps to avoid unnecessary litigation, and which helps return employees to work in an appropriate manner.

(B) Under this regulation, certain fees charged by MCOs for services provided in connection with the care given to an injured employee shall be reimbursed by the workers' compensation insurer of the injured employee's employer, provided the MCO is certified by the department under the provisions of this regulation. This certification is required in order to help assure that an MCO is capable both of providing an adequate system of cost-effective care and of properly coordinating and integrating its systems with those of their client-employers' workers' compensation insurers regarding such matters as claim reporting, claim handling, utilization review, case management and billing.

(C) Where problems in achieving the goals set forth in this section are perceived, they should be reported to the department as specified in section (21) below.

(3) The Employer's Right to Choose an MCO; an Insurer's Right to Discuss that Choice.

(A) Under subsection (10) of section 287.140, RSMo, an employer has the right to select the licensed treating physician or other health care provider to provide medical or rehabilitative care to an employee who has been injured by a work-related injury or occupational disease compensable under Missouri's Workers' Compensation Law. An employer may exercise this right to select a treating physician or other health care provider by means of a contract with an MCO certified by the department under which the employer shall direct any injured employees to the MCO's providers for treatment.

(B) Under subsection (1) of section 287.140, RSMo, an employer is required to provide such medical, surgical, chiropractic, and hospital treatment, including nursing, custodial, ambulance and medicines, as may reasonably be required after an injury or disability, to cure and relieve the effects of the injury. An employer may fulfill its responsibility to provide such ancillary services as are authorized under that statute, such as case management, by means of a contract with an MCO certified by the department, provided however, that the MCO coordinates such services with the employer's insurer.

(C) An employer shall indicate its selection of an MCO by signing the MCO Disclosure/Participation Agreement form set forth as Exhibit B of this regulation, which shall be delivered to the employer's insurer as required under section (11) of this regulation.

(D) An employer may cancel the selection of an MCO or change from one MCO to another. The MCO selection listed on the MCO Disclosure/Participation Agreement shall be deemed to remain in effect until canceled according to the provisions of section (11). An employer shall select only one MCO at a time for a given geographic area of the state.

(E) The MCO shall provide the employer's insurer with its current provider list unless the list is available through the department's web site under section (19) of this regulation.

(F) The employer's insurer is permitted to discuss the appropriateness of the treating physician or other health care provider selected by the employer with that employer, provided however, that the insurer is prohibited from directing or mandating the choice of an appropriate physician or other health care provider; in the event of a difference of opinion on such a choice, the decision of the employer shall prevail. The prohibition on an insurer directing or mandating the choice of a treating health care provider extends to the selection by the employer of an MCO; an insurer is prohibited from requiring that an employer send an injured employee to the providers of a particular MCO for treatment.

(4) Classifications of MCOs.

(A) Workers' compensation MCOs, as defined in section (1) of this regulation may operate in this state with or without certification by the department, provided, however, that only those MCOs which have been certified by the department may demand the reimbursement of fees under the provisions of section (13) of this regulation.

(B) Workers' compensation MCOs may be affiliated with various other types of organizations. Due to the relevance of

such affiliations on the philosophies, priorities and methodologies of an MCO, such affiliations shall be set forth by any MCO seeking certification under this regulation in its request for certification. After review, the department shall designate the MCO as being one of the following classifications:

1. An insurer-based MCO, which is owned and operated by an insurance company;

2. A health-care-based MCO, which is owned and operated by a health care provider or a health care system;

3. An independent MCO, which is owned and operated by an entity not affiliated with an insurance company or health care provider or system;

4. A hybrid MCO, which is owned and operated by a combination of the entities set forth in paragraphs (4)(B)1.–3. above.

(C) Insurance companies may develop their own MCOs or contract with particular MCOs to provide managed care services to their insured employers, provided however that if an insured employer has chosen an MCO other than one utilized by the insurer, the insurer must pay the reasonable fees of that other MCO, if certified, as authorized under section (13) of this regulation, except to the extent the insurer is exempted from certain such payments under section (14) of this regulation.

(5) Mandatory Components of a Department-Certified MCO. In order to be certified by the department and retain that certification, a workers' compensation MCO shall possess the following characteristics:

(A) A written organizational philosophy which has as a primary goal the use of appropriate procedures and incentives to medical providers to manage the cost and utilization of care associated with claims covered by workers' compensation insurance, and which is managed in Missouri and elsewhere by personnel with experience at successfully achieving this goal;

(B) A network of appropriately-licensed health care providers who have been selected and retained through a provider selection and peer review process as being willing and experienced at providing prompt medical care for work-related injuries and illnesses. The network shall, at a minimum, possess the following types of providers:

1. Medical doctors and surgeons;

2. Orthopedic surgeons;

3. Neurologists and neurosurgeons;

4. Physical and occupational therapists;

5. Psychologists and psychiatrists;

6. Diagnostic, laboratory and radiology services;

7. Hospital, outpatient and emergency care services; and

8. Plastic surgeons;

(C) A system of both appropriately-licensed and experienced personnel and facilities to provide, either in a hospital setting or through stand-alone centers, rehabilitation services as are appropriate to the individual injured employee. The MCO's rehabilitative services shall at a minimum include the following:

1. Comprehensive in-patient rehabilitation:

2. Chronic pain management programs;

3. Out-patient rehabilitation programs; and

4. Work-hardening programs;

(D) The ability to provide a system of appropriately-licensed and experienced personnel to provide the following types of ancillary managed care services in accordance with protocols established by the MCO, as modified by any particular agreements with individual employers or insurers. Unbundling of these services is permissible and may be necessary in order to coordinate and integrate the systems of the MCO with those of particular insurers:

1. Precertification and prospective utilization review by licensed registered nurses;

2. Concurrent utilization review by licensed registered nurses;

3. Telephonic case management by licensed registered nurses;

4. On-site case management by licensed registered nurses;

5. Retrospective utilization review by licensed registered nurses;

6. Provider bill auditing;

7. Hospital bill auditing;

8. Bill re-pricing;

9. Cost savings analysis;

10. Educational services for employers;

11. A continuing education program for network providers and other personnel; and

12. Data collection and reporting capabilities under section (18) of this regulation;

(E) A system of coordinating medical care, rehabilitation care and ancillary managed care services to manage the cost and utilization of care associated with claims covered by workers' compensation insurance while achieving prompt and appropriate maximum medical improvement and, where possible, prompt and appropriate return to work, under the direction of a medical director experienced with the Missouri workers' compensation system;

(F) Convenient access to the medical care and rehabilitative care services available through the MCO. Such convenient access shall include:

1. Telephonic access to the MCO for information and suggested referrals to area providers;

2. Twenty-four (24) hour emergency care;

3. Examinations and or evaluations within forty-eight (48) hours of request;

4. Other services accessible at reasonable times to all injured employees;

5. An adequate number of network providers for convenient access at any given location, with protocols for accessing non-network providers where necessary; and

6. MCO service areas which require an injured employee to cross no more than one county boundary to receive treatment, except to the extent the MCO will absorb any travel expenses, or to the extent such travel is authorized by the insurer;

(G) A program to encourage network providers and other MCO medical personnel to receive continuing education annually on relevant topics related to occupational medicine, workers' compensation insurance, and the management of the care thereof, including such possible topics as:

1. Developments in occupational medicine;

2. Trends in the causes of work-related injuries or illnesses;

3. Techniques for avoiding common workplace hazards;

4. Options for return-to-work decision making;

5. Vocational rehabilitation;

6. Reporting requirements and other special provider requirements under the system;

7. Required treatment parameters;

8. Determining disability ratings;

9. Determining maximum medical improvement;

10. Permanent partial disability management;

11. Fraudulent claims;

12. Cases which have led to disputes;

13. Statutory, regulatory and case law developments; and

14. Developments in the managed care market;

(H) A billing procedure which conforms to the requirements of section (16) of this regulation;

(I) A system for analyzing the savings realized by employers utilizing an MCO, both in the aggregate and for specific employers;

(J) A data collection and reporting system which conforms to the requirements of section (18) of this regulation;

(K) An internal dispute resolution procedure which informs participating employees of how, where and with whom to file a grievance and has grievances reviewed by someone within the organization of the MCO not involved in the underlying elements of the dispute, who promptly investigates the surrounding circumstances and provides a written explanation to the employee of the outcome of the investigation and recommendations for resolving the dispute, including notification of any right of appeal to the department or, where the issue relates to the appropriateness or necessity of medical treatment, to the Division of Workers' Compensation.

(6) Certification Process.

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

1. A designation of the classification of the MCO under section (4) of this regulation, with an explanation if necessary;

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

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

4. 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, particularly of those persons who will be associated with the Missouri MCO's operations;

5. A description of how the quantity and quality of care will be managed by the MCO;

6. The MCO's most recently audited financial report, if any;

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

8. A copy of the Missouri certifications for any UR firms which will be used by the MCO;

9. A copy of the current medical license of the MCO's medical director, as well as any relevant board certifications, such as a board certification for occupational medicine, as well as similar documentation for the Missouri-based assistant medical director, should the medical director not be a Missouri resident. Where one or both of the above parties lacks board certification in occupational medicine, the MCO shall also provide a copy of that provider's curriculum vitae describing the provider's prior experience, including prior experience with the management of workers' compensation injuries and illnesses;

10. An explanation of the MCO's provider selection procedures and its peer review procedures;

11. A complete list of all primary care physicians, subspecialist physicians, rehabilitation centers, hospitals and work hardening centers to be employed by the organization, divided by county or city not within a county;

12. An explanation of the compensation arrangement(s) the MCO plans to use to fund its operations;

13. A description of any discounts applied to the usual and customary fee receipts of network providers, or categories of providers, negotiated by the MCO, as well as any other arrangements designed to manage the cost or use of care;

14. Copies of any MCO/provider, MCO/employer and MCO/insurer agreements to be used which shall include the required provisions set forth in sections (8), (9) and (14), respectively, of this regulation;

15. An analysis of the estimated savings to employers and insurers resulting from the use of the MCO, which may include estimates on savings due to reduced indemnity losses as well as reduced medical losses. The analysis shall, at a minimum, include estimates of savings off billed charges, savings off usual and customary fee receipts, average cost per claim and average number of days lost due to illness or injury. The analysis shall be signed by a qualified actuary, who shall also include a brief description of his or her prior experience with workers' compensation insurance and with managed care organizations, as well as an explanation of the methodology by which the above estimates were calculated. In providing this analysis, the actuary shall rely on the Actuarial Standards of Practice No. 8 and No. 16 adopted by the Actuarial Standards Board, in addition to any other relevant standards of practice;

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

17. An outline of the MCO's dispute resolution procedures;

18. Copies of all informational materials required under section (10) of this regulation;

19. Copies of all marketing materials; and

20. Any other materials requested by the director.

(B) The materials required under subsection (6)(A) shall be collected in the order set forth above, in a main binder, separated by appropriately-labeled dividers, provided however, that any materials the MCO considers to be confidential in nature, such as MCO/provider reimbursement information, shall be placed in a supplementary binder, with appropriate cross references in the main binder where the confidential materials would otherwise have been placed. Confidential materials shall be handled by the department in accordance with the provisions of regulation 20 CSR 10-2.400, although any MCO which files materials labeled as confidential may be contacted by the department and discouraged from so filing.

(C) The materials specified in this section 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, except for the MCO's list of providers for the department's web site, which shall be updated at least quarterly, and except for marketing materials, which shall be delivered to the department prior to their use.

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

(E) The department shall designate the geographic extent to which a certified MCO's certification applies, for purposes of reimbursement under section (13) of this regulation. As part of the certification process, the MCO shall provide the department with a series of maps indicating the location of its providers, as follows:

1. The department shall provide a map of the state of Missouri showing the names and boundaries of each county;

2. The MCO shall make duplicates of said map and shall label successive copies for "Primary Care Physicians," "Specialists," "Hospitals," and "Rehabilitation Centers";

3. The MCO shall, on the successive maps, place the number of providers of the type indicated on the label within the boundaries of each of the counties where said providers are located;

4. The department shall review the completed provider maps and grant a service area to the MCO which includes every county wherein all available types of providers are present in the network, as well as any counties bordering said counties; and

5. The MCO's service area shall be listed by county in the current list of certified MCO's, which is to be maintained by the department under section 287.135, RSMo, and provided to the Division of Workers' Compensation.

(7) Criteria for Establishing the Reasonableness of MCO Fees.

(A) No insurer shall be required to reimburse a 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 fee is a standard listed fee under paragraph (9)(B)6. of this regulation, there shall be a rebuttable presumption that the fee is reasonable under subsection (A) above if:

1. It is a fee for a service the insurer has agreed the MCO shall perform, as authorized under an MCO/Insurer Coordination Form (Exhibit C), executed pursuant to the coordination and integration provisions of section (12) of this regulation; and

2. The fee for the service is the same as that indicated on the MCO's standard fee list under paragraph (9)(B)6. or has been agreed to by other insurers under alternative fee arrangements authorized under section (14).

(C) Where the type of MCO 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 (25%) of the difference between the provider's usual and customary fee receipt for the service or treatment in question and the amount the provider has agreed to accept under his contract with the MCO.

(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 section (13) of this regulation by paying an amount which conforms to those subsections.

(E) 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 regulation.

(F) 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 fee receipts, the MCO may establish the provider's usual and customary fee receipts by means of an affidavit from the provider or a duly authorized agent of the provider attesting to the provider's ten (10) most recent fee receipts for the service in question from payors who are private individuals and/or private health insurers. The affidavit shall list the names of the payors, the dates of payment and amounts received. The provider's usual and customary fee receipt will be deemed to be an average of these ten (10) most recent fee receipts.

(G) An insurer may produce evidence to rebut the presumptions of subsections (B) and (C) above by 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. An MCO may produce evidence in support of said presumptions. Such evidence 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 medical or rehabilitative 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 fee receipt of the provider;

8. What an independent database indicates is a usual and customary charge;

9. What an independent database indicates is a usual and customary fee receipt;

10. What a governmental database indicates is a usual and customary charge;

11. What a governmental database indicates is a usual and customary fee receipt;

12. The DRG, RBRVS or APC amount authorized for the procedure in question by Medicare;

13. 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; or

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

(H) Any disputes regarding MCO fees presented to the department under section (21) 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. The department will provide the parties with a written advisory opinion of its conclusions, which shall be subject to *de novo* review by a court of competent jurisdiction.

(8) Mandatory Elements of the MCO/Provider Contracts.

(A) A department-certified MCO shall execute a written agreement with each participating health care provider setting forth the terms of the relationship between the MCO and the provider.

(B) In addition to any other provisions, such written agreements shall include the following provisions:

1. An agreement by the provider to accept as reimbursement for medical services provided to an injured employee of an employer under contract with that MCO a fee based on a discount applied to the provider's usual and customary fee receipt for that service, or provisions which have this effect;

2. An agreement to request reimbursement within six (6) months of the date for any medical services provided to an injured employee of an employer under contract with that MCO;

3. An agreement by the provider to cooperate with the medical direction and control of the employer and the MCO; and

4. An agreement by the provider to send any medical bills for medical services provided to an injured employee of an employer under contract with that MCO to the MCO so that the MCO may comply with the standardized billing requirements of section (16) of this regulation, rather than the provider sending the bill directly to the payor for payment, unless authorized to do so by the insurer.

(9) Mandatory Elements of the Employer/MCO Contract.

(A) A department-certified MCO shall execute a written agreement with each participating employer setting forth the terms of the relationship between the MCO and the employer and the anticipated period of the agreement, which shall include the MCO Disclosure/Participation form set forth at Exhibit B of this regulation.

(B) In addition to any other provisions, such written agreements shall include the following provisions:

1. That the employer and the MCO have entered into an agreement under which the medical and rehabilitative treatments for all injuries to the employer's employees compensable under the Missouri Workers' Compensation Law shall, at the employer's direction and control, in accordance with section 287.140, RSMo, be directed to the MCO for treatment;

2. That the employer shall contract with only one MCO at a time for a given geographic area;

3. That the employer and the MCO have selected a named contact person to be responsible for carrying out their respective responsibilities under the agreement. Should either the employer or the MCO change their designated contact person, they shall notify the other of the change as soon as is practical. The relevant information on said contact persons shall be entered on the Disclosure/Participation Agreement set forth as Exhibit B to this regulation;

4. That either party may terminate this agreement upon written notice to the other;

5. That nothing in the agreement shall alter the employer's contractual duty under its workers' compensation insurance policy to notify its insurer of the occurrence of an injury;

6. The terms of the MCO's standard discounting arrangement with its providers and a fee disclosure list attached to the Disclosure/Participation Agreement form which lists any fees associated with the following activities and whether they will be charged to the employer or the employer's insurer:

A. Precertification;
B. Prospective utilization review;
C. Concurrent utilization review;
D. Telephonic case management;
E. On-site case management;
F. Retrospective utilization review;
G. Provider bill auditing;
H. Hospital bill auditing;
I. Bill re-pricing;
J. Cost savings analysis;
K. Educational services for employers;
L. Continuing education for network providers and other personnel; and
M. Data collection and reporting services; and

7. That an employer's insurer retains the right to review and contest the compensability, reasonableness or appropriateness of provider services.

(10) Mandatory Disclosure of Information to the Employer's Employees.

(A) Each department-certified MCO shall make the following materials available to participating employers:

1. A general statement on the purpose of the MCO and the need for coordination and communication regarding workplace injuries or illnesses;

2. General access, emergency access and after-hours access procedures;

3. The MCO's precertification procedures for non-emergency cases;

4. A current list of network providers for the area in question; and

5. General information of the availability of the MCO's services on safety, rehabilitation and return to work.

(B) An employer shall have the responsibility to make such materials available to its employees.

(11) Notification Requirements.

(A) When an employer has selected a department-certified MCO, the employer's insurer shall be notified of that fact by the MCO, which shall mail a copy of the executed MCO Disclosure/Participation Agreement, set forth at Exhibit B of this regulation, to that insurer. An insurer receiving such an MCO Disclosure/Participation notice shall circulate whatever internal notification is necessary to assure that the insurer's underwriting, claims, accounting and customer service personnel and systems duly note the existence of the employer/MCO relationship in its records, to allow for efficient coordination with the MCO in the future, should the need arise.

(B) An MCO shall send to the employer's insurer any diagnosis, medical history, treatment plan, prognosis, return-to-work date or other medically- or rehabilitation-related information or documents it receives in the course of the treatment of an injured employee within twenty-four (24) hours of the receipt of such materials. The records of the MCO should record the fact of the receipt of such information, describe the information, the date such information is sent to the insurer and the method by which it was sent. The MCO may retain a copy of such information if it chooses.

(C) An employer may cancel its selection of an MCO by notifying the MCO and the employer's insurer of the cancellation in writing, provided however, that where the employer has decided to replace one MCO with another MCO, the new MCO shall mail a copy of the executed MCO Disclosure/Participation Agreement, set forth at Exhibit B of this regulation, to the prior MCO and the insurer. This notice shall become effective on the date of mailing, provided, however, that the prior MCO shall still be entitled to reimbursement for authorized MCO fees for all services rendered prior to its receipt of the new MCO Disclosure/Participation notice.

(D) While an insurer is prohibited from directing or mandating the use by an employer of a particular MCO, the insurer may discuss the employer's choice of an MCO with the employer. Any such discussion or communication shall be accompanied by a copy of the MCO Disclosure/Participation Agreement, which includes notice of this prohibition and the department's recommended considerations for any employer seeking to choose a new or replacement MCO.

(12) Coordination and Integration. An MCO shall be deemed to have coordinated and integrated its internal operations with those of the insurer whenever:

(A) The MCO has made contact with an appropriate representative of the insurer or the insurer's TPA at the contact number recorded in the department's list of insurer contacts maintained under section (19) of this regulation, as soon as practical after the insured employer has entered into a contract with the MCO to provide workers' compensation managed care services. The MCO shall document the date, time and contact person with whom the contact is made in its records.

(B) The MCO agrees to coordinate its medical management decisions with those of the insurer, including the avoidance incurring duplicate costs associated with those elements of managed care which the insurer provides, such as case management and utilization review, and has executed a copy of the MCO/Insurer Coordination form set forth at Exhibit C of this regulation memorializing this agreement, one copy of which shall be retained in the MCO's records, one copy of which shall be sent to the insurer and one copy of which shall be sent to the insured employer.

(C) The MCO has conformed to the standardized billing procedures under section (16) of this regulation.

(13) Reimbursement of MCO Fees by Insurers.

(A) For an insurer to be required under this regulation to reimburse a fee charged by an MCO, that fee must:

1. Relate to a medical claim that has previously been reported to the insurer by the employer;

2. Relate to an injury or illness which is compensable under Chapter 287, RSMo;

3. Be from an MCO which, on the date of the bill charge, is fully certified under section (6) of this regulation;

4. Be from an MCO which is a signed agreement with the injured employee's employer, as documented in a MCO Disclosure/Participation Form set forth in Exhibit B of this regulation;

5. Relate to an employer who has a contract with the insurer for workers' compensation insurance that covers the injury or illness;

6. Be from an MCO that has coordinated and integrated its systems with those of the insurer under section (12) of this regulation;

7. Relate to a medically necessary procedure or a determination of medical necessity; and

8. Be reasonable under section (7) of this regulation.

(B) Where the insurer and the MCO have a contractual agreement regarding fees and integration and coordination under section (14) of this regulation, reimbursement of the MCO shall be governed by that arrangement.

(C) If made in accordance with this regulation, an insurer shall reimburse a department-certified MCO's bill. The insurer shall not ignore an MCO billing invoice, access fees or discount, nor shall it apply its own discount to the amount charged by the provider for the service in question.

(D) If the insurer disputes the MCO bill for its fee, the insurer shall notify the MCO in writing of that disagreement and the basis for that disagreement. The insurer may tender and the MCO may accept partial payment of the MCO fee without prejudice to the rights of either party to contest the fee under this regulation.

(14) Agreements Between Insurers and MCOs.

(A) Charges associated with MCO-related activities shall be reimbursed by insurers if they meet the requirements of this regulation, except where the insurer and the MCO have entered into a voluntary agreement under subsection 3 of section 287.135, RSMo, whereby the parties control how to accomplish reimbursement, coordination and integration in a manner different than as provided for in sections (12) and (13) of this regulation. Where such an agreement is in place, it shall determine the manner by which that particular insurer reimburses that particular MCO. Such an agreement shall not alter the manner in which the insurer reimburses other MCOs which have been selected by the insurer's insured employers who are not party to such a voluntary agreement; those MCOs shall be reimbursed according to the provisions of sections (12) and (13) of this regulation.

(B) An insurer that has entered into an agreement with an MCO under subsection (A) of this section shall execute the Disclosure/Participation Agreement at Exhibit B of this regulation with every insured employer who chooses to use the insurer's MCO.

(15) Premium Credits and Debits for an Employer's Use of an MCO.

(A) Insurers shall submit their schedule rating plans to the department for approval. Insurers seeking to grant differential schedule rating credits or debits to employers depending on which MCOs they select shall first receive the approval of the department. Information supporting the proposed ratings, including actuarial support for such ratings, shall be filed with the department in accordance with sections 287.930 to 287.975, RSMo. Any credits or debits granted in absence of such a filing and approval shall be deemed unfairly discriminatory. In providing information under this subsection, an insurer may include whatever non-actuarial information it considers relevant, including information on any differential medical outcomes produced by different medical providers or different MCOs.

(B) If approved under subsection (15)(A) above, an insurer's schedule rating plan may permit an adjustment to or imposition of different schedule credits or debits for an employer who changes from one MCO to another during the policy period, provided such a contingency is already authorized by an endorsement to the employer's workers' compensation policy which has been approved for use by the department.

(16) Standardized MCO Billing Procedures.

(A) Department-certified MCOs shall attach or include as a minimum as part of any bill invoice to an insurer for MCO services associated with work-related illnesses or injuries the following information:

1. MCO name;

2. MCO address;

3. MCO telephone number and facsimile number;

4. MCO billing contact person name;

5. Employer name;

6. Injured employee name;

7. Employee Social Security Number (SSN);

8. Provider name;

9. Provider date-of-service; and

10. Documentation or explanation of MCO charges, which shall at a minimum include the following:

A. The date of service;

B. A description of the service;

C. The CPT or ICD-9 Code for the service;

D. The amount charged by the provider;

E. The amount allowed by the MCO (and, if appropriate whether this amount is based on a non-standard discount);

F. The saving realized by using the MCO network for that service;

G. The MCO's access fee;

H. The total MCO charges due (if more than one services is listed);

I. An invoice date; and

J. An invoice number.

(B) A department-certified MCO shall submit its bills for MCO fees under subsection (16)(A) to insurers attached to a copy of the billing form from the medical provider which complies with the provisions of regulation 20 CSR 400-8.300, such as a UB-92 form or a HCFA 1500 form. An MCO's request for reimbursement for its MCO activities such as access fees shall accompany such requests for the reimbursement of the MCO's providers, provided however, that MCO reimbursement requests and provider reimbursement requests may be separate, if requested by the insurer.

(C) MCO requests for reimbursement shall include both the MCO's charge for its service and, separately, the discounted charge for the provider's services. An insurer shall reimburse the two (2) charges separately. The provisions of this section may be modified by the insurer and the MCO by mutual agreement.

(D) Insurers are not required to reimburse for MCO services if they have not received a claim relating to injury or illness to which the services relate. In addition, insurers are not required to accept MCO requests for reimbursement which are more than six (6) months after the date on which the services were rendered, unless the delay for the request for payment was not the fault of the MCO. MCO billing systems shall retain information on the date on which the original request for payment was made.

(17) Reporting of MCO-Related Costs Under the Approved Statistical Plan.

(A) Insurers shall report any access fees paid to MCOs, or fees paid for charges under paragraph (13)(B)4. of this regulation other than for on-site case management, as "Allocated Loss Adjustment Expense (ALAE) Paid" under the Statistical Plan of the National Council on Compensation Insurance, Inc. or any similar plan approved for use in Missouri.

(B) Insurers shall report any fees for reimbursement to health care providers providing services or treatment to an injured employee not covered under subsection (17)(A) above as a medical loss under the Statistical Plan of the National Council on Compensation Insurance, Inc. or any similar plan approved for use in Missouri. This shall include any fees paid for on-site case management services.

(18) Data to Be Collected by MCOs.

(A) The following data shall be reported by each department-certified MCO to the department for each calendar year beginning June 1, 2001 by July 1, 2001 and every calendar year thereafter:

1. The estimated aggregate number of participating employers during the reporting period;

2. The aggregate provider charge for treatment for participating employees;

3. The aggregate charge for treatment actually allowed by the MCO;

4. The discount on charges realized by the use of the MCO network; and

5. The charge or access fee plus other charges collected by the MCO excluding fees to providers for treatment.

(B) Each MCO shall report said information, in a computer format specified by the department.

(19) Department Web Site to Provide List of Insurance Company Contacts for Dealing with MCO-Related Issues and List of MCO Providers.

(A) Each insurance company licensed to write workers' compensation insurance in Missouri shall provide the department with the name(s) and/or job title(s), address(es), telephone number(s), fax number(s) and E-mail address(es) of the insurer employees an MCO should contact under subsection (A) of section (11) of this regulation in order to notify the insurer of the existence of an MCO contract and to initiate the coordination of services. Such information shall be updated by the insurer as necessary to remain current and shall be reported to the department in a format determined by the department. The department shall compile such insurer contact information and shall make said information available on its web site.

(B) Each department-certified MCO shall provide the department with a current list of its providers at least quarterly. The information shall be reported to the department in a format determined by the department. The department shall compile such MCO provider and shall make said information available on its web site.

(20) Recertification Process.

(A) Any MCO which desires recertification under this regulation shall submit the materials required for certification under this regulation any time during the period following the publication of the final Order of Rulemaking regarding this regulation in the *Missouri Register* and ninety (90) days after the publication of this regulation in the Missouri *Code of State Regulations*. Once certified, the MCO shall file for recertification within thirty (30) days of the new certification anniversary date granted under this subsection.

(B) These certification materials filed under subsection (20)(A) above shall be in the form prescribed in section (6) of this regulation and shall be accompanied by a filing fee of one thousand dollars ($1,000), made payable to the Missouri Department of Insurance. The MCO shall, in a cover letter, outline any significant changes made to its previous filing. Each MCO previously certified and so filing shall remain certified until recertified or, where appropriate, decertified, in writing, by the department. The department shall decertify any MCO that has not filed for recertification within thirty (30) days of its annual anniversary date.

(C) Any certified MCO shall cooperate with any reasonable on-site inspection of the MCO's facilities requested by the department.

(D) The department may, in writing, suspend or revoke the certification of an MCO at any time it establishes the criteria set forth in this regulation are no longer being met. Any MCO so suspended or decertified may request a hearing before the director or his designee concerning that suspension or decertification.

(21) Procedures for Handling MCO-Related Complaints.

(A) Any person who feels that the requirements of this regulation are not being adhered to by an MCO, an insurer or any other person may submit their concerns or complaints to the department's Property and Casualty Section for review.

(B) If after review, the department determines that there is a violation of the regulation, it may impose such penalties under section (22) or seek such remedial measures as it determines are warranted under the circumstances.

(22) Penalties.

(A) Insurers which violate the provisions of this regulation are subject to the same penalties as exist for any other violations of the general insurance laws of the state of Missouri. The department will take into consideration the extent to which a technical violation of the insurance laws by an insurer is due in whole or in part to the actions of an MCO with which it has no contract under section (14) of this regulation.

(B) Department-certified MCOs which violate the provisions of this regulation are subject to the suspension or revocation of their certification.

(23) Effective Date. This regulation shall become effective ninety (90) days after its publication in the Missouri *Code of State Regulations*.

AUTHORITY: sections ***287.135, RSMo 1994 and 287.140*** *[287.320, RSMo Supp. 1992] and 374.045 RSMo [1986]* ***Supp. 1999****. Emergency rule filed Aug. 31, 1992, effective Nov. 1, 1992, expired Feb. 28, 1993. Original rule filed April 14, 1992, effective Feb. 26, 1993. Amended: Filed March 31, 2000.*

PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions more than $500 in the aggregate. See the attached fiscal note.

PRIVATE COST: This proposed amendment will cost private entities more than $500 in the aggregate. See the attached fiscal note.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: A public hearing will be held on this proposed amendment at 10:00 a.m. on June 6, 2000. The public hearing will be held at the Harry S Truman State Office Building, Room 492, 301 West High Street, Jefferson City, Missouri. Opportunities to be heard at the hearing shall be afforded to any interested person. Interested persons, whether or not heard, may submit a written statement in support of or in opposition to the proposed amendment, until 5:00 p.m. on June 6, 2000. Written statements shall be sent to Stephen R. Gleason, Department of Insurance, P.O. Box 690, Jefferson City, MO 65102.

SPECIAL NEEDS: If you have any special needs addressed by the Americans With Disabilities Act, please notify us at (573) 751-6798 or (573) 526-4636 at least five working days prior to the hearing.

FISCAL NOTE
PUBLIC ENTITY COST

I. RULE NUMBER

Title: Department of Insurance

Division: Property and Casualty

Chapter: Workers' Compensation and Employer's Liability

Type of Rulemaking: Proposed Rule

Rule Number and Name: 20 CSR 500-6.700 Procedures Associated With Workers' Compensation Managed Care Organizations

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Department of Insurance	$42,866 first year, $34,815 annually thereafter.
Division of Workers' Compensation (DOLIR)	$40,541 first year, $33,906 annually thereafter.

III. WORKSHEET

Department of Insurance:

Item	Annual Expense
Product Analyst I	$23,988
Fringe Benefits (30.75%)	$ 7,376
State Data Center	$ 1,464
Office Supplies	$ 300
Telephone/Postage	$ 1,394
Professional Development	$ 293
Annual Expense Total	$34,815

Item	Equipment Expense
Personal Computer	$ 2,000
PC Software	$ 300
Voice/Data Wiring	$ 175
Desk	$ 500
Chair	$ 245
Side Chair	$ 125
File Cabinet	$ 500
Calculator	$ 60
Telephone	$ 46
System Furniture	$ 4,100
Equipment Expense Total	$ 8,051

Div. of Workers' Compensation:

Item	Annual Expense
Clerk Typist III	$ 23,286
Fringe (30.75%)	$ 7,160

Office Supplies	$ 300
Training	$ 300
Rent ($240/sq. ft. x 10 ft.)	$ 2,400
Telephone	$ 140
Electricity	$ 320
Total Annual Expense	$ 33,906

Item	Equipment Expense
Cubicle Furniture & PC	$ 6,460
Telecommunications (Voice and Data)	$ 175
Total Equipment Expense	$ 6,635

IV. ASSUMPTIONS

Department of Insurance: The proposed regulation increases the duties of the Department of Insurance in its oversight of managed care in the workers' compensation insurance market. One FTE will be necessary to attend to these duties on an efficient basis. New duties which will result from the implementation of this regulation will include:

a. Reviewing the materials filed by MCOs seeking annual re-certification;
b. Informing entities seeking certification for the first time of the procedures;
c. Updating the list of currently certified MCOs;
d. Updating the list of MCO providers on the Department's web site;
e. Updating the list of insurance company contact persons on the Department's web site;
f. Compiling annual MCO data on the extent of cost savings through the use of MCOs;
g. Handling complaints by MCOs, insurers, employers, employees and health care providers regarding the compliance with the regulation by other system participants.

Division of Workers' Compensation: The proposed regulation may increase the number of cases handled by the Division of Workers' Compensation regarding whether medical care services are "necessary and appropriate" (under Section 287.135.5, RSMo) or whether health care provider fees and charges are "fair and reasonable" and "usual and customary" (under Section 287.140.3, RSMo). The Division of Workers' Compensation currently handles roughly 2000 such matters a year with one FTE, most of which do not concern MCOs per se. This fiscal note presumes this workload would double, at least in the initial years the regulation is in effect. However, it is also possible that no increase in the Division's workload will result from the proposed regulation.

This fiscal note estimates an annual impact for the first year which includes start-up or one-time equipment costs. Thereafter, an annual amount is estimated without these initial costs. Estimates for subsequent years should be multiplied by the appropriate inflation factor.

FISCAL NOTE
PRIVATE ENTITY COST

I. RULE NUMBER

Title: Department of Insurance

Division: Property and Casualty

Chapter: Workers' Compensation and Employer's Liability

Type of Rulemaking: Proposed Rule

Rule Number and Name: 20 CSR 500-6.700 Procedures Associated With Workers' Compensation Managed Care Organizations

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by type of the business entities which would likely be affected:	Estimate in the aggregate as to cost of compliance with the rule by the affected entities:
25	Department-Certified Workers' Compensation Managed Care Organizations (MCOs)	$75,000 annually ($3000 per MCO per year.)
307	Missouri-Licensed Workers' Compensation Insurers	$1,293,241 annually (or .0023 of every premium dollar per year.)

III. WORKSHEET

MCO Costs

Regarding MCO costs, this fiscal note assumes that each MCO would have to spend the following amounts to comply with the regulation: $1000 annually for the certification fee under Section (20) of the proposed regulation; $1000 for the time and effort needed to compile the materials necessary for annual re-certification; and, $1000 for an annual actuarial analysis under paragraph (6)(A)15. of the proposed regulation.

Regarding costs to insurers, this fiscal note divides the costs into additional access fee expense and additional loss adjustment expense. Explanations can be found in "Assumptions" below:

Additional Insurer Access Fee Expense:

Written Premium	Step 1:	$555,748,358
Medical and Indemnity Losses (Step 1 x .5863)	Step 2:	$325,835,262
Medical Losses Only (Step 2 x .50)	Step 3:	$162,917,631
Medical Claims through Non-Affiliated MCOs (Step 3 x .05)	Step 4:	$ 8,145,882
Savings on Bills through Non-Affiliated MCOs (Step 4 x .15)	Step 5:	$ 1,221,882
Access Fee on Savings from Non-Affiliated MCOs (Step 5 x .25)	Step 6:	$ 305,471

This amount is the equivalent of ($305,471 / $555,748,358) or .0005 or .05% of every premium dollar. For calculations of the additional annual access fee expense in subsequent years, multiply the premium written in that year by .0005, and by whatever inflation factor is appropriate.

Additional Insurer Loss Adjustment Expense:

Written Premium	Step 1:	$ 555,748,358
Medical and Indemnity Losses (Step 1 x .5863)	Step 2:	$ 325,835,262
Loss Adjustment Expense (Step 2 x .188)	Step 3:	$ 61,257,029
Medical Loss Adjustment Expense: ALAE+ULAE (Step 3 x .645)	Step 4:	$ 39,510,784
Medical LAE Involving Non-Affiliated MCOs (Step 4 x .05)	Step 5:	$ 1,975,539
Additional LAE on Non-Affiliated MCO Bills (Step 6 x .50)	Step 6:	$ 987,770

This amount is the equivalent of ($987,770 / $555,748,358) or .00177 or .17.7% of every premium dollar. For calculations of the additional annual Loss Adjustment Expense for subsequent years, multiply the premium in that year by .00177, and by whatever inflation factor is appropriate.

Aggregate Annual Insurer Cost

Additional Insurer Access Fee Expense + Additional Insurer Loss Adjustment Expense:

$305,471 + 987,770 = $1,293,241

This amount is the equivalent of $1,293,241 / $555,748,358 or .0023 or .23% of every premium dollar. For calculations of the aggregate annual cost in subsequent years, multiply the premium written in that year by .0023. For the impact on individual insurers, again, multiply the annual premium written in the year in question by .0023, and by whatever inflation factor is appropriate.

IV. ASSUMPTIONS

MCO Costs

Currently, there are 21 active workers' compensation MCOs certified under the prior version of the proposed regulation. This fiscal note anticipates a modest growth in this number to 25. Additional MCOs beyond this number would incur the same annual cost of $3000.

Additional Insurer Access Fee Expense

(Step 1) The most recent full year of data on the size of Missouri's insured (as opposed to self-insured) workers' compensation market from the Department's 1998 Missouri Market Share Report, published in July, 1999, indicated the total written premium for workers' compensation insurance for 1998 to be $555,748,358.

(Step 2) The same document indicates that total losses (medical losses + indemnity losses) were 58.63% of premium.

Step 3) While the number fluctuates from year to year, the percent of total losses represented by medical losses is roughly 50%. (See Annual Statistical Bulletin, 1998 Edition, National Council on Compensation Insurance.)

(Step 4) Some insurers currently prefer to have their insured employers use a single MCO to handle work-related injuries or illnesses, others recommend a use of a limited number of MCOs. Some insurers argue that they already have a contractual relationship with such "affiliated" MCOs and do not have to pay any individual access fees to that MCO. Under the proposed regulation, an employer would have the option of using an MCO different than one affiliated with his insurer. Based on the experience of one major carrier, selecting such a non-recommended MCO currently happens less than 5% of the time. The calculation in this fiscal note uses 5% because this carrier also permits employers to use other, non-affiliated MCOs, as permitted under the regulation. Thus, under the proposed regulation, 5% of medical claims may involve non-affiliated MCOs, and thus may require the payment of an access fee the insurer would otherwise not have had to pay.

(Step 5) Under subsection 3 of Section 287.140, RSMo, health care providers are prohibited from charging fees for treatment or care for workers' compensation cases which are greater than the usual and customary fee the provider receives for the same treatment of services when the payor is a private individual or a private health insurance carrier. Some MCOs may be able to offer discounts of as much as 20% off these usual and customary fees. For purposes of this fiscal note, a more-likely aggregate discount of 15% was used.

(Step 6) Subsection (13)(C) of the proposed regulation caps the access fee an insurer must reimburse to a department-certified MCO at 25% of any savings of a provider's usual and customary fee receipts. This fiscal note applies the full 25% access fee permitted to the anticipated savings.

Additional Insurer Loss Adjustment Expense

(Step 1) The most recent full year of data on the size of Missouri's insured (as opposed to self-insured) workers' compensation market from the Department's 1998 Missouri Market Share Report, published in July, 1999, indicated the total written premium for workers' compensation insurance for 1997 to be $555,748,358.

(Step 2) The same document indicates that total losses (medical losses + indemnity losses) were 58.63% of premium.

(Step 3) In addition to access fees an insurer might not have had to pay but for the proposed regulation, some insurers have argued that the use by their insured employers of any number of non-recommended MCOs will complicate the claims processing and bill payment systems of those insurers who have chosen to use one MCO as a way to streamline procedures and cut costs. These types of expenses are reported under the current National Council on Compensation Insurance Statistical Plan as either "Allocated" or "Unallocated" Loss Adjustment Expenses. ALAE + ULAE for Missouri are 18.8% of total losses. (NCCI Voluntary Loss Cost filing, for January 1, 2000.)

(Step 4) However, not all loss adjustment expenses are connected to medical claims. Based on the experience of the NCCI, much more than half, say 75%, of ALAE is related to medical losses. Regarding ULAE, a reasonable split was estimated at 50% / 50%. Based on the NCCI Voluntary Loss Cost filing, effective January 1, 2000, this results in ALAE (9.9% x 75%) + ULAE (9.4% x 50%) = (.07425 + .047) = 12.125%, which means the medical component of LAE is (12.125 / 18.8) or 64.5% of total LAE.

(Step 5) Some insurers currently prefer to have their insured employers use a single MCO to handle work-related injuries or illnesses, while others recommend a use of a limited number of MCOs. Some insurers argue that they already have a contractual relationship with such "affiliated" MCOs and do not have to pay any individual access fees to that MCO. Under the proposed regulation, an employer would have the option of using an MCO different than one affiliated with his insurer. Based on the experience of one major carrier, selecting such a non-recommended MCO currently happens less than 5% of the time. The calculation in this fiscal note uses 5% because this carrier also permits employers to use other, non-affiliated MCOs, as permitted under the regulation. Thus, under the proposed regulation, 5% of medical claims may involve non-affiliated MCOs, and thus may require the payment of an access fee the insurer would otherwise not have had to pay.

(Step 6) Some insurers estimate that their loss adjustment expenses, such as claims handling and bill processing, expenses, will increase due to the regulation. Based on these concerns, provisions have been added to the proposed regulation which attempt to minimize such an effect (such as allowing insurers to use their own utilization review and case management personnel most of the time, and standardizing MCO billing procedures) This fiscal note assumes that the proposed regulation will at most increase the medical LAE by 50% for claims involving non-affiliated MCOs.

Additional Assumptions

This fiscal note does not estimate an impact on health care providers of the proposed regulation, for three reasons: 1) A central goal of the regulation is to assure that MCOs certified by the Department are reimbursed by insurers for MCO functions; while the department has received complaints in this regard, it has not received complaints regarding the refusal of insurers to pay health care providers. Therefore, the regulation assumes most providers are being reimbursed for their services if they are necessary and appropriate. 2) Certified MCOs have been in operation under the prior version of the proposed regulation since November 1, 1992; there are currently 21 active certified MCOs in Missouri. The fiscal note assumes that any health care providers who desired to join an MCO would already have done so and are therefore currently providing services at the discounted rates which would merely be continued under the proposed regulation. 3) Nothing in the regulation limits health care provider reimbursements to amounts less than that allowed by Section 287.140.3, RSMo, without the provider's consent. Providers are free to charge their usual and customary fees unless they voluntarily agree to discount those fees in a contract with an MCO.

This fiscal note also does not estimate an impact on insured employers. While the use of MCOs should help, in the aggregate, to reduce the medical losses and possibly the indemnity losses, the cost to employers of their workers' compensation insurance is determined by their insurers as part of the insurer's rate setting function, and it is up to insurers to decide whether and to what extent any savings realized will be passed on to employers. Unlike the prior version of this regulation, this version does not mandate a premium credit be given to employers using certified MCOs.

Exhibit A Certification Form

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 for a period of one calendar year unless 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 _____day of_____,_____.

_____
Director of Insurance

Exhibit B **MCO Disclosure/Participation Form (Side A)**

Date: _____

Insured Employer Name: _____

DBA: _____

Address: _____

City: _____ **County:** _____ **State:** _____ **Zip:** _____

Employer Contact Person Name and/or Title: _____

Telephone Number: _____

Fax Number: _____

E-Mail Address (if any): _____

Named Insurer: _____

Address: _____

City: _____ **County:** _____ **State:** _____ **Zip:** _____

Insurer Contact Person Name and/or Title: _____

Telephone Number: _____

Fax Number: _____

E-Mail Address (if any): _____

Policy Number: _____ **Policy Effective Dates:** _____ **to** _____

Certified Managed Care Organization: _____

Address: _____

City: _____ **County:** _____ **State:** _____ **Zip:** _____

Missouri Department of Insurance MCO Identification Number: _____

MCO Contact Person Name and/or Title: _____

Telephone Number: _____

Fax Number: _____

E-Mail Address (if any): _____

The above-named Missouri-certified workers' compensation Managed Care Organization and the above-named Insured Employer have entered into a contract, the form of which has been approved by the Missouri Department of Insurance, under which medical and rehabilitative treatments to injuries to the Insured Employer's employees compensable under the Missouri Workers' Compensation Law shall be directed to the Managed Care Organization's network of health care providers for treatment, under the Insured Employer's direction and control, in accordance with Section 287.140, RSMo.

Authorized Signatures: **For the Managed Care Organization:** _____

Title: _____

For the Insured Employer: _____

Title: _____

Exhibit B MCO Disclosure/Participation Form (Side B)

What to Consider When Choosing a Managed Care Organization (MCO)

Section 287.135, RSMo, provides for the certification by the department of MCOs designed to provide incentives to medical care providers to manage the cost and use of care associated with claims covered by workers' compensation insurance. In addition to assisting in the management and use of medical care, MCOs should also be able to render the following benefits to the workers' compensation system:

1. To injured employees, prompt and appropriate medical care through a system which coordinates and delivers that care so that the employee fully understands the process.

2. To employers, cost effective medical care to their injured employees which helps reduce workers' compensation losses in the aggregate, (as well as the experience modifications of experience-rated employers in particular), which helps avoid unnecessary litigation, and which helps return employees to work in an appropriate manner.

Under Section 287.140(10), RSMo, you the employer, not your insurer, have the right to select the physicians and other health care providers who provide the medical care to your injured employee. Selecting a certified MCO is one way for an employer to choose health care providers in advance of any injuries. You can receive a list of certified MCOs from the Missouri Department of Insurance by calling (573) 751-3365. Note: You are not *required* to use the services of an MCO, but if you do, you are limited to one MCO at a time for a given geographic area.

While one of the goals of using an MCO is to save on the cost of medical care, it should be understood that the savings realized by an individual employer may be higher or lower than the estimated savings for all employers using a particular workers' compensation MCO. In addition, some of the services listed on the attached fee disclosure list which the MCO is required to be able to provide, such as utilization review and case management, may also be available from your insurer as well; check with your insurer and with any MCO you are evaluating to determine how the two entities will coordinate their services to provide you with the most cost effective service possible.

When comparing MCOs, ask about:

1. The size and geographic area of their network of providers in relation to that of your business;
2. The type and quality of the providers in their network;
3. Who owns the MCO network and how that might affect your interests. (Is the MCO owned by health care providers, an insurance company, an independent entity, or is it a hybrid of two or more of these?);
4. The MCO's philosophy;
5. The possible savings you may realize by using the MCO and the possible costs. (Note: The amount of your premium is determined by your insurer, including any schedule rating debits or credits; your choice of an MCO may affect the premium charged by your insurer. Also, that portion of your premium determined by your experience modification factor —if you have one—is determined by a number of factors, including the frequency and severity of claims, only some of which are likely to be affected by the use of an MCO);
6. What arrangements, if any, the MCO and your insurer have made to coordinate care and avoid duplication of services to your injured workers; and
7. Verify that the particular health care providers you typically use are in the MCO's network or your insurer's network.

Remember, you, the employer, have the right to choose your MCO. You also have the right to change your mind and select a new MCO. Also remember to report any claims to your insurer.

Exhibit C **MCO/Insurer Coordination Form (Side A)**

Insured Employer Name: _____

DBA: _____

Address: _____

City: _____ **County:** _____ **State:** _____ **Zip:** _____

Employer Contact Person Name and/or Title: _____

Telephone Number: _____

Fax Number: _____

E-Mail Address (if any): _____

Insurance Company: _____

Address: _____

City: _____ **County:** _____ **State:** _____ **Zip:** _____

Insurer Contact Person Name and/or Title: _____

Telephone Number: _____

Fax Number: _____

E-Mail Address (if any): _____

Managed Care Organization: _____

Address: _____

City: _____ **County:** _____ **State:** _____ **Zip:** _____

MCO Contact Person Name and/or Title: _____

Telephone Number: _____

Fax Number: _____

E-Mail Address (if any): _____

Exhibit C **MCO/Insurer Coordination Form (Side B)**

Managed care services are to be provided by the entity designated below to avoid duplication of services and/or costs. (Indicate by placing an "X" in the appropriate column:)

	Insurance Co.	MCO
Precertification:	_____	_____
Prospective utilization review:	_____	_____
Concurrent utilization review:	_____	_____
Telephonic case management:	_____	_____
On-site case management:	_____	_____
Retrospective utilization review:	_____	_____
Provider bill auditing:	_____	_____
Hospital bill auditing:	_____	_____
Bill re-pricing:	_____	_____
Cost savings analysis:	_____	_____
Educational services for employer:	_____	_____
Continuing education for network providers and other personnel:	_____	_____
Data collection and reporting:	_____	_____

Insurance Company address to which re-priced medical bills are to be forwarded:

Address: _____

City: _____ **County:** _____ **State:** _____ **Zip:** _____

Insurance Company address to which MCO fees bills are to be forwarded:

Address: _____

City: _____ **County:** _____ **State:** _____ **Zip:** _____

Original First Report of Injury form and original medical reports and/or files are to be forwarded to the Insurance Company listed above, subject to the following instructions: