SENATE BILL NO. 16

INTRODUCED BY GAGE
BY REQUEST OF THE STATE AUDITOR

IN THE SENATE

DECEMBER 28, 1990	INTRODUCED AND REFERRED TO COMMITTEE ON BUSINESS & INDUSTRY.
JANUARY 7, 1991	FIRST READING.
JANUARY 11, 1991	COMMITTEE RECOMMEND BILL DO PASS AS AMENDED. REPORT ADOPTED.
JANUARY 12, 1991	PRINTING REPORT.
	SECOND READING, DO PASS.
JANUARY 14, 1991	ENGROSSING REPORT.
	THIRD READING, PASSED. AYES, 50; NOES, 0.
	TRANSMITTED TO HOUSE.

IN THE HOUSE

JANUARY 15, 1991	INTRODUCED AND REFERRED TO COMMITTEE ON BUSINESS & ECONOMIC DEVELOPMENT.
	FIRST READING.
APRIL 2, 1991	COMMITTEE RECOMMEND BILL BE CONCURRED IN. REPORT ADOPTED.
APRIL 5, 1991	SECOND READING, CONCURRED IN AS AMENDED.
APRIL 6, 1991	THIRD READING, CONCURRED IN. AYES, 92; NOES, 2.
	RETURNED TO SENATE WITH AMENDMENTS.

IN THE SENATE

APRIL 6, 1991	RECEIVED FROM HOUSE.
APRIL 9, 1991	ON MOTION, CONSIDERATION PASSED UNTIL THE 76TH LEGISLATIVE DAY.

APRIL 17, 1991	SECOND READING, AMENDMENTS NOT CONCURRED IN.
	ON MOTION, CONFERENCE COMMITTEE REQUESTED.
APRIL 18, 1991	CONFERENCE COMMITTEE APPOINTED.
APRIL 19, 1991	ON MOTION, CONFERENCE COMMITTEE DISSOLVED.
	ON MOTION, FREE CONFERENCE COMMITTEE REQUESTED AND APPOINTED.
	IN THE HOUSE
APRIL 22, 1991	ON MOTION, FREE CONFERENCE COMMITTEE REQUESTED AND APPOINTED.
	IN THE SENATE
APRIL 23, 1991	FREE CONFERENCE COMMITTEE REPORTED.
APRIL 24, 1991	SECOND READING, FREE CONFERENCE COMMITTEE REPORT ADOPTED.
APRIL 24, 1991	THIRD READING, FREE CONFERENCE COMMITTEE REPORT ADOPTED.
	IN THE HOUSE
APRIL 24, 1991	FREE CONFERENCE COMMITTEE REPORT ADOPTED.
	IN THE SENATE
APRIL 29, 1991	SENT TO ENROLLING.
	REPORTED CORRECTLY ENROLLED.

SENATE BILL NO. 16

INTRODUCED BY GAGE

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT TO GENERALLY REVISE THE LAWS RELATING TO THE REGULATION OF INSURERS AND MOTOR CLUB SERVICE COMPANIES; DIRECTING THE CODE COMMISSIONER TO CHANGE ANY REFERENCE TO THE TERM "SOLICITOR" TO "INSURANCE PRODUCER" WHEREVER IT APPEARS IN THE MONTANA CODE ANNOTATED; AND AMENDING SECTIONS 33-1-711, 33-2-705, 33-2-708, 33-2-709, 33-3-401, 33-3-431, 33-7-406, 33-17-208, 33-17-603, 33-20-303, 33-20-305, 33-22-502, 33-22-921, 33-22-923, 33-22-924, 33-22-1501, 33-22-1504, 33-22-1513, 33-22-1704, 33-23-302, 61-12-303, 61-12-304, AND 61-12-305, MCA."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 33-1-711, MCA, is amended to read:

"**33-1-711. Appeals from the commissioner.** (1) An appeal from the commissioner may be taken only from an order on hearing or with respect to a matter as to which the commissioner has refused a hearing. Any person who was a party to the hearing or whose pecuniary interests are directly and immediately affected by any order or refusal and who is aggrieved by an order or refusal may, within 30

days after the order has been mailed or delivered to the persons entitled to receive the same, the commissioner's order denying rehearing or reargument has been so mailed or delivered, or the commissioner's refusal to grant a hearing, appeal from the order on hearing or the refusal of a hearing. Any request for a stay of the commissioner's order must be made within 60 days, to run concurrently with the 30 days for appeal. The appeal must be taken to the district court of Lewis and Clark County by filing written notice of appeal in the court and by filing a copy of the notice with the commissioner, except that in appeals from the suspension or revocation of the certificate of authority of a domestic insurer or of the license of an insurance producer or surplus lines insurance producer, the person taking the appeal may at his option, in lieu of the district court of Lewis and Clark County, take the appeal to the district court of the county of Montana in which the insurer has its principal place of business or the licensee resides.

(2) Upon filing of the notice of appeal, the court has full jurisdiction and shall determine whether the filing operates as a stay of the order or action appealed from.

(3) Within 20 days after filing of the copy of the notice of appeal in his office, the commissioner shall make and return to the court in which the appeal is pending a copy of his order appealed from and a full and complete

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transcript, duly certified by the commissioner, of his record of the hearing upon which the order was issued, together with all exhibits and documentary evidence introduced at the hearing. If the appeal is from an action of the commissioner with respect to which a hearing was refused, the commissioner shall, within the 20-day period, make and return to the court a full and complete transcript, duly certified by him, of all documents on file in his office directly relating to the matter as to which the appeal is taken.

(4) Upon receipt of the transcripts and evidence, the court shall hear the matter de novo as soon as reasonably possible thereafter. Upon the hearing of the appeal, the court shall consider the evidence contained in the transcript, exhibits, and documents filed by the commissioner, together with additional proper evidence as may be offered by any party to the appeal.

(5) After hearing the appeal, the court may affirm, modify, or reverse the order or action of the commissioner, in whole or in part, or remand the action to the commissioner for further proceedings in accordance with the court's direction.

(6) Costs must be awarded as in civil actions.

(7) Appeal may be taken to the supreme court from the judgment of the district court as in other civil cases to

which the state is a party. A stay of the effectiveness of any judgment may be made only by order of the supreme court upon the giving of security as that court considers proper.

(8) This section does not apply to appeals as to matters covered by chapter 16."

Section 2. Section 33-2-705, MCA, is amended to read:

"**33-2-705. Report on premiums and other consideration -- tax.** (1) Each authorized insurer and each formerly authorized insurer with respect to premiums so received while an authorized insurer in this state shall file with the commissioner, on or before March 1 each year, a report in form as prescribed by the commissioner showing total direct premium income, including policy, membership, and other fees, premiums paid by application of dividends, refunds, savings, savings coupons, and similar returns or credits to payment of premiums for new or additional or extended or renewed insurance, charges for payment of premium in installments, and all other consideration for insurance from all kinds and classes of insurance, whether designated as a premium or otherwise, received by ~~it~~ a life insurer or written by an insurer other than a life insurer during the preceding calendar year on account of policies covering property, subjects, or risks located, resident, or to be performed in Montana, with proper proportionate allocation of premium as to such property, subjects, or

risks in Montana insured under policies or contracts covering property, subjects, or risks located or resident in more than one state, after deducting from such total direct premium income applicable cancellations, returned premiums, the unabsorbed portion of any deposit premium, the amount of reduction in or refund of premiums allowed to industrial life policyholders for payment of premiums direct to an office of the insurer, all policy dividends, refunds, savings, savings coupons, and other similar returns paid or credited to policyholders with respect to such policies. As to title insurance, "premium" includes the total charge for such insurance. No deduction shall be made of the cash surrender values of policies. Considerations received on annuity contracts shall not be included in total direct premium income and shall not be subject to tax.

(2) Coincident with the filing of the tax report referred to in subsection (1) above, each such insurer shall pay to the commissioner a tax upon such net premiums computed at the rate of 2 3/4%.

(3) That portion of the tax paid hereunder by an insurer on account of premiums received for fire insurance shall be separately specified in the report as required by the commissioner, for apportionment as provided by law. Where insurance against fire is included with insurance of property against other perils at an undivided premium, the

insurer shall make such reasonable allocation from such entire premium to the fire portion of the coverage as shall be stated in such report and as may be approved or accepted by the commissioner.

(4) With respect to authorized insurers the premium tax provided by this section shall be payment in full and in lieu of all other demands for any and all state, county, city, district, municipal, and school taxes, licenses, fees, and excises of whatever kind or character, excepting only those prescribed by this code, taxes on real and tangible personal property located in this state, and taxes payable under 50-3-109.

(5) The commissioner may suspend or revoke the certificate of authority of any insurer which fails to pay its taxes as required under this section.

(6) In addition to the penalty provided for in subsection (5), the commissioner may impose upon an insurer who fails to pay the tax required under this section a fine of $100 a day for each day the tax remains unpaid past the due date or 1% of the amount owed in tax, whichever is greater.

(7) The commissioner may by rule provide a quarterly schedule for payment of portions of the premium tax under this section during the year in which such tax liability is accrued."

Section 3. Section 33-2-708, MCA, is amended to read:

"**33-2-708. Fees and licenses.** (1) Except as provided in 33-17-212(2), the commissioner shall collect in advance and the persons served shall pay to the commissioner the following fees:

(a) certificates of authority:

(i) for filing applications for original certificates of authority, articles of incorporation (except original articles of incorporation of domestic insurers as provided in subsection (1)(b)) and other charter documents, bylaws, financial statement, examination report, power of attorney to the commissioner, and all other documents and filings required in connection with the application and for issuance of an original certificate of authority, if issued:

(A) domestic insurers ..... $ 600.00

(B) foreign insurers 600.00

(ii) annual continuation of certificate of authority 600.00

(iii) reinstatement of certificate of authority 25.00

(iv) amendment of certificate of authority 50.00

(b) articles of incorporation:

(i) filing original articles of incorporation of a domestic insurer, exclusive of fees required to be paid by the corporation to the secretary of state 20.00

(ii) filing amendment of articles of incorporation, domestic and foreign insurers, exclusive of fees required to be paid to the secretary of state by a domestic corporation 25.00

(c) filing bylaws or amendment to bylaws where required 10.00

(d) filing annual statement of insurer, other than as part of application for original certificate of authority 25.00

(e) insurance producer's license:

(i) application for original license, including issuance of license, if issued 15.00

(ii) appointment of insurance producer, each insurer 10.00

(iii) temporary license 15.00

(iv) amendment of license (excluding additions to license) or reissuance of master license 15.00

(f) nonresident insurance producer's license:

(i) application for original license, including issuance of license, if issued 100.00

(ii) appointment of insurance producer, each insurer 10.00

(iii) annual renewal of license 10.00

(iv) amendment of license (excluding additions to license) or reissuance of master license 10.00

(g) examination, if administered by the commissioner, for license as insurance producer, each examination 15.00

(h) surplus lines insurance producer license:

(i) application for original license and for issuance of license, if issued 50.00

(ii) annual renewal of license 50.00

(i) adjuster's license:

(i) application for original license and for issuance of license, if issued 15.00

(ii) annual renewal of license 15.00

(j) insurance vending machine license, each machine, each year 10.00

(k) commissioner's certificate under seal (except when on certificates of authority or licenses) 10.00

(l) copies of documents on file in the commissioner's office, per page ..... .50

(m) policy forms:

(i) filing each policy form 25.00

(ii) filing each application, rider, endorsement, amendment, insert page, schedule of rates, and clarification of risks 10.00

(iii) maximum charge if policy and all forms submitted at one time or resubmitted for approval within 180 days 100.00

(n) applications for approval of prelicensing education courses:

(i) reviewing initial application 150.00

(ii) periodic review 50.00

(2) The commissioner shall promptly deposit with the state treasurer to the credit of the general fund of this state all fines and penalties, those amounts received pursuant to 33-2-311, 33-2-705, and 33-2-706, and any fees and examination and miscellaneous charges that are collected by him pursuant to Title 33 and the rules adopted under Title 33.

(3) All fees are considered fully earned when received. In the event of overpayment, only those amounts in excess of $10 will be refunded."

Section 4. Section 33-2-709, MCA, is amended to read:

"**33-2-709. Retaliatory fees, taxes, and other obligations.** (1) When by or pursuant to the laws of any other state or foreign country any taxes, licenses, and other fees, in the aggregate, and any fines, penalties, deposit requirements, or other material obligations, prohibitions, or restrictions are or would be imposed upon Montana insurers or upon the insurance producers or representatives of such insurers which are in excess of such taxes, licenses, and other fees, in the aggregate, or which are in excess of the fines, penalties, deposit requirements,

or other obligations, prohibitions, or restrictions directly imposed upon similar insurers or upon the insurance producers or representatives of such insurers of such other state or country under the statutes of this state, so long as such laws of such other state or country continue in force or are so applied, the same taxes, licenses, and other fees, in the aggregate, or fines, penalties, or deposit requirements or other material obligations, prohibitions, or restrictions of whatever kind shall be imposed by the commissioner upon the insurers or upon the insurance producers or representatives of such insurers of such other state or country doing business or seeking to do business in Montana. Any tax, license, or other fee or other obligation imposed by any city, county, or other political subdivision or agency of such other state or country on Montana insurers or their insurance producers or representatives shall be deemed to be imposed by such state or country within the meaning of this section.

(2) This section shall not apply as to any fees in conjunction with the licensing of insurance producers, personal income taxes, ad valorem taxes on real or personal property, or special purpose obligations or assessments imposed by another state or by an agency of this state other than the department in connection with particular kinds of insurance other than property insurance, except that

deductions from premium taxes or other taxes otherwise payable allowed on account of real estate or personal property taxes paid shall be taken into consideration by the commissioner in determining the propriety and extent of retaliatory action under this section.

(3) (a) For the purposes of this section the domicile of an alien insurer, other than insurers formed under the laws of Canada, shall be that state designated by the insurer in writing filed with the commissioner at time of admission to this state or within 6 months after January 1, 1961, whichever date is the later, and may be any one of the following states:

(i) that in which the insurer was first authorized to transact insurance;

(ii) that in which is located the insurer's principal place of business in the United States;

(iii) that in which is held the larger deposit of trusteed assets of the insurer for the protection of its policyholders and creditors in the United States.

(b) If the insurer makes no such designation, its domicile shall be deemed to be that state in which is located its principal place of business in the United States."

Section 5. Section 33-3-401, MCA, is amended to read:

"33-3-401. Home office and records -- penalty for

unlawful removal of records or assets. (1) Every domestic insurer shall have and maintain its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary or suitable as to the kind or kinds of insurance transacted. Records of the insurer's operations and other financial records reasonably related to its insurance operations for the preceding 5 years must be maintained and be available to the commissioner or his duly constituted examiner.

(2) Every domestic insurer shall have and maintain its assets in this state, except as to:

(a) real property and personal property appurtenant thereto lawfully owned by the insurer and located outside this state; and

(b) such property of the insurer as may be customary, necessary, and convenient to enable and facilitate the operation of its branch offices and regional home offices located outside this state as referred to in subsection (4) below.

(3) Removal of all or a material part of the records or assets of a domestic insurer from this state except pursuant to a plan of merger or consolidation approved by the commissioner under this code or for such reasonable purposes

and periods of time as may be approved by the commissioner in writing in advance of such removal or concealment of such records or assets or material part thereof from the commissioner is prohibited. Any person who removes or attempts to remove such records or assets or such material part thereof from the home office or other place of business or of safekeeping of the insurer in this state with the intent to remove the same from this state or who conceals or attempts to conceal the same from the commissioner, in violation of this subsection, shall upon conviction thereof be guilty of a felony punishable by a fine of not more than $10,000 or by imprisonment in the penitentiary for not more than 5 years or by both such fine and imprisonment in the discretion of the court. Upon any removal or attempted removal of such records or assets or upon retention of such records or assets or material part thereof outside this state beyond the period therefor specified in the commissioner's consent under which the records were so removed thereat or upon concealment of or attempt to conceal records or assets in violation of this section, the commissioner may institute delinquency proceedings against the insurer pursuant to the provisions of chapter 2, part 13.

(4) This section shall not be deemed to prohibit or prevent an insurer from:

(a) establishing and maintaining branch offices or regional home offices in other states where necessary or convenient to the transaction of its business and keeping therein the detailed records and assets customary and necessary for the servicing of its insurance in force and affairs in the territory served by such an office, as long as such records and assets are made readily available at such office for examination by the commissioner at his request;

(b) having, depositing, or transmitting funds and assets of the insurer in or to jurisdictions outside of this state as reasonably and customarily required in the regular course of its business;

(c) making deposits under custodial arrangements as provided by 33-2-604(3)."

Section 6. Section 33-3-431, MCA, is amended to read:

"**33-3-431. Borrowed surplus.** (1) A domestic stock or mutual insurer may borrow money to defray the expenses of its organization, provide it with surplus funds, or for any purpose of its business, upon a written agreement that such money is required to be repaid only out of the insurer's surplus in excess of that stipulated in such agreement. The agreement may provide for interest ~~not--exceeding--6%--per annum~~ at a rate no greater than the rate established in 25-9-205, which interest shall or shall not constitute a

liability of the insurer as to its funds other than such excess of surplus, as stipulated in the agreement. No commission or promotion expense shall be paid in connection with any such loan.

(2) Money so borrowed, together with the interest thereon if so stipulated in the agreement, shall not form a part of the insurer's legal liabilities except as to its surplus in excess of the amount thereof stipulated in the agreement or be the basis of any setoff; but until repaid, financial statements filed or published by the insurer shall show as a footnote thereto the amount thereof then unpaid together with any interest thereon accrued but unpaid.

(3) Any such loan to a mutual insurer shall be subject to the commissioner's approval. The insurer shall, in advance of the loan, file with the commissioner a statement of the purpose of the loan and a copy of the proposed loan agreement. The loan and agreement shall be deemed approved unless within 15 days after date of such filing the insurer is notified of the commissioner's disapproval and the reasons therefor. The commissioner shall disapprove any proposed loan or agreement if he finds the loan is unnecessary or excessive for the purpose intended or that the terms of the loan agreement are not fair and equitable to the parties, and to other similar lenders, if any, to the insurer, or that the information so filed by the insurer is

inadequate.

(4) Any such loan to a mutual insurer or substantial portion thereof shall be repaid by the insurer when no longer reasonably necessary for the purpose originally intended. No repayment of such loan shall be made by a mutual insurer unless in advance approved by the commissioner.

(5) This section shall not apply to loans obtained by the insurer in ordinary course of business from banks and other financial institutions or to loans secured by pledge or mortgage of assets."

Section 7. Section 33-7-406, MCA, is amended to read:

"33-7-406. Annual statement -- penalty for failure to file ~~or--to-comply. A-society-neglecting-to-file-the-annual statement-in-the-form-and-within-the-time-provided--in--this part-shall-forfeit~~ The commissioner may impose a fine upon a society not to exceed $100 for each day ~~during-which-such neglect-continues,-and,-upon-notice-by-the--commissioner--to that--effect,--its--authority--to--do-business-in-this-state shall-cease-while-such-default-continues~~ after March 1 that a society fails to file the annual statement required by 33-7-404. The fine may not exceed $1,000."

Section 8. Section 33-17-208, MCA, is amended to read:

"33-17-208. Prelicensing education -- basic requirement. (1) (a) A person applying for a license to act

as an insurance producer for property, casualty, and surety insurance shall complete 40 hours of approved prelicensing education courses in those areas of insurance within 12 months prior to the examination, unless he is exempted from the requirement under subsection (3).

(b) A person applying for a license to act as an insurance producer for life and disability insurance or as an enrollment representative for a health service corporation shall complete 40 hours of approved prelicensing education courses in those areas of insurance within 12 months prior to the examination, unless he is exempted from the requirement under subsection (3).

(2) A person applying for licenses to act as an insurance producer for both the property, casualty, and surety areas and the life and or disability areas must meet the education requirements in all the areas of insurance.

(3) The minimum prelicensing education requirement does not apply to a person who:

(a) has been licensed within the 12 preceding months as an insurance producer in another state that requires prelicensing education and has completed the education in the other state;

(b) seeks a nonresident license, having been licensed as an insurance provider in his state of residence for at least 1 year;

(c) seeks a nonresident license and is from a state having a prelicensing education requirement;

(d) seeks to reinstate a license lapsed for less than 2 years;

(e) seeks a temporary license under 33-17-216; or

(f) is exempt from examination requirements under 33-17-212~~(5)~~(7)."

Section 9. Section 33-17-603, MCA, is amended to read:

"33-17-603. Certificate of registration. (1) Except as provided in 33-17-604, a person may not act as or hold himself out to be an administrator in this state unless he holds a certificate of registration as an administrator.

(2) An application for a certificate of registration must be accompanied by a fee of $100. The commissioner shall issue the certificate unless he finds that the applicant is not competent, trustworthy, financially responsible, or of good personal and business reputation or that the applicant has had a previous application for a license denied for cause within 5 years.

(3) The certificate of registration is renewable annually on ~~the date of issue~~ July 1. A request for renewal must be accompanied by a renewal fee of $100.

(4) The certificate of registration may be suspended or revoked if, after notice and hearing, the commissioner finds that the administrator has violated any of the requirements

of this part or that the administrator is not competent, trustworthy, financially responsible, or of good personal and business reputation.

(5) Unless the certification requirement is waived, a person who acts as an administrator without a certificate of registration is subject to a fine of not less than $500 or more than $1,500."

Section 10. Section 33-20-303, MCA, is amended to read:

"33-20-303. Incontestability. If any statements other than those relating to age~~, sex~~, and identity are required as a condition to issuing an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, and subject to 33-20-305, there shall be a provision that the contract shall be incontestable after it has been in force during the lifetime of the person or of each of the persons as to whom such statements are required, for a period of 2 years from its date of issue, except for nonpayment of stipulated payments to the insurer; and at the option of the insurer such contract may also except any provisions relative to benefits in the event of disability and any provisions which grant insurance specifically against death by accident or accidental means."

Section 11. Section 33-20-305, MCA, is amended to read:

"33-20-305. Misstatement of age or sex. In an annuity or pure endowment contract, other than a reversionary,

survivorship, or group annuity, there shall be a provision that if the age ~~or sex~~ of the person or persons upon whose life or lives the contract is made, or of any of them, has been misstated, the amount payable or benefits accruing under the contract shall be such as the stipulated payment or payments to the insurer would have purchased according to the correct age ~~or sex~~ and that if the insurer shall make or has made any overpayment or overpayments on account of any such misstatement, the amount thereof, with interest at the rate to be specified in the contract but not exceeding 6% per annum, may be charged against the current or next succeeding payment or payments to be made by the insurer under the contract."

Section 12. Section 33-22-502, MCA, is amended to read:

"**33-22-502. Required provisions of group policies.** Each ~~such~~ group disability insurance policy ~~shall~~ delivered or issued for delivery in this state must contain in substance the following provisions:

(1) a provision that, in the absence of fraud, all statements made by applicants or the policyholder or by an insured person shall be deemed representations and not warranties and that no statement made for the purpose of effecting insurance shall avoid such insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has

been furnished to such policyholder or to such person or his beneficiary;

(2) a provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group a statement in summary form of the essential features of the insurance coverage of such employee or member and to whom benefits thereunder are payable. If dependents are included in the coverage, only one certificate need be issued for each family unit.

(3) a provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.

(4) a provision that reads:

Conformity with state statutes. A provision of this policy that on its effective date conflicts with the statutes of the state in which the insured resides on that date is hereby amended to conform to the minimum requirements of those statutes."

Section 13. Section 33-22-921, MCA, is amended to read:

"**33-22-921. Discontinuance or nonrenewal -- alternate policy or certificate -- same insurer.** (1) If a disability insurer discontinues or does not renew a medicare supplement policy product or certificate and offers an alternate medicare supplement policy or certificate to its insureds

within this state, it may not deny benefits under the replacing policy or certificate to an insured who receives treatment for a condition that was a covered expense under the replaced policy or certificate and is a covered expense under the replacing policy or certificate if the insured enrolls in and pays the premium for the replacing policy or certificate within 31 days after the termination of the replaced policy or certificate.

(2) A disability insurer who discontinues or does not renew a medicare supplement policy product or certificate and offers an alternate medicare supplement policy or certificate shall base its premium for the alternate policy or certificate on the rates currently in place for that policy or certificate.

(3) If the insured has not satisfied the preexisting condition limitation under the replaced medicare supplement policy or certificate, any period of time that was covered by that policy or certificate must be credited toward the preexisting condition limitation period of the replacing policy or certificate."

Section 14. Section 33-22-923, MCA, is amended to read:

"**33-22-923. Replacement policy** or certificate -- **different insurer.** (1) If a disability insurer replaces a medicare supplement policy or certificate, it may not deny benefits under the replacing policy or certificate to an

insured who receives treatment for a condition that was a covered expense under the replaced policy or certificate and is a covered expense under the replacing policy or certificate if the insured pays the premium for the replacing policy or certificate when due or within 31 days after the termination of the replaced policy or certificate.

(2) An insurer who replaces a medicare supplement policy or certificate shall base its premium for the replacement policy or certificate on the rates currently in place for that policy or certificate.

(3) If the insured has not satisfied the preexisting condition limitation under the replaced medicare supplement policy or certificate, any period of time that was covered by that policy or certificate must be credited toward the preexisting condition limitation period of the replacing policy or certificate.

(4) To receive the benefits of subsections (1) through (3), a person shall submit to the replacing insurer proof of prior coverage, evidence of benefits provided under the previous policy or certificate, and the effective date and the date of termination of coverage under the previous policy or certificate."

Section 15. Section 33-22-924, MCA, is amended to read:

"**33-22-924. Renewal requirement.** (1) If a person pays a renewal premium on the date it is due or within 31 days

after it is due, an insurer may not refuse to renew a medicare supplement policy or certificate unless the insurer:

(a) refuses to renew all policies or certificates in this state that are of the same form and issued to persons of the same class; and

(b) offers a replacement policy or certificate at actuarially justified rates.

(2) If an insurer refuses to renew all policies or certificates in this state that are of the same form and issued to persons of the same class, the policies or certificates will remain in force during the grace period stated in the replaced policy or certificate. An insurer's refusal to renew a policy or certificate may not affect a claim that arose under the ~~replaced~~ discontinued policy or certificate during the period in which an insured was confined without interruption to a medical care facility for treatment."

Section 16. Section 33-22-1501, MCA, is amended to read:

"33-22-1501. Definitions. As used in this part, the following definitions apply:

(1) "Association" means the comprehensive health association created by 33-22-1503.

(2) "Association plan" means a policy of insurance

coverage offered by the association through the lead carrier.

(3) "Association plan premium" means the charge determined pursuant to 33-22-1512 for membership in the association plan based on the benefits provided in 33-22-1521.

(4) "Eligible person" means an individual who:

(a) is a resident of this state and applies for coverage under the association plan; and

(b) unless the individual's eligibility is waived by the association, within 6 months prior to the date of application, has been rejected for disability insurance or health service benefits by at least two insurers, societies, or health service corporations, or has had a restrictive rider or preexisting conditions limitation, which limitation is required by at least two insurers, societies, or health service corporations, which has the effect of substantially reducing coverage from that received by a person considered a standard risk.

(5) "Health service corporation" means a corporation operating pursuant to Title 33, chapter 30, and offering or selling contracts of disability insurance.

(6) "Insurance arrangement" means any plan, program, contract, or other arrangement to the extent not exempt from inclusion by virtue of the provisions of the federal

Employee Retirement Income Security Act of 1974 under which one or more employers, unions, or other organizations provide to their employees or members, either directly or indirectly through a trust of a third-party administrator, health care services or benefits other than through an insurer.

(7) "Insurer" means a company operating pursuant to Title 33, chapter 2 or 3, and offering or selling policies or contracts of disability insurance, as provided in Title 33, chapter 22.

(8) "Lead carrier" means the licensed administrator or insurer selected by the association to administer the association plan.

(9) "Preexisting condition" means any condition for which an applicant for coverage under the association plan has received medical attention during the 5 years immediately preceding the filing of an application.

(10) "Qualified plan" means those health benefit plans certified by the commissioner as providing the minimum benefits required by 33-22-1521 or the actuarial equivalent of those benefits.

(11) "Society" means a fraternal benefit society operating pursuant to Title 33, chapter 7, and offering or selling certificates of disability insurance."

Section 17. Section 33-22-1504, MCA, is amended to

read:

"33-22-1504. Association board of directors -- organization. (1) There is a board of directors of the association, consisting of eight individuals:

(a) one from each of the seven participating members of the association with the highest annual premium volume of disability insurance contracts or health service corporation contracts, derived from or on behalf of residents in the previous calendar year, as determined by the commissioner; and

(b) a member at large, appointed by the commissioner to represent the public interest, who shall serve in an advisory capacity only.

(2) Each of the seven board members representing the association members is entitled to a weighted average vote, in person or by proxy, based on the association member's annual Montana premium volume. However, a board member may not have more than 50% of the vote.

(3) Members of the board may be reimbursed from the money of the association for expenses incurred by them due to their service as board members but may not otherwise be compensated by the association for their services. The costs of conducting the meetings of the association and its board of directors must be borne by participating members of the association in accordance with 33-22-1513."

Section 18. Section 33-22-1513, MCA, is amended to read:

"**33-22-1513. Operation of association plan.** (1) Upon acceptance by the lead carrier under 33-22-1516, an eligible person may enroll in the association plan by payment of the association plan premium to the lead carrier.

(2) Not less than 88% of the association plan premiums paid to the lead carrier may be used to pay claims and not more than 12% may be used for payment of the lead carrier's direct and indirect expenses as specified in 33-22-1514.

(3) Any income in excess of the costs incurred by the association in providing reinsurance or administrative services must be held at interest and used by the association to offset past and future losses due to claims expenses of the association plan or be allocated to reduce association plan premiums.

(4) (a) Each participating member of the association shall share the losses due to claims expenses of the association plan for plans issued or approved for issuance by the association and shall share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs. Claims expenses of the association plan that exceed the premium payments allocated to the payment of benefits are the liability of the association members. Association

members shall share in the claims expenses of the association plan and operating and administrative expenses of the association in an amount equal to the ratio of:

~~(a)~~(i) the association member's total disability insurance premium received from or on behalf of Montana residents divided by;

~~(b)~~(ii) the total disability premium received by all association members from or on behalf of Montana residents, as determined by the commissioner.

(b) For purposes of this subsection (4), "total disability insurance premium" does not include premiums received from disability income insurance, credit disability insurance, disability waiver insurance, or life insurance.

(5) The association shall make an annual determination of each association member's liability, if any, and may make an annual fiscal yearend assessment if necessary. The association may also, subject to the approval of the commissioner, provide for interim assessments against the association members as may be necessary to assure the financial capability of the association in meeting the incurred or estimated claims expenses of the association plan and operating and administrative expenses of the association until the association's next annual fiscal yearend assessment. Payment of an assessment is due within 30 days of receipt by an association member of a written

notice of a fiscal yearend or interim assessment. Failure by a contributing member to tender to the association the assessment within 30 days is grounds for termination of membership. An association member that ceases to do disability insurance business within the state remains liable for assessments through the calendar year during which disability insurance business ceased. The association may decline to levy an assessment against an association member if the assessment, as determined pursuant to this section, would not exceed $10.

(6) Any annual fiscal yearend or interim assessment levied against an association member may be offset, in an amount equal to the assessment paid to the association, against the premium tax payable by that association member pursuant to 33-2-705 for the year in which the annual fiscal yearend or interim assessment is levied. The insurance commissioner shall, each year the legislature meets in regular session, on or before January 15, report to the legislature the total amount of premium tax offset claimed by association members during the preceding biennium."

Section 19. Section 33-22-1704, MCA, is amended to read:

"**33-22-1704. Preferred provider agreements authorized.** (1) Notwithstanding any other provision of law to the contrary, a health care insurer may:

(a) enter into agreements with providers relating to health care services that may be rendered to insureds or subscribers on whose behalf the health care insurer is providing health care coverage, including preferred provider agreements relating to:

(i) the amounts an insured may be charged for services rendered; and

(ii) the amount and manner of payment to the provider; and

(b) issue or administer policies or subscriber contracts in this state that include incentives for the insured to use the services of a provider that has entered into an agreement with the insurer pursuant to subsection (1)(a).

(2) A preferred provider agreement issued or delivered in this state may not unfairly deny health benefits for health care services covered.

(3) ~~This part does not require that an insurer negotiate or enter into agreements with any specific provider or class of providers.~~ Health care insurers may place reasonable limits on the number or classes of preferred providers that satisfy the standards set forth by the health care insurer. However, insurers may not discriminate against providers on the basis of religion, race, color, national origin, age, sex, or marital status

and shall select preferred providers primarily on but not limited to cost and availability of covered services and the quality of services performed by the providers."

Section 20. Section 33-23-302, MCA, is amended to read:

"**33-23-302. Cancellation or** alteration of policy -- **increase of premium rates -- sixty days' written notice required.** Any insurer who insures a physician and surgeon, dentist, registered nurse, nursing home administrator, registered physical therapist, podiatrist, licensed psychologist, osteopath, chiropractor, pharmacist, optometrist, or veterinarian, duly licensed ~~as--such~~ under the laws of this state, or a licensed hospital or long-term care facility as the employer of any such person against liability for error, omission, professional negligence, or performance of services without consent ~~shall~~ may not cancel or alter the policy ~~so~~ insuring ~~such~~ the person or increase the premium rates thereon without first providing the insured 60 days' written notice of the insurer's intention to cancel or alter the policy or increase the premium rates."

Section 21. Section 61-12-303, MCA, is amended to read:

"**61-12-303. Requirements for license.** (1) ~~No-license shall-be-issued-by-the~~ The commissioner may not issue a license to a company until the company has filed with him the following:

(a) a formal application in such form and detail as the commissioner may require, executed under oath by its president or other principal officer;

(b) a copy of the form of its contract;

(c) a certified copy of its charter or articles of incorporation and its bylaws, if any;

(d) a financial statement in such form and detail as the commissioner may require, executed on oath by its president or other principal officer;

(e) a certificate from the ~~state-treasurer~~ commissioner that it has complied with 61-12-304 in all cases where a deposit of cash or a bond is required by this part;

(f) a certificate from the corporation commissioner of the state of Montana, in the event it be a corporation, that it has complied with the corporation laws of said state.

(2) ~~No-license-shall-be-issued-by-the~~ The commissioner may not issue a license to a company until the company has paid to the commissioner $100 as an annual license fee, or the pro rata portion thereof necessary to be paid to the end of the current calendar year from the date of the application for ~~such~~ the license.

(3) ~~No-license-shall-be-issued-by-the~~ The commissioner may not issue a license until the company has satisfied him by ~~such~~ an examination ~~as-he-may-make~~ and ~~such~~ evidence ~~as he~~ the commissioner may require, in his discretion, that

such the company has complied with the laws of the state of Montana and that its management is trustworthy and competent."

Section 22. Section 61-12-304, MCA, is amended to read:

"61-12-304. Deposits required. No--license--shall--be granted The commissioner may not grant a license to a company as-herein-defined-except-as-hereinafter-stated until it has deposited with the state-treasurer commissioner the sum of $25,000 in cash or in lieu thereof a bond in a form prescribed by the commissioner payable to the state of Montana in the sum of $25,000, with surety approved by the commissioner, conditioned upon the faithful performance of its service contracts and payment of any fines or penalties levied against it for failure to comply with this part; provided,-however,--that. However, when any company,--as herein--defined,-shall-prove proves to the commissioner that it has been in continuous, active operation in the state for a period of more than the preceding 5 years immediately-last past and has a paid membership of more than 5,000 members within the state or that there are more than 5,000 holders of its service contracts within the state and that it is being properly managed, is rendering to its members the services promised to them, and is financially responsible, no--such a cash deposit or bond shall-be is not required while such the company remains in such that condition. The

foregoing cash deposit or bond is not required-in-any instance-as a penalty, but is for the protection of the public only."

Section 23. Section 61-12-305, MCA, is amended to read:

"61-12-305. Expiration Continuance of license. Every Subject to payment by January 1 of each year of the annual license fee required under 61-12-303, each license issued hereunder-shall-expire-annually-on-January-1--of--each--year unless--sooner continues in force as long as the company is entitled to the license under this part or until the license is revoked, or suspended, as--hereinafter--provided or otherwise terminated."

NEW SECTION. **Section 24.** Policy provisions -- conformity with state statutes. Each policy regulated by this part must contain a provision as follows:

Conformity with state statutes. A provision of this policy that on its effective date conflicts with the statutes of the state in which the insured resides on that date is hereby amended to conform to the minimum requirements of those statutes.

NEW SECTION. **Section 25.** Casualty insurance policy -- conformity with state statutes. A casualty insurance policy relative to a risk resident, located, or to be performed in this state must contain a provision as follows:

Conformity with state statutes. A provision of this

policy that on its effective date conflicts with the statutes of the state in which the insured resides on that date is hereby amended to conform to the minimum requirements of those statutes.

NEW SECTION. **Section 26.** **Property insurance policy -- conformity with state statutes.** A property insurance policy relative to a risk resident, located, or to be performed in this state must contain a provision as follows:

Conformity with state statutes. A provision of this policy that on its effective date conflicts with the statutes of the state in which the insured resides on that date is hereby amended to conform to the minimum requirements of those statutes.

NEW SECTION. **Section 27.** **Name change -- short form amendment.** Wherever it appears in 33-7-519, 33-17-206, 33-18-210, and 33-18-501 or in insurance laws enacted by the 52nd legislature, the code commissioner is directed to change the term "solicitor" to "insurance producer".

NEW SECTION. **Section 28.** **Codification instruction.** (1) [Section 24] is intended to be codified as an integral part of Title 33, chapter 20, parts 1 and 12, and the provisions of Title 33, chapter 20, parts 1 and 12, apply to [section 24].

(2) [Section 25] is intended to be codified as an integral part of Title 33, chapter 23, part 1, and the

provisions of Title 33, chapter 23, part 1, apply to [section 25].

(3) [Section 26] is intended to be codified as an integral part of Title 33, chapter 24, part 1, and the provisions of Title 33, chapter 24, part 1, apply to [section 26].

-End-

APPROVED BY COMM. ON
BUSINESS & INDUSTRY

SENATE BILL NO. 16

INTRODUCED BY GAGE

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT TO GENERALLY REVISE THE LAWS RELATING TO THE REGULATION OF INSURERS AND MOTOR CLUB SERVICE COMPANIES; DIRECTING THE CODE COMMISSIONER TO CHANGE ANY REFERENCE TO THE TERM "SOLICITOR" TO "INSURANCE PRODUCER" WHEREVER IT APPEARS IN THE MONTANA CODE ANNOTATED; ~~AND~~ AMENDING SECTIONS 33-1-704, 33-1-711, 33-2-705, 33-2-708, 33-2-709, 33-3-401, 33-3-431, 33-7-406, 33-17-102, 33-17-208, 33-17-603, 33-20-303, 33-20-305, 33-22-502, 33-22-921, 33-22-923, 33-22-924, 33-22-1501, 33-22-1504, 33-22-1511, 33-22-1512, 33-22-1513, 33-22-1514, 33-22-1515, 33-22-1516, 33-22-1521, ~~33-22-1704,~~ 33-23-302, 61-12-303, 61-12-304, AND 61-12-305, MCA; AND REPEALING SECTION 33-22-1522, MCA."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 33-1-711, MCA, is amended to read:

"**33-1-711. Appeals from the commissioner.** (1) An appeal from the commissioner may be taken only from an order on hearing or with respect to a matter as to which the commissioner has refused a hearing. Any person who was a party to the hearing or whose pecuniary interests are directly and immediately affected by any order or refusal and who is aggrieved by an order or refusal may, within 30 days after the order has been mailed or delivered to the persons entitled to receive the same, the commissioner's order denying rehearing or reargument has been so mailed or delivered, or the commissioner's refusal to grant a hearing, appeal from the order on hearing or the refusal of a hearing. Any request for a stay of the commissioner's order must be made within 60 days, to run concurrently with the 30 days for appeal. The appeal must be taken to the district court of Lewis and Clark County by filing written notice of appeal in the court and by filing a copy of the notice with the commissioner, except that in appeals from the suspension or revocation of the certificate of authority of a domestic insurer or of the license of an insurance producer or surplus lines insurance producer, the person taking the appeal may at his option, in lieu of the district court of Lewis and Clark County, take the appeal to the district court of the county of Montana in which the insurer has its principal place of business or the licensee resides.

(2) Upon filing of the notice of appeal, the court has full jurisdiction and shall determine whether the filing operates as a stay of the order or action appealed from.

(3) Within 20 days after filing of the copy of the notice of appeal in his office, the commissioner shall make

and return to the court in which the appeal is pending a copy of his order appealed from and a full and complete transcript, duly certified by the commissioner, of his record of the hearing upon which the order was issued, together with all exhibits and documentary evidence introduced at the hearing. If the appeal is from an action of the commissioner with respect to which a hearing was refused, the commissioner shall, within the 20-day period, make and return to the court a full and complete transcript, duly certified by him, of all documents on file in his office directly relating to the matter as to which the appeal is taken.

(4) Upon receipt of the transcripts and evidence, the court shall hear the matter de-novo as soon as reasonably possible thereafter. Upon the hearing of the appeal, the court shall consider the evidence contained in the transcript, exhibits, and documents filed by the commissioner, together with additional proper evidence as may be offered by any party to the appeal.

(5) After hearing the appeal, the court may affirm, modify, or reverse the order or action of the commissioner, in whole or in part, or remand the action to the commissioner for further proceedings in accordance with the court's direction.

(6) Costs must be awarded as in civil actions.

(7) Appeal may be taken to the supreme court from the judgment of the district court as in other civil cases to which the state is a party. A stay of the effectiveness of any judgment may be made only by order of the supreme court upon the giving of security as that court considers proper.

(8) This section does not apply to appeals as to matters covered by chapter 16."

Section 2. Section 33-2-705, MCA, is amended to read:

"33-2-705. Report on premiums and other consideration -- tax. (1) Each authorized insurer and each formerly authorized insurer with respect to premiums so received while an authorized insurer in this state shall file with the commissioner, on or before March 1 each year, a report in form as prescribed by the commissioner showing total direct premium income, including policy, membership, and other fees, premiums paid by application of dividends, refunds, savings, savings coupons, and similar returns or credits to payment of premiums for new or additional or extended or renewed insurance, charges for payment of premium in installments, and all other consideration for insurance from all kinds and classes of insurance, whether designated as a premium or otherwise, received by ~~it~~ a life insurer or written by an insurer other than a life insurer during the preceding calendar year on account of policies covering property, subjects, or risks located, resident, or

to be performed in Montana, with proper proportionate allocation of premium as to such property, subjects, or risks in Montana insured under policies or contracts covering property, subjects, or risks located or resident in more than one state, after deducting from such total direct premium income applicable cancellations, returned premiums, the unabsorbed portion of any deposit premium, the amount of reduction in or refund of premiums allowed to industrial life policyholders for payment of premiums direct to an office of the insurer, all policy dividends, refunds, savings, savings coupons, and other similar returns paid or credited to policyholders with respect to such policies. As to title insurance, "premium" includes the total charge for such insurance. No deduction shall be made of the cash surrender values of policies. Considerations received on annuity contracts shall not be included in total direct premium income and shall not be subject to tax.

(2) Coincident with the filing of the tax report referred to in subsection (1) above, each such insurer shall pay to the commissioner a tax upon such net premiums computed at the rate of 2 3/4%.

(3) That portion of the tax paid hereunder by an insurer on account of premiums received for fire insurance shall be separately specified in the report as required by the commissioner, for apportionment as provided by law.

Where insurance against fire is included with insurance of property against other perils at an undivided premium, the insurer shall make such reasonable allocation from such entire premium to the fire portion of the coverage as shall be stated in such report and as may be approved or accepted by the commissioner.

(4) With respect to authorized insurers the premium tax provided by this section shall be payment in full and in lieu of all other demands for any and all state, county, city, district, municipal, and school taxes, licenses, fees, and excises of whatever kind or character, excepting only those prescribed by this code, taxes on real and tangible personal property located in this state, and taxes payable under 50-3-109.

(5) The commissioner may suspend or revoke the certificate of authority of any insurer which fails to pay its taxes as required under this section.

(6) In addition to the penalty provided for in subsection (5), the commissioner may impose upon an insurer who fails to pay the tax required under this section a fine of $100 a day for each day the tax remains unpaid past the due date or 1% of the amount owed in tax, whichever is greater.

(7) The commissioner may by rule provide a quarterly schedule for payment of portions of the premium tax under

this section during the year in which such tax liability is accrued."

Section 3. Section 33-2-708, MCA, is amended to read:

"**33-2-708. Fees and licenses.** (1) Except as provided in 33-17-212(2), the commissioner shall collect in advance and the persons served shall pay to the commissioner the following fees:

(a) certificates of authority:

(i) for filing applications for original certificates of authority, articles of incorporation (except original articles of incorporation of domestic insurers as provided in subsection (1)(b)) and other charter documents, bylaws, financial statement, examination report, power of attorney to the commissioner, and all other documents and filings required in connection with the application and for issuance of an original certificate of authority, if issued:

(A) domestic insurers ..... $ 600.00

(B) foreign insurers 600.00

(ii) annual continuation of certificate of authority 600.00

(iii) reinstatement of certificate of authority 25.00

(iv) amendment of certificate of authority 50.00

(b) articles of incorporation:

(i) filing original articles of incorporation of a

domestic insurer, exclusive of fees required to be paid by the corporation to the secretary of state 20.00

(ii) filing amendment of articles of incorporation, domestic and foreign insurers, exclusive of fees required to be paid to the secretary of state by a domestic corporation 25.00

(c) filing bylaws or amendment to bylaws where required 10.00

(d) filing annual statement of insurer, other than as part of application for original certificate of authority 25.00

(e) insurance producer's license:

(i) application for original license, including issuance of license, if issued 15.00

(ii) appointment of insurance producer, each insurer 10.00

(iii) temporary license 15.00

(iv) amendment of license (excluding additions to license) or reissuance of master license 15.00

(f) nonresident insurance producer's license:

(i) application for original license, including issuance of license, if issued 100.00

(ii) appointment of insurance producer, each insurer 10.00

(iii) annual renewal of license 10.00

(iv) amendment of license (excluding additions to license) or reissuance of master license 10.00

(g) examination, if administered by the commissioner, for license as insurance producer, each examination 15.00

(h) surplus lines insurance producer license:

(i) application for original license and for issuance of license, if issued 50.00

(ii) annual renewal of license 50.00

(i) adjuster's license:

(i) application for original license and for issuance of license, if issued 15.00

(ii) annual renewal of license 15.00

(j) insurance vending machine license, each machine, each year 10.00

(k) commissioner's certificate under seal (except when on certificates of authority or licenses) 10.00

(l) copies of documents on file in the commissioner's office, per page ..... .50

(m) policy forms:

(i) filing each policy form 25.00

(ii) filing each application, rider, endorsement, amendment, insert page, schedule of rates, and clarification of risks 10.00

(iii) maximum charge if policy and all forms submitted

at one time or resubmitted for approval within 180 days 100.00

(n) applications for approval of prelicensing education courses:

(i) reviewing initial application 150.00

(ii) periodic review 50.00

(2) The commissioner shall promptly deposit with the state treasurer to the credit of the general fund of this state all fines and penalties, those amounts received pursuant to 33-2-311, 33-2-705, and 33-2-706, and any fees and examination and miscellaneous charges that are collected by him pursuant to Title 33 and the rules adopted under Title 33.

(3) All fees are considered fully earned when received. In the event of overpayment, only those amounts in excess of $10 will be refunded."

Section 4. Section 33-2-709, MCA, is amended to read:

"**33-2-709. Retaliatory fees, taxes, and other obligations.** (1) When by or pursuant to the laws of any other state or foreign country any taxes, licenses, and other fees, in the aggregate, and any fines, penalties, deposit requirements, or other material obligations, prohibitions, or restrictions are or would be imposed upon Montana insurers or upon the insurance producers or representatives of such insurers which are in excess of such

taxes, licenses, and other fees, in the aggregate, or which are in excess of the fines, penalties, deposit requirements, or other obligations, prohibitions, or restrictions directly imposed upon similar insurers or upon the insurance producers or representatives of such insurers of such other state or country under the statutes of this state, so long as such laws of such other state or country continue in force or are so applied, the same taxes, licenses, and other fees, in the aggregate, or fines, penalties, or deposit requirements or other material obligations, prohibitions, or restrictions of whatever kind shall be imposed by the commissioner upon the insurers or upon the insurance producers or representatives of such insurers of such other state or country doing business or seeking to do business in Montana. Any tax, license, or other fee or other obligation imposed by any city, county, or other political subdivision or agency of such other state or country on Montana insurers or their insurance producers or representatives shall be deemed to be imposed by such state or country within the meaning of this section.

(2) This section shall not apply as to any fees in conjunction with the licensing of insurance producers, personal income taxes, ad valorem taxes on real or personal property, or special purpose obligations or assessments imposed by another state or by an agency of this state other

than the department in connection with particular kinds of insurance other than property insurance, except that deductions from premium taxes or other taxes otherwise payable allowed on account of real estate or personal property taxes paid shall be taken into consideration by the commissioner in determining the propriety and extent of retaliatory action under this section.

(3) (a) For the purposes of this section the domicile of an alien insurer, other than insurers formed under the laws of Canada, shall be that state designated by the insurer in writing filed with the commissioner at time of admission to this state or within 6 months after January 1, 1961, whichever date is the later, and may be any one of the following states:

(i) that in which the insurer was first authorized to transact insurance;

(ii) that in which is located the insurer's principal place of business in the United States;

(iii) that in which is held the larger deposit of trusteed assets of the insurer for the protection of its policyholders and creditors in the United States.

(b) If the insurer makes no such designation, its domicile shall be deemed to be that state in which is located its principal place of business in the United States."

Section 5. Section 33-3-401, MCA, is amended to read:

"**33-3-401. Home office and records -- penalty for unlawful removal of records or assets.** (1) Every domestic insurer shall have and maintain its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary or suitable as to the kind or kinds of insurance transacted. Records of the insurer's operations and other financial records reasonably related to its insurance operations for the preceding 5 years must be maintained and be available to the commissioner or his duly constituted examiner.

(2) Every domestic insurer shall have and maintain its assets in this state, except as to:

(a) real property and personal property appurtenant thereto lawfully owned by the insurer and located outside this state; and

(b) such property of the insurer as may be customary, necessary, and convenient to enable and facilitate the operation of its branch offices and regional home offices located outside this state as referred to in subsection (4) below.

(3) Removal of all or a material part of the records or assets of a domestic insurer from this state except pursuant

to a plan of merger or consolidation approved by the commissioner under this code or for such reasonable purposes and periods of time as may be approved by the commissioner in writing in advance of such removal or concealment of such records or assets or material part thereof from the commissioner is prohibited. Any person who removes or attempts to remove such records or assets or such material part thereof from the home office or other place of business or of safekeeping of the insurer in this state with the intent to remove the same from this state or who conceals or attempts to conceal the same from the commissioner, in violation of this subsection, shall upon conviction thereof be guilty of a felony punishable by a fine of not more than $10,000 or by imprisonment in the penitentiary for not more than 5 years or by both such fine and imprisonment in the discretion of the court. Upon any removal or attempted removal of such records or assets or upon retention of such records or assets or material part thereof outside this state beyond the period therefor specified in the commissioner's consent under which the records were so removed thereat or upon concealment of or attempt to conceal records or assets in violation of this section, the commissioner may institute delinquency proceedings against the insurer pursuant to the provisions of chapter 2, part 13.

(4) This section shall not be deemed to prohibit or prevent an insurer from:

(a) establishing and maintaining branch offices or regional home offices in other states where necessary or convenient to the transaction of its business and keeping therein the detailed records and assets customary and necessary for the servicing of its insurance in force and affairs in the territory served by such an office, as long as such records and assets are made readily available at such office for examination by the commissioner at his request;

(b) having, depositing, or transmitting funds and assets of the insurer in or to jurisdictions outside of this state as reasonably and customarily required in the regular course of its business;

(c) making deposits under custodial arrangements as provided by 33-2-604(3)."

Section 6. Section 33-3-431, MCA, is amended to read:

"**33-3-431. Borrowed surplus.** (1) A domestic stock or mutual insurer may borrow money to defray the expenses of its organization, provide it with surplus funds, or for any purpose of its business, upon a written agreement that such money is required to be repaid only out of the insurer's surplus in excess of that stipulated in such agreement. The agreement may provide for interest ~~not--exceeding--6%--per~~

~~annum~~ at a rate no greater than the rate established in 25-9-205, which interest shall or shall not constitute a liability of the insurer as to its funds other than such excess of surplus, as stipulated in the agreement. No commission or promotion expense shall be paid in connection with any such loan.

(2) Money so borrowed, together with the interest thereon if so stipulated in the agreement, shall not form a part of the insurer's legal liabilities except as to its surplus in excess of the amount thereof stipulated in the agreement or be the basis of any setoff; but until repaid, financial statements filed or published by the insurer shall show as a footnote thereto the amount thereof then unpaid together with any interest thereon accrued but unpaid.

(3) Any such loan to a mutual insurer shall be subject to the commissioner's approval. The insurer shall, in advance of the loan, file with the commissioner a statement of the purpose of the loan and a copy of the proposed loan agreement. The loan and agreement shall be deemed approved unless within 15 days after date of such filing the insurer is notified of the commissioner's disapproval and the reasons therefor. The commissioner shall disapprove any proposed loan or agreement if he finds the loan is unnecessary or excessive for the purpose intended or that the terms of the loan agreement are not fair and equitable

to the parties, and to other similar lenders, if any, to the insurer, or that the information so filed by the insurer is inadequate.

(4) Any such loan to a mutual insurer or substantial portion thereof shall be repaid by the insurer when no longer reasonably necessary for the purpose originally intended. No repayment of such loan shall be made by a mutual insurer unless in advance approved by the commissioner.

(5) This section shall not apply to loans obtained by the insurer in ordinary course of business from banks and other financial institutions or to loans secured by pledge or mortgage of assets."

Section 7. Section 33-7-406, MCA, is amended to read:

"**33-7-406. Annual statement -- penalty for failure to file or to comply.** ~~A society neglecting to file the annual statement in the form and within the time provided in this part shall forfeit~~ The commissioner may impose a fine upon a society not to exceed $100 for each day ~~during which such neglect continues, and, upon notice by the commissioner to that effect, its authority to do business in this state shall cease while such default continues~~ after March 1 that a society fails to file the annual statement required by 33-7-404. The fine may not exceed $1,000."

Section 8. Section 33-17-208, MCA, is amended to read:

"**33-17-208. Prelicensing education -- basic requirement.** (1) (a) A person applying for a license to act as an insurance producer for property, casualty, and surety insurance shall complete 40 hours of approved prelicensing education courses in those areas of insurance within 12 months prior to the examination, unless he is exempted from the requirement under subsection (3).

(b) A person applying for a license to act as an insurance producer for life and disability insurance or as an enrollment representative for a health service corporation shall complete 40 hours of approved prelicensing education courses in those areas of insurance within 12 months prior to the examination, unless he is exempted from the requirement under subsection (3).

(2) A person applying for licenses to act as an insurance producer for both the property, casualty, and surety areas and the life and or disability areas must meet the education requirements in all the areas of insurance.

(3) The minimum prelicensing education requirement does not apply to a person who:

(a) has been licensed within the 12 preceding months as an insurance producer in another state that requires prelicensing education and has completed the education in the other state;

(b) seeks a nonresident license, having been licensed

as an insurance provider in his state of residence for at least 1 year;

(c) seeks a nonresident license and is from a state having a prelicensing education requirement;

(d) seeks to reinstate a license lapsed for less than 2 years;

(e) seeks a temporary license under 33-17-216; or

(f) is exempt from examination requirements under 33-17-212~~(5)~~(7)."

Section 9. Section 33-17-603, MCA, is amended to read:

"**33-17-603. Certificate of registration.** (1) Except as provided in 33-17-604, a person may not act as or hold himself out to be an administrator in this state unless he holds a certificate of registration as an administrator.

(2) An application for a certificate of registration must be accompanied by a fee of $100. The commissioner shall issue the certificate unless he finds that the applicant is not competent, trustworthy, financially responsible, or of good personal and business reputation or that the applicant has had a previous application for a license denied for cause within 5 years.

(3) The certificate of registration is renewable annually on ~~the date of issue~~ July 1. A request for renewal must be accompanied by a renewal fee of $100.

(4) The certificate of registration may be suspended or

revoked if, after notice and hearing, the commissioner finds that the administrator has violated any of the requirements of this part or that the administrator is not competent, trustworthy, financially responsible, or of good personal and business reputation.

(5) Unless the certification requirement is waived, a person who acts as an administrator without a certificate of registration is subject to a fine of not less than $500 or more than $1,500."

Section 10. Section 33-20-303, MCA, is amended to read:

"**33-20-303. Incontestability.** If any statements other than those relating to age~~,~~ ~~sex,~~ and identity are required as a condition to issuing an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, and subject to 33-20-305, there shall be a provision that the contract shall be incontestable after it has been in force during the lifetime of the person or of each of the persons as to whom such statements are required, for a period of 2 years from its date of issue, except for nonpayment of stipulated payments to the insurer; and at the option of the insurer such contract may also except any provisions relative to benefits in the event of disability and any provisions which grant insurance specifically against death by accident or accidental means."

Section 11. Section 33-20-305, MCA, is amended to read:

"33-20-305. Misstatement of age ~~or sex~~. In an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, there shall be a provision that if the age ~~or sex~~ of the person or persons upon whose life or lives the contract is made, or of any of them, has been misstated, the amount payable or benefits accruing under the contract shall be such as the stipulated payment or payments to the insurer would have purchased according to the correct age ~~or sex~~ and that if the insurer shall make or has made any overpayment or overpayments on account of any such misstatement, the amount thereof, with interest at the rate to be specified in the contract but not exceeding 6% per annum, may be charged against the current or next succeeding payment or payments to be made by the insurer under the contract."

Section 12. Section 33-22-502, MCA, is amended to read:

"33-22-502. Required provisions of group policies. Each ~~such~~ group disability insurance policy ~~shall~~ delivered or issued for delivery in this state must contain in substance the following provisions:

(1) a provision that, in the absence of fraud, all statements made by applicants or the policyholder or by an insured person shall be deemed representations and not warranties and that no statement made for the purpose of effecting insurance shall avoid such insurance or reduce

benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to such policyholder or to such person or his beneficiary;

(2) a provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group a statement in summary form of the essential features of the insurance coverage of such employee or member and to whom benefits thereunder are payable. If dependents are included in the coverage, only one certificate need be issued for each family unit.

(3) a provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.

(4) a provision OR THE EQUIVALENT THERETO that reads:

Conformity with state statutes. A provision of this policy that on its effective date conflicts with the statutes of the state in which the insured resides on that date is hereby amended to conform to the minimum requirements of those statutes."

Section 13. Section 33-22-921, MCA, is amended to read:

"33-22-921. Discontinuance or nonrenewal -- alternate policy or certificate -- same insurer. (1) If a disability insurer discontinues or does not renew a medicare supplement

policy product or certificate and offers an alternate medicare supplement policy or certificate to its insureds within this state, it may not deny benefits under the replacing policy or certificate to an insured who receives treatment for a condition that was a covered expense under the replaced policy or certificate and is a covered expense under the replacing policy or certificate if the insured enrolls in and pays the premium for the replacing policy or certificate within 31 days after the termination of the replaced policy or certificate.

(2) A disability insurer who discontinues or does not renew a medicare supplement policy product or certificate and offers an alternate medicare supplement policy or certificate shall base its premium for the alternate policy or certificate on the rates currently in place for that policy or certificate.

(3) If the insured has not satisfied the preexisting condition limitation under the replaced medicare supplement policy or certificate, any period of time that was covered by that policy or certificate must be credited toward the preexisting condition limitation period of the replacing policy or certificate."

Section 14. Section 33-22-923, MCA, is amended to read:

"33-22-923. Replacement policy or certificate -- different insurer. (1) If a disability insurer replaces a

medicare supplement policy or certificate, it may not deny benefits under the replacing policy or certificate to an insured who receives treatment for a condition that was a covered expense under the replaced policy or certificate and is a covered expense under the replacing policy or certificate if the insured pays the premium for the replacing policy or certificate when due or within 31 days after the termination of the replaced policy or certificate.

(2) An insurer who replaces a medicare supplement policy or certificate shall base its premium for the replacement policy or certificate on the rates currently in place for that policy or certificate.

(3) If the insured has not satisfied the preexisting condition limitation under the replaced medicare supplement policy or certificate, any period of time that was covered by that policy or certificate must be credited toward the preexisting condition limitation period of the replacing policy or certificate.

(4) To receive the benefits of subsections (1) through (3), a person shall submit to the replacing insurer proof of prior coverage, evidence of benefits provided under the previous policy or certificate, and the effective date and the date of termination of coverage under the previous policy or certificate."

Section 15. Section 33-22-924, MCA, is amended to read:

"33-22-924. Renewal requirement. (1) If a person pays a renewal premium on the date it is due or within 31 days after it is due, an insurer may not refuse to renew a medicare supplement policy or certificate unless the insurer:

(a) refuses to renew all policies or certificates in this state that are of the same form and issued to persons of the same class; and

(b) offers a replacement policy or certificate at actuarially justified rates.

(2) If an insurer refuses to renew all policies or certificates in this state that are of the same form and issued to persons of the same class, the policies or certificates will remain in force during the grace period stated in the replaced policy or certificate. An insurer's refusal to renew a policy or certificate may not affect a claim that arose under the ~~replaced~~ discontinued policy or certificate during the period in which an insured was confined without interruption to a medical care facility for treatment."

Section 16. Section 33-22-1501, MCA, is amended to read:

"33-22-1501. Definitions. As used in this part, the following definitions apply:

(1) "Association" means the comprehensive health

association created by 33-22-1503.

(2) "Association plan" means a policy of insurance coverage offered by the association ~~through the lead carrier~~ THAT IS CERTIFIED BY THE ASSOCIATION AS REQUIRED BY 33-22-1521.

(3) "Association plan premium" means the charge determined pursuant to 33-22-1512 for membership in the association plan based on the benefits provided in 33-22-1521.

(4) "Eligible person" means an individual who:

(a) is a resident of this state and applies for coverage under the association plan; and

(b) unless the individual's eligibility is waived by the association, within 6 months prior to the date of application, has been rejected for disability insurance or health service benefits by at least two insurers, societies, or health service corporations, or has had a restrictive rider or preexisting conditions limitation, which limitation is required by at least two insurers, societies, or health service corporations, which has the effect of substantially reducing coverage from that received by a person considered a standard risk.

(5) "Health service corporation" means a corporation operating pursuant to Title 33, chapter 30, and offering or selling contracts of disability insurance.

(6) "Insurance arrangement" means any plan, program, contract, or other arrangement to the extent not exempt from inclusion by virtue of the provisions of the federal Employee Retirement Income Security Act of 1974 under which one or more employers, unions, or other organizations provide to their employees or members, either directly or indirectly through a trust of a third-party administrator, health care services or benefits other than through an insurer.

(7) "Insurer" means a company operating pursuant to Title 33, chapter 2 or 3, and offering or selling policies or contracts of disability insurance, as provided in Title 33, chapter 22.

(8) "Lead carrier" means the licensed administrator or insurer selected by the association to administer the association plan.

(9) "Preexisting condition" means any condition for which an applicant for coverage under the association plan has received medical attention during the 5 years immediately preceding the filing of an application.

~~(10) "Qualified plan" means those health benefit plans certified by the commissioner as providing the minimum benefits required by 33-22-1521 or the actuarial equivalent of those benefits.~~

~~(11)~~(10) "Society" means a fraternal benefit society

operating pursuant to Title 33, chapter 7, and offering or selling certificates of disability insurance."

Section 17. Section 33-22-1504, MCA, is amended to read:

"33-22-1504. Association board of directors -- organization. (1) There is a board of directors of the association, consisting of eight individuals:

(a) one from each of the seven participating members of the association with the highest annual premium volume of disability insurance contracts or health service corporation contracts, derived from or on behalf of residents in the previous calendar year, as determined by the commissioner; and

(b) a member at large, appointed by the commissioner to represent the public interest, who shall serve in an advisory capacity only.

(2) Each of the seven board members representing the association members is entitled to a weighted average vote, in person or by proxy, based on the association member's annual Montana premium volume. However, a board member may not have more than 50% of the vote.

(3) Members of the board may be reimbursed from the money of the association for expenses incurred by them due to their service as board members but may not otherwise be compensated by the association for their services. The costs

of conducting the meetings of the association and its board of directors must be borne by participating members of the association in accordance with 33-22-1513."

Section 18. Section 33-22-1513, MCA, is amended to read:

"**33-22-1513. Operation of association plan.** (1) Upon acceptance by the lead carrier under 33-22-1516, an eligible person may enroll in the association plan by payment of the association plan premium to the lead carrier.

(2) Not less than 88% of the association plan premiums paid to the lead carrier may be used to pay claims and not more than 12% may be used for payment of the lead carrier's direct and indirect expenses as specified in 33-22-1514.

(3) Any income in excess of the costs incurred by the association in providing reinsurance or administrative services must be held at interest and used by the association to offset past and future losses due to claims expenses of the association plan or be allocated to reduce association plan premiums.

(4) (a) Each participating member of the association shall share the losses due to claims expenses of the association plan for plans issued or approved for issuance by the association and shall share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs.

Claims expenses of the association plan that exceed the premium payments allocated to the payment of benefits are the liability of the association members. Association members shall share in the claims expenses of the association plan and operating and administrative expenses of the association in an amount equal to the ratio of:

~~(a)~~(i) the association member's total disability insurance premium received from or on behalf of Montana residents divided by;

~~(b)~~(ii) the total disability premium received by all association members from or on behalf of Montana residents, as determined by the commissioner.

(b) For purposes of this subsection (4), "total disability insurance premium" does not include premiums received from disability income insurance, credit disability insurance, disability waiver insurance, or life insurance.

(5) The association shall make an annual determination of each association member's liability, if any, and may make an annual fiscal yearend assessment if necessary. The association may also, subject to the approval of the commissioner, provide for interim assessments against the association members as may be necessary to assure the financial capability of the association in meeting the incurred or estimated claims expenses of the association plan and operating and administrative expenses of the

association until the association's next annual fiscal yearend assessment. Payment of an assessment is due within 30 days of receipt by an association member of a written notice of a fiscal yearend or interim assessment. Failure by a contributing member to tender to the association the assessment within 30 days is grounds for termination of membership. An association member that ceases to do disability insurance business within the state remains liable for assessments through the calendar year during which disability insurance business ceased. The association may decline to levy an assessment against an association member if the assessment, as determined pursuant to this section, would not exceed $10.

(6) Any annual fiscal yearend or interim assessment levied against an association member may be offset, in an amount equal to the assessment paid to the association, against the premium tax payable by that association member pursuant to 33-2-705 for the year in which the annual fiscal yearend or interim assessment is levied. The insurance commissioner shall, each year the legislature meets in regular session, on or before January 15, report to the legislature the total amount of premium tax offset claimed by association members during the preceding biennium."

Section 19. ~~Section 33-22-1704, MCA, is amended to read:~~

~~"33-22-1704. Preferred provider agreements authorized. (1) Notwithstanding any other provision of law to the contrary, a health care insurer may:~~

~~(a) enter into agreements with providers relating to health care services that may be rendered to insureds or subscribers on whose behalf the health care insurer is providing health care coverage, including preferred provider agreements relating to:~~

~~(i) the amounts an insured may be charged for services rendered; and~~

~~(ii) the amount and manner of payment to the provider; and~~

~~(b) issue or administer policies or subscriber contracts in this state that include incentives for the insured to use the services of a provider that has entered into an agreement with the insurer pursuant to subsection (1)(a).~~

~~(2) A preferred provider agreement issued or delivered in this state may not unfairly deny health benefits for health care services covered.~~

~~(3) This part does not require that an insurer negotiate or enter into agreements with any specific provider or class of providers.~~ Health care insurers may place reasonable limits on the number or classes of preferred providers that satisfy the standards set forth by

~~the--health--care--insurer.--However,---insurers---may---not discriminate--against--providers--on--the-basis-of-religion, race,-color,-national-origin,-age,-sex,--or--marital--status and--shall--select--preferred-providers-primarily-on-but-not limited-to-cost-and-availability-of-covered-services-and-the quality-of-services-performed-by-the-providers.~~"

Section 19. Section 33-23-302, MCA, is amended to read:

"**33-23-302. Cancellation or** alteration of policy -- **increase of premium rates -- sixty days' written notice required.** Any insurer who insures a physician and surgeon, dentist, registered nurse, nursing home administrator, registered physical therapist, podiatrist, licensed psychologist, osteopath, chiropractor, pharmacist, optometrist, or veterinarian, duly licensed ~~as--such~~ under the laws of this state, or a licensed hospital or long-term care facility as the employer of any such person against liability for error, omission, professional negligence, or performance of services without consent ~~shall~~ may not cancel or alter the policy so insuring ~~such~~ the person or increase the premium rates thereon without first providing the insured 60 days' written notice of the insurer's intention to cancel or alter the policy or increase the premium rates."

Section 20. Section 61-12-303, MCA, is amended to read:

"**61-12-303. Requirements for license.** (1) ~~No-license~~

~~shall-be-issued-by-the~~ The commissioner may not issue a license to a company until the company has filed with him the following:

(a) a formal application in such form and detail as the commissioner may require, executed under oath by its president or other principal officer;

(b) a copy of the form of its contract;

(c) a certified copy of its charter or articles of incorporation and its bylaws, if any;

(d) a financial statement in such form and detail as the commissioner may require, executed on oath by its president or other principal officer;

(e) a certificate from the ~~state-treasurer~~ commissioner that it has complied with 61-12-304 in all cases where a deposit of cash or a bond is required by this part;

(f) a certificate from the corporation commissioner of the state of Montana, in the event it be a corporation, that it has complied with the corporation laws of said state.

(2) ~~No-license-shall-be-issued-by-the~~ The commissioner may not issue a license to a company until the company has paid to the commissioner $100 as an annual license fee, or the pro rata portion thereof necessary to be paid to the end of the current calendar year from the date of the application for ~~such~~ the license.

(3) ~~No-license-shall-be-issued-by-the~~ The commissioner

may not issue a license TO A COMPANY until the company has satisfied him by such an examination as-he-may-make and such evidence as--he the commissioner may require, in his discretion, that such the company has complied with the laws of the state of Montana and that its management is trustworthy and competent."

Section 21. Section 61-12-304, MCA, is amended to read:

"61-12-304. Deposits required. No--license--shall--be granted The commissioner may not grant a license to a company as-herein-defined-except-as-hereinafter-stated until it has deposited with the state-treasurer commissioner the sum of $25,000 in cash or in lieu thereof a bond in a form prescribed by the commissioner payable to the state of Montana in the sum of $25,000, with surety approved by the commissioner, conditioned upon the faithful performance of its service contracts and payment of any fines or penalties levied against it for failure to comply with this part; provided,-however,--that. However, when any company,--as herein--defined,-shall-prove proves to the commissioner that it has been in continuous, active operation in the state for a period of more than the preceding 5 years immediately-last past and has a paid membership of more than 5,000 members within the state or that there are more than 5,000 holders of its service contracts within the state and that it is being properly managed, is rendering to its members the

services promised to them, and is financially responsible, no--such THE COMMISSIONER MAY NOT REQUIRE a cash deposit or bond shall-be is-not required while such the company remains in such that condition. The foregoing cash deposit or bond is not required-in-any-instance-as a penalty, but is for the protection of the public only."

Section 22. Section 61-12-305, MCA, is amended to read:

"61-12-305. Expiration Continuance of license. Every Subject to payment by January 1 of each year of the annual license fee required under 61-12-303, each license issued hereunder-shall-expire-annually-on-January-1--of--each--year unless--sooner continues in force as long as the company is entitled to the license under this part or until the license is revoked, or suspended, as--hereinafter--provided or otherwise terminated."

NEW SECTION. **Section 23.** Policy provisions -- conformity with state statutes. Each policy regulated by this part must contain a provision OR THE EQUIVALENT THERETO as follows:

Conformity with state statutes. A provision of this policy that on its effective date conflicts with the statutes of the state in which the insured resides on that date is hereby amended to conform to the minimum requirements of those statutes.

NEW SECTION. **Section 24.** Casualty insurance policy --

conformity with state statutes. A casualty insurance policy relative to a risk resident, located, or to be performed in this state must contain a provision OR THE EQUIVALENT THERETO as follows:

Conformity with state statutes. A provision of this policy that on its effective date conflicts with the statutes of the state in which the insured resides on that date is hereby amended to conform to the minimum requirements of those statutes.

NEW SECTION. **Section 25.** **Property insurance policy -- conformity with state statutes.** A property insurance policy relative to a risk resident, located, or to be performed in this state must contain a provision OR THE EQUIVALENT THERETO as follows:

Conformity with state statutes. A provision of this policy that on its effective date conflicts with the statutes of the state in which the insured resides on that date is hereby amended to conform to the minimum requirements of those statutes.

SECTION 26. SECTION 33-17-102, MCA, IS AMENDED TO READ:

"33-17-102. Definitions. As used in this title, the following definitions apply:

(1) "Adjuster" means a person who, on behalf of the insurer, for compensation as an independent contractor or as the employee of an independent contractor or for fee or

commission investigates and negotiates settlement of claims arising under insurance contracts or otherwise acts on behalf of the insurer. The term does not include a:

(a) licensed attorney who is qualified to practice law in this state;

(b) salaried employee of an insurer or of a managing general agent; or

(c) licensed insurance producer who adjusts or assists in adjustment of losses arising under policies issued by the insurer.

(2) "Adjuster license" means a document issued by the commissioner that authorizes a person to act as an adjuster.

(3) (a) "Administrator" means a person who collects charges or premiums from residents of this state in connection with life, disability, property, or casualty insurance or annuities or who adjusts or settles claims on such coverage.

(b) The term does not mean:

(i) an employer on behalf of its employees or on behalf of the employees of one or more subsidiaries of affiliated corporations of the employer;

(ii) a union on behalf of its members;

(iii) (A) an insurer that is either authorized in this state or acting as an insurer with respect to a policy lawfully issued and delivered by it in and pursuant to the

laws of a state in which the insurer is authorized to transact insurance; or

(B) a health service corporation as defined in 33-30-101;

(iv) a life, disability, property, or casualty insurance producer who is licensed in this state and whose activities are limited exclusively to the sale of insurance;

(v) a creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors;

(vi) a trust established in conformity with 29 U.S.C. 186 or the trustees, agents, and employees of the trust;

(vii) a trust exempt from taxation under section 501(a) of the Internal Revenue Code or the trustees and employees of the trust;

(viii) a custodian acting pursuant to a custodian account that meets the requirements of section 401(f) of the Internal Revenue Code or the agents and employees of the custodian;

(ix) a bank, credit union, or other financial institution that is subject to supervision or examination by federal or state banking authorities;

(x) a company that issues credit cards and that advances for and collects premiums or charges from its credit card holders who have authorized it to do so, if the

company does not adjust or settle claims; or

(xi) a person who adjusts or settles claims in the normal course of his practice or employment as an attorney and who does not collect charges or premiums in connection with life or disability insurance or annuities.

(4) "Administrator license" means a document issued by the commissioner that authorizes a person to act as an administrator.

(5) "Consultant" means a person who for a fee examines, appraises, reviews, or evaluates an insurance policy, annuity, or pension contract, plan, or program or who makes recommendations or gives advice on an insurance policy, annuity, or pension contract, plan, or program.

(6) "Consultant license" means a document issued by the commissioner that authorizes a person to act as an insurance consultant.

(7) "Controlled business" means insurance procured or to be procured by or through a person upon the life, person, property, or risks of himself, his spouse, his employer, or his business.

(8) "Individual" means a private or natural person, as distinguished from a partnership, corporation, or association.

(9) "Insurance producer", except as provided in 33-17-103:

(a) means:

(i) a person who solicits, negotiates, effects, procures, delivers, renews, continues, or binds:

(A) policies of insurance for risks residing, located, or to be performed in this state; or

(B) membership contracts as defined in 33-30-101;

(ii) a managing general agent. For purposes of this definition, a "managing general agent" is a person who, on behalf of an insurer, exercises general supervision over the business of the insurer in this state or in any other state, including the authority to contract with an insurance producer for the insurer and terminate those contracts.

(b) does not mean a customer service representative. For purposes of this definition, a "customer service representative" means a salaried employee of an insurance producer who assists and is responsible to the insurance producer.

(10) "License" means a document issued by the commissioner that authorizes a person to act as an insurance producer for the kinds of insurance specified in the document. The license itself does not create actual, apparent, or inherent authority in the holder to represent or commit an insurer to a binding agreement.

(11) "Person" means an individual, partnership, corporation, association, or other legal entity.

(12) "Public adjuster" means an adjuster employed by and representing the interests of the insured."

SECTION 27. SECTION 33-22-1511, MCA, IS AMENDED TO READ:

"**33-22-1511. Minimum benefits of association plan.** The association through the association plan shall offer a policy that provides at least the benefits ~~of-a-qualified plan-as~~ required by 33-22-1521."

SECTION 28. SECTION 33-22-1512, MCA, IS AMENDED TO READ:

"**33-22-1512. Association plan premium.** The association shall establish the schedule of premiums to be charged eligible persons for membership in the association plan. The schedule of premiums may not be less than 150% or more than 400% of the average premium rates charged by the five ~~largest~~ insurers with the largest premium amount of individual ~~qualified--plan~~ plans of major medical insurance in force in this state. The premium rates of the five insurers used to establish the premium rates for each type of coverage offered by the association must be determined by the commissioner from information provided annually by all insurers at the request of the commissioner. ~~The-information requested--must--include--the--number--of-qualified-plans-or actuarial-equivalent-plans--offered--by--each--insurer,--the rates--charged--by-the-insurer-for-each-type-of-plan-offered~~

~~by-the-insurer,-and-any-other-information--the--commissioner considers-necessary.~~ The association shall utilize generally acceptable actuarial principles and structurally compatible rates."

SECTION 29. SECTION 33-22-1514, MCA, IS AMENDED TO READ:

"**33-22-1514. Administration of association plan -- rules.** ~~(1)--Any-member-of-the-association-may-submit-to-the commissioner--policies--to--be--proposed--to--serve--as--the association-plan.-The-commissioner-shall-prescribe--by--rule the-time-and-manner-of-the-submission.~~

~~(2)~~(1) ~~Upon--the--commissioner's-approval-of-the-policy forms-and-contracts-submitted,-the-association-shall--select policies--and--contracts--by--a--member--or--members--of-the association-to-be--the--association--plan.~~ The association shall select one lead carrier to issue the ~~qualified-plans~~ association plan. The board of directors of the association shall prepare appropriate specifications and bid forms and may solicit bids from licensed administrators and the members of the association for the purpose of selecting the lead carrier. The selection of the lead carrier must be based upon criteria established by the board of directors.

~~(3)~~(2) The lead carrier shall perform all administrative and claims payment functions required by this section upon the commissioner's approval of the policy forms

and contracts submitted. The lead carrier shall provide these services for a period of at least 3 years, unless a request to terminate is approved by the association and the commissioner. The association and the commissioner shall approve or deny a request to terminate within 90 days of its receipt. A failure to make a final decision on a request to terminate within the specified period is considered an approval. The association shall invite submissions of policy forms from members of the association, including the lead carrier, 6 months prior to the expiration of each 3-year period. The association shall follow the procedure provided in subsection ~~(2)~~ (1) in selecting a lead carrier for the subsequent 3-year period or, if a request to terminate is approved, on or before the end of the 3-year period.

~~(4)~~(3) The lead carrier shall provide all eligible persons involved in the association plan an individual certificate setting forth a statement as to the insurance protection to which the person is entitled, the method and place of filing claims, and to whom benefits are payable. The certificate must indicate that coverage was obtained through the association.

~~(5)~~(4) The lead carrier shall submit to the association and the commissioner on a semiannual basis a report of the operation of the association plan. The association must determine the specific information to be contained in the

report prior to the effective date of the association plan.

~~(6)~~(5) The lead carrier shall pay all claims pursuant to this part and shall indicate that the claim was paid by the association plan. Each claim payment must include information specifying the procedure involved in the event a dispute over the amount of payment arises.

~~(7)~~(6) The lead carrier must be reimbursed from the association plan premiums received for its direct and indirect expenses. Direct and indirect expenses include a prorated reimbursement for the portion of the lead carrier's administrative, printing, claims administration, management, and building overhead expenses, which are assignable to the maintenance and administration of the association plan. The association must approve cost accounting methods to substantiate the lead carrier's cost reports consistent with generally accepted accounting principles. Direct and indirect expenses may not include costs directly related to the original submission of policy forms prior to selection as the lead carrier.

~~(8)~~(7) The lead carrier is, when carrying out its duties under this part, an independent contractor for the association and is individually liable for its actions, subject to the laws of this state."

SECTION 30. SECTION 33-22-1515, MCA, IS AMENDED TO READ:

"**33-22-1515. Solicitation of eligible persons.** (1) The association, pursuant to a plan approved by the commissioner, shall disseminate appropriate information to the residents of this state regarding the existence of the association plan and the means of enrollment. Means of communication may include use of the press, radio, and television, as well as publication in appropriate state offices and publications.

(2) The association shall devise and implement means of maintaining public awareness of this part and shall administer this part in a manner which facilitates public participation in the association plan.

(3) All licensed disability insurance producers may engage in the selling or marketing of ~~qualified~~ the association ~~plans~~ plan. The lead carrier shall pay an insurance producer's referral fee of $25 to each licensed disability insurance producer who refers an applicant to the association plan, if the applicant is accepted. The referral fees must be paid ~~to~~ by the lead carrier from money received as premiums for the association plan.

(4) An insurer, society, or health service corporation that rejects or applies underwriting restrictions to an applicant for disability insurance must notify the applicant of the existence of the association plan, requirements for being accepted in it, and the procedure for applying to it."

SECTION 31. SECTION 33-22-1516, MCA, IS AMENDED TO READ:

"33-22-1516. Enrollment by eligible person. (1) The association plan must be open for enrollment by eligible persons. An eligible person may enroll in the plan by submission of a certificate of eligibility to the lead carrier. The certificate must provide:

(a) the name, address, and age of the applicant and length of the applicant's residence in this state;

(b) the name, address, and age of spouse and children, if any, if they are to be insured;

(c) written evidence that he fulfills all of the elements of an eligible person, as defined in 33-22-1501; and

(d) a designation of coverage desired.

(2) Within 30 days of receipt of the certificate, the lead carrier shall either reject the application for failing to comply with the requirements of subsection (1) or forward the eligible person a notice of acceptance and billing information. Insurance is effective on the first of the month following acceptance.

(3) An eligible person may not purchase more than one policy from the association plan.

(4) A person who obtains coverage pursuant to this section may not be covered for any preexisting condition

during the first 12 months of coverage under the association plan if the person was diagnosed or treated for that condition during the 5 years immediately preceding the filing of an application. This subsection does not apply to a person who has had continuous coverage under an individual, family, or group policy during the year immediately preceding the filing of an application and whose cancellation date was within 30 days prior to the date of submission of a certificate of eligibility to the lead carrier for nonelective procedures.

(5) A change of residence from Montana to another state immediately terminates eligibility for renewal of coverage under the association plan."

SECTION 32. SECTION 33-22-1521, MCA, IS AMENDED TO READ:

"33-22-1521. ~~Qualified~~ Association plan -- minimum benefits. A plan of health coverage must be certified as a ~~qualified~~ association plan if it otherwise meets the requirements of Title 33, chapters 15, 22 (excepting part 7), and 30, and other laws of this state, whether or not the policy is issued in this state, and meets or exceeds the following minimum standards:

(1) The minimum benefits for an insured must, subject to the other provisions of this section, be equal to at least 80% of the covered expenses required by this section

in excess of an annual deductible that does not exceed $1,000 per person. The coverage must include a limitation of $5,000 per person on the total annual out-of-pocket expenses for services covered under this section. Coverage must be subject to a maximum lifetime benefit, but such maximums may not be less than $100,000.

(2) Covered expenses must be the usual and customary charges for the following services and articles when prescribed by a physician or other licensed health care professional provided for in 33-22-111:

(a) hospital services;

(b) professional services for the diagnosis or treatment of injuries, illness, or conditions, other than dental;

(c) use of radium or other radioactive materials;

(d) oxygen;

(e) anesthetics;

(f) diagnostic x-rays and laboratory tests, except as specifically provided in subsection (3);

(g) services of a physical therapist;

(h) transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition;

(i) oral surgery for the gums and tissues of the mouth when not performed in connection with the extraction or

repair of teeth or in connection with TMJ;

(j) rental or purchase of medical equipment, which shall be reimbursed after the deductible has been met at the rate of 50%, up to a maximum of $1,000;

(k) prosthetics, other than dental; and

(l) services of a licensed home health agency, up to a maximum of 180 visits per year.

(3) (a) Covered expenses for the services or articles specified in this section do not include:

(i) drugs requiring a physician's prescription;

(ii) services of a nursing home;

(iii) home and office calls, except as specifically provided in subsection (2);

(iv) rental or purchase of durable medical equipment, except as specifically provided in subsection (2);

(v) the first $20 of diagnostic x-ray and laboratory charges in each 14-day period;

(vi) oral surgery, except as specifically provided in subsection (2);

(vii) that part of a charge for services or articles which exceeds the prevailing charge in the locality where the service is provided; or

(viii) care that is primarily for custodial or domiciliary purposes which would not qualify as eligible services under medicare.

(b) Covered expenses for the services or articles specified in this section do not include charges for:

(i) care or for any injury or disease either arising out of an injury in the course of employment and subject to a workers' compensation or similar law, for which benefits are payable under another policy of disability insurance or medicare;

(ii) treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or congenital bodily defect to restore normal bodily functions;

(iii) travel other than transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition;

(iv) confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as medically necessary by a physician;

(v) services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles;

(vi) organ transplants, including bone marrow transplants;

(vii) room and board for a nonemergency admission on Friday or Saturday;

(viii) pregnancy, except complications of pregnancy;

(ix) routine well baby care;

(x) complications to a newborn, unless no other source of coverage is available;

(xi) sterilization or reversal of sterilization;

(xii) abortion, unless the life of the mother would be endangered if the fetus were carried to term;

(xiii) weight modification or modification of the body to improve the mental or emotional well-being of an insured;

(xiv) artificial insemination or treatment for infertility; or

(xv) breast augmentation or reduction."

SECTION 33. SECTION 33-1-704, MCA, IS AMENDED TO READ:

"33-1-704. Hearing procedure. (1) All hearings shall be open to the public unless closed pursuant to the provisions of 2-3-203.

(2) The commissioner shall allow any party to the hearing to appear in person and by counsel, to be present during the giving of all evidence, to have a reasonable opportunity to inspect all documentary evidence and to examine witnesses, to present evidence in support of his interest, and to have subpoenas issued by the commissioner to compel attendance of witnesses and production of evidence in his behalf.

(3) The commissioner shall permit to become a party to the hearing by intervention, if timely, any person who was

not an original party thereto and whose pecuniary interests will be directly and immediately affected by the commissioner's order made upon the hearing.

(4) Except as provided in 33-31-404, rules of pleading ~~or evidence~~ need not be observed at any hearing, but the rules of evidence must be observed.

(5) Upon written request seasonably made by a party to the hearing and at that person's expense, the commissioner shall cause a full stenographic record of the proceedings to be made by a competent reporter. If transcribed, a copy of such stenographic record shall be furnished to the commissioner without cost to the commissioner or the state and shall be a part of the commissioner's record of the hearing. If so transcribed, a copy of such stenographic record shall be furnished to any other party to such hearing at the request and expense of such other party. If no stenographic record is made or transcribed, the commissioner shall prepare an adequate record of the evidence and of the proceedings."

NEW SECTION. **SECTION 34.** REPEALER. SECTION 33-22-1522, MCA, IS REPEALED.

NEW SECTION. **Section 35.** **Name change -- short form amendment.** Wherever it appears in 33-7-519, 33-17-206, 33-18-210, and 33-18-501 or in insurance laws enacted by the 52nd legislature, the code commissioner is directed to

change the term "solicitor" to "insurance producer".

NEW SECTION. **Section 36.** **Codification instruction.** (1) [Section ~~24~~ 23] is intended to be codified as an integral part of Title 33, chapter 20, parts 1 and 12, and the provisions of Title 33, chapter 20, parts 1 and 12, apply to [section ~~24~~ 23].

(2) [Section ~~25~~ 24] is intended to be codified as an integral part of Title 33, chapter 23, part 1, and the provisions of Title 33, chapter 23, part 1, apply to [section ~~25~~ 24].

(3) [Section ~~26~~ 25] is intended to be codified as an integral part of Title 33, chapter 24, part 1, and the provisions of Title 33, chapter 24, part 1, apply to [section ~~26~~ 25].

-End-

SENATE BILL NO. 16

INTRODUCED BY GAGE

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT TO GENERALLY REVISE THE LAWS RELATING TO THE REGULATION OF INSURERS AND MOTOR CLUB SERVICE COMPANIES; DIRECTING THE CODE COMMISSIONER TO CHANGE ANY REFERENCE TO THE TERM "SOLICITOR" TO "INSURANCE PRODUCER" WHEREVER IT APPEARS IN THE MONTANA CODE ANNOTATED; AND AMENDING SECTIONS 33-1-704, 33-1-711, 33-2-705, 33-2-708, 33-2-709, 33-3-401, 33-3-431, 33-7-406, 33-17-102, 33-17-208, 33-17-603, 33-20-303, 33-20-305, 33-22-502, 33-22-921, 33-22-923, 33-22-924, 33-22-1501, 33-22-1504, 33-22-1511, 33-22-1512, 33-22-1513, 33-22-1514, 33-22-1515, 33-22-1516, 33-22-1521, ~~33-22-1704,~~ 33-23-302, 61-12-303, 61-12-304, AND 61-12-305, MCA; AND REPEALING SECTION 33-22-1522, MCA."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 33-1-711, MCA, is amended to read:

"**33-1-711. Appeals from the commissioner.** (1) An appeal from the commissioner may be taken only from an order on hearing or with respect to a matter as to which the commissioner has refused a hearing. Any person who was a party to the hearing or whose pecuniary interests are

SB 0016/02

There are no changes in this bill and will not be reprinted. Please refer to yellow copy for complete text.

HOUSE COMMITTEE OF THE WHOLE AMENDMENT
Senate Bill 16
Representative T. Nelson

April 4, 1991 11:52 am

Mr. Chairman: I move to amend Senate Bill 16 (third reading copy -- blue).

Signed: James E. Nelson
Representative T. Nelson

And, that such amendments to Senate Bill 16 read as follows:

1. Page 22, lines 17 through 22.
Strike: line 17 through 22 in their entirety
Insert: "Conformity with Montana statutes. The provisions of this policy conforms to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this policy."

2. Page 36, lines 20 through 24.
Strike: lines 20 through 24 in their entirety
Insert: "Conformity with Montana statutes. The provisions of this policy conforms to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this policy."

3. Page 37, lines 5 through 9.
Strike: lines 5 through 9 in their entirety
Insert: "Conformity with Montana statutes. The provisions of this policy conforms to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this policy."

4. Page 37, lines 15 through 19.
Strike: lines 15 through 19 in their entirety
Insert: "Conformity with Montana statutes. The provisions of this policy conforms to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this policy."

5. Page 53, line 20.
Following: line 19

ADOPT

REJECT

SB001601
711152CW.Hpd

Insert: " Section 33 Section 33-22-229, MCA, is amended to read:
"33-22-229. Conformity with state statutes. There must be a provision OR THE EQUIVILANT THERETO as follows:
"Conformity with ~~State~~ Montana Statutes: ~~Any provision of this policy which on its effective date is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.~~ The provisions of this policy conforms to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this policy."""

HOUSE
SB 16

SENATE BILL NO. 16

INTRODUCED BY GAGE

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT TO GENERALLY REVISE THE LAWS RELATING TO THE REGULATION OF INSURERS AND MOTOR CLUB SERVICE COMPANIES; DIRECTING THE CODE COMMISSIONER TO CHANGE ANY REFERENCE TO THE TERM "SOLICITOR" TO "INSURANCE PRODUCER" WHEREVER IT APPEARS IN THE MONTANA CODE ANNOTATED; AND AMENDING SECTIONS 33-1-704, 33-1-711, 33-2-705, 33-2-708, 33-2-709, 33-3-401, 33-3-431, 33-7-406, 33-17-102, 33-17-208, 33-17-603, 33-20-303, 33-20-305, 33-22-229, 33-22-502, 33-22-921, 33-22-923, 33-22-924, 33-22-1501, 33-22-1504, 33-22-1511, 33-22-1512, 33-22-1513, 33-22-1514, 33-22-1515, 33-22-1516, 33-22-1521, ~~33-22-1704,~~ 33-23-302, 61-12-303, 61-12-304, AND 61-12-305, MCA; AND REPEALING SECTION 33-22-1522, MCA."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 33-1-711, MCA, is amended to read:

"**33-1-711. Appeals from the commissioner.** (1) An appeal from the commissioner may be taken only from an order on hearing or with respect to a matter as to which the commissioner has refused a hearing. Any person who was a party to the hearing or whose pecuniary interests are directly and immediately affected by any order or refusal and who is aggrieved by an order or refusal may, within 30 days after the order has been mailed or delivered to the persons entitled to receive the same, the commissioner's order denying rehearing or reargument has been so mailed or delivered, or the commissioner's refusal to grant a hearing, appeal from the order on hearing or the refusal of a hearing. Any request for a stay of the commissioner's order must be made within 60 days, to run concurrently with the 30 days for appeal. The appeal must be taken to the district court of Lewis and Clark County by filing written notice of appeal in the court and by filing a copy of the notice with the commissioner, except that in appeals from the suspension or revocation of the certificate of authority of a domestic insurer or of the license of an insurance producer or surplus lines insurance producer, the person taking the appeal may at his option, in lieu of the district court of Lewis and Clark County, take the appeal to the district court of the county of Montana in which the insurer has its principal place of business or the licensee resides.

(2) Upon filing of the notice of appeal, the court has full jurisdiction and shall determine whether the filing operates as a stay of the order or action appealed from.

(3) Within 20 days after filing of the copy of the notice of appeal in his office, the commissioner shall make

REFERENCE BILL

and return to the court in which the appeal is pending a copy of his order appealed from and a full and complete transcript, duly certified by the commissioner, of his record of the hearing upon which the order was issued, together with all exhibits and documentary evidence introduced at the hearing. If the appeal is from an action of the commissioner with respect to which a hearing was refused, the commissioner shall, within the 20-day period, make and return to the court a full and complete transcript, duly certified by him, of all documents on file in his office directly relating to the matter as to which the appeal is taken.

(4) Upon receipt of the transcripts and evidence, the court shall hear the matter ~~de novo~~ as soon as reasonably possible thereafter. Upon the hearing of the appeal, the court shall consider the evidence contained in the transcript, exhibits, and documents filed by the commissioner, together with additional proper evidence as may be offered by any party to the appeal.

(5) After hearing the appeal, the court may affirm, modify, or reverse the order or action of the commissioner, in whole or in part, or remand the action to the commissioner for further proceedings in accordance with the court's direction.

(6) Costs must be awarded as in civil actions.

(7) Appeal may be taken to the supreme court from the judgment of the district court as in other civil cases to which the state is a party. A stay of the effectiveness of any judgment may be made only by order of the supreme court upon the giving of security as that court considers proper.

(8) This section does not apply to appeals as to matters covered by chapter 16."

Section 2. Section 33-2-705, MCA, is amended to read:

"**33-2-705. Report on premiums and other consideration -- tax.** (1) Each authorized insurer and each formerly authorized insurer with respect to premiums so received while an authorized insurer in this state shall file with the commissioner, on or before March 1 each year, a report in form as prescribed by the commissioner showing total direct premium income, including policy, membership, and other fees, premiums paid by application of dividends, refunds, savings, savings coupons, and similar returns or credits to payment of premiums for new or additional or extended or renewed insurance, charges for payment of premium in installments, and all other consideration for insurance from all kinds and classes of insurance, whether designated as a premium or otherwise, received by ~~it~~ a life insurer or written by an insurer other than a life insurer during the preceding calendar year on account of policies covering property, subjects, or risks located, resident, or

to be performed in Montana, with proper proportionate allocation of premium as to such property, subjects, or risks in Montana insured under policies or contracts covering property, subjects, or risks located or resident in more than one state, after deducting from such total direct premium income applicable cancellations, returned premiums, the unabsorbed portion of any deposit premium, the amount of reduction in or refund of premiums allowed to industrial life policyholders for payment of premiums direct to an office of the insurer, all policy dividends, refunds, savings, savings coupons, and other similar returns paid or credited to policyholders with respect to such policies. As to title insurance, "premium" includes the total charge for such insurance. No deduction shall be made of the cash surrender values of policies. Considerations received on annuity contracts shall not be included in total direct premium income and shall not be subject to tax.

(2) Coincident with the filing of the tax report referred to in subsection (1) above, each such insurer shall pay to the commissioner a tax upon such net premiums computed at the rate of 2 3/4%.

(3) That portion of the tax paid hereunder by an insurer on account of premiums received for fire insurance shall be separately specified in the report as required by the commissioner, for apportionment as provided by law.

Where insurance against fire is included with insurance of property against other perils at an undivided premium, the insurer shall make such reasonable allocation from such entire premium to the fire portion of the coverage as shall be stated in such report and as may be approved or accepted by the commissioner.

(4) With respect to authorized insurers the premium tax provided by this section shall be payment in full and in lieu of all other demands for any and all state, county, city, district, municipal, and school taxes, licenses, fees, and excises of whatever kind or character, excepting only those prescribed by this code, taxes on real and tangible personal property located in this state, and taxes payable under 50-3-109.

(5) The commissioner may suspend or revoke the certificate of authority of any insurer which fails to pay its taxes as required under this section.

(6) In addition to the penalty provided for in subsection (5), the commissioner may impose upon an insurer who fails to pay the tax required under this section a fine of $100 a day for each day the tax remains unpaid past the due date or 1% of the amount owed in tax, whichever is greater.

(7) The commissioner may by rule provide a quarterly schedule for payment of portions of the premium tax under

this section during the year in which such tax liability is accrued."

Section 3. Section 33-2-708, MCA, is amended to read:

"**33-2-708. Fees and licenses.** (1) Except as provided in 33-17-212(2), the commissioner shall collect in advance and the persons served shall pay to the commissioner the following fees:

(a) certificates of authority:

(i) for filing applications for original certificates of authority, articles of incorporation (except original articles of incorporation of domestic insurers as provided in subsection (1)(b)) and other charter documents, bylaws, financial statement, examination report, power of attorney to the commissioner, and all other documents and filings required in connection with the application and for issuance of an original certificate of authority, if issued:

(A) domestic insurers ..... $ 600.00

(B) foreign insurers 600.00

(ii) annual continuation of certificate of authority 600.00

(iii) reinstatement of certificate of authority 25.00

(iv) amendment of certificate of authority 50.00

(b) articles of incorporation:

(i) filing original articles of incorporation of a

domestic insurer, exclusive of fees required to be paid by the corporation to the secretary of state 20.00

(ii) filing amendment of articles of incorporation, domestic and foreign insurers, exclusive of fees required to be paid to the secretary of state by a domestic corporation 25.00

(c) filing bylaws or amendment to bylaws where required 10.00

(d) filing annual statement of insurer, other than as part of application for original certificate of authority 25.00

(e) insurance producer's license:

(i) application for original license, including issuance of license, if issued 15.00

(ii) appointment of insurance producer, each insurer 10.00

(iii) temporary license 15.00

(iv) amendment of license (excluding additions to license) or reissuance of master license 15.00

(f) nonresident insurance producer's license:

(i) application for original license, including issuance of license, if issued 100.00

(ii) appointment of insurance producer, each insurer 10.00

(iii) annual renewal of license 10.00

(iv) amendment of license (excluding additions to license) or reissuance of master license 10.00

(g) examination, if administered by the commissioner, for license as insurance producer, each examination 15.00

(h) surplus lines insurance producer license:

(i) application for original license and for issuance of license, if issued 50.00

(ii) annual renewal of license 50.00

(i) adjuster's license:

(i) application for original license and for issuance of license, if issued 15.00

(ii) annual renewal of license 15.00

(j) insurance vending machine license, each machine, each year 10.00

(k) commissioner's certificate under seal (except when on certificates of authority or licenses) 10.00

(l) copies of documents on file in the commissioner's office, per page ..... .50

(m) policy forms:

(i) filing each policy form 25.00

(ii) filing each application, rider, endorsement, amendment, insert page, schedule of rates, and clarification of risks 10.00

(iii) maximum charge if policy and all forms submitted

at one time or resubmitted for approval within 180 days 100.00

(n) applications for approval of prelicensing education courses:

(i) reviewing initial application 150.00

(ii) periodic review 50.00

(2) The commissioner shall promptly deposit with the state treasurer to the credit of the general fund of this state all fines and penalties, those amounts received pursuant to 33-2-311, 33-2-705, and 33-2-706, and any fees and examination and miscellaneous charges that are collected by him pursuant to Title 33 and the rules adopted under Title 33.

(3) All fees are considered fully earned when received. In the event of overpayment, only those amounts in excess of $10 will be refunded."

Section 4. Section 33-2-709, MCA, is amended to read:

"**33-2-709. Retaliatory fees, taxes, and other obligations.** (1) When by or pursuant to the laws of any other state or foreign country any taxes, licenses, and other fees, in the aggregate, and any fines, penalties, deposit requirements, or other material obligations, prohibitions, or restrictions are or would be imposed upon Montana insurers or upon the insurance producers or representatives of such insurers which are in excess of such

taxes, licenses, and other fees, in the aggregate, or which are in excess of the fines, penalties, deposit requirements, or other obligations, prohibitions, or restrictions directly imposed upon similar insurers or upon the insurance producers or representatives of such insurers of such other state or country under the statutes of this state, so long as such laws of such other state or country continue in force or are so applied, the same taxes, licenses, and other fees, in the aggregate, or fines, penalties, or deposit requirements or other material obligations, prohibitions, or restrictions of whatever kind shall be imposed by the commissioner upon the insurers or upon the insurance producers or representatives of such insurers of such other state or country doing business or seeking to do business in Montana. Any tax, license, or other fee or other obligation imposed by any city, county, or other political subdivision or agency of such other state or country on Montana insurers or their insurance producers or representatives shall be deemed to be imposed by such state or country within the meaning of this section.

(2) This section shall not apply as to any fees in conjunction with the licensing of insurance producers, personal income taxes, ad valorem taxes on real or personal property, or special purpose obligations or assessments imposed by another state or by an agency of this state other

than the department in connection with particular kinds of insurance other than property insurance, except that deductions from premium taxes or other taxes otherwise payable allowed on account of real estate or personal property taxes paid shall be taken into consideration by the commissioner in determining the propriety and extent of retaliatory action under this section.

(3) (a) For the purposes of this section the domicile of an alien insurer, other than insurers formed under the laws of Canada, shall be that state designated by the insurer in writing filed with the commissioner at time of admission to this state or within 6 months after January 1, 1961, whichever date is the later, and may be any one of the following states:

(i) that in which the insurer was first authorized to transact insurance;

(ii) that in which is located the insurer's principal place of business in the United States;

(iii) that in which is held the larger deposit of trusteed assets of the insurer for the protection of its policyholders and creditors in the United States.

(b) If the insurer makes no such designation, its domicile shall be deemed to be that state in which is located its principal place of business in the United States."

Section 5. Section 33-3-401, MCA, is amended to read:

"**33-3-401. Home office and records -- penalty for unlawful removal of records or assets.** (1) Every domestic insurer shall have and maintain its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary or suitable as to the kind or kinds of insurance transacted. Records of the insurer's operations and other financial records reasonably related to its insurance operations for the preceding 5 years must be maintained and be available to the commissioner or his duly constituted examiner.

(2) Every domestic insurer shall have and maintain its assets in this state, except as to:

(a) real property and personal property appurtenant thereto lawfully owned by the insurer and located outside this state; and

(b) such property of the insurer as may be customary, necessary, and convenient to enable and facilitate the operation of its branch offices and regional home offices located outside this state as referred to in subsection (4) below.

(3) Removal of all or a material part of the records or assets of a domestic insurer from this state except pursuant

to a plan of merger or consolidation approved by the commissioner under this code or for such reasonable purposes and periods of time as may be approved by the commissioner in writing in advance of such removal or concealment of such records or assets or material part thereof from the commissioner is prohibited. Any person who removes or attempts to remove such records or assets or such material part thereof from the home office or other place of business or of safekeeping of the insurer in this state with the intent to remove the same from this state or who conceals or attempts to conceal the same from the commissioner, in violation of this subsection, shall upon conviction thereof be guilty of a felony punishable by a fine of not more than $10,000 or by imprisonment in the penitentiary for not more than 5 years or by both such fine and imprisonment in the discretion of the court. Upon any removal or attempted removal of such records or assets or upon retention of such records or assets or material part thereof outside this state beyond the period therefor specified in the commissioner's consent under which the records were so removed thereat or upon concealment of or attempt to conceal records or assets in violation of this section, the commissioner may institute delinquency proceedings against the insurer pursuant to the provisions of chapter 2, part 13.

(4) This section shall not be deemed to prohibit or prevent an insurer from:

(a) establishing and maintaining branch offices or regional home offices in other states where necessary or convenient to the transaction of its business and keeping therein the detailed records and assets customary and necessary for the servicing of its insurance in force and affairs in the territory served by such an office, as long as such records and assets are made readily available at such office for examination by the commissioner at his request;

(b) having, depositing, or transmitting funds and assets of the insurer in or to jurisdictions outside of this state as reasonably and customarily required in the regular course of its business;

(c) making deposits under custodial arrangements as provided by 33-2-604(3)."

Section 6. Section 33-3-431, MCA, is amended to read:

"**33-3-431. Borrowed surplus.** (1) A domestic stock or mutual insurer may borrow money to defray the expenses of its organization, provide it with surplus funds, or for any purpose of its business, upon a written agreement that such money is required to be repaid only out of the insurer's surplus in excess of that stipulated in such agreement. The agreement may provide for interest ~~not--exceeding--6%--per~~

~~annum~~ at a rate no greater than the rate established in 25-9-205, which interest shall or shall not constitute a liability of the insurer as to its funds other than such excess of surplus, as stipulated in the agreement. No commission or promotion expense shall be paid in connection with any such loan.

(2) Money so borrowed, together with the interest thereon if so stipulated in the agreement, shall not form a part of the insurer's legal liabilities except as to its surplus in excess of the amount thereof stipulated in the agreement or be the basis of any setoff; but until repaid, financial statements filed or published by the insurer shall show as a footnote thereto the amount thereof then unpaid together with any interest thereon accrued but unpaid.

(3) Any such loan to a mutual insurer shall be subject to the commissioner's approval. The insurer shall, in advance of the loan, file with the commissioner a statement of the purpose of the loan and a copy of the proposed loan agreement. The loan and agreement shall be deemed approved unless within 15 days after date of such filing the insurer is notified of the commissioner's disapproval and the reasons therefor. The commissioner shall disapprove any proposed loan or agreement if he finds the loan is unnecessary or excessive for the purpose intended or that the terms of the loan agreement are not fair and equitable

to the parties, and to other similar lenders, if any, to the insurer, or that the information so filed by the insurer is inadequate.

(4) Any such loan to a mutual insurer or substantial portion thereof shall be repaid by the insurer when no longer reasonably necessary for the purpose originally intended. No repayment of such loan shall be made by a mutual insurer unless in advance approved by the commissioner.

(5) This section shall not apply to loans obtained by the insurer in ordinary course of business from banks and other financial institutions or to loans secured by pledge or mortgage of assets."

Section 7. Section 33-7-406, MCA, is amended to read:

"**33-7-406. Annual statement -- penalty for failure to file or ~~--to-comply. A-society-neglecting-to-file-the-annual statement-in-the-form-and-within-the-time-provided--in--this part-shall-forfeit~~** The commissioner may impose a fine upon a society not to exceed $100 for each day ~~during-which-such neglect-continues,-and,-upon-notice-by-the--commissioner--to that--effect,--its--authority--to--do-business-in-this-state shall-cease-while-such-default-continues~~ after March 1 that a society fails to file the annual statement required by 33-7-404. The fine may not exceed $1,000."

Section 8. Section 33-17-208, MCA, is amended to read:

"**33-17-208. Prelicensing education -- basic requirement.** (1) (a) A person applying for a license to act as an insurance producer for property, casualty, and surety insurance shall complete 40 hours of approved prelicensing education courses in those areas of insurance within 12 months prior to the examination, unless he is exempted from the requirement under subsection (3).

(b) A person applying for a license to act as an insurance producer for life and disability insurance or as an enrollment representative for a health service corporation shall complete 40 hours of approved prelicensing education courses in those areas of insurance within 12 months prior to the examination, unless he is exempted from the requirement under subsection (3).

(2) A person applying for licenses to act as an insurance producer for both the property, casualty, and surety areas and the life and or disability areas must meet the education requirements in all the areas of insurance.

(3) The minimum prelicensing education requirement does not apply to a person who:

(a) has been licensed within the 12 preceding months as an insurance producer in another state that requires prelicensing education and has completed the education in the other state;

(b) seeks a nonresident license, having been licensed

as an insurance provider in his state of residence for at least 1 year;

(c) seeks a nonresident license and is from a state having a prelicensing education requirement;

(d) seeks to reinstate a license lapsed for less than 2 years;

(e) seeks a temporary license under 33-17-216; or

(f) is exempt from examination requirements under 33-17-212~~(5)~~(7)."

Section 9. Section 33-17-603, MCA, is amended to read:

"**33-17-603. Certificate of registration.** (1) Except as provided in 33-17-604, a person may not act as or hold himself out to be an administrator in this state unless he holds a certificate of registration as an administrator.

(2) An application for a certificate of registration must be accompanied by a fee of $100. The commissioner shall issue the certificate unless he finds that the applicant is not competent, trustworthy, financially responsible, or of good personal and business reputation or that the applicant has had a previous application for a license denied for cause within 5 years.

(3) The certificate of registration is renewable annually on ~~the date of issue~~ July 1. A request for renewal must be accompanied by a renewal fee of $100.

(4) The certificate of registration may be suspended or

revoked if, after notice and hearing, the commissioner finds that the administrator has violated any of the requirements of this part or that the administrator is not competent, trustworthy, financially responsible, or of good personal and business reputation.

(5) Unless the certification requirement is waived, a person who acts as an administrator without a certificate of registration is subject to a fine of not less than $500 or more than $1,500."

Section 10. Section 33-20-303, MCA, is amended to read:

"**33-20-303. Incontestability.** If any statements other than those relating to age, ~~sex,~~ and identity are required as a condition to issuing an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, and subject to 33-20-305, there shall be a provision that the contract shall be incontestable after it has been in force during the lifetime of the person or of each of the persons as to whom such statements are required, for a period of 2 years from its date of issue, except for nonpayment of stipulated payments to the insurer; and at the option of the insurer such contract may also except any provisions relative to benefits in the event of disability and any provisions which grant insurance specifically against death by accident or accidental means."

Section 11. Section 33-20-305, MCA, is amended to read:

"**33-20-305. Misstatement of age or sex.** In an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, there shall be a provision that if the age ~~or sex~~ of the person or persons upon whose life or lives the contract is made, or of any of them, has been misstated, the amount payable or benefits accruing under the contract shall be such as the stipulated payment or payments to the insurer would have purchased according to the correct age ~~or sex~~ and that if the insurer shall make or has made any overpayment or overpayments on account of any such misstatement, the amount thereof, with interest at the rate to be specified in the contract but not exceeding 6% per annum, may be charged against the current or next succeeding payment or payments to be made by the insurer under the contract."

Section 12. Section 33-22-502, MCA, is amended to read:

"**33-22-502. Required provisions of group policies.** Each ~~such~~ group disability insurance policy ~~shall~~ delivered or issued for delivery in this state must contain in substance the following provisions:

(1) a provision that, in the absence of fraud, all statements made by applicants or the policyholder or by an insured person shall be deemed representations and not warranties and that no statement made for the purpose of effecting insurance shall avoid such insurance or reduce

benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to such policyholder or to such person or his beneficiary;

(2) a provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group a statement in summary form of the essential features of the insurance coverage of such employee or member and to whom benefits thereunder are payable. If dependents are included in the coverage, only one certificate need be issued for each family unit.

(3) a provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.

(4) a provision OR THE EQUIVALENT THERETO that reads: ~~Conformity with state statutes. A provision of this policy that on its effective date conflicts with the statutes of the state in which the insured resides on that date is hereby amended to conform to the minimum requirements of those statutes.~~ "CONFORMITY WITH MONTANA STATUTES. THE PROVISIONS OF THIS POLICY CONFORM TO THE MINIMUM REQUIREMENTS OF MONTANA LAW AND CONTROL OVER ANY CONFLICTING STATUTES OF ANY STATE IN WHICH THE INSURED RESIDES ON OR AFTER THE EFFECTIVE DATE OF THIS POLICY.""

Section 13. Section 33-22-921, MCA, is amended to read:

"**33-22-921. Discontinuance or nonrenewal -- alternate policy** or certificate **-- same insurer.** (1) If a disability insurer discontinues or does not renew a medicare supplement policy product or certificate and offers an alternate medicare supplement policy or certificate to its insureds within this state, it may not deny benefits under the replacing policy or certificate to an insured who receives treatment for a condition that was a covered expense under the replaced policy or certificate and is a covered expense under the replacing policy or certificate if the insured enrolls in and pays the premium for the replacing policy or certificate within 31 days after the termination of the replaced policy or certificate.

(2) A disability insurer who discontinues or does not renew a medicare supplement policy product or certificate and offers an alternate medicare supplement policy or certificate shall base its premium for the alternate policy or certificate on the rates currently in place for that policy or certificate.

(3) If the insured has not satisfied the preexisting condition limitation under the replaced medicare supplement policy or certificate, any period of time that was covered by that policy or certificate must be credited toward the preexisting condition limitation period of the replacing

policy or certificate."

Section 14. Section 33-22-923, MCA, is amended to read:

"**33-22-923. Replacement policy** or certificate **-- different insurer.** (1) If a disability insurer replaces a medicare supplement policy or certificate, it may not deny benefits under the replacing policy or certificate to an insured who receives treatment for a condition that was a covered expense under the replaced policy or certificate and is a covered expense under the replacing policy or certificate if the insured pays the premium for the replacing policy or certificate when due or within 31 days after the termination of the replaced policy or certificate.

(2) An insurer who replaces a medicare supplement policy or certificate shall base its premium for the replacement policy or certificate on the rates currently in place for that policy or certificate.

(3) If the insured has not satisfied the preexisting condition limitation under the replaced medicare supplement policy or certificate, any period of time that was covered by that policy or certificate must be credited toward the preexisting condition limitation period of the replacing policy or certificate.

(4) To receive the benefits of subsections (1) through (3), a person shall submit to the replacing insurer proof of prior coverage, evidence of benefits provided under the

previous policy or certificate, and the effective date and the date of termination of coverage under the previous policy or certificate."

Section 15. Section 33-22-924, MCA, is amended to read:

"**33-22-924. Renewal requirement.** (1) If a person pays a renewal premium on the date it is due or within 31 days after it is due, an insurer may not refuse to renew a medicare supplement policy or certificate unless the insurer:

(a) refuses to renew all policies or certificates in this state that are of the same form and issued to persons of the same class; and

(b) offers a replacement policy or certificate at actuarially justified rates.

(2) If an insurer refuses to renew all policies or certificates in this state that are of the same form and issued to persons of the same class, the policies or certificates will remain in force during the grace period stated in the replaced policy or certificate. An insurer's refusal to renew a policy or certificate may not affect a claim that arose under the ~~replaced~~ discontinued policy or certificate during the period in which an insured was confined without interruption to a medical care facility for treatment."

Section 16. Section 33-22-1501, MCA, is amended to

read:

"**33-22-1501. Definitions.** As used in this part, the following definitions apply:

(1) "Association" means the comprehensive health association created by 33-22-1503.

(2) "Association plan" means a policy of insurance coverage offered by the association ~~through the lead carrier~~ THAT IS CERTIFIED BY THE ASSOCIATION AS REQUIRED BY 33-22-1521.

(3) "Association plan premium" means the charge determined pursuant to 33-22-1512 for membership in the association plan based on the benefits provided in 33-22-1521.

(4) "Eligible person" means an individual who:

(a) is a resident of this state and applies for coverage under the association plan; and

(b) unless the individual's eligibility is waived by the association, within 6 months prior to the date of application, has been rejected for disability insurance or health service benefits by at least two insurers, societies, or health service corporations, or has had a restrictive rider or preexisting conditions limitation, which limitation is required by at least two insurers, societies, or health service corporations, which has the effect of substantially reducing coverage from that received by a person considered

a standard risk.

(5) "Health service corporation" means a corporation operating pursuant to Title 33, chapter 30, and offering or selling contracts of disability insurance.

(6) "Insurance arrangement" means any plan, program, contract, or other arrangement to the extent not exempt from inclusion by virtue of the provisions of the federal Employee Retirement Income Security Act of 1974 under which one or more employers, unions, or other organizations provide to their employees or members, either directly or indirectly through a trust of a third-party administrator, health care services or benefits other than through an insurer.

(7) "Insurer" means a company operating pursuant to Title 33, chapter 2 or 3, and offering or selling policies or contracts of disability insurance, as provided in Title 33, chapter 22.

(8) "Lead carrier" means the licensed administrator or insurer selected by the association to administer the association plan.

(9) "Preexisting condition" means any condition for which an applicant for coverage under the association plan has received medical attention during the 5 years immediately preceding the filing of an application.

~~(10) "Qualified plan" means those health benefit plans~~

~~certified by the commissioner as providing the minimum benefits required by 33-22-1521 or the actuarial equivalent of those benefits.~~

~~(11)~~(10) "Society" means a fraternal benefit society operating pursuant to Title 33, chapter 7, and offering or selling certificates of disability insurance."

Section 17. Section 33-22-1504, MCA, is amended to read:

"**33-22-1504. Association board of directors -- organization.** (1) There is a board of directors of the association, consisting of eight individuals:

(a) one from each of the seven participating members of the association with the highest annual premium volume of disability insurance contracts or health service corporation contracts, derived from or on behalf of residents in the previous calendar year, as determined by the commissioner; and

(b) a member at large, appointed by the commissioner to represent the public interest, who shall serve in an advisory capacity only.

(2) Each of the seven board members representing the association members is entitled to a weighted average vote, in person or by proxy, based on the association member's annual Montana premium volume. However, a board member may not have more than 50% of the vote.

(3) Members of the board may be reimbursed from the money of the association for expenses incurred by them due to their service as board members but may not otherwise be compensated by the association for their services. The costs of conducting the meetings of the association and its board of directors must be borne by participating members of the association in accordance with 33-22-1513."

Section 18. Section 33-22-1513, MCA, is amended to read:

"**33-22-1513. Operation of association plan.** (1) Upon acceptance by the lead carrier under 33-22-1516, an eligible person may enroll in the association plan by payment of the association plan premium to the lead carrier.

(2) Not less than 88% of the association plan premiums paid to the lead carrier may be used to pay claims and not more than 12% may be used for payment of the lead carrier's direct and indirect expenses as specified in 33-22-1514.

(3) Any income in excess of the costs incurred by the association in providing reinsurance or administrative services must be held at interest and used by the association to offset past and future losses due to claims expenses of the association plan or be allocated to reduce association plan premiums.

(4) (a) Each participating member of the association shall share the losses due to claims expenses of the

association plan for plans issued or approved for issuance by the association and shall share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs. Claims expenses of the association plan that exceed the premium payments allocated to the payment of benefits are the liability of the association members. Association members shall share in the claims expenses of the association plan and operating and administrative expenses of the association in an amount equal to the ratio of:

~~(a)~~ (i) the association member's total disability insurance premium received from or on behalf of Montana residents divided by;

~~(b)~~ (ii) the total disability premium received by all association members from or on behalf of Montana residents, as determined by the commissioner.

(b) For purposes of this subsection (4), "total disability insurance premium" does not include premiums received from disability income insurance, credit disability insurance, disability waiver insurance, or life insurance.

(5) The association shall make an annual determination of each association member's liability, if any, and may make an annual fiscal yearend assessment if necessary. The association may also, subject to the approval of the commissioner, provide for interim assessments against the

association members as may be necessary to assure the financial capability of the association in meeting the incurred or estimated claims expenses of the association plan and operating and administrative expenses of the association until the association's next annual fiscal yearend assessment. Payment of an assessment is due within 30 days of receipt by an association member of a written notice of a fiscal yearend or interim assessment. Failure by a contributing member to tender to the association the assessment within 30 days is grounds for termination of membership. An association member that ceases to do disability insurance business within the state remains liable for assessments through the calendar year during which disability insurance business ceased. The association may decline to levy an assessment against an association member if the assessment, as determined pursuant to this section, would not exceed $10.

(6) Any annual fiscal yearend or interim assessment levied against an association member may be offset, in an amount equal to the assessment paid to the association, against the premium tax payable by that association member pursuant to 33-2-705 for the year in which the annual fiscal yearend or interim assessment is levied. The insurance commissioner shall, each year the legislature meets in regular session, on or before January 15, report to the

legislature the total amount of premium tax offset claimed by association members during the preceding biennium."

~~**Section 19.** Section 33-22-1704, MCA, is amended to read:~~

~~"33-22-1704. Preferred provider agreements authorized. (1) Notwithstanding any other provision of law to the contrary, a health care insurer may:~~

~~(a) enter into agreements with providers relating to health care services that may be rendered to insureds or subscribers on whose behalf the health care insurer is providing health care coverage, including preferred provider agreements relating to:~~

~~(i) the amounts an insured may be charged for services rendered; and~~

~~(ii) the amount and manner of payment to the provider; and~~

~~(b) issue or administer policies or subscriber contracts in this state that include incentives for the insured to use the services of a provider that has entered into an agreement with the insurer pursuant to subsection (1)(a).~~

~~(2) A preferred provider agreement issued or delivered in this state may not unfairly deny health benefits for health care services covered.~~

~~(3) This part does not require that an insurer~~

~~negotiate--or--enter--into--agreements--with--any---specific provider--or--class--of--providers.~~ Health-care-insurers-may place--reasonable--limits--on--the--number--or--classes---of preferred--providers-that-satisfy-the-standards-set-forth-by the--health--care--insurer.--However,---insurers---may---not discriminate--against--providers--on--the-basis-of-religion, race,-color,-national-origin,-age,-sex,--or--marital--status and--shall--select--preferred-providers-primarily-on-but-not limited-to-cost-and-availability-of-covered-services-and-the quality-of-services-performed-by-the-providers."

Section 19. Section 33-23-302, MCA, is amended to read:

"**33-23-302. Cancellation or** alteration of policy -- **increase of premium rates -- sixty days' written notice required.** Any insurer who insures a physician and surgeon, dentist, registered nurse, nursing home administrator, registered physical therapist, podiatrist, licensed psychologist, osteopath, chiropractor, pharmacist, optometrist, or veterinarian, duly licensed ~~as--such~~ under the laws of this state, or a licensed hospital or long-term care facility as the employer of any such person against liability for error, omission, professional negligence, or performance of services without consent ~~shall~~ may not cancel or alter the policy so insuring ~~such~~ the person or increase the premium rates thereon without first providing the insured 60 days' written notice of the insurer's intention

to cancel or alter the policy or increase the premium rates."

Section 20. Section 61-12-303, MCA, is amended to read:

"**61-12-303. Requirements for license.** (1) ~~No-license shall-be-issued-by-the~~ The commissioner may not issue a license to a company until the company has filed with him the following:

(a) a formal application in such form and detail as the commissioner may require, executed under oath by its president or other principal officer;

(b) a copy of the form of its contract;

(c) a certified copy of its charter or articles of incorporation and its bylaws, if any;

(d) a financial statement in such form and detail as the commissioner may require, executed on oath by its president or other principal officer;

(e) a certificate from the ~~state-treasurer~~ commissioner that it has complied with 61-12-304 in all cases where a deposit of cash or a bond is required by this part;

(f) a certificate from the corporation commissioner of the state of Montana, in the event it be a corporation, that it has complied with the corporation laws of said state.

(2) ~~No-license-shall-be-issued-by-the~~ The commissioner may not issue a license to a company until the company has paid to the commissioner $100 as an annual license fee, or

the pro rata portion thereof necessary to be paid to the end of the current calendar year from the date of the application for ~~such~~ the license.

(3) ~~No license shall be issued by the~~ The commissioner may not issue a license TO A COMPANY until the company has satisfied him by ~~such~~ an examination ~~as he may make~~ and ~~such~~ evidence ~~as he~~ the commissioner may require, in his discretion, that ~~such~~ the company has complied with the laws of the state of Montana and that its management is trustworthy and competent."

Section 21. Section 61-12-304, MCA, is amended to read:

"61-12-304. ~~Deposits~~ required. ~~No license shall be granted~~ The commissioner may not grant a license to a company ~~as herein defined except as hereinafter stated~~ until it has deposited with the ~~state treasurer~~ commissioner the sum of $25,000 in cash or in lieu thereof a bond in a form prescribed by the commissioner payable to the state of Montana in the sum of $25,000, with surety approved by the commissioner, conditioned upon the faithful performance of its service contracts and payment of any fines or penalties levied against it for failure to comply with this part; ~~provided, however, that~~. However, when any company, ~~as herein defined, shall prove~~ proves to the commissioner that it has been in continuous, active operation in the state for a period of more than the preceding 5 years ~~immediately last~~

past and has a paid membership of more than 5,000 members within the state or that there are more than 5,000 holders of its service contracts within the state and that it is being properly managed, is rendering to its members the services promised to them, and is financially responsible, ~~no such~~ THE COMMISSIONER MAY NOT REQUIRE a cash deposit or bond ~~shall be is not required~~ while ~~such~~ the company remains in ~~such~~ that condition. The ~~foregoing~~ cash deposit or bond is not ~~required in any instance as~~ a penalty, but is for the protection of the public only."

Section 22. Section 61-12-305, MCA, is amended to read:

"61-12-305. ~~Expiration~~ Continuance of license. ~~Every~~ Subject to payment by January 1 of each year of the annual license fee required under 61-12-303, each license ~~issued hereunder shall expire annually on January 1 of each year unless sooner~~ continues in force as long as the company is entitled to the license under this part or until the license is revoked, ~~or~~ suspended, ~~as hereinafter provided~~ or otherwise terminated."

NEW SECTION. **Section 23.** Policy provisions -- conformity with state statutes. Each policy regulated by this part must contain a provision OR THE EQUIVALENT THERETO as follows:

~~Conformity with state statutes. A provision of this policy that on its effective date conflicts with the~~

~~statutes--of--the-state-in-which-the-insured-resides-on-that date--is--hereby--amended--to---conform---to---the---minimum requirements--of--those--statutes:~~ "CONFORMITY WITH MONTANA STATUTES. THE PROVISIONS OF THIS POLICY CONFORM TO THE MINIMUM REQUIREMENTS OF MONTANA LAW AND CONTROL OVER ANY CONFLICTING STATUTES OF ANY STATE IN WHICH THE INSURED RESIDES ON OR AFTER THE EFFECTIVE DATE OF THIS POLICY."

NEW SECTION. **Section 24.** **Casualty insurance policy -- conformity with state statutes.** A casualty insurance policy relative to a risk resident, located, or to be performed in this state must contain a provision OR THE EQUIVALENT THERETO as follows:

~~Conformity--with--state--statutes:--A--provision-of-this policy--that--on--its--effective--date--conflicts--with--the statutes-of-the-state-in-which-the-insured-resides--on--that date---is---hereby---amended---to--conform--to--the--minimum requirements-of-those--statutes:~~ "CONFORMITY WITH MONTANA STATUTES. THE PROVISIONS OF THIS POLICY CONFORM TO THE MINIMUM REQUIREMENTS OF MONTANA LAW AND CONTROL OVER ANY CONFLICTING STATUTES OF ANY STATE IN WHICH THE INSURED RESIDES ON OR AFTER THE EFFECTIVE DATE OF THIS POLICY."

NEW SECTION. **Section 25.** **Property insurance policy -- conformity with state statutes.** A property insurance policy relative to a risk resident, located, or to be performed in this state must contain a provision OR THE EQUIVALENT

THERETO as follows:

~~Conformity-with-state--statutes:--A--provision--of--this policy--that--on--its--effective--date--conflicts--with--the statutes--of--the-state-in-which-the-insured-resides-on-that date--is--hereby--amended--to---conform---to---the---minimum requirements--of--those--statutes:~~ "CONFORMITY WITH MONTANA STATUTES. THE PROVISIONS OF THIS POLICY CONFORM TO THE MINIMUM REQUIREMENTS OF MONTANA LAW AND CONTROL OVER ANY CONFLICTING STATUTES OF ANY STATE IN WHICH THE INSURED RESIDES ON OR AFTER THE EFFECTIVE DATE OF THIS POLICY."

SECTION 26. SECTION 33-17-102, MCA, IS AMENDED TO READ:

"33-17-102. Definitions. As used in this title, the following definitions apply:

(1) "Adjuster" means a person who, on behalf of the insurer, for compensation as an independent contractor or as the employee of an independent contractor or for fee or commission investigates and negotiates settlement of claims arising under insurance contracts or otherwise acts on behalf of the insurer. The term does not include a:

(a) licensed attorney who is qualified to practice law in this state;

(b) salaried employee of an insurer or of a managing general agent; or

(c) licensed insurance producer who adjusts or assists in adjustment of losses arising under policies issued by the

insurer.

(2) "Adjuster license" means a document issued by the commissioner that authorizes a person to act as an adjuster.

(3) (a) "Administrator" means a person who collects charges or premiums from residents of this state in connection with life, disability, property, or casualty insurance or annuities or who adjusts or settles claims on such coverage.

(b) The term does not mean:

(i) an employer on behalf of its employees or on behalf of the employees of one or more subsidiaries of affiliated corporations of the employer;

(ii) a union on behalf of its members;

(iii) (A) an insurer that is either authorized in this state or acting as an insurer with respect to a policy lawfully issued and delivered by it in and pursuant to the laws of a state in which the insurer is authorized to transact insurance; or

(B) a health service corporation as defined in 33-30-101;

(iv) a life, disability, property, or casualty insurance producer who is licensed in this state and whose activities are limited exclusively to the sale of insurance;

(v) a creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its

debtors;

(vi) a trust established in conformity with 29 U.S.C. 186 or the trustees, agents, and employees of the trust;

(vii) a trust exempt from taxation under section 501(a) of the Internal Revenue Code or the trustees and employees of the trust;

(viii) a custodian acting pursuant to a custodian account that meets the requirements of section 401(f) of the Internal Revenue Code or the agents and employees of the custodian;

(ix) a bank, credit union, or other financial institution that is subject to supervision or examination by federal or state banking authorities;

(x) a company that issues credit cards and that advances for and collects premiums or charges from its credit card holders who have authorized it to do so, if the company does not adjust or settle claims; or

(xi) a person who adjusts or settles claims in the normal course of his practice or employment as an attorney and who does not collect charges or premiums in connection with life or disability insurance or annuities.

(4) "Administrator license" means a document issued by the commissioner that authorizes a person to act as an administrator.

(5) "Consultant" means a person who for a fee examines,

appraises, reviews, or evaluates an insurance policy, annuity, or pension contract, plan, or program or who makes recommendations or gives advice on an insurance policy, annuity, or pension contract, plan, or program.

(6) "Consultant license" means a document issued by the commissioner that authorizes a person to act as an insurance consultant.

(7) "Controlled business" means insurance procured or to be procured by or through a person upon the life, person, property, or risks of himself, his spouse, his employer, or his business.

(8) "Individual" means a private or natural person, as distinguished from a partnership, corporation, or association.

(9) "Insurance producer", except as provided in 33-17-103:

(a) means:

(i) a person who solicits, negotiates, effects, procures, delivers, renews, continues, or binds:

(A) policies of insurance for risks residing, located, or to be performed in this state; or

(B) membership contracts as defined in 33-30-101;

(ii) a managing general agent. For purposes of this definition, a "managing general agent" is a person who, on behalf of an insurer, exercises general supervision over the

business of the insurer in this state or in any other state, including the authority to contract with an insurance producer for the insurer and terminate those contracts.

(b) does not mean a customer service representative. For purposes of this definition, a "customer service representative" means a salaried employee of an insurance producer who assists and is responsible to the insurance producer.

(10) "License" means a document issued by the commissioner that authorizes a person to act as an insurance producer for the kinds of insurance specified in the document. The license itself does not create actual, apparent, or inherent authority in the holder to represent or commit an insurer to a binding agreement.

(11) "Person" means an individual, partnership, corporation, association, or other legal entity.

(12) "Public adjuster" means an adjuster employed by and representing the interests of the insured."

SECTION 27. SECTION 33-22-1511, MCA, IS AMENDED TO READ:

"33-22-1511. **Minimum benefits of association plan.** The association through the association plan shall offer a policy that provides at least the benefits ~~of a qualified plan as~~ required by 33-22-1521."

SECTION 28. SECTION 33-22-1512, MCA, IS AMENDED TO

READ:

"33-22-1512. Association plan premium. The association shall establish the schedule of premiums to be charged eligible persons for membership in the association plan. The schedule of premiums may not be less than 150% or more than 400% of the average premium rates charged by the five ~~largest~~ insurers with the largest premium amount of individual ~~qualified--plan~~ plans of major medical insurance in force in this state. The premium rates of the five insurers used to establish the premium rates for each type of coverage offered by the association must be determined by the commissioner from information provided annually by all insurers at the request of the commissioner. ~~The-information-requested--must--include--the--number--of-qualified-plans-or-actuarial-equivalent-plans--offered--by--each--insurer,--the-rates--charged--by-the-insurer-for-each-type-of-plan-offered-by-the-insurer,-and-any-other-information--the--commissioner-considers-necessary.~~ The association shall utilize generally acceptable actuarial principles and structurally compatible rates."

SECTION 29. SECTION 33-22-1514, MCA, IS AMENDED TO READ:

"33-22-1514. Administration of association plan -- rules. ~~(1)--Any-member-of-the-association-may-submit-to-the-commissioner--policies--to--be--proposed--to--serve--as--the-association-plan.--The-commissioner-shall-prescribe--by--rule-the-time-and-manner-of-the-submission.~~

~~(2)~~(1) ~~Upon--the--commissioner's-approval-of-the-policy-forms-and-contracts-submitted,-the-association-shall--select-policies--and--contracts--by--a--member--or--members--of-the-association-to-be--the--association--plan.~~ The association shall select one lead carrier to issue the ~~qualified-plans~~ association plan. The board of directors of the association shall prepare appropriate specifications and bid forms and may solicit bids from licensed administrators and the members of the association for the purpose of selecting the lead carrier. The selection of the lead carrier must be based upon criteria established by the board of directors.

~~(3)~~(2) The lead carrier shall perform all administrative and claims payment functions required by this section upon the commissioner's approval of the policy forms and contracts submitted. The lead carrier shall provide these services for a period of at least 3 years, unless a request to terminate is approved by the association and the commissioner. The association and the commissioner shall approve or deny a request to terminate within 90 days of its receipt. A failure to make a final decision on a request to terminate within the specified period is considered an approval. The association shall invite submissions of policy forms from members of the association, including the lead

carrier, 6 months prior to the expiration of each 3-year period. The association shall follow the procedure provided in subsection ~~(2)~~ (1) in selecting a lead carrier for the subsequent 3-year period or, if a request to terminate is approved, on or before the end of the 3-year period.

~~(4)~~(3) The lead carrier shall provide all eligible persons involved in the association plan an individual certificate setting forth a statement as to the insurance protection to which the person is entitled, the method and place of filing claims, and to whom benefits are payable. The certificate must indicate that coverage was obtained through the association.

~~(5)~~(4) The lead carrier shall submit to the association and the commissioner on a semiannual basis a report of the operation of the association plan. The association must determine the specific information to be contained in the report prior to the effective date of the association plan.

~~(6)~~(5) The lead carrier shall pay all claims pursuant to this part and shall indicate that the claim was paid by the association plan. Each claim payment must include information specifying the procedure involved in the event a dispute over the amount of payment arises.

~~(7)~~(6) The lead carrier must be reimbursed from the association plan premiums received for its direct and indirect expenses. Direct and indirect expenses include a

prorated reimbursement for the portion of the lead carrier's administrative, printing, claims administration, management, and building overhead expenses, which are assignable to the maintenance and administration of the association plan. The association must approve cost accounting methods to substantiate the lead carrier's cost reports consistent with generally accepted accounting principles. Direct and indirect expenses may not include costs directly related to the original submission of policy forms prior to selection as the lead carrier.

~~(8)~~(7) The lead carrier is, when carrying out its duties under this part, an independent contractor for the association and is individually liable for its actions, subject to the laws of this state."

SECTION 30. SECTION 33-22-1515, MCA, IS AMENDED TO READ:

"**33-22-1515. Solicitation of eligible persons.** (1) The association, pursuant to a plan approved by the commissioner, shall disseminate appropriate information to the residents of this state regarding the existence of the association plan and the means of enrollment. Means of communication may include use of the press, radio, and television, as well as publication in appropriate state offices and publications.

(2) The association shall devise and implement means of

maintaining public awareness of this part and shall administer this part in a manner which facilitates public participation in the association plan.

(3) All licensed disability insurance producers may engage in the selling or marketing of ~~qualified~~ the association ~~plans~~ plan. The lead carrier shall pay an insurance producer's referral fee of $25 to each licensed disability insurance producer who refers an applicant to the association plan, if the applicant is accepted. The referral fees must be paid to by the lead carrier from money received as premiums for the association plan.

(4) An insurer, society, or health service corporation that rejects or applies underwriting restrictions to an applicant for disability insurance must notify the applicant of the existence of the association plan, requirements for being accepted in it, and the procedure for applying to it."

SECTION 31. SECTION 33-22-1516, MCA, IS AMENDED TO READ:

"**33-22-1516. Enrollment by eligible person.** (1) The association plan must be open for enrollment by eligible persons. An eligible person may enroll in the plan by submission of a certificate of eligibility to the lead carrier. The certificate must provide:

(a) the name, address, and age of the applicant and length of the applicant's residence in this state;

(b) the name, address, and age of spouse and children, if any, if they are to be insured;

(c) written evidence that he fulfills all of the elements of an eligible person, as defined in 33-22-1501; and

(d) a designation of coverage desired.

(2) Within 30 days of receipt of the certificate, the lead carrier shall either reject the application for failing to comply with the requirements of subsection (1) or forward the eligible person a notice of acceptance and billing information. Insurance is effective on the first of the month following acceptance.

(3) An eligible person may not purchase more than one policy from the association plan.

(4) A person who obtains coverage pursuant to this section may not be covered for any preexisting condition during the first 12 months of coverage under the association plan if the person was diagnosed or treated for that condition during the 5 years immediately preceding the filing of an application. This subsection does not apply to a person who has had continuous coverage under an individual, family, or group policy during the year immediately preceding the filing of an application and whose cancellation date was within 30 days prior to the date of submission of a certificate of eligibility to the lead

carrier for nonelective procedures.

* (5) A change of residence from Montana to another state immediately terminates eligibility for renewal of coverage under the association plan."

SECTION 32. SECTION 33-22-1521, MCA, IS AMENDED TO READ:

"33-22-1521. ~~Qualified~~ Association plan -- minimum benefits. A plan of health coverage must be certified as a ~~qualified~~ association plan if it otherwise meets the requirements of Title 33, chapters 15, 22 (excepting part 7), and 30, and other laws of this state, whether or not the policy is issued in this state, and meets or exceeds the following minimum standards:

(1) The minimum benefits for an insured must, subject to the other provisions of this section, be equal to at least 80% of the covered expenses required by this section in excess of an annual deductible that does not exceed $1,000 per person. The coverage must include a limitation of $5,000 per person on the total annual out-of-pocket expenses for services covered under this section. Coverage must be subject to a maximum lifetime benefit, but such maximums may not be less than $100,000.

(2) Covered expenses must be the usual and customary charges for the following services and articles when prescribed by a physician or other licensed health care

professional provided for in 33-22-111:

(a) hospital services;

(b) professional services for the diagnosis or treatment of injuries, illness, or conditions, other than dental;

(c) use of radium or other radioactive materials;

(d) oxygen;

(e) anesthetics;

(f) diagnostic x-rays and laboratory tests, except as specifically provided in subsection (3);

(g) services of a physical therapist;

(h) transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition;

(i) oral surgery for the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth or in connection with TMJ;

(j) rental or purchase of medical equipment, which shall be reimbursed after the deductible has been met at the rate of 50%, up to a maximum of $1,000;

(k) prosthetics, other than dental; and

(l) services of a licensed home health agency, up to a maximum of 180 visits per year.

(3) (a) Covered expenses for the services or articles specified in this section do not include:

(i) drugs requiring a physician's prescription;

(ii) services of a nursing home;

(iii) home and office calls, except as specifically provided in subsection (2);

(iv) rental or purchase of durable medical equipment, except as specifically provided in subsection (2);

(v) the first $20 of diagnostic x-ray and laboratory charges in each 14-day period;

(vi) oral surgery, except as specifically provided in subsection (2);

(vii) that part of a charge for services or articles which exceeds the prevailing charge in the locality where the service is provided; or

(viii) care that is primarily for custodial or domiciliary purposes which would not qualify as eligible services under medicare.

(b) Covered expenses for the services or articles specified in this section do not include charges for:

(i) care or for any injury or disease either arising out of an injury in the course of employment and subject to a workers' compensation or similar law, for which benefits are payable under another policy of disability insurance or medicare;

(ii) treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or congenital

bodily defect to restore normal bodily functions;

(iii) travel other than transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition;

(iv) confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as medically necessary by a physician;

(v) services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles;

(vi) organ transplants, including bone marrow transplants;

(vii) room and board for a nonemergency admission on Friday or Saturday;

(viii) pregnancy, except complications of pregnancy;

(ix) routine well baby care;

(x) complications to a newborn, unless no other source of coverage is available;

(xi) sterilization or reversal of sterilization;

(xii) abortion, unless the life of the mother would be endangered if the fetus were carried to term;

(xiii) weight modification or modification of the body to improve the mental or emotional well-being of an insured;

(xiv) artificial insemination or treatment for

infertility; or

(xv) breast augmentation or reduction."

SECTION 33. SECTION 33-1-704, MCA, IS AMENDED TO READ:

"**33-1-704. Hearing procedure.** (1) All hearings shall be open to the public unless closed pursuant to the provisions of 2-3-203.

(2) The commissioner shall allow any party to the hearing to appear in person and by counsel, to be present during the giving of all evidence, to have a reasonable opportunity to inspect all documentary evidence and to examine witnesses, to present evidence in support of his interest, and to have subpoenas issued by the commissioner to compel attendance of witnesses and production of evidence in his behalf.

(3) The commissioner shall permit to become a party to the hearing by intervention, if timely, any person who was not an original party thereto and whose pecuniary interests will be directly and immediately affected by the commissioner's order made upon the hearing.

(4) Except as provided in 33-31-404, rules of pleading ~~or evidence~~ need not be observed at any hearing, but the rules of evidence must be observed.

(5) Upon written request seasonably made by a party to the hearing and at that person's expense, the commissioner shall cause a full stenographic record of the proceedings to

be made by a competent reporter. If transcribed, a copy of such stenographic record shall be furnished to the commissioner without cost to the commissioner or the state and shall be a part of the commissioner's record of the hearing. If so transcribed, a copy of such stenographic record shall be furnished to any other party to such hearing at the request and expense of such other party. If no stenographic record is made or transcribed, the commissioner shall prepare an adequate record of the evidence and of the proceedings."

SECTION 34. SECTION 33-22-229, MCA, IS AMENDED TO READ:

"**33-22-229. Conformity with state statutes.** There must be a provision or the equivalent thereto as follows:

"Conformity with ~~State Statutes~~ Montana statutes: ~~Any provision of this policy which on its effective date is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.~~ The provisions of this policy conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this policy.""

NEW SECTION. **SECTION 35.** REPEALER. SECTION 33-22-1522, MCA, IS REPEALED.

NEW SECTION. **Section 36.** Name change -- short form

amendment. Wherever it appears in 33-7-519, 33-17-206, 33-18-210, and 33-18-501 or in insurance laws enacted by the 52nd legislature, the code commissioner is directed to change the term "solicitor" to "insurance producer".

NEW SECTION. **Section 37.** Codification instruction. (1) [Section ~~24~~ 23] is intended to be codified as an integral part of Title 33, chapter 20, parts 1 and 12, and the provisions of Title 33, chapter 20, parts 1 and 12, apply to [section ~~24~~ 23].

(2) [Section ~~25~~ 24] is intended to be codified as an integral part of Title 33, chapter 23, part 1, and the provisions of Title 33, chapter 23, part 1, apply to [section ~~25~~ 24].

(3) [Section ~~26~~ 25] is intended to be codified as an integral part of Title 33, chapter 24, part 1, and the provisions of Title 33, chapter 24, part 1, apply to [section ~~26~~ 25].

-End-

Free Conference Committee
on Senate Bill No. 16
Report No. 1, April 23, 1991

Mr. President and Mr. Speaker:

We, your Free Conference Committee on Senate Bill No. 16, met, considered and recommend that Senate Bill No. 16 (reference copy - salmon) be amended as follows:

1. Title, line 11.
Strike: "33-7-406,"

2. Page 9, line 2.
Strike: "10.00"
Insert: "15.00"

3. Page 17, lines 14 through 24.
Strike: section 7 in its entirety
Renumber: subsequent sections

4. Page 55, line 6.
Strike: "23"
Insert: "22"

5. Page 55, line 9.
Strike: "23"
Insert: "22"

6. Page 55, line 10.
Strike: "24"
Insert: "23"

7. Page 55, line 13.
Strike: "24"
Insert: "23"

8. Page 55, line 14.
Strike: "25"
Insert: "24"

9. Page 55, line 17.
Strike: "25"
Insert: "24"

ADOPT

REJECT

And that this Free Conference Committee report be adopted.

For the Senate:

Chair, Sen. Kennedy

Sen. Bruski

Sen. Gage

For the House:

Chair, Rep. McCulloch

Rep. Pavlovich

Rep. T. Nelson

Amd. Coord. 4/23

Sec. of Senate SB 4/23

FCCR #1
SB 16

AN ACT TO GENERALLY REVISE THE LAWS RELATING TO THE REGULATION OF INSURERS AND MOTOR CLUB SERVICE COMPANIES; DIRECTING THE CODE COMMISSIONER TO CHANGE ANY REFERENCE TO THE TERM "SOLICITOR" TO "INSURANCE PRODUCER" WHEREVER IT APPEARS IN THE MONTANA CODE ANNOTATED; AMENDING SECTIONS 33-1-704, 33-1-711, 33-2-705, 33-2-708, 33-2-709, 33-3-401, 33-3-431, 33-17-102, 33-17-208, 33-17-603, 33-20-303, 33-20-305, 33-22-229, 33-22-502, 33-22-921, 33-22-923, 33-22-924, 33-22-1501, 33-22-1504, 33-22-1511, 33-22-1512, 33-22-1513, 33-22-1514, 33-22-1515, 33-22-1516, 33-22-1521, 33-23-302, 61-12-303, 61-12-304, AND 61-12-305, MCA; AND REPEALING SECTION 33-22-1522, MCA.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 33-1-711, MCA, is amended to read:

"33-1-711. Appeals from the commissioner. (1) An appeal from the commissioner may be taken only from an order on hearing or with respect to a matter as to which the commissioner has refused a hearing. Any person who was a party to the hearing or whose pecuniary interests are directly and immediately affected by any order or refusal and who is aggrieved by an order or refusal may, within 30 days after the order has been mailed or delivered to the persons entitled to receive the same, the commissioner's order denying rehearing or reargument has been so mailed or delivered, or the commissioner's refusal to grant a hearing, appeal from the order on hearing or the refusal of a hearing. Any request for a

stay of the commissioner's order must be made within 60 days, to run concurrently with the 30 days for appeal. The appeal must be taken to the district court of Lewis and Clark County by filing written notice of appeal in the court and by filing a copy of the notice with the commissioner, except that in appeals from the suspension or revocation of the certificate of authority of a domestic insurer or of the license of an insurance producer or surplus lines insurance producer, the person taking the appeal may at his option, in lieu of the district court of Lewis and Clark County, take the appeal to the district court of the county of Montana in which the insurer has its principal place of business or the licensee resides.

(2) Upon filing of the notice of appeal, the court has full jurisdiction and shall determine whether the filing operates as a stay of the order or action appealed from.

(3) Within 20 days after filing of the copy of the notice of appeal in his office, the commissioner shall make and return to the court in which the appeal is pending a copy of his order appealed from and a full and complete transcript, duly certified by the commissioner, of his record of the hearing upon which the order was issued, together with all exhibits and documentary evidence introduced at the hearing. If the appeal is from an action of the commissioner with respect to which a hearing was refused, the commissioner shall, within the 20-day period, make and return to the court a full and complete transcript, duly

certified by him, of all documents on file in his office directly relating to the matter as to which the appeal is taken.

(4) Upon receipt of the transcripts and evidence, the court shall hear the matter de--novo as soon as reasonably possible thereafter. Upon the hearing of the appeal, the court shall consider the evidence contained in the transcript, exhibits, and documents filed by the commissioner, together with additional proper evidence as may be offered by any party to the appeal.

(5) After hearing the appeal, the court may affirm, modify, or reverse the order or action of the commissioner, in whole or in part, or remand the action to the commissioner for further proceedings in accordance with the court's direction.

(6) Costs must be awarded as in civil actions.

(7) Appeal may be taken to the supreme court from the judgment of the district court as in other civil cases to which the state is a party. A stay of the effectiveness of any judgment may be made only by order of the supreme court upon the giving of security as that court considers proper.

(8) This section does not apply to appeals as to matters covered by chapter 16."

Section 2. Section 33-2-705, MCA, is amended to read:

"**33-2-705. Report on premiums and other consideration -- tax.** (1) Each authorized insurer and each formerly authorized insurer with respect to premiums so received while an authorized insurer in this state shall file with the commissioner, on or before March

1 each year, a report in form as prescribed by the commissioner showing total direct premium income, including policy, membership, and other fees, premiums paid by application of dividends, refunds, savings, savings coupons, and similar returns or credits to payment of premiums for new or additional or extended or renewed insurance, charges for payment of premium in installments, and all other consideration for insurance from all kinds and classes of insurance, whether designated as a premium or otherwise, received by ~~it~~ a life insurer or written by an insurer other than a life insurer during the preceding calendar year on account of policies covering property, subjects, or risks located, resident, or to be performed in Montana, with proper proportionate allocation of premium as to such property, subjects, or risks in Montana insured under policies or contracts covering property, subjects, or risks located or resident in more than one state, after deducting from such total direct premium income applicable cancellations, returned premiums, the unabsorbed portion of any deposit premium, the amount of reduction in or refund of premiums allowed to industrial life policyholders for payment of premiums direct to an office of the insurer, all policy dividends, refunds, savings, savings coupons, and other similar returns paid or credited to policyholders with respect to such policies. As to title insurance, "premium" includes the total charge for such insurance. No deduction shall be made of the cash surrender values of policies. Considerations received on annuity contracts shall

not be included in total direct premium income and shall not be subject to tax.

(2) Coincident with the filing of the tax report referred to in subsection (1) above, each such insurer shall pay to the commissioner a tax upon such net premiums computed at the rate of 2 3/4%.

(3) That portion of the tax paid hereunder by an insurer on account of premiums received for fire insurance shall be separately specified in the report as required by the commissioner, for apportionment as provided by law. Where insurance against fire is included with insurance of property against other perils at an undivided premium, the insurer shall make such reasonable allocation from such entire premium to the fire portion of the coverage as shall be stated in such report and as may be approved or accepted by the commissioner.

(4) With respect to authorized insurers the premium tax provided by this section shall be payment in full and in lieu of all other demands for any and all state, county, city, district, municipal, and school taxes, licenses, fees, and excises of whatever kind or character, excepting only those prescribed by this code, taxes on real and tangible personal property located in this state, and taxes payable under 50-3-109.

(5) The commissioner may suspend or revoke the certificate of authority of any insurer which fails to pay its taxes as required under this section.

(6) In addition to the penalty provided for in subsection (5), the commissioner may impose upon an insurer who fails to pay the tax required under this section a fine of $100 a day for each day the tax remains unpaid past the due date or 1% of the amount owed in tax, whichever is greater.

(7) The commissioner may by rule provide a quarterly schedule for payment of portions of the premium tax under this section during the year in which such tax liability is accrued."

Section 3. Section 33-2-708, MCA, is amended to read:

"33-2-708. Fees and licenses. (1) Except as provided in 33-17-212(2), the commissioner shall collect in advance and the persons served shall pay to the commissioner the following fees:

(a) certificates of authority:

(i) for filing applications for original certificates of authority, articles of incorporation (except original articles of incorporation of domestic insurers as provided in subsection (1)(b)) and other charter documents, bylaws, financial statement, examination report, power of attorney to the commissioner, and all other documents and filings required in connection with the application and for issuance of an original certificate of authority, if issued:

(A) domestic insurers ..... $ 600.00

(B) foreign insurers 600.00

(ii) annual continuation of certificate of authority . 600.00

(iii) reinstatement of certificate of authority 25.00

(iv) amendment of certificate of authority 50.00

(b) articles of incorporation:

(i) filing original articles of incorporation of a domestic insurer, exclusive of fees required to be paid by the corporation to the secretary of state 20.00

(ii) filing amendment of articles of incorporation, domestic and foreign insurers, exclusive of fees required to be paid to the secretary of state by a domestic corporation 25.00

(c) filing bylaws or amendment to bylaws where required 10.00

(d) filing annual statement of insurer, other than as part of application for original certificate of authority 25.00

(e) insurance producer's license:

(i) application for original license, including issuance of license, if issued 15.00

(ii) appointment of insurance producer, each insurer . 10.00

(iii) temporary license 15.00

(iv) amendment of license (excluding additions to license) or reissuance of master license 15.00

(f) nonresident insurance producer's license:

(i) application for original license, including issuance of license, if issued 100.00

(ii) appointment of insurance producer, each insurer . 10.00

(iii) annual renewal of license 10.00

(iv) amendment of license (excluding additions to license) or

reissuance of master license ..... ~~10.00~~ 15.00

(g) examination, if administered by the commissioner, for license as insurance producer, each examination 15.00

(h) surplus lines insurance producer license:

(i) application for original license and for issuance of license, if issued 50.00

(ii) annual renewal of license 50.00

(i) adjuster's license:

(i) application for original license and for issuance of license, if issued 15.00

(ii) annual renewal of license 15.00

(j) insurance vending machine license, each machine, each year 10.00

(k) commissioner's certificate under seal (except when on certificates of authority or licenses) 10.00

(l) copies of documents on file in the commissioner's office, per page ..... .50

(m) policy forms:

(i) filing each policy form 25.00

(ii) filing each application, rider, endorsement, amendment, insert page, schedule of rates, and clarification of risks 10.00

(iii) maximum charge if policy and all forms submitted at one time or resubmitted for approval within 180 days 100.00

(n) applications for approval of prelicensing education

courses:

(i) reviewing initial application 150.00

(ii) periodic review 50.00

(2) The commissioner shall promptly deposit with the state treasurer to the credit of the general fund of this state all fines and penalties, those amounts received pursuant to 33-2-311, 33-2-705, and 33-2-706, and any fees and examination and miscellaneous charges that are collected by him pursuant to Title 33 and the rules adopted under Title 33.

(3) All fees are considered fully earned when received. In the event of overpayment, only those amounts in excess of $10 will be refunded."

Section 4. Section 33-2-709, MCA, is amended to read:

"33-2-709. Retaliatory fees, taxes, and other obligations. (1) When by or pursuant to the laws of any other state or foreign country any taxes, licenses, and other fees, in the aggregate, and any fines, penalties, deposit requirements, or other material obligations, prohibitions, or restrictions are or would be imposed upon Montana insurers or upon the insurance producers or representatives of such insurers which are in excess of such taxes, licenses, and other fees, in the aggregate, or which are in excess of the fines, penalties, deposit requirements, or other obligations, prohibitions, or restrictions directly imposed upon similar insurers or upon the insurance producers or representatives of such insurers of such other state or country

under the statutes of this state, so long as such laws of such other state or country continue in force or are so applied, the same taxes, licenses, and other fees, in the aggregate, or fines, penalties, or deposit requirements or other material obligations, prohibitions, or restrictions of whatever kind shall be imposed by the commissioner upon the insurers or upon the insurance producers or representatives of such insurers of such other state or country doing business or seeking to do business in Montana. Any tax, license, or other fee or other obligation imposed by any city, county, or other political subdivision or agency of such other state or country on Montana insurers or their insurance producers or representatives shall be deemed to be imposed by such state or country within the meaning of this section.

(2) This section shall not apply as to any fees in conjunction with the licensing of insurance producers, personal income taxes, ad valorem taxes on real or personal property, or special purpose obligations or assessments imposed by another state or by an agency of this state other than the department in connection with particular kinds of insurance other than property insurance, except that deductions from premium taxes or other taxes otherwise payable allowed on account of real estate or personal property taxes paid shall be taken into consideration by the commissioner in determining the propriety and extent of retaliatory action under this section.

(3) (a) For the purposes of this section the domicile of an

alien insurer, other than insurers formed under the laws of Canada, shall be that state designated by the insurer in writing filed with the commissioner at time of admission to this state or within 6 months after January 1, 1961, whichever date is the later, and may be any one of the following states:

(i) that in which the insurer was first authorized to transact insurance;

(ii) that in which is located the insurer's principal place of business in the United States;

(iii) that in which is held the larger deposit of trusteed assets of the insurer for the protection of its policyholders and creditors in the United States.

(b) If the insurer makes no such designation, its domicile shall be deemed to be that state in which is located its principal place of business in the United States."

Section 5. Section 33-3-401, MCA, is amended to read:

"**33-3-401. Home office and records -- penalty for unlawful removal of records or assets.** (1) Every domestic insurer shall have and maintain its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary or suitable as to the kind or kinds of insurance transacted. Records of the insurer's operations and other financial records reasonably related to its insurance operations for the preceding 5 years must be maintained and be

available to the commissioner or his duly constituted examiner.

(2) Every domestic insurer shall have and maintain its assets in this state, except as to:

(a) real property and personal property appurtenant thereto lawfully owned by the insurer and located outside this state; and

(b) such property of the insurer as may be customary, necessary, and convenient to enable and facilitate the operation of its branch offices and regional home offices located outside this state as referred to in subsection (4) below.

(3) Removal of all or a material part of the records or assets of a domestic insurer from this state except pursuant to a plan of merger or consolidation approved by the commissioner under this code or for such reasonable purposes and periods of time as may be approved by the commissioner in writing in advance of such removal or concealment of such records or assets or material part thereof from the commissioner is prohibited. Any person who removes or attempts to remove such records or assets or such material part thereof from the home office or other place of business or of safekeeping of the insurer in this state with the intent to remove the same from this state or who conceals or attempts to conceal the same from the commissioner, in violation of this subsection, shall upon conviction thereof be guilty of a felony punishable by a fine of not more than $10,000 or by imprisonment in the penitentiary for not more than 5 years or by both such fine and imprisonment in the discretion of the court.

Upon any removal or attempted removal of such records or assets or upon retention of such records or assets or material part thereof outside this state beyond the period therefor specified in the commissioner's consent under which the records were so removed thereat or upon concealment of or attempt to conceal records or assets in violation of this section, the commissioner may institute delinquency proceedings against the insurer pursuant to the provisions of chapter 2, part 13.

(4) This section shall not be deemed to prohibit or prevent an insurer from:

(a) establishing and maintaining branch offices or regional home offices in other states where necessary or convenient to the transaction of its business and keeping therein the detailed records and assets customary and necessary for the servicing of its insurance in force and affairs in the territory served by such an office, as long as such records and assets are made readily available at such office for examination by the commissioner at his request;

(b) having, depositing, or transmitting funds and assets of the insurer in or to jurisdictions outside of this state as reasonably and customarily required in the regular course of its business;

(c) making deposits under custodial arrangements as provided by 33-2-604(3)."

Section 6. Section 33-3-431, MCA, is amended to read:

"**33-3-431. Borrowed surplus.** (1) A domestic stock or mutual insurer may borrow money to defray the expenses of its organization, provide it with surplus funds, or for any purpose of its business, upon a written agreement that such money is required to be repaid only out of the insurer's surplus in excess of that stipulated in such agreement. The agreement may provide for interest ~~not exceeding 6% per annum~~ at a rate no greater than the rate established in 25-9-205, which interest shall or shall not constitute a liability of the insurer as to its funds other than such excess of surplus, as stipulated in the agreement. No commission or promotion expense shall be paid in connection with any such loan.

(2) Money so borrowed, together with the interest thereon if so stipulated in the agreement, shall not form a part of the insurer's legal liabilities except as to its surplus in excess of the amount thereof stipulated in the agreement or be the basis of any setoff; but until repaid, financial statements filed or published by the insurer shall show as a footnote thereto the amount thereof then unpaid together with any interest thereon accrued but unpaid.

(3) Any such loan to a mutual insurer shall be subject to the commissioner's approval. The insurer shall, in advance of the loan, file with the commissioner a statement of the purpose of the loan and a copy of the proposed loan agreement. The loan and agreement shall be deemed approved unless within 15 days after

date of such filing the insurer is notified of the commissioner's disapproval and the reasons therefor. The commissioner shall disapprove any proposed loan or agreement if he finds the loan is unnecessary or excessive for the purpose intended or that the terms of the loan agreement are not fair and equitable to the parties, and to other similar lenders, if any, to the insurer, or that the information so filed by the insurer is inadequate.

(4) Any such loan to a mutual insurer or substantial portion thereof shall be repaid by the insurer when no longer reasonably necessary for the purpose originally intended. No repayment of such loan shall be made by a mutual insurer unless in advance approved by the commissioner.

(5) This section shall not apply to loans obtained by the insurer in ordinary course of business from banks and other financial institutions or to loans secured by pledge or mortgage of assets."

Section 7. Section 33-17-208, MCA, is amended to read:

"33-17-208. Prelicensing education -- basic requirement. (1) (a) A person applying for a license to act as an insurance producer for property, casualty, and surety insurance shall complete 40 hours of approved prelicensing education courses in those areas of insurance within 12 months prior to the examination, unless he is exempted from the requirement under subsection (3).

(b) A person applying for a license to act as an insurance

producer for life and disability insurance or as an enrollment representative for a health service corporation shall complete 40 hours of approved prelicensing education courses in those areas of insurance within 12 months prior to the examination, unless he is exempted from the requirement under subsection (3).

(2) A person applying for licenses to act as an insurance producer for both the property, casualty, and surety areas and the life and/or disability areas must meet the education requirements in all the areas of insurance.

(3) The minimum prelicensing education requirement does not apply to a person who:

(a) has been licensed within the 12 preceding months as an insurance producer in another state that requires prelicensing education and has completed the education in the other state;

(b) seeks a nonresident license, having been licensed as an insurance provider in his state of residence for at least 1 year;

(c) seeks a nonresident license and is from a state having a prelicensing education requirement;

(d) seeks to reinstate a license lapsed for less than 2 years;

(e) seeks a temporary license under 33-17-216; or

(f) is exempt from examination requirements under 33-17-212~~(5)~~(7)."

Section 8. Section 33-17-603, MCA, is amended to read:

"33-17-603. Certificate of registration. (1) Except as

provided in 33-17-604, a person may not act as or hold himself out to be an administrator in this state unless he holds a certificate of registration as an administrator.

(2) An application for a certificate of registration must be accompanied by a fee of $100. The commissioner shall issue the certificate unless he finds that the applicant is not competent, trustworthy, financially responsible, or of good personal and business reputation or that the applicant has had a previous application for a license denied for cause within 5 years.

(3) The certificate of registration is renewable annually on ~~the--date--of--issue~~ July 1. A request for renewal must be accompanied by a renewal fee of $100.

(4) The certificate of registration may be suspended or revoked if, after notice and hearing, the commissioner finds that the administrator has violated any of the requirements of this part or that the administrator is not competent, trustworthy, financially responsible, or of good personal and business reputation.

(5) Unless the certification requirement is waived, a person who acts as an administrator without a certificate of registration is subject to a fine of not less than $500 or more than $1,500."

Section 9. Section 33-20-303, MCA, is amended to read:

"**33-20-303. Incontestability.** If any statements other than those relating to age~~,--sex,~~ and identity are required as a condition to issuing an annuity or pure endowment contract, other

than a reversionary, survivorship, or group annuity, and subject to 33-20-305, there shall be a provision that the contract shall be incontestable after it has been in force during the lifetime of the person or of each of the persons as to whom such statements are required, for a period of 2 years from its date of issue, except for nonpayment of stipulated payments to the insurer; and at the option of the insurer such contract may also except any provisions relative to benefits in the event of disability and any provisions which grant insurance specifically against death by accident or accidental means."

Section 10. Section 33-20-305, MCA, is amended to read:

"**33-20-305. Misstatement of age ~~or--sex~~.** In an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, there shall be a provision that if the age ~~or--sex~~ of the person or persons upon whose life or lives the contract is made, or of any of them, has been misstated, the amount payable or benefits accruing under the contract shall be such as the stipulated payment or payments to the insurer would have purchased according to the correct age ~~or--sex~~ and that if the insurer shall make or has made any overpayment or overpayments on account of any such misstatement, the amount thereof, with interest at the rate to be specified in the contract but not exceeding 6% per annum, may be charged against the current or next succeeding payment or payments to be made by the insurer under the contract."

Section 11. Section 33-22-502, MCA, is amended to read:

"33-22-502. Required provisions of group policies. Each ~~such~~ group disability insurance policy ~~shall~~ delivered or issued for delivery in this state must contain in substance the following provisions:

(1) a provision that, in the absence of fraud, all statements made by applicants or the policyholder or by an insured person shall be deemed representations and not warranties and that no statement made for the purpose of effecting insurance shall avoid such insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to such policyholder or to such person or his beneficiary;

(2) a provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group a statement in summary form of the essential features of the insurance coverage of such employee or member and to whom benefits thereunder are payable. If dependents are included in the coverage, only one certificate need be issued for each family unit.

(3) a provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.

(4) a provision or the equivalent thereto that reads:

"Conformity with Montana statutes. The provisions of this

policy conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this policy.""

Section 12. Section 33-22-921, MCA, is amended to read:

"33-22-921. Discontinuance or nonrenewal -- alternate policy or certificate -- same insurer. (1) If a disability insurer discontinues or does not renew a medicare supplement policy product or certificate and offers an alternate medicare supplement policy or certificate to its insureds within this state, it may not deny benefits under the replacing policy or certificate to an insured who receives treatment for a condition that was a covered expense under the replaced policy or certificate and is a covered expense under the replacing policy or certificate if the insured enrolls in and pays the premium for the replacing policy or certificate within 31 days after the termination of the replaced policy or certificate.

(2) A disability insurer who discontinues or does not renew a medicare supplement policy product or certificate and offers an alternate medicare supplement policy or certificate shall base its premium for the alternate policy or certificate on the rates currently in place for that policy or certificate.

(3) If the insured has not satisfied the preexisting condition limitation under the replaced medicare supplement policy or certificate, any period of time that was covered by that policy or certificate must be credited toward the preexisting condition

limitation period of the replacing policy or certificate."

Section 13. Section 33-22-923, MCA, is amended to read:

"33-22-923. **Replacement policy** or certificate -- **different insurer.** (1) If a disability insurer replaces a medicare supplement policy or certificate, it may not deny benefits under the replacing policy or certificate to an insured who receives treatment for a condition that was a covered expense under the replaced policy or certificate and is a covered expense under the replacing policy or certificate if the insured pays the premium for the replacing policy or certificate when due or within 31 days after the termination of the replaced policy or certificate.

(2) An insurer who replaces a medicare supplement policy or certificate shall base its premium for the replacement policy or certificate on the rates currently in place for that policy or certificate.

(3) If the insured has not satisfied the preexisting condition limitation under the replaced medicare supplement policy or certificate, any period of time that was covered by that policy or certificate must be credited toward the preexisting condition limitation period of the replacing policy or certificate.

(4) To receive the benefits of subsections (1) through (3), a person shall submit to the replacing insurer proof of prior coverage, evidence of benefits provided under the previous policy or certificate, and the effective date and the date of termination of coverage under the previous policy or certificate."

Section 14. Section 33-22-924, MCA, is amended to read:

"33-22-924. **Renewal requirement.** (1) If a person pays a renewal premium on the date it is due or within 31 days after it is due, an insurer may not refuse to renew a medicare supplement policy or certificate unless the insurer:

(a) refuses to renew all policies or certificates in this state that are of the same form and issued to persons of the same class; and

(b) offers a replacement policy or certificate at actuarially justified rates.

(2) If an insurer refuses to renew all policies or certificates in this state that are of the same form and issued to persons of the same class, the policies or certificates will remain in force during the grace period stated in the replaced policy or certificate. An insurer's refusal to renew a policy or certificate may not affect a claim that arose under the ~~replaced~~ discontinued policy or certificate during the period in which an insured was confined without interruption to a medical care facility for treatment."

Section 15. Section 33-22-1501, MCA, is amended to read:

"33-22-1501. **Definitions.** As used in this part, the following definitions apply:

(1) "Association" means the comprehensive health association created by 33-22-1503.

(2) "Association plan" means a policy of insurance coverage

offered by the association ~~through--the--lead--carrier~~ that is certified by the association as required by 33-22-1521.

(3) "Association plan premium" means the charge determined pursuant to 33-22-1512 for membership in the association plan based on the benefits provided in 33-22-1521.

(4) "Eligible person" means an individual who:

(a) is a resident of this state and applies for coverage under the association plan; and

(b) unless the individual's eligibility is waived by the association, within 6 months prior to the date of application, has been rejected for disability insurance or health service benefits by at least two insurers, societies, or health service corporations, or has had a restrictive rider or preexisting conditions limitation, which limitation is required by at least two insurers, societies, or health service corporations, which has the effect of substantially reducing coverage from that received by a person considered a standard risk.

(5) "Health service corporation" means a corporation operating pursuant to Title 33, chapter 30, and offering or selling contracts of disability insurance.

(6) "Insurance arrangement" means any plan, program, contract, or other arrangement to the extent not exempt from inclusion by virtue of the provisions of the federal Employee Retirement Income Security Act of 1974 under which one or more employers, unions, or other organizations provide to their

employees or members, either directly or indirectly through a trust of a third-party administrator, health care services or benefits other than through an insurer.

(7) "Insurer" means a company operating pursuant to Title 33, chapter 2 or 3, and offering or selling policies or contracts of disability insurance, as provided in Title 33, chapter 22.

(8) "Lead carrier" means the licensed administrator or insurer selected by the association to administer the association plan.

(9) "Preexisting condition" means any condition for which an applicant for coverage under the association plan has received medical attention during the 5 years immediately preceding the filing of an application.

~~(10)--"Qualified--plan"--means--those--health---benefit---plans certified--by--the--commissioner-as-providing-the-minimum-benefits required-by--33-22-1521--or--the--actuarial--equivalent--of--those benefits.~~

~~(11)~~(10) "Society" means a fraternal benefit society operating pursuant to Title 33, chapter 7, and offering or selling certificates of disability insurance."

Section 16. Section 33-22-1504, MCA, is amended to read:

"33-22-1504. Association board of directors -- organization. (1) There is a board of directors of the association, consisting of eight individuals:

(a) one from each of the seven participating members of the

association with the highest annual premium volume of disability insurance contracts or health service corporation contracts, derived from or on behalf of residents in the previous calendar year, as determined by the commissioner; and

(b) a member at large, appointed by the commissioner to represent the public interest, who shall serve in an advisory capacity only.

(2) Each of the seven board members representing the association members is entitled to a weighted average vote, in person or by proxy, based on the association member's annual Montana premium volume. However, a board member may not have more than 50% of the vote.

(3) Members of the board may be reimbursed from the money of the association for expenses incurred by them due to their service as board members but may not otherwise be compensated by the association for their services. The costs of conducting the meetings of the association and its board of directors must be borne by participating members of the association in accordance with 33-22-1513."

Section 17. Section 33-22-1513, MCA, is amended to read:

"33-22-1513. Operation of association plan. (1) Upon acceptance by the lead carrier under 33-22-1516, an eligible person may enroll in the association plan by payment of the association plan premium to the lead carrier.

(2) Not less than 88% of the association plan premiums paid

to the lead carrier may be used to pay claims and not more than 12% may be used for payment of the lead carrier's direct and indirect expenses as specified in 33-22-1514.

(3) Any income in excess of the costs incurred by the association in providing reinsurance or administrative services must be held at interest and used by the association to offset past and future losses due to claims expenses of the association plan or be allocated to reduce association plan premiums.

(4) (a) Each participating member of the association shall share the losses due to claims expenses of the association plan for plans issued or approved for issuance by the association and shall share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs. Claims expenses of the association plan that exceed the premium payments allocated to the payment of benefits are the liability of the association members. Association members shall share in the claims expenses of the association plan and operating and administrative expenses of the association in an amount equal to the ratio of:

~~(a)~~(i) the association member's total disability insurance premium received from or on behalf of Montana residents divided by;

~~(b)~~(ii) the total disability premium received by all association members from or on behalf of Montana residents, as determined by the commissioner.

(b) For purposes of this subsection (4), "total disability insurance premium" does not include premiums received from disability income insurance, credit disability insurance, disability waiver insurance, or life insurance.

(5) The association shall make an annual determination of each association member's liability, if any, and may make an annual fiscal yearend assessment if necessary. The association may also, subject to the approval of the commissioner, provide for interim assessments against the association members as may be necessary to assure the financial capability of the association in meeting the incurred or estimated claims expenses of the association plan and operating and administrative expenses of the association until the association's next annual fiscal yearend assessment. Payment of an assessment is due within 30 days of receipt by an association member of a written notice of a fiscal yearend or interim assessment. Failure by a contributing member to tender to the association the assessment within 30 days is grounds for termination of membership. An association member that ceases to do disability insurance business within the state remains liable for assessments through the calendar year during which disability insurance business ceased. The association may decline to levy an assessment against an association member if the assessment, as determined pursuant to this section, would not exceed $10.

(6) Any annual fiscal yearend or interim assessment levied

against an association member may be offset, in an amount equal to the assessment paid to the association, against the premium tax payable by that association member pursuant to 33-2-705 for the year in which the annual fiscal yearend or interim assessment is levied. The insurance commissioner shall, each year the legislature meets in regular session, on or before January 15, report to the legislature the total amount of premium tax offset claimed by association members during the preceding biennium."

Section 18. Section 33-23-302, MCA, is amended to read:

"33-23-302. Cancellation or alteration of policy -- increase of premium rates -- sixty days' written notice required. Any insurer who insures a physician and surgeon, dentist, registered nurse, nursing home administrator, registered physical therapist, podiatrist, licensed psychologist, osteopath, chiropractor, pharmacist, optometrist, or veterinarian, duly licensed ~~as such~~ under the laws of this state, or a licensed hospital or long-term care facility as the employer of any such person against liability for error, omission, professional negligence, or performance of services without consent ~~shall~~ may not cancel or alter the policy ~~so~~ insuring ~~such~~ the person or increase the premium rates thereon without first providing the insured 60 days' written notice of the insurer's intention to cancel or alter the policy or increase the premium rates."

Section 19. Section 61-12-303, MCA, is amended to read:

"61-12-303. Requirements for license. (1) ~~No license shall be~~

~~issued--by--the~~ The commissioner may not issue a license to a company until the company has filed with him the following:

(a) a formal application in such form and detail as the commissioner may require, executed under oath by its president or other principal officer;

(b) a copy of the form of its contract;

(c) a certified copy of its charter or articles of incorporation and its bylaws, if any;

(d) a financial statement in such form and detail as the commissioner may require, executed on oath by its president or other principal officer;

(e) a certificate from the ~~state-treasurer~~ commissioner that it has complied with 61-12-304 in all cases where a deposit of cash or a bond is required by this part;

(f) a certificate from the corporation commissioner of the state of Montana, in the event it be a corporation, that it has complied with the corporation laws of said state.

(2) ~~No--license--shall--be-issued-by-the~~ The commissioner may not issue a license to a company until the company has paid to the commissioner $100 as an annual license fee, or the pro rata portion thereof necessary to be paid to the end of the current calendar year from the date of the application for ~~such~~ the license.

(3) ~~No--license--shall--be-issued-by-the~~ The commissioner may not issue a license to a company until the company has satisfied

him by ~~such~~ an examination ~~as-he-may-make~~ and ~~such~~ evidence ~~as-he~~ the commissioner may require, in his discretion, that ~~such~~ the company has complied with the laws of the state of Montana and that its management is trustworthy and competent."

Section 20. Section 61-12-304, MCA, is amended to read:

"61-12-304. Deposits required. ~~No-license--shall--be--granted~~ The commissioner may not grant a license to a company ~~as-herein defined-except-as-hereinafter-stated~~ until it has deposited with the ~~state-treasurer~~ commissioner the sum of $25,000 in cash or in lieu thereof a bond in a form prescribed by the commissioner payable to the state of Montana in the sum of $25,000, with surety approved by the commissioner, conditioned upon the faithful performance of its service contracts and payment of any fines or penalties levied against it for failure to comply with this part; ~~provided,--however,--that~~. However, when any company, ~~as-herein defined,-shall-prove~~ proves to the commissioner that it has been in continuous, active operation in the state for a period of more than the preceding 5 years ~~immediately-last-past~~ and has a paid membership of more than 5,000 members within the state or that there are more than 5,000 holders of its service contracts within the state and that it is being properly managed, is rendering to its members the services promised to them, and is financially responsible, ~~no--such~~ the commissioner may not require a cash deposit or bond ~~shall-be required~~ while ~~such~~ the company remains in ~~such~~ that condition. The ~~foregoing~~ cash deposit or bond is not

~~required in any instance as~~ a penalty, but is for the protection of the public only."

Section 21. Section 61-12-305, MCA, is amended to read:

"61-12-305. ~~Expiration~~ Continuance of license. ~~Every~~ Subject to payment by January 1 of each year of the annual license fee required under 61-12-303, each license ~~issued hereunder shall expire annually on January 1 of each year unless sooner~~ continues in force as long as the company is entitled to the license under this part or until the license is revoked, or suspended, ~~as hereinafter provided~~ or otherwise terminated."

Section 22. **Policy provisions -- conformity with state statutes.** Each policy regulated by this part must contain a provision or the equivalent thereto as follows:

"Conformity with Montana statutes. The provisions of this policy conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this policy."

Section 23. **Casualty insurance policy -- conformity with state statutes.** A casualty insurance policy relative to a risk resident, located, or to be performed in this state must contain a provision or the equivalent thereto as follows:

"Conformity with Montana statutes. The provisions of this policy conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this policy."

Section 24. **Property insurance policy -- conformity with state statutes.** A property insurance policy relative to a risk resident, located, or to be performed in this state must contain a provision or the equivalent thereto as follows:

"Conformity with Montana statutes. The provisions of this policy conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this policy."

Section 25. Section 33-17-102, MCA, is amended to read:

"33-17-102. **Definitions.** As used in this title, the following definitions apply:

(1) "Adjuster" means a person who, on behalf of the insurer, for compensation as an independent contractor or as the employee of an independent contractor or for fee or commission investigates and negotiates settlement of claims arising under insurance contracts or otherwise acts on behalf of the insurer. The term does not include a:

(a) licensed attorney who is qualified to practice law in this state;

(b) salaried employee of an insurer or of a managing general agent; or

(c) licensed insurance producer who adjusts or assists in adjustment of losses arising under policies issued by the insurer.

(2) "Adjuster license" means a document issued by the commissioner that authorizes a person to act as an adjuster.

(3) (a) "Administrator" means a person who collects charges or premiums from residents of this state in connection with life, disability, property, or casualty insurance or annuities or who adjusts or settles claims on such coverage.

(b) The term does not mean:

(i) an employer on behalf of its employees or on behalf of the employees of one or more subsidiaries of affiliated corporations of the employer;

(ii) a union on behalf of its members;

(iii) (A) an insurer that is either authorized in this state or acting as an insurer with respect to a policy lawfully issued and delivered by it in and pursuant to the laws of a state in which the insurer is authorized to transact insurance; or

(B) a health service corporation as defined in 33-30-101;

(iv) a life, disability, property, or casualty insurance producer who is licensed in this state and whose activities are limited exclusively to the sale of insurance;

(v) a creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors;

(vi) a trust established in conformity with 29 U.S.C. 186 or the trustees, agents, and employees of the trust;

(vii) a trust exempt from taxation under section 501(a) of the Internal Revenue Code or the trustees and employees of the trust;

(viii) a custodian acting pursuant to a custodian account that meets the requirements of section 401(f) of the Internal Revenue

Code or the agents and employees of the custodian;

(ix) a bank, credit union, or other financial institution that is subject to supervision or examination by federal or state banking authorities;

(x) a company that issues credit cards and that advances for and collects premiums or charges from its credit card holders who have authorized it to do so, if the company does not adjust or settle claims; or

(xi) a person who adjusts or settles claims in the normal course of his practice or employment as an attorney and who does not collect charges or premiums in connection with life or disability insurance or annuities.

(4) "Administrator license" means a document issued by the commissioner that authorizes a person to act as an administrator.

(5) "Consultant" means a person who for a fee examines, appraises, reviews, or evaluates an insurance policy, annuity, or pension contract, plan, or program or who makes recommendations or gives advice on an insurance policy, annuity, or pension contract, plan, or program.

(6) "Consultant license" means a document issued by the commissioner that authorizes a person to act as an insurance consultant.

(7) "Controlled business" means insurance procured or to be procured by or through a person upon the life, person, property, or risks of himself, his spouse, his employer, or his business.

(8) "Individual" means a private or natural person, as distinguished from a partnership, corporation, or association.

(9) "Insurance producer", except as provided in 33-17-103:

(a) means:

(i) a person who solicits, negotiates, effects, procures, delivers, renews, continues, or binds:

(A) policies of insurance for risks residing, located, or to be performed in this state; or

(B) membership contracts as defined in 33-30-101;

(ii) a managing general agent. For purposes of this definition, a "managing general agent" is a person who, on behalf of an insurer, exercises general supervision over the business of the insurer in this state or in any other state, including the authority to contract with an insurance producer for the insurer and terminate those contracts.

(b) does not mean a customer service representative. For purposes of this definition, a "customer service representative" means a salaried employee of an insurance producer who assists and is responsible to the insurance producer.

(10) "License" means a document issued by the commissioner that authorizes a person to act as an insurance producer for the kinds of insurance specified in the document. The license itself does not create actual, apparent, or inherent authority in the holder to represent or commit an insurer to a binding agreement.

(11) "Person" means an individual, partnership, corporation,

association, or other legal entity.

(12) "Public adjuster" means an adjuster employed by and representing the interests of the insured."

Section 26. Section 33-22-1511, MCA, is amended to read:

"**33-22-1511. Minimum benefits of association plan.** The association through the association plan shall offer a policy that provides at least the benefits ~~of a qualified plan as~~ required by 33-22-1521."

Section 27. Section 33-22-1512, MCA, is amended to read:

"**33-22-1512. Association plan premium.** The association shall establish the schedule of premiums to be charged eligible persons for membership in the association plan. The schedule of premiums may not be less than 150% or more than 400% of the average premium rates charged by the five ~~largest~~ insurers with the largest premium amount of individual ~~qualified plan~~ plans of major medical insurance in force in this state. The premium rates of the five insurers used to establish the premium rates for each type of coverage offered by the association must be determined by the commissioner from information provided annually by all insurers at the request of the commissioner. ~~The information requested must include the number of qualified plans or actuarial equivalent plans offered by each insurer, the rates charged by the insurer for each type of plan offered by the insurer, and any other information the commissioner considers necessary.~~ The association shall utilize generally acceptable actuarial principles and

structurally compatible rates."

Section 28. Section 33-22-1514, MCA, is amended to read:

"33-22-1514. Administration of association plan -- rules. ~~(1) Any member of the association may submit to the commissioner policies to be proposed to serve as the association plan. The commissioner shall prescribe by rule the time and manner of the submission.~~

~~(2)~~(1) ~~Upon the commissioner's approval of the policy forms and contracts submitted, the association shall select policies and contracts by a member or members of the association to be the association plan.~~ The association shall select one lead carrier to issue the ~~qualified plans~~ association plan. The board of directors of the association shall prepare appropriate specifications and bid forms and may solicit bids from licensed administrators and the members of the association for the purpose of selecting the lead carrier. The selection of the lead carrier must be based upon criteria established by the board of directors.

~~(3)~~(2) The lead carrier shall perform all administrative and claims payment functions required by this section upon the commissioner's approval of the policy forms and contracts submitted. The lead carrier shall provide these services for a period of at least 3 years, unless a request to terminate is approved by the association and the commissioner. The association and the commissioner shall approve or deny a request to terminate within 90 days of its receipt. A failure to make a final decision

on a request to terminate within the specified period is considered an approval. The association shall invite submissions of policy forms from members of the association, including the lead carrier, 6 months prior to the expiration of each 3-year period. The association shall follow the procedure provided in subsection ~~(2)~~ (1) in selecting a lead carrier for the subsequent 3-year period or, if a request to terminate is approved, on or before the end of the 3-year period.

~~(4)~~(3) The lead carrier shall provide all eligible persons involved in the association plan an individual certificate setting forth a statement as to the insurance protection to which the person is entitled, the method and place of filing claims, and to whom benefits are payable. The certificate must indicate that coverage was obtained through the association.

~~(5)~~(4) The lead carrier shall submit to the association and the commissioner on a semiannual basis a report of the operation of the association plan. The association must determine the specific information to be contained in the report prior to the effective date of the association plan.

~~(6)~~(5) The lead carrier shall pay all claims pursuant to this part and shall indicate that the claim was paid by the association plan. Each claim payment must include information specifying the procedure involved in the event a dispute over the amount of payment arises.

~~(7)~~(6) The lead carrier must be reimbursed from the

association plan premiums received for its direct and indirect expenses. Direct and indirect expenses include a prorated reimbursement for the portion of the lead carrier's administrative, printing, claims administration, management, and building overhead expenses, which are assignable to the maintenance and administration of the association plan. The association must approve cost accounting methods to substantiate the lead carrier's cost reports consistent with generally accepted accounting principles. Direct and indirect expenses may not include costs directly related to the original submission of policy forms prior to selection as the lead carrier.

~~(8)~~(7) The lead carrier is, when carrying out its duties under this part, an independent contractor for the association and is individually liable for its actions, subject to the laws of this state."

Section 29. Section 33-22-1515, MCA, is amended to read:

"33-22-1515. Solicitation of eligible persons. (1) The association, pursuant to a plan approved by the commissioner, shall disseminate appropriate information to the residents of this state regarding the existence of the association plan and the means of enrollment. Means of communication may include use of the press, radio, and television, as well as publication in appropriate state offices and publications.

(2) The association shall devise and implement means of maintaining public awareness of this part and shall administer

this part in a manner which facilitates public participation in the association plan.

(3) All licensed disability insurance producers may engage in the selling or marketing of ~~qualified~~ the association ~~plans~~ plan. The lead carrier shall pay an insurance producer's referral fee of $25 to each licensed disability insurance producer who refers an applicant to the association plan, if the applicant is accepted. The referral fees must be paid ~~to~~ by the lead carrier from money received as premiums for the association plan.

(4) An insurer, society, or health service corporation that rejects or applies underwriting restrictions to an applicant for disability insurance must notify the applicant of the existence of the association plan, requirements for being accepted in it, and the procedure for applying to it."

Section 30. Section 33-22-1516, MCA, is amended to read:

"33-22-1516. Enrollment by eligible person. (1) The association plan must be open for enrollment by eligible persons. An eligible person may enroll in the plan by submission of a certificate of eligibility to the lead carrier. The certificate must provide:

(a) the name, address, and age of the applicant and length of the applicant's residence in this state;

(b) the name, address, and age of spouse and children, if any, if they are to be insured;

(c) written evidence that he fulfills all of the elements of

an eligible person, as defined in 33-22-1501; and

(d) a designation of coverage desired.

(2) Within 30 days of receipt of the certificate, the lead carrier shall either reject the application for failing to comply with the requirements of subsection (1) or forward the eligible person a notice of acceptance and billing information. Insurance is effective on the first of the month following acceptance.

(3) An eligible person may not purchase more than one policy from the association plan.

(4) A person who obtains coverage pursuant to this section may not be covered for any preexisting condition during the first 12 months of coverage under the association plan if the person was diagnosed or treated for that condition during the 5 years immediately preceding the filing of an application. This subsection does not apply to a person who has had continuous coverage under an individual, family, or group policy during the year immediately preceding the filing of an application and whose cancellation date was within 30 days prior to the date of submission of a certificate of eligibility to the lead carrier for nonelective procedures.

(5) A change of residence from Montana to another state immediately terminates eligibility for renewal of coverage under the association plan."

Section 31. Section 33-22-1521, MCA, is amended to read:

"33-22-1521. ~~Qualified~~ Association plan -- minimum benefits.

A plan of health coverage must be certified as a ~~qualified~~ association plan if it otherwise meets the requirements of Title 33, chapters 15, 22 (excepting part 7), and 30, and other laws of this state, whether or not the policy is issued in this state, and meets or exceeds the following minimum standards:

(1) The minimum benefits for an insured must, subject to the other provisions of this section, be equal to at least 80% of the covered expenses required by this section in excess of an annual deductible that does not exceed $1,000 per person. The coverage must include a limitation of $5,000 per person on the total annual out-of-pocket expenses for services covered under this section. Coverage must be subject to a maximum lifetime benefit, but such maximums may not be less than $100,000.

(2) Covered expenses must be the usual and customary charges for the following services and articles when prescribed by a physician or other licensed health care professional provided for in 33-22-111:

(a) hospital services;

(b) professional services for the diagnosis or treatment of injuries, illness, or conditions, other than dental;

(c) use of radium or other radioactive materials;

(d) oxygen;

(e) anesthetics;

(f) diagnostic x-rays and laboratory tests, except as specifically provided in subsection (3);

(g) services of a physical therapist;

(h) transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition;

(i) oral surgery for the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth or in connection with TMJ;

(j) rental or purchase of medical equipment, which shall be reimbursed after the deductible has been met at the rate of 50%, up to a maximum of $1,000;

(k) prosthetics, other than dental; and

(l) services of a licensed home health agency, up to a maximum of 180 visits per year.

(3) (a) Covered expenses for the services or articles specified in this section do not include:

(i) drugs requiring a physician's prescription;

(ii) services of a nursing home;

(iii) home and office calls, except as specifically provided in subsection (2);

(iv) rental or purchase of durable medical equipment, except as specifically provided in subsection (2);

(v) the first $20 of diagnostic x-ray and laboratory charges in each 14-day period;

(vi) oral surgery, except as specifically provided in subsection (2);

(vii) that part of a charge for services or articles which

exceeds the prevailing charge in the locality where the service is provided; or

(viii) care that is primarily for custodial or domiciliary purposes which would not qualify as eligible services under medicare.

(b) Covered expenses for the services or articles specified in this section do not include charges for:

(i) care or for any injury or disease either arising out of an injury in the course of employment and subject to a workers' compensation or similar law, for which benefits are payable under another policy of disability insurance or medicare;

(ii) treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or congenital bodily defect to restore normal bodily functions;

(iii) travel other than transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition;

(iv) confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as medically necessary by a physician;

(v) services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles;

(vi) organ transplants, including bone marrow transplants;

(vii) room and board for a nonemergency admission on Friday or Saturday;

(viii) pregnancy, except complications of pregnancy;

(ix) routine well baby care;

(x) complications to a newborn, unless no other source of coverage is available;

(xi) sterilization or reversal of sterilization;

(xii) abortion, unless the life of the mother would be endangered if the fetus were carried to term;

(xiii) weight modification or modification of the body to improve the mental or emotional well-being of an insured;

(xiv) artificial insemination or treatment for infertility; or

(xv) breast augmentation or reduction."

Section 32. Section 33-1-704, MCA, is amended to read:

"**33-1-704. Hearing procedure.** (1) All hearings shall be open to the public unless closed pursuant to the provisions of 2-3-203.

(2) The commissioner shall allow any party to the hearing to appear in person and by counsel, to be present during the giving of all evidence, to have a reasonable opportunity to inspect all documentary evidence and to examine witnesses, to present evidence in support of his interest, and to have subpoenas issued by the commissioner to compel attendance of witnesses and production of evidence in his behalf.

(3) The commissioner shall permit to become a party to the hearing by intervention, if timely, any person who was not an

original party thereto and whose pecuniary interests will be directly and immediately affected by the commissioner's order made upon the hearing.

(4) Except as provided in 33-31-404, rules of pleading ~~or evidence~~ need not be observed at any hearing, but the rules of evidence must be observed.

(5) Upon written request seasonably made by a party to the hearing and at that person's expense, the commissioner shall cause a full stenographic record of the proceedings to be made by a competent reporter. If transcribed, a copy of such stenographic record shall be furnished to the commissioner without cost to the commissioner or the state and shall be a part of the commissioner's record of the hearing. If so transcribed, a copy of such stenographic record shall be furnished to any other party to such hearing at the request and expense of such other party. If no stenographic record is made or transcribed, the commissioner shall prepare an adequate record of the evidence and of the proceedings."

Section 33. Section 33-22-229, MCA, is amended to read:

"**33-22-229. Conformity with state statutes.** There must be a provision or the equivalent thereto as follows:

"Conformity with ~~State---Statutes~~ Montana statutes: ~~Any provision-of-this--policy--which--on--its--effective--date--is--in conflict--with--the--statutes--of--the--state-in-which-the-insured resides-on-such-date-is-hereby-amended-to-conform-to--the--minimum~~

~~requirements--of--such--statutes.~~ The provisions of this policy conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this policy.""

Section 34. Repealer. Section 33-22-1522, MCA, is repealed.

Section 35. **Name change -- short form amendment.** Wherever it appears in 33-7-519, 33-17-206, 33-18-210, and 33-18-501 or in insurance laws enacted by the 52nd legislature, the code commissioner is directed to change the term "solicitor" to "insurance producer".

Section 36. **Codification instruction.** (1) [Section 22] is intended to be codified as an integral part of Title 33, chapter 20, parts 1 and 12, and the provisions of Title 33, chapter 20, parts 1 and 12, apply to [section 22].

(2) [Section 23] is intended to be codified as an integral part of Title 33, chapter 23, part 1, and the provisions of Title 33, chapter 23, part 1, apply to [section 23].

(3) [Section 24] is intended to be codified as an integral part of Title 33, chapter 24, part 1, and the provisions of Title 33, chapter 24, part 1, apply to [section 24].