House BILL NO. 556

INTRODUCED BY Simon Rosendale

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING STATE INSURANCE LAWS; PROVIDING FOR THE DISCLOSURE OF MATERIAL TRANSACTIONS; CREATING A RISK-BASED CAPITAL FOR INSURERS ACT; AMENDING SECTIONS 2-6-109, 33-1-207, 33-1-208, 33-1-209, 33-1-311, 33-1-501, 33-2-117, 33-2-301, 33-2-302, 33-2-305, 33-2-307, 33-2-501, 33-2-521, 33-2-523, 33-2-525, 33-2-526, 33-2-528, 33-2-529, 33-2-531, 33-2-701, 33-2-705, 33-2-708, 33-2-803, 33-2-806, 33-2-820, 33-2-1111, 33-2-1201, 33-2-1216, 33-2-1217, 33-2-1218, 33-2-1510, 33-2-1605, 33-3-431, 33-4-202, 33-4-203, 33-5-401, 33-7-117, 33-10-201, 33-10-202, 33-11-102, 33-11-104, 33-11-108, 33-14-304, 33-15-301, 33-15-303, 33-16-202, 33-16-235, 33-17-102, 33-17-211, 33-17-405, 33-17-503, 33-17-603, 33-17-1001, 33-18-212, 33-18-301, 33-22-131, 33-22-132, 33-22-201, 33-22-202, 33-22-301, 33-22-303, 33-22-504, 33-22-508, 33-22-1120, 33-22-1803, 33-22-1819, 33-30-102, 33-30-107, 33-30-108, 33-30-202, 33-30-204, 33-30-311, 33-30-1001, AND 33-31-311, MCA; AND REPEALING SECTIONS 33-30-312 AND 33-30-313, MCA."

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

Section 1. Section 2-6-109, MCA, is amended to read:

"**2-6-109. Prohibition on distribution or sale of mailing lists -- exceptions -- penalty.** (1) Except as provided in subsections (3) through (7), in order to protect the privacy of those who deal with state and local government:

(a) ~~no~~ an agency may not distribute or sell for use as a mailing list any list of persons without first securing the permission of those on the list; and

(b) ~~no~~ a list of persons prepared by the agency may not be used as a mailing list except by the agency or another agency without first securing the permission of those on the list.

(2) As used in this section, "agency" means any board, bureau, commission, department, division, authority, or officer of the state or a local government.

(3) Except as provided in 30-9-403, this section does not prevent an individual from compiling a

mailing list by examination of original documents or applications which are otherwise open to public inspection.

(4) This section does not apply to the lists of registered electors and the new voter lists provided for in 13-2-115 and 13-38-103, to lists of the names of employees governed by Title 39, chapter 31, or to lists of persons holding driver's licenses provided for under 61-5-126.

(5) This section ~~shall~~ does not prevent an agency from providing a list to persons providing prelicensing or continuing educational courses subject to Title 20, chapter 30, or specifically exempted ~~therefrom~~ as provided in 20-30-102, or subject to Title 33, chapter 17.

(6) This section does not apply to the right of access either by Montana law enforcement agencies or, by purchase or otherwise, of public records dealing with motor vehicle registration.

(7) This section does not apply to a corporate information list developed by the secretary of state containing the name, address, registered agent, officers, and directors of business, nonprofit, religious, professional, and close corporations authorized to do business in this state.

(8) A person violating the provisions of subsection (1)(b) is guilty of a misdemeanor."

Section 2. Section 33-1-207, MCA, is amended to read:

"**33-1-207. Disability insurance.** (1) Disability insurance, including credit disability insurance, is insurance of human beings: (a) against bodily injury, disablement, or death by accident or accidental means or the medical expense ~~thereof~~ or indemnity involved; or

(b) against disablement or medical expense or indemnity resulting from sickness ~~and every insurance appertaining thereto~~.

(2) Transaction of disability insurance does not include workers' compensation insurance."

Section 3. Section 33-1-208, MCA, is amended to read:

"**33-1-208. Life insurance.** Life insurance, including credit life insurance, is insurance on human lives. The transaction of life insurance includes ~~also~~ the granting of endowment benefits, additional benefits in event of death or dismemberment by accident or accidental means, additional benefits in event of the insured's disability, benefits that provide reimbursement or payment for long-term home health care or long-term care in a nursing home or other related institution, and optional modes of settlement of proceeds of life insurance. Transaction of life insurance does not include workers' compensation insurance."

Section 4. Section 33-1-209, MCA, is amended to read:

"**33-1-209. Marine protection and indemnity and wet marine insurance.** (1) ~~Marine insurance includes marine protection and indemnity insurance, meaning insurance against, or against legal liability of the insured for, loss, damage, or expense arising out of or incident to the ownership, operation, chartering, maintenance, use, repair, or construction of any vessel, craft, or instrumentality in use in ocean or inland waterways, including liability of the insured for personal injury, illness, or death or for loss of or damage to the property of another person.~~ Marine and transportation insurance means insurance against loss of or damage to:

(a) vessels, craft, aircraft, vehicles, goods, freights, cargoes, merchandise, effects, disbursements, profits, money, securities, choses in action, evidences of debt, valuable papers, bottomry, respondentia, and any interest therein, with respect to risks and perils, including war risks, marine builder's risks, and personal property floater risks, of navigation and transportation or while being assembled, packed, crated, baled, compressed, or similarly prepared for shipment, while awaiting shipment, or during any delays, storage, transshipment, or reshipment;

(b) person or property in connection with marine, transit, or transportation insurance, including liability for loss or damage to either person or property incident to the construction, repair, operation, maintenance, or use of the subject matter of the insurance, but not including life insurance, surety bonds, or insurance against bodily injury arising out of the ownership, maintenance, or use of an automobile;

(c) jewels, jewelry, or precious metals, whether in the course of transportation or otherwise; and

(d) bridges; tunnels; and other instrumentalities of transportation and communication, excluding buildings and their furnishings, fixed contents, and supplies held in storage (unless fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot, or civil commotion are the only hazards to be covered); piers; wharves; docks; slips; and other aids to navigation and transportation, including drydocks, marina railways, and dams and appurtenant facilities for the control of waterways.

(2) Marine protection and indemnity insurance means insurance against liability of the insured for loss, damage, or expense incident to ownership, operation, charter, maintenance, use, repair, or construction of any vessel, craft, or instrumentality for use in ocean or inland waterways. The term includes insurance against the liability of the insured for personal injury, illness, death, or loss or damage of the property of another person.

~~(2)~~(3) For the purposes of this code, wet marine and transportation insurance is that part of marine

insurance ~~which~~ that includes only:

(a) insurance upon vessels, crafts, and hulls and of interests ~~therein or with relation thereto~~ in or relating to the vessels, crafts, and hulls;

(b) insurance of marine builders' risks, marine war risks, and contracts of marine protection and indemnity insurance;

(c) insurance of freights and disbursements pertaining to a subject of insurance ~~coming within~~ subject to this subsection; and

(d) insurance of personal property and interests ~~therein~~ in the personal property, in the course of exportation from or importation into any country and in the course of transportation coastwise or on inland waters, including transportation by land, water, or air from point of origin to final destination, ~~in~~ with respect to~~, appertaining to, or in connection with any and all~~ risks or perils of navigation, transit, or transportation or while being prepared for ~~and~~ or ~~while~~ awaiting shipment ~~and~~ or during any delays, storage, transshipment, or reshipment incident ~~thereto~~ to preparation or shipment."

Section 5. Section 33-1-311, MCA, is amended to read:

"**33-1-311. General powers and duties.** (1) The commissioner shall enforce the applicable provisions of ~~this code~~ the laws of this state and shall execute the duties imposed on the commissioner by ~~this code~~ the laws of this state.

(2) The commissioner ~~shall have~~ has the powers and authority expressly conferred upon the commissioner by or reasonably implied from the provisions of ~~this code~~ the laws of this state.

(3) The commissioner shall administer the department to ensure that the interests of insurance consumers are protected.

(4) The commissioner may conduct examinations and investigations of insurance matters, in addition to examinations and investigations expressly authorized, as the commissioner considers proper, to determine whether any person has violated any provision of ~~this code~~ the laws of this state or to secure information useful in the lawful administration of any provision. The cost of additional examinations and investigations must be borne by the state.

~~(5) The commissioner has additional powers and duties as provided by other laws of this state.~~

~~(6)~~(5) The department is a criminal justice agency as defined in 44-5-103."

Section 6. Section 33-1-501, MCA, is amended to read:

"**33-1-501. Filing and approval of forms.** (1) (a) An insurance policy or annuity contract form, certificate, enrollment form, application form, printed rider or endorsement form, or form of renewal certificate may not be delivered or issued for delivery in Montana unless the form has been filed with and approved by the commissioner and, if required, the regulatory official of the state of domicile of the insurer, ~~if required~~. This provision does not apply to surety bonds or policies, riders, endorsements, or forms of unique character designed for and used with relation to insurance upon a particular subject or that relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or disability insurance policies and are used at the request of the individual policyholder, contract holder, or certificate holder. Forms for use in property, marine, ~~(~~other than ocean marine and foreign trade coverages~~)~~, casualty, and surety insurance coverages may be filed by a rating organization on behalf of its members and subscribers or by a member or subscriber on its own behalf.

(b) The approval of an insurance policy or annuity contract form, certificate, enrollment form, application form, or other related insurance form by the state of domicile may be waived by the commissioner if the commissioner considers the requirements of subsection (1)(a) unnecessary for the protection of Montana insurance consumers. If the requirement is waived, an insurer shall notify the commissioner in writing within 10 days of disapproval, denial, or withdrawal of approval of a form by the state of domicile.

(2) The filing must be made not less than 60 days in advance of delivery. Approval of a form by the commissioner constitutes a waiver of any unexpired portion of the waiting period. The commissioner may extend by not more than an additional 60 days the period within which the commissioner may approve or disapprove a form by giving notice of the extension before expiration of the initial 60-day period. The commissioner may at any time, after notice and for cause shown, withdraw any approval.

(3) ~~An order of~~ Notice by the commissioner disapproving a form or withdrawing a previous approval must state the grounds for disapproval or withdrawal in sufficient detail to inform the insurer.

(4) The commissioner may exempt from the requirements of this section, for so long as the commissioner considers proper, an insurance document, form, or type of document or form ~~specified~~ to which, in the commissioner's opinion, this section may not practicably be applied or the filing and approval of which are~~, in the commissioner's opinion,~~ not desirable or necessary for the protection of the public.

(5) This section applies to a form used by a domestic insurer for delivery in a jurisdiction outside

Montana if the insurance supervisory official of the jurisdiction informs the commissioner that the form is not subject to approval or disapproval by the official and upon the commissioner's order requiring the form to be submitted to the commissioner for the purpose. The same standards apply to these forms as apply to forms for domestic use.

(6) This section and 33-1-502 do not apply to:

(a) reinsurance;

(b) policies or contracts not issued for delivery in Montana or delivered in Montana, except as provided in subsection (5);

(c) ocean marine and foreign trade insurances.

(7) Except as provided in chapter 21, group certificates that are delivered or issued for delivery in Montana for group insurance policies effectuated and delivered outside Montana but covering persons resident in Montana must be filed with the commissioner upon request. The certificates must meet the minimum provisions mandated by Montana if Montana law prevails over conflicting provisions of other state law."

Section 7. Section 33-2-117, MCA, is amended to read:

"**33-2-117. Continuance, expiration, reinstatement, and amendment of certificate of authority.** (1) Certificates of authority issued or renewed under this code ~~shall~~ must continue in force as long as the insurer is entitled thereto under this code and until suspended or revoked or otherwise terminated~~;~~. ~~subject, however,~~ A certificate is subject to continuance ~~of the certificate~~ by the insurer each year by payment prior to ~~May 15~~ March 1 of the continuation fee provided in 33-2-708.

(2) If not ~~so~~ continued by the insurer, ~~its~~ the certificate of authority ~~shall expire~~ expires at midnight on May 31 ~~next~~ following ~~such~~ failure of the insurer ~~so~~ to continue it in force. The commissioner shall promptly notify the insurer of ~~the occurrence of any such failure resulting in impending~~ its failure to pay the continuation fee that can result in the expiration of its certificate of authority.

(3) The commissioner may~~, in his discretion,~~ reinstate a certificate of authority ~~which~~ that the insurer has inadvertently permitted to expire~~,~~ after the insurer ~~has fully cured all its~~ cures any failures ~~which resulted~~ resulting in ~~such~~ expiration and upon payment ~~by the insurer~~ of the fee for reinstatement in addition to the current continuation fee, as provided in 33-2-708. Otherwise, the insurer ~~shall~~ may be granted another certificate of authority only after filing an application ~~therefor~~ and meeting all other

requirements ~~as~~ for an original certificate of authority in this state.

(4) The commissioner may amend a certificate of authority at any time to accord with changes in the insurer's charter of insuring powers."

Section 8. Section 33-2-301, MCA, is amended to read:

"**33-2-301. Short title -- purpose -- definitions.** (1) This part constitutes and may be referred to as "The Surplus Lines Insurance Law".

(2) This part must be applied to:

(a) protect persons seeking insurance in this state;

(b) permit surplus lines insurance to be placed with reputable and financially sound unauthorized insurers and to be exported from this state pursuant to this part;

(c) establish a system of regulation that will permit orderly access to surplus lines insurance in this state and encourage authorized insurers to provide new and innovative types of insurance to consumers in this state; and

(d) protect revenues of this state.

(3) As used in this part, the following definitions apply:

(a) "Authorized insurer" means an insurer authorized pursuant to 33-2-101 to transact insurance in this state.

(b) "Eligible surplus lines insurer" means an unauthorized insurer with which a surplus lines insurance producer may place surplus lines insurance under 33-2-307.

(c) "Export" means to place surplus lines insurance with an unauthorized insurer.

~~(d) "Kind of insurance" means one of the types of insurance required to be reported in the annual statement filed with the commissioner by an authorized insurer.~~

~~(e)~~(d) "Producing insurance producer" means the individual insurance producer dealing directly with the person seeking insurance.

~~(f)~~(e) "Surplus lines insurance" means any insurance ~~(~~on risks resident, located, or to be performed in this state~~)~~ permitted to be placed through a surplus lines insurance producer with an unauthorized insurer eligible to accept the insurance. The term does not include the kinds of insurance exempted under 33-2-317.

~~(g)~~(f) "Surplus lines insurance producer" means an individual, partnership, or corporation licensed

under 33-2-305 to place surplus lines insurance ~~(~~on risks resident, located, or to be performed in this state~~)~~ with unauthorized insurers eligible to accept ~~such~~ the insurance.

~~(h)~~(g) "Unauthorized insurer" means an insurer not authorized pursuant to 33-2-101 to transact insurance in this state. The term includes insurance exchanges authorized under the laws of other states."

Section 9. Section 33-2-302, MCA, is amended to read:

"**33-2-302. Conditions precedent to sale of surplus lines insurance.** ~~Insurance may be procured through a licensed surplus lines insurance producer from~~ A producing insurance producer may request a surplus lines insurance producer to place or a surplus lines insurance producer may place a contract of insurance with an unauthorized insurer if:

(1) the insurer is an eligible surplus lines insurer;

(2) the line of insurance or the full amount of the line of insurance cannot be obtained from authorized insurers;

(3) the producing insurance producer makes a diligent effort to place the business with a minimum of three insurers authorized and actually transacting that line of business in this state. If fewer than three insurers are authorized and actually transacting the line of business in this state, diligent effort must be met by searching this lesser market.

(4) the insurance is not procured for the purpose of securing:

(a) a lower premium rate than would be accepted by an authorized insurer; or

(b) an advantage in terms of the insurance contract; ~~and~~

(5) in case of renewal, the line has not become available from an authorized insurer; and

~~(5)~~(6) all other requirements of this part are met."

Section 10. Section 33-2-305, MCA, is amended to read:

"**33-2-305. Licensing of surplus lines insurance producer -- fee and bond.** (1) A person may not ~~procure~~ place a contract of surplus lines insurance with an unauthorized insurer unless the person is licensed as a property and casualty insurance producer and possesses a current surplus lines insurance license issued by the commissioner.

(2) The commissioner shall issue a surplus lines insurance license to any qualified holder of a current property and casualty insurance producer license only if the insurance producer has:

(a) remitted to the commissioner the annual fee prescribed by 33-2-708;

(b) submitted to the commissioner a completed license application on a form supplied by the commissioner;

(c) been licensed as a property and casualty insurance producer continuously for 5 years or more; and

(d) filed with the commissioner and, for as long as the license remains in effect, kept in force a bond in favor of the state of Montana in the amount of $10,000, with authorized corporate sureties approved by the commissioner. The bond must be conditioned that the insurance producer will conduct business under the license in accordance with the provisions of The Surplus Lines Insurance Law and that the insurance producer will promptly remit the taxes provided in 33-2-311. The bond may not be terminated unless the surety gives the surplus lines insurance producer, the producing insurance producer, and the commissioner at least 30 days' prior written notice of termination.

(3) The license expires on April 1 after its date of issue. A surplus lines insurance producer shall renew the license on or before March 1 of each year upon payment of the annual renewal fee prescribed in 33-2-708. A surplus lines insurance producer who fails to apply for a renewal of the license on or before March 1 shall pay a fine of $100 before the commissioner renews the license.

(4) A corporation is eligible to be licensed as a surplus lines insurance producer if:

(a) the corporate license lists the individuals within the corporation who have satisfied the requirements of this part to become surplus lines insurance producers; and

(b) only those individuals listed on the corporate license transact surplus lines insurance.

(5) This section may not be construed to require agents, producers, or brokers acting as intermediaries between a surplus lines insurance producer and an unauthorized insurer under this part to hold a valid Montana surplus lines insurance producer's license."

Section 11. Section 33-2-307, MCA, is amended to read:

"**33-2-307. Requirements for eligible surplus lines insurers.** (1) A surplus lines insurance producer may not place insurance with an unauthorized insurer unless, at the time of placement, the unauthorized insurer:

(a) has established satisfactory evidence of good reputation and financial integrity; and

(b) is qualified under one of the following subsections:

(i) the insurer maintains capital and surplus or its equivalent under the laws of its state of domicile, which equals the greater of:

(A) the minimum capital and surplus requirements of 33-2-109 and 33-2-110; or

(B) ~~$3~~ $7 million. An insurer possessing less than ~~$4~~ $6 million capital and surplus may satisfy the requirements of this subsection upon an affirmative finding of acceptability by the commissioner. The commissioner's finding must be based upon such factors as quality of management, capital, and surplus of a parent company; company underwriting profit and investment income trends; and company record and reputation within the industry. The commissioner may not make an affirmative finding of acceptability when the surplus lines insurer's capital and surplus is less than ~~$3~~ $6 million.

(ii) in the case of Lloyd's or another similar ~~unincorporated~~ group ~~of~~ including incorporated and unincorporated alien ~~individual~~ insurers, the insurer maintains a trust fund of not less than $50 million as security to the full amount of capital and surplus for all policyholders and creditors in the United States of each member of the group. The incorporated members of the group may not engage in any business other than underwriting as a member of the group and must be subject to the same level of solvency regulation and control by the groups of domiciliary regulators as are the unincorporated members. The trust must comply with the terms and conditions established in subsection (1)(b)(iv) for alien insurers.

(iii) in the case of an insurance exchange created by the laws of individual states, the insurer maintains capital and surplus, or their substantial equivalent, of not less than $15 million in the aggregate. For an insurance exchange that maintains funds for the protection of each insurance exchange policyholder, each individual syndicate shall maintain minimum capital and surplus, or their substantial equivalent, of not less than $1.5 million. If the insurance exchange does not maintain funds for the protection of each insurance exchange policyholder, each individual syndicate shall meet the minimum capital and surplus requirements of subsection (1)(b)(i).

(iv) in the case of an alien insurer, the insurer maintains in the United States an irrevocable trust fund in either a national bank or a member of the federal reserve system, in an amount not less than $1.5 million, for the protection of all its policyholders in the United States and the trust fund consists of cash, securities, or letters of credit or of investments of substantially the same character and quality as those which are eligible investments for the capital and statutory reserves of insurers authorized to write like kinds of insurance in this state. The trust fund, which must be included in any calculation of capital and surplus or its equivalent, must have an expiration date that may not at any time be less than 5 years. In addition,

the alien insurer must appear on the national association of insurance commissioners' Non-Admitted Insurers Quarterly Listing.

(c) has provided the commissioner a copy of its current annual statement, certified by the insurer no more than 6 months after the close of the period reported upon, ~~(~~or quarterly if considered necessary by the commissioner~~)~~, and which is either:

(i) filed with and approved by the regulatory authority in the state of domicile of the unauthorized insurer; or

(ii) certified by an accounting or auditing firm licensed in the jurisdiction of the insurer's state of domicile.

(2) In the case of an insurance exchange, the statement required by subsection (1)(c) may be an aggregate combined statement of all underwriting syndicates operating during the period reported.

(3) In addition to meeting the requirements in subsection (1), an insurer is an eligible surplus lines insurer only if it appears on the most recent list of eligible surplus lines insurers published at least semiannually by the commissioner. This subsection does not require the commissioner to place or maintain the name of any unauthorized insurer on the list of eligible surplus lines insurers. An action may not lie against the commissioner or an employee of the commissioner for anything said in issuing the list of eligible surplus lines insurers referred to in this subsection.

(4) (a) The commissioner may declare an eligible surplus lines insurer ineligible if at any time the commissioner has reason to believe that it:

(i) is in unsound financial condition;

(ii) is no longer eligible under subsections (1) through (3);

(iii) has willfully violated the laws of this state; or

(iv) does not make reasonably prompt payment of just losses and claims in this state or elsewhere.

(b) The commissioner shall promptly mail notice of all declarations to each surplus lines insurance producer.

(5) As used in this section, the following definitions apply:

(a) "Capital", as used in the financial requirements of this section, means funds invested in for stocks or other evidences of ownership.

(b) "Surplus", as used in the financial requirements of this section, means funds over and above liabilities and capital of the insurer for the protection of policyholders."

Section 12. Section 33-2-501, MCA, is amended to read:

"**33-2-501. Assets allowed.** In any determination of the financial condition of an insurer, there must be allowed as assets only assets that are owned by the insurer and that consist of:

(1) cash in the possession of the insurer or in transit under its control and including the true balance of any deposit in a solvent bank or trust company;

(2) investments, securities, properties, and loans acquired or held in accordance with this code and in connection therewith the following items:

(a) interest due or accrued on any bond or evidence of indebtedness which is not in default and which is not valued on a basis including accrued interest;

(b) declared and unpaid dividends on stock and shares unless the amount has otherwise been allowed as an asset;

(c) interest due or accrued upon a collateral loan in an amount not to exceed 1 year's interest on the loan;

(d) interest due or accrued on deposits in solvent banks and trust companies and interest due or accrued on other assets, if the interest is in the judgment of the commissioner a collectible asset;

(e) interest due or accrued on a mortgage loan in an amount not exceeding in any event the amount, if any, of the excess of the value of the property less delinquent taxes on the property over the unpaid principal. Interest accrued for a period in excess of 18 months may not be allowed as an asset.

(f) rent due or accrued on real property if the rent is not in arrears for more than 3 months and rent more than 3 months in arrears if the payment of the rent is adequately secured by property held in the name of the tenant and conveyed to the insurer as collateral;

(g) the unaccrued portion of taxes paid prior to the due date on real property;

(3) premium notes, policy loans, and other policy assets and liens on policies and certificates of life insurance and annuity contracts and accrued interest, in an amount not exceeding the legal reserve and other policy liabilities carried on each individual policy;

(4) the net amount of uncollected and deferred premiums and annuity considerations in the case of a life insurer;

(5) premiums in the course of collection, other than for life insurance, not more than 3 months past due, less commissions payable on the premiums. The limitation in this subsection does not apply to premiums payable directly or indirectly by the United States government or by any of its instrumentalities.

(6) installment premiums other than life insurance premiums to the extent of the unearned premium reserve carried on the policy to which premiums apply;

(7) notes and like written obligations not past due, taken for premiums other than life insurance premiums, on policies permitted to be issued on that basis, to the extent of the unearned premium reserves carried on the policies;

(8) the full amount of reinsurance recoverable by a ceding insurer from a solvent reinsurer and which reinsurance is authorized under chapter 2, part 12;

(9) amounts receivable by an assuming insurer representing funds withheld by a solvent ceding insurer under a reinsurance treaty;

(10) deposits or equities recoverable from underwriting associations, syndicates, and reinsurance funds or from any suspended banking institution, to the extent considered by the commissioner available for the payment of losses and claims and at values to be determined by the commissioner;

(11) electronic data processing equipment if the cost of the equipment is ~~at least $100,000, which cost must be~~ amortized in full over a period of not to exceed ~~10~~ 8 calendar years. However, ~~with regard to life insurers, the equipment must be allowed as an asset if the cost of the equipment is at least $25,000, which cost must be amortized in full over a period of not to exceed 5 calendar years, and~~ the amount of the asset allowed may not exceed 1% of the total of the other allowable assets of the insurer.

(12) all assets, whether or not consistent with the provisions of this section, as may be allowed pursuant to the annual statement form approved by the commissioner for the kinds of insurance to be reported upon in the annual statement;

(13) other assets, not inconsistent with the provisions of this section, considered by the commissioner to be available for the payment of losses and claims, at values to be determined by the commissioner."

Section 13. Section 33-2-521, MCA, is amended to read:

"**33-2-521. Standard valuation of reserve liabilities law -- life insurance.** (1) The commissioner shall annually value or cause to be valued the reserve liabilities (~~hereinafter called~~ reserves) for all outstanding life insurance policies and annuity and pure endowment contracts of every life insurer doing business in this state and may certify the amount of any ~~such~~ reserves, specifying the mortality table or tables, rate or rates of interest, and methods (net level premium method or other) used in the calculation

of ~~such~~ reserves. In calculating ~~such~~ the reserves, ~~he~~ the commissioner may use group methods and approximate averages for fractions of a year or otherwise. ~~In the case of an alien insurer, such valuation shall be limited to its insurance transactions in the United States.~~

(2) ~~For the purpose of making such valuation, the commissioner may employ a competent actuary who shall be paid by the insurer for which the service is rendered; but a domestic insurer may make such valuation and it may be received by the commissioner upon satisfactory proof of its correctness.~~ In lieu of the valuation of the reserves ~~herein~~ required in this section of any foreign or alien insurer, the commissioner may accept any valuation made or caused to be made by the insurance supervisory official of any state or other jurisdiction when ~~such~~ the valuation complies with the minimum standard ~~herein~~ provided in this section and if the official of ~~such~~ the other state or jurisdiction accepts as sufficient and valid for all legal purposes the certificate of valuation of the commissioner when ~~such~~ the certificate states the valuation to have been made in a specified manner according to which the aggregate reserves would be at least as large as if they had been computed in the manner prescribed by the law of that state or jurisdiction.

(3) Any insurer ~~which at any time shall have~~ that has adopted any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard ~~herein~~ provided in this section may, with the approval of the commissioner, adopt any lower standard of valuation but not lower than the minimum ~~herein provided~~ in this section. For the purposes of this section, the holding of additional reserves previously determined by a qualified actuary to be necessary to render the opinion required in subsection (4) may not be considered to be the adoption of a higher standard of valuation.

(4) (a) Each life insurer doing business in this state shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by rule are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this state. The commissioner by rule shall define the specifics of this opinion and add any other items considered necessary to its scope.

(b) Each life insurer, except as exempted by or pursuant to regulation, shall also annually include in the opinion required by subsection (4)(a) an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by rule, when considered in light of the assets held by the insurer with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and

the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the insurer's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts.

(c) The commissioner may provide by rule for a transition period for establishing any higher reserves that the qualified actuary may consider necessary in order to render the opinion required by this subsection (4).

(d) Each opinion required by this subsection (4) must be governed by the following provisions:

(i) A memorandum, in form and substance acceptable to the commissioner as specified by rule, must be prepared to support each actuarial opinion.

(ii) If the insurer fails to provide a supporting memorandum at the request of the commissioner within a period specified by rule or if the commissioner determines that the supporting memorandum provided by the insurer fails to meet the standards prescribed by the rules or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the insurer to review the opinion and the basis for the opinion and to prepare any supporting memorandum as is required by the commissioner.

(iii) The opinion must be submitted with the annual statement reflecting the valuation of the reserve liabilities for each year ending on or after December 31, 1995.

(iv) The opinion must apply to all business in force, including individual and group health insurance plans, in form and substance acceptable to the commissioner as specified by rule.

(v) The opinion must be based on standards adopted from time to time by the actuarial standards board and on additional standards as the commissioner may prescribe by rule.

(vi) In the case of an opinion required to be submitted by a foreign or alien insurer, the commissioner may accept the opinion filed by that insurer with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.

(vii) Except in cases of fraud or willful misconduct, the qualified actuary is not liable for damages to any person, other than the insurer and the commissioner, for any act, error, omission, decision, or conduct with respect to the actuary's opinion.

(viii) Disciplinary action by the commissioner against the insurer or the qualified actuary must be defined in rules by the commissioner.

(ix) Any memorandum in support of the opinion and any other material provided by the insurer to the commissioner in connection with those items must be kept confidential by the commissioner, may not be made public, and is subject to subpoena, other than for the purpose of defending an action seeking damages from any person by reason of any action required by this subsection (4) or by rules promulgated under this subsection (4). However, the memorandum or other material may otherwise be released by the commissioner:

(A) with the written consent of the insurer; or

(B) to the American academy of actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the commissioner for preserving the confidentiality of the memorandum or other material. Once any portion of the confidential memorandum is cited by the insurer in its marketing, is cited before any governmental agency other than a state insurance department, or is released by the insurer to the news media, all portions of the confidential memorandum are no longer confidential.

(5) For purposes of this section, "qualified actuary" means a member in good standing of the American academy of actuaries who meets the requirements set forth in the academy's rules."

Section 14. Section 33-2-523, MCA, is amended to read:

"**33-2-523. Contracts on or after the operative date of 33-20-213 -- valuation.** (1) This section ~~shall apply~~ applies to only those policies and contracts issued on or after the operative date of 33-20-213, except as otherwise provided in 33-2-524 for group annuity and pure endowment contracts issued prior to that date.

(2) Except as otherwise provided in 33-2-524, ~~and~~ 33-2-525, and [section 76(2)], the minimum standard for the valuation of all ~~such~~ the policies and contracts issued prior to October 1, 1995, ~~shall~~ must be the standard provided by the laws in effect prior to October 1, 1995. Except as otherwise provided in 33-2-524, 33-2-525, and [section 76(2)], the minimum standard for the valuation of all policies and contracts must be the commissioner's reserve valuation methods defined in 33-2-525, ~~and~~ 32-2-526(3), and (4), and [section 76], 5% interest for group annuity and pure endowment contracts, and 3 1/2% interest for all other ~~such~~ policies and contracts or, in the case of life insurance policies and contracts other than annuity and pure endowment contracts issued on or after March 17, 1973, 4% interest for ~~such~~ all other policies issued prior to July 1, 1979, 5 1/2% interest for single-premium life insurance policies, and

4 1/2% interest for ~~such~~ policies issued on or after July 1, 1979, and the following tables:

(a) for all ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in ~~such~~ the policies~~,~~:

(i) the commissioner's 1941 standard ordinary mortality table~~:~~

~~(i)~~ for ~~such~~ policies issued prior to the operative date of 33-20-206, as amended, and the commissioner's 1958 standard ordinary mortality table for ~~such~~ policies issued on or after that operative date but prior to January 1, 1989, except that for any category of ~~such~~ the policies issued on female risks, modified net premiums and present values, referred to in 33-2-525 and 33-2-526, may be calculated, at the option of the insurer, with the approval of the commissioner, according to an age younger than the actual age of the insured; or

(ii) for ~~such~~ policies issued on or after January 1, 1989:

(A) the commissioner's 1980 standard ordinary mortality table;

(B) at the election of the company for any one or more specified plans of life insurance, the commissioner's 1980 standard ordinary mortality table with 10-year select mortality factors; or

(C) any ordinary mortality table adopted after 1980 by the national association of insurance commissioners that is approved by the commissioner by rule for use in determining the minimum standard of valuation for ~~such~~ policies;

(b) for all industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in ~~such~~ the policies, the 1941 standard industrial mortality table for ~~such~~ policies issued prior to the operative date of 33-20-207~~, as amended,~~ and~~,~~ for ~~such~~ policies issued on or after that operative date, the commissioner's 1961 standard industrial mortality table or any industrial mortality table adopted after 1980 by the national association of insurance commissioners that is approved by the commissioner by rule for use in determining the minimum standard of valuation for ~~such~~ the policies;

(c) for individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in ~~such~~ the policies, the 1937 standard annuity mortality table or, at the option of the insurer, the annuity mortality table for 1949, ultimate, or any modification of either of these tables approved by the commissioner;

(d) for group annuity and pure endowment contracts, excluding any disability and accidental death benefits in ~~such~~ the policies, the group annuity mortality table for 1951, any modification of ~~such~~ the table approved by the commissioner, or, at the option of the insurer, any of the tables or modifications of tables

specified for individual annuity and pure endowment contracts;

(e) (i) for total and permanent disability benefits in or supplementary to ordinary policies or contracts:

(A) for policies or contracts issued on or after January 1, 1966, the tables of period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 disability study of the society of actuaries, with due regard to the type of benefit, or any tables of disablement rates and termination rates adopted after 1980 by the national association of insurance commissioners that are approved by the commissioner by rule for use in determining the minimum standard of valuation for ~~such~~ the policies;

(B) for policies or contracts issued on or after January 1, 1961, and prior to January 1, 1966, either ~~such~~ the tables or, at the option of the insurer, the class 3 disability table (1926); and

(C) for policies issued prior to January 1, 1961, the class 3 disability table (1926);

(ii) any ~~such~~ table ~~shall~~ must, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies;

(f) (i) for accidental death benefits in or supplementary to policies:

(A) for policies issued on or after January 1, 1966, the 1959 accidental death benefits table or any accidental death benefits table adopted after 1980 by the national association of insurance commissioners that is approved by the commissioner by rule for use in determining the minimum standard of valuation for ~~such~~ the policies;

(B) for policies issued on or after January 1, 1961, and prior to January 1, 1966, either such table or, at the option of the insurer, the intercompany double indemnity mortality table; and

(C) for policies issued prior to January 1, 1961, the intercompany double indemnity mortality table;

(ii) either table ~~shall~~ must be combined with a mortality table permitted for calculating the reserves for life insurance policies;

(g) for group life insurance, life insurance issued on the substandard basis, and other special benefits, ~~such~~ the tables as may be approved by the commissioner."

Section 15. Section 33-2-525, MCA, is amended to read:

"33-2-525. Commissioner's reserve valuation method. (1) Except as otherwise provided in subsection (4) of this section, ~~and~~ 33-2-526(3) and (4), and [section 76(2)], reserves according to the commissioner's reserve valuation method, for the life insurance and endowment benefits of policies

providing for a uniform amount of insurance and requiring the payment of uniform premiums, ~~shall~~ must be the excess, if any, of the present value, at the date of valuation, of ~~such~~ future guaranteed benefits provided for by ~~such~~ the policies, over the then present value of any future modified net premiums ~~therefor~~. The modified net premiums for any ~~such~~ policy ~~shall~~ must be ~~such~~ the uniform percentage of the respective contract premiums for ~~such~~ the benefits that the present value, at the date of issue of the policy, of all ~~such~~ modified net premiums ~~shall~~ must be equal to the sum of the then present value of ~~such~~ the benefits provided for by the policy and the excess of (a) over (b), as follows:

(a) a net level annual premium equal to the present value, at the date of issue, of ~~such~~ benefits provided for after the first policy year, divided by the present value, at the date of issue of an annuity of one per annum payable on the first and each subsequent anniversary of ~~such~~ the policy on which a premium falls due~~;~~. ~~provided, however~~ However, ~~that such~~ the net level annual premium ~~shall~~ may not exceed the net level annual premium on the 19-year premium whole life plan for insurance of the same amount at an age 1 year higher than the age at issue of ~~such~~ the policy;

(b) a net 1-year term premium for ~~such~~ benefits provided for in the first policy year.

(2) (a) For ~~every~~ each life insurance policy issued on or after January 1, 1987, for which the contract premium in the first policy year exceeds that of the second year, for which ~~no~~ a comparable additional benefit is not provided in the first year for ~~such~~ the excess, and that provides an endowment benefit, a cash surrender value, or a combination of both in an amount greater than ~~such~~ the excess premium, the reserve according to the commissioner's reserve valuation method, as of any policy anniversary occurring on or before the assumed ending date as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than ~~such~~ the excess premium, is, except as otherwise provided in 33-2-526, the greater of the reserve as of ~~such~~ the policy anniversary calculated as described in subsection (1) or the reserve as of ~~such~~ the policy anniversary calculated as described in subsection (1) with the following exceptions:

(i) the value defined in subsection (1)(a) is reduced by 15% of the amount of ~~such~~ the excess first-year premium;

(ii) all present values of benefits and premiums are determined without reference to premiums or benefits provided for in the policy after the assumed ending date;

(iii) the policy is assumed to mature on ~~such~~ the assumed ending date as an endowment; and

(iv) the cash surrender value provided on ~~such~~ the assumed ending date is considered an

endowment benefit.

(b) In making the comparisons in subsection (2)(a), the mortality and interest bases stated in 33-2-523 and 33-2-527 must be used.

(3) Reserves according to the commissioner's reserve valuation method for the following ~~shall~~ must be calculated by a method consistent with the principles of this section, except that any extra premiums charged because of impairments or special hazards ~~shall~~ must be disregarded in the determination of modified net premiums:

(a) life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums;

(b) group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, ~~(~~including a partnership or sole proprietorship~~)~~, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the Internal Revenue Code, as ~~now or hereafter~~ amended;

(c) disability and accidental death benefits in all policies and contracts; and

(d) all other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts.

(4) (a) Subsection (4)(b) applies to any annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation established or maintained by an employer, ~~(~~including a partnership or sole proprietorship~~)~~, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the Internal Revenue Code, as ~~now or hereafter~~ amended.

(b) Reserves according to the commissioner's annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in ~~such~~ the contracts, ~~shall~~ must be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by ~~such~~ the contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations required by the terms of ~~such~~ the contract that become payable prior to the end of ~~such~~ the respective contract year. The future guaranteed benefits ~~shall~~ must be determined by using the mortality table, if any, and the interest rate or rates specified in ~~such~~

the contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of ~~such~~ the contracts to determine nonforfeiture values."

Section 16. Section 33-2-526, MCA, is amended to read:

"**33-2-526. Limits -- options -- minimum reserves.** (1) ~~In no event shall an~~ An insurer's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits issued on or after October 1, 1995, may not be less than the aggregate reserves calculated in accordance with the methods set forth in 33-2-525, ~~and~~ subsection (3) of this section, [section 76(2)] and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for ~~such~~ the policies.

(2) Reserves for all policies and contracts issued prior to October 1, 1995, may be calculated, at the option of the insurer, according to standards that produce greater aggregate reserves for those policies and contracts than the minimum reserves required by the laws in effect immediately prior to October 1, 1995. Reserves for any category of policies, contracts, or benefits as established by the commissioner, issued on or after October 1, 1995, may be calculated at the option of the insurer according to any standards which produce greater aggregate reserves for ~~such~~ a category than those calculated according to the minimum standard ~~herein~~ provided in this section, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, ~~shall~~ may not be higher than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided for ~~therein~~ a category.

(3) If in any contract year the gross premium charged by any life insurer on any policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve ~~thereon~~ on the policy or contract but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for ~~such~~ the policy or contract ~~shall~~ must be the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for ~~such~~ the policy or contract or the reserve calculated by the method actually used for ~~such~~ the policy or contract but using the minimum standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this section are those standards stated in 33-2-524 and 33-2-527.

(4) For every life insurance policy issued after December 30, 1986, for which the gross premium in the first policy year exceeds that of the second year, for which ~~no~~ a comparable additional benefit is not provided in the first year for ~~such~~ an excess, and that provides an endowment benefit, a cash surrender value, or a combination of both in an amount greater than ~~such~~ the excess premium, subsections (1) through (3) of this section must be applied as if the method actually used in calculating the reserve for ~~such~~ the policy were the method described in 33-2-525(1). The minimum reserve at each policy anniversary of ~~such a~~ the policy must be the greater of the minimum reserve calculated in accordance with 33-2-525 and the minimum reserve calculated in accordance with this section."

Section 17. Section 33-2-528, MCA, is amended to read:

"**33-2-528. Interest rate weighting factor.** (1) The weighting factors referred to in the formulas stated in 33-2-527 are as follows:

(a) (i) for life insurance:

Guarantee Duration in Years	Weighting Factors
10 or less	.50
More than 10 but not more than 20	.45
More than 20	.35

(ii) for life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values, or both, that are guaranteed in the original policy;

(b) .80 for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options;

(c) for other annuities and for guaranteed interest contracts, except as stated in subsection (1)(b), according to the guarantee duration established in ~~subsection (2)~~ subsections (1)(c)(i) through (1)(c)(iii) and the ~~type of plan~~ rules and definitions established in established in ~~subsection~~ subsections (2), (3), and (4):

(i) for annuities and guaranteed interest contracts valued on an issue year basis:

Guarantee Duration in Years	Weighting Factor for Plan Type

	A	B	C
5 or less	.80	.60	.50
More than 5 but not more than 10	.75	.60	.50
More than 10 but not more than 20	.65	.50	.45
More than 20	.45	.35	.35

	Plan Type		
(ii)	A	B	C
for annuities and guaranteed interest contracts valued on a change-in-fund basis, the factors shown in subsection (1)(c)(i) increased by:	.15	.25	.05

	Plan Type		
(iii)	A	B	C
for annuities and guaranteed interest contracts valued on an issue year basis, ~~(~~other than those ~~with no~~ without cash settlement options~~)~~, that do not guarantee interest on considerations received more than 1 year after issue or purchase and for annuities and guaranteed interest contracts valued on a change-in-fund basis that do not guarantee interest rates on considerations received more than 12 months beyond the valuation date, the factors set forth in subsection (1)(c)(i) or derived in subsection (1)(c)(ii) increased by:	.05	.05	.05

(2) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of 20 years. For other annuities ~~with no~~ without cash settlement options and for guaranteed interest contracts ~~with no~~ without cash settlement options, the guarantee duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.

(3) Plan types used in subsection (1)(c) are:

(a) Plan Type A--No withdrawal is permitted or at any time policyholder may withdraw funds only:

(i) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company;

(ii) without ~~such~~ an adjustment but in installments over 5 years or more; or

(iii) as an immediate life annuity.

(b) Plan Type B--(i) Before expiration of the interest rate guarantee, no withdrawal is permitted or a policyholder may withdraw funds only:

(A) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company;

(B) without ~~such~~ an adjustment but in installments over 5 years or more.

(ii) At the end of the interest rate guarantee, funds may be withdrawn without ~~such~~ an adjustment in a single sum or installments over less than 5 years.

(c) Plan Type C--A policyholder may withdraw funds before expiration of the interest rate guarantee in a single sum or installments over less than 5 years either:

(i) without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company; or

(ii) subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

(4) (a) An insurer may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue year basis or on a change-in-fund basis. Guaranteed interest contracts ~~with no~~ without cash settlement options and other annuities ~~with no~~ without cash settlement options must be valued on an issue year basis.

(b) As used in subsection (4):

(i) issue year basis of valuation is a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract; and

(ii) change-in-fund basis of valuation is a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund."

Section 18. Section 33-2-529, MCA, is amended to read:

"**33-2-529. Reference interest rate.** (1) The reference interest rate referred to in the formulas in 33-2-527 is:

(a) for all life insurance, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year next preceding the year of issue, of Moody's ~~corporate bond yield average~~ monthly average ~~corporates~~ composite yield on seasoned corporate bonds;

(b) for single-premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of Moody's ~~corporate bond yield average~~ monthly average ~~corporates~~ composite yield on seasoned corporate bonds;

(c) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options valued on a year-of-issue basis, except as stated in subsection (1)(b), with guarantee duration in excess of 10 years, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of Moody's ~~corporate bond yield average~~ monthly average ~~corporates~~ composite yield on seasoned corporate bonds;

(d) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options valued on a year-of-issue basis, except as stated in subsection (1)(b), with guarantee duration of 10 years or less, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of Moody's ~~corporate bond yield average~~ monthly average ~~corporates~~ composite yield on seasoned corporate bonds;

(e) for other annuities ~~with no~~ without cash settlement options and for guaranteed interest contracts ~~with no~~ without cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of Moody's ~~corporate bond yield average~~ monthly average ~~corporates~~ composite yield on seasoned corporate bonds; or

(f) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options valued on a change-in-fund basis, except as stated in subsection (1)(b), the average over a period of 12 months, ending on June 30 of the calendar year of the change in the fund, of Moody's ~~corporate bond yield average~~ monthly average ~~corporates~~ composite yield on seasoned corporate bonds.

(2) If Moody's ~~corporate bond yield average~~ monthly average ~~corporates~~ composite yield on seasoned corporate bonds is no longer published by Moody's investors service, inc., or if the national association of insurance commissioners determines that Moody's ~~corporate bond yield average~~ monthly average ~~corporates~~ composite yield on seasoned corporate bonds, as published by Moody's investors service, inc., is no longer appropriate for the determination of the reference interest rate, then an alternative method for determination of the reference interest rate adopted by the national association of insurance commissioners and approved by rule promulgated by the commissioner may be substituted."

Section 19. Section 33-2-531, MCA, is amended to read:

"**33-2-531. Deposit of reserves -- domestic life insurers.** (1) Domestic life insurers shall deposit and maintain on deposit, in securities and assets, with depositaries and subject to conditions as provided for in part 6 of this chapter, an amount not less than the reserves on its outstanding life insurance policies and annuity contracts, as valued under 33-2-521 through 33-2-526, minus policy loans.

(2) Annually on or before April 1, the insurer shall ~~so~~ deposit any additional ~~such~~ securities or assets required under subsection (1) and related to the increase of ~~such~~ the reserves, minus policy loans, during the calendar year next preceding, as determined from the insurer's annual statement as at December 31 of ~~such~~ the preceding year.

(3) A domestic stock life insurer may credit toward ~~such~~ the deposit the amount of any other deposit of the insurer held under part 6 of this chapter for the protection of its policyholders or of its policyholders and creditors.

(4) Deposits of the reserves of a domestic life insurer under this section ~~shall~~ must consist of securities and assets acquired and valued in accordance with parts 5 and 8 of this chapter.

(5) Real estate mortgage loans~~,~~ and chattel mortgage loans~~, and policy loans~~ may be made a part of the deposit by filing a verified statement of the loans with the commissioner~~, which statement shall be~~. The statement is subject to audit at all times by the commissioner. Nonnegotiable securities ~~where~~ deposited with the commissioner ~~shall~~ must be accompanied by transfer powers in due form. If the insurer uses real estate acquired under 33-2-832 as a deposit, then a deed of trust, mortgage, or other instrument sufficient to convey a security interest in ~~such~~ the real estate, in a form acceptable to the commissioner, ~~shall~~ must be completed in due form and recorded prior to being deposited with the commissioner.

(6) If default occurs in the payment of interest or principal of any deposited security and ~~such~~ the

default continues for a period of 120 days, the commissioner may declare ~~such~~ the security no longer eligible for deposit under this section."

Section 20. Section 33-2-701, MCA, is amended to read:

"**33-2-701. Annual statement -- revocation or fine for failure to file -- penalty for perjury.** (1) Each authorized insurer shall annually on or before March 1 file with the commissioner a full and true statement of its financial condition, transactions, and affairs as of the preceding December 31 ~~preceding~~. The statement must be in the general form and context as is required or not disapproved by the commissioner, as is in current use for similar reports to states in general with respect to the type of insurer and kinds of insurance to be reported upon, and as supplemented for additional information required by the commissioner. The statement must be completed in accordance with the annual statement instructions and the accounting practices and procedures manual of the national association of insurance commissioners. The statement must be accompanied by an actuarial opinion attesting to the adequacy of the insurer's reserves. The statement must be verified by the oath of the insurer's president or vice-president and secretary or, if a reciprocal insurer, by the oath of the attorney-in-fact or its like officers if a corporation. The commissioner may waive the verification under oath.

(2) (a) Each domestic insurer shall file electronic diskette versions of its annual and quarterly financial statements with the national association of insurance commissioners. The filing date for submission of the annual statement diskette is March 1. The filing dates for the quarterly statement diskettes are as follows:

(i) the first calendar quarter filing is due May 15;

(ii) the second calendar quarter filing is due August 15; and

(iii) the third calendar quarter filing is due November 15.

(b) The commissioner may exempt insurers that operate only in Montana from these filing requirements.

~~(2)~~(3) The statement of an alien insurer must relate only to its transactions and affairs in the United States unless the commissioner requires otherwise. If the commissioner requires a statement as to an alien insurer's affairs throughout the world, the insurer shall file the statement with the commissioner as soon as reasonably possible. The statement must be verified by the insurer's United States manager or other authorized officer.

~~(3)~~(4) The commissioner may refuse to accept the fee for continuance of the insurer's certificate of authority, as provided in 33-2-117, or may suspend or revoke the certificate of authority of any insurer failing to file its annual statement when due or within an extension of time that the commissioner may grant.

~~(4)~~(5) Any director, officer or insurance producer, or employee of any company who subscribes to, makes, or concurs in making or publishing any annual statement or any other statement required by law knowing that the ~~same to contain~~ statement contains any material statement which is false shall be punished by a fine of not more than $1,000.

~~(5)~~(6) At time of filing, the insurer shall pay to the commissioner the fee for filing its statement as prescribed in 33-2-708.

~~(6)~~(7) The commissioner may impose a fine not to exceed $100 a day for each day after March 1 that an insurer fails to file the annual statement referred to in subsection (1). The fine may not exceed a maximum of $1,000."

Section 21. 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 received while an authorized insurer in this state shall file with the commissioner, on or before March 1 each year, a report in a form 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 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 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 the 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 the policies. As to title insurance, "premium" includes the total charge for the insurance. A deduction may not be made of the cash surrender values of policies. Considerations received on annuity contracts may not be included in total direct premium income and are not subject to tax.

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

(3) That portion of the tax paid under this section by an insurer on account of premiums received for fire insurance must be separately specified in the report as required by the commissioner, for apportionment as provided by law. When insurance against fire is included with insurance of property against other perils at an undivided premium, the insurer shall make a reasonable allocation from the entire premium to the fire portion of the coverage as must be stated in the report and as may be approved or accepted by the commissioner.

(4) With respect to authorized insurers, the premium tax provided by this section must 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~~ that 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 plus interest on the delinquent amount at the annual interest rate ~~established in 31-1-107~~ of 12%.

(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 tax liability is accrued."

Section 22. 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 when 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, electronically filed 10.00

(iii) appointment of insurance producer, each insurer, nonelectronically filed 15.00

(iv) temporary license 15.00

(v) amendment of license, ~~(~~excluding additions to license~~)~~, or reissuance of master license 15.00

(vi) termination of insurance producer, each insurer, electronically filed 10.00

(vii) termination of insurance producer, each insurer, nonelectronically filed 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, electronically filed 10.00

(iii) appointment of insurance producer, each insurer, nonelectronically filed 15.00

(iv) annual renewal of license 10.00

(v) amendment of license, ~~(~~excluding additions to license~~)~~, or reissuance of master license 15.00

(vi) termination of insurance producer, each insurer, electronically filed 10.00

(vii) termination of insurance producer, each insurer, nonelectronically filed 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) motor club representative's license:

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

(ii) annual renewal of license 15.00

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

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

~~(m)~~(n) policy forms:

(i) filing each policy form 25.00

(ii) filing each application, certificate, enrollment form, 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, provided that all additional forms relate to the same policy 100.00

~~(n)~~(o) applications for approval of prelicensing education courses:

(i) reviewing initial application 150.00

(ii) periodic review 50.00

(2) The commissioner shall establish by rule fees commensurate with costs for filing documents and conducting the course reviews required by 33-17-1204 and 33-17-1205.

(3) The commissioner shall establish by rule an annual accreditation fee to be paid by each domestic and foreign insurer when it submits a fee for annual continuation of its certificate of authority.

(4)(a) Except as provided in subsection (4)(b), 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 the commissioner pursuant to Title 33 and the rules adopted under Title 33, except that all fees for filing documents and conducting the course reviews required by 33-17-1204 and 33-17-1205 must be deposited in the state special revenue fund pursuant to 33-17-1207.

(b) The accreditation fee required by subsection (3) must be turned over promptly to the state treasurer who shall deposit the money in the state special revenue fund to the credit of the commissioner's office. The accreditation fee funds must be used only to pay the expenses of the commissioner's office in discharging the administrative and regulatory duties that are required to meet the minimum financial regulatory standards established by the national association of insurance commissioners, subject to the applicable laws relating to the appropriation of state funds and to the deposit and expenditure of money. The commissioner is responsible for the proper expenditure of the accreditation money.

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

Section 23. Section 33-2-803, MCA, is amended to read:

"**33-2-803. General qualifications of investments.** (1) ~~No~~ A security or investment, other than real and personal property acquired under 33-2-832, ~~shall be~~ is not eligible for acquisition unless it is interest bearing or interest accruing or dividend or income paying, if not then in default in any respect, and the insurer is entitled to receive for its exclusive account and benefit the interest or income accruing ~~thereon~~ on the security or investment. However, up to 3% of a company's total assets may be invested in nondividend-paying common stock as described in 33-2-820.

(2) ~~No~~ A security or investment ~~shall be~~ is not eligible for purchase at a price above its market value.

(3) ~~No~~ A provision of this part ~~shall~~ may not prohibit the acquisition by an insurer of other or additional securities or property if received as a dividend or as a lawful distribution of assets or under a lawful and bona fide agreement of bulk reinsurance, merger, or consolidation. Any investment ~~so~~ acquired ~~which~~ that is not otherwise eligible under this part ~~shall~~ must be disposed of pursuant to 33-2-842 if personal property or securities or pursuant to 33-2-841 if real property."

Section 24. Section 33-2-806, MCA, is amended to read:

"**33-2-806. Diversification of investments.** An insurer shall invest in or hold as admitted assets categories of investments only within applicable limits as follows:

(1) An insurer ~~shall~~ may not, except with the consent of the commissioner, have at any one time any combination of investments in or loans upon the security of the obligations, property, or securities of any one person or insurer aggregating an amount exceeding 5% of the insurer's assets. This restriction ~~shall~~ does not apply as to general obligations of the United States of America or of any state or include policy loans made under 33-2-825.

(2) An insurer ~~shall~~ may not invest in or hold at any one time more than 10% of the outstanding voting stock of any corporation, except with the consent of the commissioner given with respect to voting rights of preference stock during default of dividends. This provision does not apply as to stock of a wholly-owned subsidiary of the insurer or to controlling stock of an insurer acquired under 33-2-821.

(3) An insurer, other than title insurer, shall invest and maintain invested funds not less in amount than the minimum paid-in capital stock required under this code of a domestic stock insurer transacting like kinds of insurance, only in cash and the securities provided for under the following sections: 33-2-811(1), 33-2-812, and 33-2-830.

(4) A life insurer shall also invest and keep invested its funds in an amount not less than the reserves under its life insurance policies and annuity contracts, other than variable annuities, in force in cash, ~~and/or the~~ in securities, in both cash and securities, or in investments provided for under 33-2-531.

(5) Except with the commissioner's consent, an insurer ~~shall~~ may not have invested at any one time more than 20% of its assets in the class of securities described in 33-2-818, exclusive of obligations of public utilities.

(6) An insurer may not invest and have invested at any one time in aggregate amount ~~not~~ more than ~~10%~~ 15% of its assets in all stocks under 33-2-820 and 33-2-821. Determination of the amount ~~which~~ that an insurer has invested in common stocks for the purposes of this provision ~~shall~~ must be based on the cost of ~~such~~ the stocks to the insurer. This provision ~~shall~~ does not apply as to stock of a controlled or subsidiary insurance corporation or other corporations under 33-2-821 and 33-2-822.

(7) Except with the commissioner's consent, an insurer may not have invested at any one time more than 5% of its assets in securities allowed under 33-2-824.

(8) Except with the commissioner's consent, an insurer ~~shall~~ may not have invested at any one

time more than 10% of its assets in the class of securities described in any one of the following sections: 33-2-814, 33-2-819, and 33-2-823.

(9) Limits as to investments in the category of real estate shall be as provided in 33-2-832. Other specific limits ~~shall~~ apply as stated in the sections dealing with other respective kinds of investments."

Section 25. Section 33-2-820, MCA, is amended to read:

"**33-2-820. Common stocks.** An insurer may invest in nonassessable common stocks, other than insurance stocks, of any solvent corporation existing under the laws of the United States of America or of Canada or any state or province ~~thereof if cash or stock dividends have been earned and paid on its common stock in each of the 5 fiscal years preceding such acquisition and if, further, all prior obligations or preference stock of such corporation, if any, are eligible for investment under this part. If the issuing corporation has not been in legal existence for the whole of the 5 preceding fiscal years but was formed as a consolidation or merger of two or more businesses, the test of eligibility for investment of its common stock under this section shall be based upon consolidation pro forma statements of the predecessor or constituent institutions~~."

Section 26. Section 33-2-1111, MCA, is amended to read:

"**33-2-1111. Registration of insurers -- requisites -- termination.** (1) ~~Every~~ An insurer ~~which is~~ authorized to do business in this state ~~and which~~ that is a member of an insurance holding company system shall register with the commissioner, except that a foreign insurer subject to disclosure requirements and standards adopted by statute or regulation in the jurisdiction of its domicile ~~which~~ that are substantially similar to those contained in this section is not required to register. Any insurer ~~which is~~ subject to registration under this section shall register within 15 days after ~~it becomes~~ becoming subject to registration, unless the commissioner for good cause ~~shown~~ extends the time for registration~~, and then within the extended time~~. The commissioner may require any authorized insurer ~~which~~ that is a member of a holding company system ~~which~~ that is not subject to registration under this section to furnish a copy of the registration statement or other information filed by the insurance company with the insurance regulatory authority ~~of domiciliary~~ in the jurisdiction where the company is domiciled.

(2) ~~Every~~ An insurer subject to registration shall file with the commissioner, on or before April 30 each year, a registration statement on a form provided by the commissioner~~, which~~ that must contain

current information about:

(a) the capital structure, general financial condition, ownership, and management of the insurer and any person controlling the insurer;

(b) the identity of every member of the insurance holding company system;

(c) ~~the following agreements in force,~~ existing relationships ~~subsisting~~, ~~and~~ transactions currently outstanding between the insurer and its affiliates, and the following agreements that are in force:

(i) loans, other investments, or purchases, sales, or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates;

(ii) purchases, sales, or exchanges of assets;

(iii) transactions not in the ordinary course of business;

(iv) guaranties or undertakings for the benefit of an affiliate ~~which~~ that result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business;

(v) ~~all~~ management and service contracts and ~~all~~ cost-sharing arrangements~~, other than cost allocation arrangements based upon generally accepted accounting principles~~;

(vi) reinsurance agreements covering all or substantially all of one or more lines of insurance of the ceding company;

(vii) dividends and other distributions to shareholders; and

(viii) consolidated tax allocation agreements;

(d) ~~any~~ a pledge of the insurer's stock, including stock of a subsidiary or controlling affiliate for a loan made to a member of the insurance holding company system;

(e) all matters concerning transactions between registered insurers and any affiliates as may be included from time to time in ~~any~~ registration forms adopted or approved by the commissioner.

(3) A registration statement must contain a summary outlining each item in the current registration statement that represents a change from the prior registration statement.

(4) Information need not be disclosed on the registration statement filed pursuant to subsection (2) if the information is not material for the purposes of this section. Unless the commissioner by rule or order provides otherwise, sales, purchases, exchanges, loans or extensions of credit, or investments involving 1/2 of 1% or less of an insurer's admitted assets as of the prior December 31 ~~next preceding~~ are not material for purposes of this section.

(5) A person within an insurance holding company system subject to registration shall provide complete and accurate information to an insurer if the information is reasonably necessary to enable the insurer to comply with Title 33, chapter 2, part 11.

(6) Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions on amendment forms provided by the commissioner within 15 days after the end of the month in which it learns of each change or addition.

(7) The commissioner shall terminate the registration of any insurer ~~which~~ that demonstrates that it no longer is a member of an insurance holding company system.

(8) The commissioner may require or allow two or more affiliated insurers subject to registration under this section to file a consolidated registration statement or consolidated reports amending their consolidated registration statement or their individual registration statements.

(9) The commissioner may allow an insurer ~~which~~ that is authorized to do business in this state and ~~which~~ that is part of an insurance holding company system to register on behalf of any affiliated insurer which is required to register under subsection (1) and to file all information and material required to be filed under this section."

Section 27. Section 33-2-1201, MCA, is amended to read:

"**33-2-1201. Limit of risk.** (1) An insurer may not retain any risk on any one subject of insurance, whether located or to be performed in this state or elsewhere, in an amount exceeding 10% of its surplus to policyholders.

(2) A "subject of insurance" for the purposes of this section, as to insurance against fire and hazards other than windstorm, earthquake, or other catastrophe hazards, includes all properties insured by the same insurer which are customarily considered by underwriters to be subject to loss or damage from the same fire or the same occurrence of the other hazard insured against.

(3) Reinsurance ceded as authorized by this part must be deducted in determining risk retained. As to surety risks, deduction must also be made of the amount assumed by any established incorporated cosurety and the value of any security deposited, pledged, or held subject to the surety's consent and for the surety's protection.

(4) As to alien insurers, this section only relates to risks and surplus to policyholders of the insurer's United States branch.

(5) "Surplus to policyholders" for the purposes of this section, in addition to the insurer's capital and surplus, is considered to include any voluntary reserves which are not required pursuant to law and are determined from the last sworn statement of the insurer on file with the commissioner or by the last report of examination of the insurer, whichever is the more recent at time of assumption of risk.

(6) This section does not apply to life or disability insurance, title insurance, insurance of wet marine and transportation risks, workers' compensation insurance, employer's liability coverages, ~~sprinklered risks,~~ or any policy or type of coverage as to which the maximum possible loss to the insurer is not readily ascertainable on issuance of the policy."

Section 28. Section 33-2-1216, MCA, is amended to read:

"**33-2-1216. Credit allowed domestic ceding insurer.** (1) Credit for reinsurance is allowed to a domestic ceding insurer as either an asset or a deduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of subsection (2), (3), (4), (5), or (6). If the requirements of subsection (4) or (5) are met, the requirements of subsection (7) must also be met.

(2) Credit must be allowed when the reinsurance is ceded to an assuming insurer that is licensed to transact insurance or reinsurance in this state.

(3) Credit must be allowed when the reinsurance is ceded to an assuming insurer that is accredited as a reinsurer in this state. Credit may not be allowed a domestic ceding insurer if the assuming insurer's accreditation has been revoked by the commissioner after notice and hearing. An accredited reinsurer is one that:

(a) files with the commissioner evidence of its submission to this state's jurisdiction;

(b) submits to this state's authority to examine its books and records;

(c) is licensed to transact insurance or reinsurance in at least one state or, in the case of a United States branch of an alien assuming insurer, is entered through and licensed to transact insurance or reinsurance in at least one state;

(d) files annually with the commissioner a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement and either:

(i) maintains a surplus with regard to policyholders in an amount that is not less than $20 million and whose accreditation has not been denied by the commissioner within 90 days of its submission; or

(ii) maintains a surplus with regard to policyholders in an amount less than $20 million and whose

accreditation has been approved by the commissioner.

(4) (a) Subject to subsection (4)(b), credit must be allowed when:

(i) the reinsurance is ceded to an assuming insurer that is domiciled and licensed in or, in the case of a United States branch of an alien assuming insurer, is entered through a state that employs standards regarding credit for reinsurance substantially similar to those applicable under this statute; and

(ii) the assuming insurer or the United States branch of an alien assuming insurer:

(A) maintains a surplus with regard to policyholders in an amount not less than $20 million; and

(B) submits to the authority of this state to examine its books and records.

(b) The requirement of subsection (4)(a)(i) does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

(5) (a) Credit must be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund in a qualified United States financial institution for the payment of the valid claims of its United States policyholders and ceding insurers and their assigns and successors in interest. The assuming insurer shall report annually to the commissioner information substantially the same as that required to be reported on the NAIC annual statement form by licensed insurers to enable the commissioner to determine the sufficiency of the trust fund.

(b) (i) In the case of a single assuming insurer, the trust must consist of a trusteed account representing the assuming insurer's liabilities attributable to business written in the United States, and in addition, the assuming insurer shall maintain a surplus with the trustee of not less than $20 million.

(ii) In the case of a group, ~~of~~ including incorporated and individual unincorporated underwriters, the trust must consist of a trusteed account representing the group's liabilities attributable to business written in the United States, and in addition, the group shall maintain a surplus with the trustee of which $100 million must be held jointly for the benefit of United States ceding insurers of any member of the group.

(iii) The incorporated members of the group, as group members, may not be engaged in a business other than underwriting as members of the group and are subject to the same level of solvency regulation and control by the insurance regulator as the unincorporated members. The group shall make available to the commissioner an annual certification of the solvency of each underwriter by the ~~group's domiciliary~~ insurance regulator and the independent public accountants in the jurisdiction where the underwriter is domiciled ~~and its independent public accountants~~.

~~(iii)~~(iv) In the case of a group of incorporated insurers under common administration:

(A) the provisions of subsection ~~(5)(b)(iii)(B)~~ (5)(b)(iv)(B) apply~~,~~ to the group that:

(I) complies with the reporting requirements contained in subsection (5)(a);

(II) has continuously transacted an insurance business outside the United States for at least 3 years immediately prior to making application for accreditation;

(III) submits to this state's authority to examine its books and records and bears the expense of the examination; and

(IV) has aggregate policyholders' surplus of $10 billion;

(B) (I) the trust must be in an amount equal to the group's several liabilities attributable to business ceded by United States ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of the group;

(II) the group shall maintain a joint surplus with a trustee of which $100 million is held jointly for the benefit of United States ceding insurers of any member of the group as additional security for any liabilities; and

(III) each member of the group shall make available to the commissioner an annual certification of the member's solvency by the ~~member's domiciliary regulator and its independent public accountant~~ insurance regulator and the independent public accountants in the jurisdiction where the underwriter is domiciled.

(c) The trust must be established in a form approved by the commissioner. The trust instrument must provide that contested claims are valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust must vest legal title to its assets in the trustees of the trust for its United States policyholders and ceding insurers and their assigns and successors in interest. The trust and the assuming insurer are subject to examination as determined by the commissioner. The trust described in this subsection (c) must remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust.

(d) No later than February 28 of each year, the trustees of the trust shall report to the commissioner in writing setting forth the balance of the trust and listing the trust's investments at the end of the preceding year. The trustees shall certify the date of termination of the trust, if planned, or certify that the trust may not expire prior to the following December 31.

(6) Credit must be allowed when the reinsurance is ceded to an assuming insurer that does not

meet the requirements of subsection (2), (3), (4), or (5) but only with respect to the insurance of risks located in a jurisdiction in which the reinsurance is required by applicable law or regulation of that jurisdiction.

(7) (a) If the assuming insurer is not licensed or accredited to transact insurance or reinsurance in this state, the credit permitted by subsections (4) and (5) may not be allowed unless the assuming insurer agrees in the reinsurance agreements:

(i) that in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, will:

(A) submit to the jurisdiction of any court of competent jurisdiction in any state of the United States;

(B) comply with all requirements necessary to give the court jurisdiction; and

(C) abide by the final decision of the court or of any appellate court in the event of an appeal; and

(ii) to designate the commissioner or a designated attorney as its attorney upon whom may be served any lawful process in any action, suit, or proceeding instituted by or on behalf of the ceding company.

(b) Subsection (7)(a)(i) is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes if an obligation is created in the agreement."

Section 29. Section 33-2-1217, MCA, is amended to read:

"**33-2-1217. Reduction of liability for reinsurance ceded by domestic insurer to assuming insurer -- definition.** A reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of 33-2-1216 must be allowed in an amount not exceeding the liabilities carried by the ceding insurer. The reduction must be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer:

(1) under a reinsurance contract with the assuming insurer as security for the payment of obligations under the contract if the security is held in the United States subject to withdrawal solely by and under the exclusive control of the ceding insurer; or

(2) in the case of a trust, in a qualified United States financial institution. This security may be in the form of:

(a) cash;

(b) securities listed by the securities valuation office of the NAIC and qualifying as admitted assets;

(c) clean, irrevocable, unconditional letters of credit that are issued or confirmed by a qualified United States financial institution no later than December 31 of the year for which filing is being made and that are in the possession of the ceding company on or before the filing date of its annual statement. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation must, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification, or amendment, whichever occurs first.

(d) any other form of security acceptable to the commissioner.

(3) For the purposes of subsection (2)(c), a "qualified United States financial institution" means an institution that:

(a) is organized or, in the case of a United States office of a foreign banking organization, licensed under the laws of the United States or any of its states;

(b) is regulated, supervised, and examined by United States federal or state authorities with regulatory authority over banks and trust companies; and

(c) has been determined by either the commissioner or the securities valuation office of the national association of insurance commissioners to meet the standards of financial condition and standing that are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner.

(4) For the purposes of this part, except for subsection (2)(c), "qualified United States financial institution" means, with respect to institutions eligible to act as a fiduciary of a trust, an institution that:

(a) is organized or, in the case of a United States branch or agency office of a foreign banking corporation, licensed under the laws of the United States or any of its states and that has been granted authority to operate with fiduciary powers; and

(b) is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies.

(5) The commissioner may adopt rules implementing the provisions of 33-2-307, 33-2-708, and 33-2-806."

Section 30. Section 33-2-1218, MCA, is amended to read:

"**33-2-1218. Reinsurance agreements affected.** Sections 33-2-1216 and 33-2-1217 apply to all cessions after October 1, 1993, under reinsurance agreements that have had an inception, anniversary, or renewal date on or ~~before~~ after April 1, 1993."

Section 31. Section 33-2-1510, MCA, is amended to read:

"**33-2-1510. Minimum standards.** Unless there is a written contract between a controlling producer and a controlled insurer specifying the responsibilities of each party, the controlled insurer may not accept business from the controlling producer and the controlling producer may not place business with the controlled insurer. The contract must be approved by the board of directors of the controlled insurer and must contain the following minimum provisions:

(1) The controlled insurer may terminate the contract for cause, upon written notice to the controlling producer. The controlled insurer shall suspend the authority of the controlling producer to write business during the pendency of any dispute regarding the cause for the termination.

(2) The controlling producer shall render to the controlled insurer accounts detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by or owing to the controlling producer.

(3) On at least a monthly basis, the controlling producer shall remit to the controlled insurer all funds due under the terms of the contract. The due date must be fixed so that premiums or installments of premiums collected must be remitted no later than 90 days after the effective date of any policy placed with the controlled insurer under the contract.

(4) In accordance with the provisions of this title, all funds collected for the controlled insurer's account must be held by the controlling producer in a fiduciary capacity, in one or more appropriately identified bank accounts in banks that are members of the federal reserve system. However, funds of a controlling producer not required to be licensed in this state must be maintained in compliance with the requirements of the jurisdiction in which the controlling ~~producer's domiciliary jurisdiction~~ producer is domiciled.

(5) The controlling producer shall maintain separately identifiable records of business written for the controlled insurer.

(6) The contract may not be assigned in whole or in part by the controlling producer.

(7) The controlled insurer shall provide the controlling producer with its underwriting standards,

rules, procedures, manuals setting forth the rates to be charged, and the conditions for the acceptance or rejection of risks. The controlling producer shall adhere to the standards, rules, procedures, rates, and conditions. The standards, rules, procedures, rates, and conditions must be the same as those applicable to comparable business placed with the controlled insurer by a producer other than the controlling producer.

(8) The rates and terms of the controlling producer's commissions, charges, or other fees and the purposes of those commissions, charges, or fees must be contained in the contract. The rates of the controlling producer's commissions, charges, and other fees may not be greater than those applicable to comparable business placed with the controlled insurer by producers other than controlling producers. For purposes of subsection (7) and this subsection, examples of "comparable business" include the same lines of insurance, same kinds of insurance, same kinds of risks, similar policy limits, and similar quality of business.

(9) If the contract provides that on insurance business placed with the controlled insurer, the controlling producer is to be compensated contingent upon the controlled insurer's profits on that business, then the compensation may not be determined and paid until at least 5 years after the premiums on liability insurance are earned and at least 1 year after the premiums are earned on any other insurance. The commissions may not be paid until the adequacy of the controlled insurer's reserves on remaining claims has been independently verified pursuant to 33-2-1512.

(10) The rates and terms of the controlling producer's commissions, charges, or other fees and the purposes of those commissions, charges, or fees must be contained in the contract. The controlled insurer may establish a different limit for each line or subline of business. The controlled insurer shall notify the controlling producer when the applicable limit is approached and may not accept business from the controlling producer if the limit is reached. The controlling producer may not place business with the controlled insurer if it has been notified by the controlled insurer that the limit has been reached.

(11) The controlling producer may negotiate but may not bind reinsurance on behalf of the controlled insurer on business that the controlling producer places with the controlled insurer, except that the controlling producer may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the controlled insurer contains underwriting guidelines. For reinsurance assumed and ceded, the guidelines must include a list of reinsurers with which the automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured, and commission schedules."

Section 32. Section 33-2-1605, MCA, is amended to read:

"**33-2-1605. Penalties and liabilities.** (1) If, after a hearing conducted in accordance with Title 33, chapter 1, part 7, the commissioner finds that a person has violated any provision of this part, the commissioner may order:

(a) a penalty in an amount of $5,000 for each separate violation;

(b) revocation or suspension of the producer's license; and

(c) the managing general agent to reimburse the insurer, the rehabilitator, or a liquidator of the insurer for any losses incurred by the insurer caused by a violation of this part committed by the managing general agent.

(2) An order of the commissioner pursuant to subsection (1) is subject to judicial review pursuant to 33-1-711.

(3) This section does not limit the power of the commissioner to impose any other penalty provided in this title.

(4) This part does not limit the rights of policyholders, claimants, or ~~auditors~~ creditors."

Section 33. 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, to provide it with surplus funds, or for any purpose of its business~~,~~ upon a written agreement that ~~such~~ the money is required to be repaid only out of the insurer's surplus in excess of that stipulated in ~~such~~ the agreement. The agreement may provide for interest at a rate ~~no~~ not 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~~ and whether the interest constitutes a liability of the insurer must be stipulated in the agreement. ~~No~~ A commission or promotion expense ~~shall~~ may not be paid in connection with ~~any such~~ a loan of the type described in this section.

(2) Money ~~so~~ borrowed, together with the interest ~~thereon~~ if ~~so~~ stipulated in the agreement, ~~shall~~ does 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~~ However, until the money or interest, or both, are repaid, financial statements filed or published by the insurer ~~shall~~ must show as a footnote ~~thereto~~ the amount ~~thereof~~ then unpaid together with any interest ~~thereon~~ accrued but unpaid.

(3) ~~Any such~~ A loan of this type to a mutual or stock insurer ~~shall be~~ is 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~~ are approved unless within 15 days after ~~date of such~~ filing the insurer is notified of the commissioner's disapproval and ~~the reasons therefor~~ reasons for the disapproval. The commissioner shall disapprove any proposed loan or agreement if ~~he~~ the commissioner 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~~ A loan to a mutual or stock insurer or a substantial portion ~~thereof~~ of the loan ~~shall~~ must be repaid by the insurer when it is no longer reasonably necessary for the purpose originally intended. ~~No repayment of such loan shall~~ Repayment of either principal or interest on the loan may not be made by a mutual or stock insurer unless ~~in advance~~ approved in advance by the commissioner.

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

Section 34. Section 33-4-202, MCA, is amended to read:

"**33-4-202. Declaration of intention to incorporate -- articles of incorporation -- fee.** (1) The individuals proposing to form a farm mutual insurer as referred to in 33-4-201 shall file with the commissioner:

(a) a declaration of their intention to form ~~such a~~ the corporation~~, which declaration shall be~~ signed by at least 100 incorporators if a proposed state mutual insurer or by at least 25 incorporators if a proposed county mutual insurer; and

(b) proposed articles of incorporation executed in ~~quadruplicate~~ triplicate by three or more of the incorporators and acknowledged by each before a person authorized to take and verify acknowledgments of conveyance of real property.

(2) The articles of incorporation ~~shall~~ must state:

(a) the name of the corporation. If a state mutual insurer, the words "farm mutual" must be a part of the name; if a county mutual insurer, the name ~~shall~~ must contain the words "farm mutual" or "rural mutual" together with the name of the county ~~wherein is to be located~~ in which its principal place of business is to be located. The name ~~shall~~ may not be so similar to one already used by a corporation in

this state as to be misleading.

(b) if a county mutual insurer, the name of the county or counties in which the corporation is to transact insurance and the address where its principal business office will be located;

(c) if a state mutual insurer, the location of its principal business office, which ~~office~~ must be located in this state;

(d) the objects and purposes for which the corporation is formed;

(e) whether it intends to transact business on the cash premium plan or the assessment plan;

(f) the duration of its existence, which may be perpetual;

(g) the number of its directors, which ~~shall~~ may not be less than 5 or more than 11~~; also~~, and the names and addresses of the members of the initial board of directors appointed to manage the affairs of the corporation until the first annual meeting of the members and ~~until their~~ successors are elected and qualified;

(h) ~~such~~ other provisions, not inconsistent with law, ~~deemed~~ considered appropriate by the incorporators;

(i) the names, residences, and addresses of the incorporators and the value of ~~the~~ their property ~~desired~~ to be insured ~~owned by each~~ in the county or counties where the operations of the corporation are to be carried on.

(3) At the time of filing of the articles of incorporation as provided in subsection (1) ~~above~~, the incorporators shall pay to the commissioner a filing fee of $10. The commissioner shall deposit ~~all such~~ the fees with the state treasurer to the credit of the general fund ~~of this state~~."

Section 35. Section 33-4-203, MCA, is amended to read:

"**33-4-203. Approval of articles -- commencement of corporate existence.** (1) ~~Upon receipt of proposed articles of incorporation, the commissioner shall forward the proposed articles of incorporation to the attorney general for examination.~~ If the ~~attorney general~~ commissioner finds the proposed articles of incorporation to be in accordance with the provisions of this chapter and not in conflict with the constitution and laws of the United States of America or of this state, the ~~attorney general~~ commissioner shall make a certificate of the facts ~~and return it with the proposed articles to the commissioner~~.

(2) If the commissioner considers the name of the proposed corporation to be so similar to one already appropriated by another company or corporation as to be likely to mislead the public, the

commissioner shall reject the name applied for and shall notify the incorporators of the rejection.

(3) When the proposed articles of incorporation have been approved by the ~~attorney general~~ commissioner, the commissioner shall ~~likewise~~ endorse the commissioner's approval upon each set of the articles and forward ~~four~~ three sets of articles to the incorporators. The incorporators shall file one of the sets of articles with the secretary of state, one set with the commissioner bearing the certification of the secretary of state, and one set with the county clerk of the county in which the principal place of business of the corporation is located and shall pay to the secretary of state and the county clerk the customary filing fees. The remaining set of articles must be made a part of the corporation's records.

(4) The corporation has legal existence upon the approval of the articles by the ~~attorney general and the~~ commissioner and completion of the filings referred to in subsection (3), but it may not transact business as an insurer until it has fulfilled the requirements for and has obtained a certificate of authority as provided in 33-4-505."

Section 36. Section 33-5-401, MCA, is amended to read:

"**33-5-401. Surplus funds required.** (1) A domestic reciprocal insurer ~~hereunder formed~~ subject to this part, if it has otherwise complied with the applicable provisions of this code, may be authorized to transact insurance if it has and ~~thereafter~~ maintains surplus funds as follows:

(a) to transact property insurance, surplus funds of not less than $400,000;

(b) to transact casualty insurance:~~; other than workers' compensation, surplus funds of not less than $400,000.~~

(i) including authority for workers' compensation insurance, surplus funds of not less than $600,000; or

(ii) excluding authority for workers' compensation insurance, surplus funds of not less than $400,000.

(2) In addition to surplus funds required to be maintained under subsection (1) ~~above~~, the insurer ~~shall~~ must have, when first ~~so~~ authorized, expendable surplus in the same amount as required of a like foreign reciprocal insurer under 33-2-110.

(3) A domestic reciprocal insurer may be authorized to transact additional kinds of insurance if it has otherwise complied with the provisions of this code ~~therefor~~ for the additional kinds of insurance and ~~possesses and so~~ maintains surplus funds in an amount equal to the minimum capital stock required of a

stock insurer for authority to transact a like combination of kinds of insurance."

Section 37. Section 33-7-117, MCA, is amended to read:

"**33-7-117. Scope -- provisions applicable.** (1) Except as provided in subsection (2), societies are governed by this chapter and are exempt from all other provisions of the insurance laws of this state, not only in governmental relations with the state but for every other purpose. The provisions of a law enacted after January 1, 1992, do not apply to fraternal benefit societies unless expressly made applicable by the provisions of the law.

(2) In addition to the provisions of this chapter, the provisions of chapter 1, parts 1 through 4 and 7; 33-2-104; 33-2-107; 33-2-112; chapter 2, part 13; 33-3-308; 33-15-502; ~~and~~ chapters 17, 18, 20, and 22; and [sections 78 through 81] apply to fraternal benefit societies to the extent applicable and to the extent not in conflict with the provisions of this chapter and the reasonable implications of this chapter."

Section 38. Section 33-10-201, MCA, is amended to read:

"**33-10-201. Short title, purpose, scope, and construction.** (1) This part ~~shall be known and~~ may be cited as the "Montana Life and Health Insurance Guaranty Association Act".

(2) The purpose of this part is to protect policyowners, insureds, beneficiaries, annuitants, payees, and assignees of life insurance policies, health insurance policies, annuity contracts, and supplemental contracts, subject to certain limitations, against failure in the performance of contractual obligations due to the impairment of the insurer issuing the policies or contracts.

(3) To provide this protection:

(a) an association of insurers is created to enable the guaranty of payment of benefits and of continuation of coverages;

(b) members of the association are subject to assessment to provide funds to carry out the purpose of this part; and

(c) the association is authorized to assist the commissioner, in the prescribed manner, in the detection and prevention of insurer impairments.

(4) This part applies to direct, nongroup life, health, annuity, and supplemental policies or contracts, to certificates under direct group policies and contracts, and to unallocated annuity contracts issued by member insurers, except as limited by this part. Annuity contracts and certificates under group

annuity contracts include but are not limited to guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement agreements, lottery contracts, and any immediate or deferred annuity contracts.

(5) This part provides coverage for ~~covered~~ policies and contracts specified in subsection (6):

(a) to persons who are owners of or certificate holders under covered policies or, in the case of unallocated annuity contracts, to the persons who are contract holders ~~and who~~ if the persons:

(i) are residents; or

(ii) are not residents, but only under all of the following conditions:

(A) the insurers that issued the policies are domiciled in this state;

(B) the insurers have not held a license or certificate of authority in the state in which the persons reside;

(C) the state has an association similar to the association created under this part; and

(D) the persons are not eligible for coverage by that association; and

(b) to persons who, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees, or payees of the persons covered under subsection (5)(a).

(6) This part covers persons specified in subsection (5)(a) for direct, nongroup life, health, annuity, and supplemental policies and contracts, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by this part. Annuity contracts and certificates under group annuity contracts include but are not limited to guaranteed investment contracts, deposit administration contracts, allocated and unallocated funding agreements, structured settlement agreements, lottery contracts, and immediate or deferred annuity contracts. This part does not apply to:

(a) ~~any~~ policies or contracts or any part of the policies or contracts under which the risk is borne by the policyholder;

(b) ~~any~~ a policy or contract or part of the policy or contract assumed by the impaired insurer under a contract of reinsurance, other than reinsurance for which assumption certificates have been issued;

(c) any portion of a policy or contract to the extent that the rate of interest on which it is based:

(i) averaged over the period of 4 years prior to the date on which the association becomes obligated with respect to the policy or contract, exceeds a rate of interest determined by subtracting 2

percentage points from Moody's corporate bond yield average averaged for that same 4-year period or for the lesser period if the policy or contract was issued less than 4 years before the association became obligated; and

(ii) on and after the date on which the association becomes obligated with respect to the policy or contract, exceeds the rate of interest determined by subtracting 3 percentage points from Moody's corporate bond yield average as is most recently available;

(d) any plan or program of an employer, association, or similar entity to provide life, health, or annuity benefits to its employees or members to the extent that the plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association, or similar entity under:

(i) a multiple employer welfare arrangement, as defined in section 514 of the Employee Retirement Income Security Act of 1974, as amended;

(ii) a minimum premium group insurance plan;

(iii) a stop-loss group insurance plan; or

(iv) an administrative services only contract;

(e) any portion of a policy or contract to the extent that it provides dividends or experience rating credits or provides that any fees or allowances be paid to any person, including the policy or contract holder, in connection with the service to or administration of the policy or contract;

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

(g) any unallocated annuity contract issued to an employee benefit plan that is protected under the federal pension benefit guaranty corporation; and

(h) any portion of any unallocated annuity contract that is not issued to or in connection with a specific employee, union, or association of natural persons benefit plan or a government lottery.

(7) This part must be liberally construed to effect the purpose under subsections (2) and (3), which constitute an aid and guide to interpretation.

(8) This part may not be construed to reduce the liability for unpaid assessments of the insureds of an impaired insurer operating under a plan with assessment liability."

Section 39. Section 33-10-202, MCA, is amended to read:

"**33-10-202. Definitions.** As used in this part, the following definitions apply:

(1) "Account" means any of the three accounts created under 33-10-203.

(2) "Association" means the Montana life and health insurance guaranty association created under 33-10-203.

(3) "Contractual obligation" means any obligation under covered policies.

(4) "Covered policy" means any policy or contract within the scope of this part under subsections (4) through (6) of 33-10-201.

(5) "Impaired insurer" means:

(a) an insurer which after July 1, 1974, becomes insolvent and is placed under a final order of liquidation, rehabilitation, or supervision by a court of competent jurisdiction; or

(b) an insurer considered by the commissioner after July 1, 1974, to be unable or potentially unable to fulfill its contractual obligations.

(6) (a) "Member insurer" means any ~~person authorized to transact in this state any kind of insurance to which this part applies under subsections (4) and (6) of 33-10-201~~ insurer that is licensed or that holds a certificate of authority to transact any kind of insurance in this state for which coverage is provided under 33-2-201 and includes any insurer whose license or certificate of authority may have been suspended, revoked, not renewed, or voluntarily withdrawn.

(b) The term does not include:

(i) a health service corporation;

(ii) a health maintenance organization;

(iii) a fraternal benefit society;

(iv) a mandatory state pooling plan;

(v) a mutual assessment company or any entity that operates on an assessment basis;

(vi) an insurance exchange; or

(vii) an entity similar to any of the entities listed in subsections (6)(b)(i) through (6)(b)(vi).

(7) "Person" means any individual, corporation, partnership, association, or voluntary organization.

(8) "Premiums" means direct gross insurance premiums and annuity considerations written on covered policies, less return premiums and considerations on premiums and dividends paid or credited to policyholders on the direct business. "Premiums" do not include premiums and considerations on contracts between insurers and reinsurers. As used in 33-10-227, "premiums" are those for the calendar year preceding the determination of impairment.

(9) "Resident" means any person who resides in this state at the time the impairment is determined and to whom contractual obligations are owed.

(10) "Unallocated annuity contract" means an annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of annuity benefits guaranteed to an individual by the insurer under the contract or certificate."

Section 40. Section 33-11-102, MCA, is amended to read:

"**33-11-102. Definitions.** As used in this part, the following definitions apply:

(1) "Completed operations liability" means:

(a) liability arising out of the installation, maintenance, or repair of any product at a site that is not owned or controlled by:

(i) a person who performs that work; or

(ii) a person who hires an independent contractor to perform that work; and

(b) liability for activities that are completed or abandoned before the date of the occurrence giving rise to the liability.

(2) "Domicile", for purposes of determining the state where a purchasing group is domiciled, means:

(a) for a corporation, the state where the purchasing group is incorporated; and

(b) for an unincorporated entity, the state of its principal place of business.

~~(2)~~(3) "Hazardous financial condition" means that, based on its present or reasonably anticipated financial condition, a risk retention group, although not yet financially impaired or insolvent, is unlikely to be able to:

(a) meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

(b) pay other obligations in the normal course of business.

~~(3)~~(4) "Insurance" means primary insurance, excess insurance, reinsurance, surplus line insurance, and any other arrangement for shifting and distributing risk that is determined to be insurance under the laws of this state.

~~(4)~~(5) (a) "Liability" means legal liability for damages, including costs of defense, legal costs and fees, and other claims expenses, because of injuries to other persons, damage to their property, or other

damage or loss to other persons resulting from or arising out of:

(i) a business, whether profit or nonprofit, trade, product, service (including professional service), premises, or operation; or

(ii) an activity of any state or local government or an agency or political subdivision ~~thereof~~ of state or local government.

(b) The term does not include personal risk liability or an employer's liability with respect to its employees other than legal liability under the federal Employers' Liability Act, ~~(~~45 U.S.C. 51 through 60~~)~~. As used in this subsection, "personal risk liability" means liability for damages because of injury to any person, damage to property, or other loss or damage resulting from personal, familial, or household responsibilities or activities rather than from responsibilities or activities referred to in subsection ~~(4)(a)~~ (5)(a).

~~(5)~~(6) "Plan of operation or a feasibility study" means an analysis that presents the expected activities and results of a risk retention group, including at a minimum:

(a) the coverages, deductibles, coverage limits, rates, and rating classification systems for each line of insurance the group intends to offer;

(b) historical and expected loss experience of the proposed members and national experience of similar exposures to the extent this experience is reasonably available;

(c) pro forma financial statements and projections;

(d) appropriate opinions by a qualified independent casualty actuary, including a determination of minimum premium or participation levels required to commence operations and to prevent a hazardous financial condition;

(e) identification of management, underwriting procedures, managerial oversight methods, and investment policies; and

(f) other matters as may be prescribed by the commissioner for liability insurance companies authorized by the insurance laws of the state where the risk retention group is chartered.

~~(6)~~(7) "Purchasing group" means a group that:

(a) has as one of its purposes the purchase of liability insurance on a group basis;

(b) purchases liability insurance only for its group members and only to cover their similar or related liability exposure, as described in subsection ~~(6)(c)~~ (7)(c);

(c) is composed of members whose businesses or activities are similar or related with respect to

the liability to which members are exposed by virtue of any related, similar, or common business, trade, product, service, premises, or operation; and

(d) is domiciled in any state.

~~(7)~~(8) "Risk retention group" means a corporation or other limited liability association formed under the laws of any state, Bermuda, or the Cayman Islands:

(a) whose primary activity consists of assuming and spreading all or any portion of the liability exposure of its group members;

(b) that is organized for the primary purpose of conducting the activity described under subsection ~~(7)(a)~~ (8)(a);

(c) (i) that is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state; or

(ii) that, before January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before that date, had certified to the insurance regulatory official of at least one state that it satisfied the capitalization requirements of that state. However, ~~such~~ the group is considered to be a risk retention group only if it has been engaged in business continuously since January 1, 1985, and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability.

~~(A) For purposes of this subsection (7), "completed operations liability" means liability arising out of the installation, maintenance, or repair of any product at a site which is not owned or controlled by a person who performs that work or hires an independent contractor to perform that work and includes liability for activities which are completed or abandoned before the date of the occurrence giving rise to the liability.~~

~~(B)~~ For purposes of this subsection ~~(7)~~ (8), "product liability" means liability for damages because of any personal injury, death, emotional harm, consequential economic damage, or property damage, ~~(~~including damages resulting from the loss of use of property~~)~~, arising out of the manufacture, design, importation, distribution, packaging, labeling, lease, or sale of a product but does not include the liability of any person for those damages if the product involved was in the possession of that person when the incident giving rise to the claim occurred.

(d) that does not exclude any person from membership in the group solely to provide to members of the group a competitive advantage over ~~such~~ the person;

(e) (i) that has as its members only persons who have an ownership interest in the group and that has as its owners only persons who are members and who are provided insurance by the risk retention group; or

(ii) that has as its sole member and sole owner an organization that is owned by persons who are provided insurance by the risk retention group;

(f) whose members are engaged in businesses or activities that are similar or related with respect to the liability to which the members are exposed by virtue of any related, similar, or common business, trade, product, service, premises, or operation;

(g) whose activities do not include the provision of insurance other than:

(i) liability insurance for assuming and spreading all or any portion of the liability of its group members; and

(ii) reinsurance with respect to the liability of any other risk retention group or member of ~~such~~ the other group that is engaged in businesses or activities so that ~~such~~ the group or member meets the requirement described in subsection ~~(7)(f)~~ (8)(f) for membership in the risk retention group that provides the reinsurance; and

(h) whose name includes the phrase "risk retention group".

~~(8)~~(9) "State" means any state of the United States or the District of Columbia."

Section 41. Section 33-11-104, MCA, is amended to read:

"**33-11-104. Risk retention groups not chartered in this state.** A risk retention group chartered in a state other than this state and seeking to do business as a risk retention group in this state must observe and abide by the laws of this state as follows:

(1) Before offering insurance in this state, a risk retention group shall submit to the commissioner:

(a) a statement identifying the state or states where the risk retention group is chartered and authorized as a casualty insurer, date of chartering, its principal place of business, and other information, including information on its membership, as the commissioner requires to verify that the risk retention group is qualified under 33-11-102~~(7)~~(8);

(b) a copy of its plan of operation or a feasibility study and revisions of the plan or study submitted to its state of domicile. However, this provision relating to the submission of a plan of operation or a feasibility study does not apply with respect to any line or classification of liability insurance that was

defined in the federal Product Liability Risk Retention Act of 1981 (15 U.S.C. 3901 through 3904) before it was amended by P.L. 99-563, approved on October 27, 1986, and that was offered before that date by a risk retention group that had been chartered and operated for not less than 3 years before that date; and

(c) a statement of registration that designates the commissioner as its agent for the purpose of receiving service of legal documents or process.

(2) A risk retention group doing business in this state shall submit to the commissioner:

(a) a copy of the group's financial statement submitted to its state of domicile, which must be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American academy of actuaries or by a qualified loss reserve specialist under criteria established by the national association of insurance commissioners;

(b) a copy of each examination of the risk retention group as certified by the insurance regulatory official of the state in which the examination was conducted or public official conducting the examination;

(c) upon request by the commissioner, a copy of any audit performed with respect to the risk retention group; and

(d) any information as may be required to verify the group's continuing qualification as a risk retention group under 33-11-102~~(7)~~(8).

(3) (a) Each risk retention group is liable for the payment of premium taxes and taxes on premiums of direct business for risks resident or located within this state and shall report to the commissioner the net premiums written for risks resident or located within this state. The risk retention group is subject to taxation and any applicable interest, fines, and penalties for nonpayment that apply to foreign admitted insurers.

(b) To the extent that an insurance producer is used, the insurance producer shall report to the commissioner the premiums of direct business for risks resident or located within this state that the licensees have placed with or on behalf of a risk retention group not chartered in this state.

(c) To the extent that an insurance producer is used, the insurance producer shall keep a complete and separate record of all policies procured from each risk retention group. The record is open to examination by the commissioner, as provided in 33-1-408. The records must, for each policy and each kind of insurance provided under the policy, include the limit of liability, the time period covered, the effective date, the name of the risk retention group that issued the policy, the gross premium charged, and the amount of return premiums, if any.

(4) Each risk retention group, its insurance producers, and its representatives shall comply with Title 33, chapter 18, part 2.

(5) Each risk retention group shall comply with the provisions of Title 33, chapter 18, part 2, regarding deceptive, false, or fraudulent acts or practices. However, if the commissioner seeks an injunction regarding the risk retention group's conduct, the injunction must be obtained from a court of competent jurisdiction.

(6) Each risk retention group shall submit to an examination by the commissioner to determine its financial condition if the insurance regulatory official of the jurisdiction where the group is chartered has not initiated an examination or does not initiate an examination within 60 days after a request by the commissioner. The examination must be coordinated to avoid unjustified repetition and be conducted in an expeditious manner in accordance with the national association of insurance commissioners examiners handbook.

(7) Each policy issued by a risk retention group must contain, in 10-point type on the front page and the declaration page, the following notice:

"NOTICE

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group."

(8) The following acts by a risk retention group are prohibited:

(a) the solicitation or sale of insurance by a risk retention group to any person who is not eligible for membership in the group; and

(b) the solicitation or sale of insurance by or operation of a risk retention group that is in a hazardous financial condition or is financially impaired.

(9) A risk retention group is not allowed to do business in this state if an insurer is directly or indirectly a member or owner of the risk retention group, other than in the case of a risk retention group all of whose members are insurers.

(10) A risk retention group may not offer insurance policy coverage declared unlawful by the Montana supreme court.

(11) A risk retention group not chartered in this state and doing business in this state shall comply with a lawful order issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced

by the insurance regulatory official of any state if there has been a finding of financial impairment after an examination under subsection (6).

(12) Upon completion of registration requirements, the commissioner shall issue to the risk retention group a proper certificate of registration.

(13) A risk retention group that violates any provision of this chapter is subject to fines and penalties, including revocation of the right to do business in this state, applicable to licensed insurers generally."

Section 42. Section 33-11-108, MCA, is amended to read:

"**33-11-108. Notice and registration requirements of purchasing groups.** (1) A purchasing group that intends to do business in this state shall furnish notice to the commissioner that:

(a) identifies the state where the group is domiciled and all other states in which the group intends to do business;

(b) specifies the lines and classifications of liability insurance that the purchasing group intends to purchase;

(c) identifies the insurer from which the purchasing group intends to purchase its insurance and the domicile of ~~the~~ that insurer;

(d) identifies the Montana-licensed insurance producer or Montana-licensed surplus lines insurance producer through which the purchasing group intends to place its business;

(e) identifies the principal place of business of the purchasing group; ~~and~~

(f) provides information required by the commissioner to verify that the purchasing group is qualified under 33-11-102~~(6)~~(7)~~.~~; and

(g) identifies the person or persons controlling the activities of the group and includes biographical information on the person or persons.

(2) The purchasing group shall register with and designate the commissioner as its agent solely for the purpose of receiving service of legal documents or process. However, the requirements do not apply in the case of a purchasing group:

(a) (i) that was domiciled before April 2, 1986, in any state of the United States; and

(ii) that was domiciled on and after October 27, 1986, in any state of the United States;

(b) (i) that, before October 27, 1986, purchased insurance from an insurer licensed in any state;

and

(ii) that, since October 27, 1986, purchased its insurance from an insurer licensed in any state;

(c) that was a purchasing group under the requirements of the federal Product Liability Risk Retention Act of 1981 (15 U.S.C. 3901 through 3904) before it was amended by P.L. 99-563, approved on October 27, 1986; and

(d) that does not purchase insurance that was not authorized for purposes of an exemption under the federal Product Liability Risk Retention Act of 1981, as in effect before October 27, 1986.

(3) Upon completion of registration requirements, the commissioner shall issue a proper certificate of registration to the purchasing group."

Section 43. Section 33-14-304, MCA, is amended to read:

"**33-14-304. Cancellation of insurance upon default.** (1) When a premium finance agreement contains a power of attorney or other authority enabling the insurance premium finance company to cancel any insurance contract listed in the agreement, the insurance contract or contracts may not be canceled by the premium finance company unless ~~such~~ the cancellation is effectuated in accordance with this section.

(2) ~~Not less than 10 days' written~~ Written notice must be mailed to the insured setting forth the intent of the insurance premium finance company to cancel the insurance contract unless the default is cured prior to the date stated in the notice. The written notice must be mailed at least 10 days prior to the date stated in the notice. The insurance producer ~~or broker~~ indicated on the premium finance agreement ~~shall~~ must also be mailed 10 days' notice of this action.

(3) Pursuant to the power of attorney or other authority referred to above, the insurance premium finance company may cancel on behalf of the insured by mailing to the insurer written notice stating when ~~thereafter~~ the cancellation ~~shall be~~ will become effective, and the insurance contract ~~shall~~ must be canceled as if ~~such~~ the notice of cancellation had been submitted by the insured ~~himself~~ but without requiring the return of the insurance contract. If the insurer or its insurance producer does not provide the insurance premium finance company with a specific mailing address for the purpose of receipt of the ~~above~~ notice, mailing by the insurance premium finance company to the insurer at the address that is on file ~~and of record~~ with the commissioner is considered sufficient notice under this section. The insurance premium finance company shall also mail a notice of cancellation to the insured at ~~his~~ the insured's last-known address and

to the insurance producer ~~or broker~~ indicated on the premium finance agreement.

(4) All statutory, regulatory, and contractual restrictions providing that the insurance contract may not be canceled unless notice is given to a governmental agency, mortgagee, or other third party apply whenever cancellation is effected under the provisions of this section. The insurer shall give the prescribed notice in behalf of itself or the insured to any governmental agency, mortgagee, or other third party on or before the second business day after the day it receives the notice of cancellation from the premium finance company and shall determine the effective date of cancellation taking into consideration the number of days' notice required to complete the cancellation."

Section 44. Section 33-15-301, MCA, is amended to read:

"**33-15-301. Requiring standard provisions -- waiver.** (1) Insurance contracts ~~shall~~ must contain ~~such~~ the standard or uniform provisions ~~as are~~ and benefits required by the applicable provisions of this code pertaining to contracts of particular kinds of insurance. The commissioner may waive ~~the required use~~ ~~of~~ a particular provision in a particular insurance policy form if:

(a) ~~he~~ the commissioner finds ~~such~~ the provision or benefit unnecessary for the protection of the insured and inconsistent with the purposes of the policy; and

(b) the policy is otherwise approved by ~~him~~ the commissioner.

(2) ~~No~~ A policy or certificate ~~shall~~ may not contain any provision or benefit inconsistent with or contradictory to any standard or uniform provision or benefit used or required to be used, but the commissioner may approve any substitute provision or benefit ~~which~~ that is, in ~~his~~ the commissioner's opinion, not less favorable in any particular to the insured or beneficiary than the provisions otherwise required.

(3) In lieu of the provisions required by this code for contracts for particular kinds of insurance, substantially similar provisions required by the law of the domicile of a foreign or alien insurer may be used when approved by the commissioner.

(4) ~~No such~~ A provision, if required to be contained in the policy, ~~can~~ may not be waived by agreement between the insurer and any other person."

Section 45. Section 33-15-303, MCA, is amended to read:

"**33-15-303. Contents of policies in general -- identification.** (1) ~~Every~~ Each policy ~~shall~~ must

specify:

(a) the names of the parties to the contract;

(b) the subject of the insurance;

(c) the risks insured against;

(d) the time when the insurance under the policy takes effect and the period during which the insurance is to continue;

(e) the premium;

(f) the conditions pertaining to the insurance.

(2) If under the policy the exact amount of premium is determinable only at stated intervals or termination of the contract, a statement of the basis and rates upon which the premium is to be determined and paid must be included.

(3) All policies and annuity contracts issued by insurers and the forms of policies and annuity contracts filed with the commissioner must have printed on the policy or annuity contract an appropriate designating letter or figure, combination of letters or figures, or terms identifying the respective forms of policies or contracts~~, together with the year of adoption of the form~~. Each form, including riders and endorsements, must be identified by a designating letter or figure placed in a lower, preferably left-hand, corner of the first page of the form. Whenever any change is made in any form, the designating letters, figures, or terms ~~and year of adoption~~ on the form must be correspondingly changed and the revision date must be noted next to the designating letters."

Section 46. Section 33-16-202, MCA, is amended to read:

"**33-16-202. Recording and reporting of loss and expense experience.** (1) The commissioner ~~shall~~ may promulgate and may modify reasonable rules and statistical plans, reasonably adapted to each of the rating systems used, ~~and~~ which ~~shall~~ must ~~thereafter~~ be used by each insurer in the recording and reporting of its loss and countrywide expense experience, in order that the experience of all insurers may be made available at least annually in ~~such~~ form and detail as ~~may be~~ necessary to aid ~~him~~ the commissioner in determining whether rates comply with the applicable standards of this chapter. ~~Such~~ The rules and plans may also provide for the recording and reporting of expense experience items ~~which~~ that are specially applicable to this state and are not susceptible of determination by a prorating of countrywide expense experience.

(2) In promulgating ~~such~~ rules and plans, the commissioner shall give ~~due~~ consideration to the rating systems in use in this state and, in order that ~~such~~ the rules and plans may be as uniform as is practicable among the several states, to the rules and to the form of the plans used for ~~such~~ rating systems in other states. ~~No~~ An insurer ~~shall~~ may not be required to record or report its loss experience on a classification basis that is inconsistent with the rating system used by it.

(3) The commissioner may designate one or more rating organizations or other agencies to assist ~~him~~ in gathering ~~such~~ and making compilations of loss and expense experience ~~and making compilations thereof~~, and ~~such~~ the compilations ~~shall~~ must be made available, subject to reasonable rules promulgated by the commissioner, to insurers and rating organizations."

Section 47. Section 33-16-235, MCA, is amended to read:

"**33-16-235. Data reporting -- rules.** (1) An insurer that has transacted a line of insurance designated as noncompetitive or volatile ~~shall~~ may report once a year to the commissioner, on forms prescribed by the commissioner, information including:

(a) reported and estimated ultimate exposure, by year of exposure to loss;

(b) reported and estimated ultimate premiums, by year of exposure to loss;

(c) losses paid, by year incurred;

(d) loss adjustment expense paid, by year incurred;

(e) reported and ultimately incurred losses and loss adjustment expenses, by year incurred; and

(f) any other information required by the commissioner.

(2) An insurer transacting a line of insurance designated as noncompetitive or volatile shall provide to the commissioner information concerning at least 5 years of experience, with information evaluated as of the end of each calendar year. In addition to the latest reported information for each year, the insurer shall document any adjustments, including but not limited to development factors and trend adjustments, made to the reported data in projecting losses.

(3) The commissioner ~~shall~~ may adopt by rule reasonable development factors and trend adjustments to be applied to the reported data."

Section 48. 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~~.~~; or

(d) licensed third-party administrator 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~~ these coverages.

(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~~ the person's 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~~ the person~~, his~~ or the person's 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~~ chapter, the term "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~~ has the same meaning as set forth in 33-2-1501.

(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 49. Section 33-17-211, MCA, is amended to read:

"33-17-211. General qualifications -- application for license. (1) An individual applying for a license shall apply on a form specified by the commissioner and declare under penalty of refusal, suspension, or revocation of the license that statements made in the application are true, correct, and complete to the best of the individual's knowledge and belief. Before approving the application, the commissioner shall verify that the individual:

(a) is 18 years of age or older;

(b) has not committed an act that is a ground for refusal, suspension, or revocation as set forth in 33-17-1001;

(c) has paid the license fees stated in 33-2-708;

(d) has successfully passed the examinations for each kind of insurance for which the individual has applied within 12 months of application;

(e) is a resident of this state or of another state that grants similar privileges to residents of this state. Licenses issued based upon Montana state residency terminate if the licensee relocates to another state;

(f) is competent, trustworthy, and of good reputation;

(g) has experience or training or otherwise is qualified in the kind or kinds of insurance for which ~~he~~ the applicant applies to be licensed and is reasonably familiar with the provisions of this code which

govern ~~his~~ the applicant's operations as an insurance producer; and

(h) if applying for a license as to life or disability insurance:

(i) is not a funeral director, undertaker, or mortician operating in this or any other state;

(ii) is not an officer, employee, or representative of a funeral director, undertaker, or mortician operating in this or any other state; or

(iii) does not hold an interest in or benefit from a business of a funeral director, undertaker, or mortician operating in this or any other state.

(2) A person acting as an insurance producer shall obtain a license. A person shall apply for a license on a form specified by the commissioner. Before approving the application, the commissioner shall verify that:

(a) the person meets the requirements listed in subsection (1);

(b) the person has paid the licensing fees stated in 33-2-708 for each individual licensed in conjunction with the person's license. A licensed person shall promptly notify the commissioner of each change relating to an individual listed in the license.

(c) the person has designated a licensed officer responsible for compliance by the person with the insurance laws and rules of this state;

(d) each member and employee of a partnership and each officer, director, stockholder, or employee of a corporation who is acting as an insurance producer in this state has obtained a license;

(e) (i) if the person is a partnership or corporation, the transaction of insurance business is within the purposes stated in the partnership agreement or the articles of incorporation; and

(ii) if the person is a corporation, the secretary of state has issued a certificate of existence or authorization under 35-1-1312 or filed articles of incorporation under ~~35-2-214~~ 35-1-220.

(3) The commissioner may license as a resident insurance producer an association of licensed Montana insurance producers, whether or not incorporated, formed and existing substantially for purposes other than insurance. The license must be used solely for the purpose of enabling the association to place, as a resident insurance producer, insurance of the properties, interests, and risks of the state of Montana and of other public agencies, bodies, and institutions and to receive the customary commission for the placement. The president and secretary of the association shall apply for the license in the name of the association, and the commissioner shall issue the license to the association in its name alone. The fee for the license is the same as that required by 33-2-708 for the license of an insurance producer. The

commissioner may, after a hearing with notice to the association, revoke the license if ~~he~~ the commissioner finds that continuation of the license is not in the public interest or that a ground listed in 33-17-1001 exists.

(4) An insurance producer using an assumed business name shall register the name with the commissioner before using it."

Section 50. Section 33-17-405, MCA, is amended to read:

"**33-17-405. Service of process -- commissioner as agent.** ~~A nonresident person shall file with the commissioner the required forms appointing the~~ The commissioner ~~and his successors in office~~ shall act as ~~the~~ a nonresident person's agent upon whom process in a legal proceeding against the nonresident person may be served. ~~and shall agree that such~~ Service of process on the commissioner ~~process has~~ has the same legal force and validity as personal service of process upon the nonresident person. The commissioner shall, within 3 working days after receiving process, forward by certified mail, ~~at~~ to the nonresident person's address of record, a copy of the process ~~by certified mail to the person for whom he has received the process~~."

Section 51. Section 33-17-503, MCA, is amended to read:

"**33-17-503. Application -- fee -- expiration.** (1) Before a consultant license is issued or renewed, the prospective licensee shall:

(a) properly file in the office of the commissioner a written application on forms the commissioner prescribes; and

(b) pay a fee of $50, which the commissioner shall deposit with the state treasurer to be credited to the state's general fund.

(2) Each consultant license ~~expires on May 31 next following the date of issue~~ must be renewed each year by the consultant paying a continuation fee on or before May 31, and the license continues in force unless suspended, revoked, or otherwise terminated."

Section 52. 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~~ represent to the public that the person is an administrator in this state

unless ~~he~~ the person 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~~ the commissioner 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~~ A certificate of registration ~~is renewable annually on July 1. A request for renewal must be accompanied by a renewal fee of $100~~ must be renewed each year by the administrator paying a continuation fee of $100 on or before July 1. Upon payment, the license continues in force unless suspended, revoked, or otherwise terminated. The commissioner shall deposit the fee with the state treasurer to be credited to the general fund.

(4) ~~The~~ A 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~~ a 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 53. Section 33-17-1001, MCA, is amended to read:

"**33-17-1001. Suspension, revocation, or refusal of license.** (1) Except as provided in 33-17-411, after a hearing, which must be held no less than 10 days after advance notice by certified mail, on charges given under 33-1-314(3), the commissioner may suspend for up to 5 years, revoke, refuse to continue, or deny a license issued under this chapter if the commissioner finds that the licensee or applicant has:

(a) engaged or is about to engage in an act or practice for which issuance of the license could have been refused;

(b) obtained or attempted to obtain a license through misrepresentation or fraud;

(c) violated or failed to comply with a provision of this code or has violated a rule, subpoena, or order of the commissioner or of the commissioner of any other state;

(d) improperly withheld, misappropriated, or converted to the licensee's or applicant's own use money or property belonging to policyholders, insurers, beneficiaries, or others and received in conduct of business under the license;

(e) been convicted of a felony;

(f) in the conduct of the affairs under the license, used fraudulent, coercive, or dishonest practices or the licensee or applicant is incompetent, untrustworthy, financially irresponsible, or a source of injury and loss to the public;

(g) made a materially untrue statement in the license application or in the continuing education affidavit;

(h) misrepresented the terms of an actual or proposed insurance contract;

(i) been found guilty of an unfair trade practice or fraud prohibited by Title 33, chapter 18;

(j) had a similar license suspended or revoked in any other state;

(k) forged another's name to an application for insurance;

(l) cheated on an examination for a license; or

(m) knowingly accepted insurance business from a person who is not licensed.

(2) The license of a partnership or corporation may be suspended, revoked, refused, or denied if a reason listed in subsection (1) applies to an individual designated in the license to exercise its powers or to a partner or officer in the partnership or corporation.

(3) The commissioner may suspend, revoke, or refuse to continue a license under subsection (1)(e) without conducting an investigation pursuant to 37-1-203 or making a written finding pursuant to 37-1-204."

Section 54. Section 33-18-212, MCA, is amended to read:

"**33-18-212. Illegal dealing in premiums -- improper charges for insurance.** (1) A person may not willfully collect any sum as a premium or charge for insurance~~, which insurance~~ that is not then provided or is not in due course to be provided, ~~(~~subject to acceptance of the risk by the insurer~~)~~, by an insurance policy issued by an insurer as authorized by this code.

(2) A person may not willfully collect as a premium or charge for insurance any sum in excess of or less than the premium or charge applicable to ~~such~~ the insurance and, as specified in the policy, in accordance with the applicable classifications and rates ~~as~~ filed with ~~and~~ or approved by the commissioner; or in cases ~~where~~ in which classifications, premiums, or rates are not required by this code to be ~~so~~ filed ~~and~~ or approved, ~~such~~ the premiums and charges may not be in excess of or less than those specified in the policy and as fixed by the insurer. This provision may not ~~be deemed to~~ prohibit the charging and

collection, by surplus lines insurance producers licensed under chapter 2, part 3, of the amount of applicable state and federal taxes in addition to the premium required by the insurer. ~~It~~ This provision may not ~~be considered to~~ prohibit the charging and collection, by a life insurer, of amounts actually to be expended for medical examination of an applicant for life insurance or for reinstatement of a life insurance policy.

(3) Each violation of this section is punishable under 33-1-104."

Section 55. Section 33-18-301, MCA, is amended to read:

"**33-18-301. Prohibited relations with mortuaries.** (1) ~~No~~ A life insurer and its officers, employees, or representatives may not own, manage, supervise, operate, or maintain any mortuary, funeral, or undertaking establishment ~~or permit its officers, employees, or representatives to own, operate, maintain, or be employed in any such business~~ in Montana.

(2) ~~No~~ A life insurer may not contract or agree with any funeral director, mortuary, or undertaker ~~to the effect~~ that ~~such~~ the funeral director, undertaker, or mortuary shall conduct the funeral or be named beneficiary of any person insured by ~~such~~ the insurer. This subsection does not prohibit a life insurer from making insurance, designated as funeral insurance, available.

(3) A funeral insurance policy and any solicitation material for the policy must clearly indicate that:

(a) the policy is a life insurance product;

(b) the applicant may designate the beneficiary, provided that there is an appropriate and insurable interest;

(c) the beneficiary may use the proceeds for any purpose; and

(d) any attempt by the insurer or its representative to have the insured designate a specific beneficiary, including but not limited to a funeral director, mortuary, or undertaker, constitutes a violation of this section punishable as a misdemeanor pursuant to subsection (4).

~~(3)~~(4) Each violation of this section constitutes a misdemeanor punishable by a fine of not more than $1,000 or by imprisonment for not more than 6 months or ~~by~~ both ~~such fine and imprisonment~~."

Section 56. Section 33-22-131, MCA, is amended to read:

"**33-22-131. Coverage for phenylketonuria treatment.** (1) Each group or individual medical expense disability policy, certificate of insurance, and membership contract that is delivered, issued for

delivery, renewed, extended, or modified in this state must provide coverage for the treatment of phenylketonuria.

(2) For purposes of this section, "treatment" means licensed professional medical services under the supervision of a physician and a dietary formula product to achieve and maintain normalized blood levels of phenylalanine and adequate nutritional status.

(3) These services are subject to the terms of the applicable group or individual disability policy, certificate, or membership contract that establishes durational limits, dollar limits, deductibles, and copayment provisions as long as the terms are not less favorable than for physical illness generally.

(4) This section does not apply to disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, or specified disease policies."

Section 57. Section 33-22-132, MCA, is amended to read:

"**33-22-132. Coverage for mammography examinations.** (1) Each group or individual medical expense, cancer, hospital indemnity, and blanket disability policy, certificate of insurance, and membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide minimum mammography examination coverage.

(2) For the purpose of this section, "minimum mammography examination" means:

(a) one baseline mammogram for a woman who is 35 years of age or older and under 40 years of age;

(b) a mammogram every 2 years for any woman who is 40 years of age or older and under 50 years of age or more frequently if recommended by the woman's physician; and

(c) a mammogram each year for a woman who is 50 years of age or older.

(3) A minimum $70 payment or the actual charge if the charge is less than $70 must be made for each mammography examination performed before the application of the terms of the applicable group or individual disability policy, certificate of insurance, or membership contract that establish durational limits, deductibles, and copayment provisions as long as the terms are not less favorable than for physical illness generally.

(4) This section does not apply to disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, or specified disease policies."

Section 58. Section 33-22-201, MCA, is amended to read:

"**33-22-201. Format and content.** ~~A~~ An individual policy of disability insurance may not be delivered or issued for delivery to any person in this state unless it otherwise complies with this code and complies with the following:

(1) The entire money and other considerations for the policy must be expressed in the policy.

(2) The time when the insurance takes effect and terminates must be expressed in the policy.

(3) The policy may insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who is the policyholder, any two or more eligible members of that family, including husband, wife, dependent children or any children under a specified age that may not exceed ~~19~~ 25 years, and any other person dependent upon the policyholder.

(4) The style, arrangement, and overall appearance of the policy may not give undue prominence to any portion of the text, and every printed portion of the text of the policy and of any endorsements or attached papers must be plainly printed in lightfaced type of a style in general use, the size of which must be uniform and not less than 10 point with a lowercase, unspaced alphabet length not less than 120 point.

(5) The "text" must include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions.

(6) The exceptions and reductions of indemnity must be set forth in the policy and, other than those contained in 33-22-204 through 33-22-215 and ~~33-22-217~~ 33-22-221 through 33-22-231, must be printed, at the insurer's option, either included with the benefit provision to which they apply or under an appropriate caption such as "Exceptions" or "Exceptions and Reductions", except that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction must be included with the benefit provision to which it applies.

~~(7) Each form, including riders and endorsements, must be identified by a form number in the lower left-hand corner of the first page of the form.~~

~~(8)~~(7) The policy may not contain a provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless the portion is set forth in full in the policy, except in the case of the incorporation of or reference to a statement of rates or classification of risks or short-rate table filed with the commissioner.

~~(9) Each individual disability policy, except for a single-premium nonrenewable policy, issued for~~

~~delivery in this state on or after January 1, 1980, must contain a notice stating in substance that if the person to whom the policy is issued is not satisfied for any reason, the person is permitted to return the policy within 10 days of its delivery, or a longer period as the policy may provide, and to have refunded the amount of the premium paid. A policy returned pursuant to this subsection is void from the beginning.~~"

Section 59. Section 33-22-202, MCA, is amended to read:

"**33-22-202. Required provisions -- captions -- omissions -- substitutions -- order.** (1) Except as provided in subsection (2), each policy delivered or issued for delivery to any person in this state must contain the provisions specified in 33-22-204 through 33-22-215, ~~in the words in which the~~ as those provisions appear, except that the insurer may, at its option, substitute for one or more of the provisions corresponding provisions of different wording approved by the commissioner ~~which are in each instance~~ and not less favorable in any respect to the insured or the beneficiary. Each provision must be preceded ~~individually~~ by the applicable caption shown or, at the option of the insurer, by the appropriate individual or group captions or subcaptions as the commissioner may approve.

(2) If any provision is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the commissioner, shall omit from the policy any inapplicable provision or part of a provision and shall modify any inconsistent provision or part of a provision in a manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

(3) The provisions that are the subject of 33-22-204 through 33-22-215 and ~~33-22-217~~ 33-22-221 through 33-22-232 or any corresponding provisions which are used in accordance with the cited sections must be printed in the consecutive order of the provisions in the sections or, at the option of the insurer, any provision may appear as a unit in any part of the policy with other provisions to which it may be logically related, provided that the resulting policy is not in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered, or issued."

Section 60. Section 33-22-301, MCA, is amended to read:

"**33-22-301. Coverage of newborn under disability policy.** (1) Each policy of disability insurance or certificate issued ~~thereunder shall~~ must contain a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any insured.

(2) The coverage for newborn infants must be the same as provided by the policy for the other covered persons~~;~~. ~~provided, however~~ However, that for newborn infants there ~~shall be no~~ may not be waiting or elimination periods. A deductible or reduction in benefits applicable to the coverage for newborn infants is not permissible unless it conforms and is consistent with the deductible or reduction in benefits applicable to all other covered persons.

(3) ~~No~~ A policy or certificate of insurance may not be issued or amended in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an insured from and after the moment of birth.

(4) ~~If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within 31 days after the date of birth in order to have the coverage continue beyond such 31-day period.~~ The policy or contract may require notification of the birth of a child and payment of a required premium or subscription fee to be furnished to the insurer or nonprofit or indemnity corporation within 31 days of the birth in order to have the coverage extend beyond 31 days."

Section 61. Section 33-22-303, MCA, is amended to read:

"**33-22-303. Coverage for well-child care.** (1) Each medical expense policy of disability insurance or certificate issued under the policy that is delivered, issued for delivery, renewed, extended, or modified in this state by a disability insurer and that provides coverage for a family member of the insured or subscriber must provide coverage for well-child care for children from the moment of birth through 2 years of age. Benefits provided under this coverage are exempt from any deductible provision that may be in force in the policy or certificate issued under the policy.

(2) Coverage for well-child care under subsection (1) must include:

(a) a history, physical examination, developmental assessment, anticipatory guidance, and laboratory tests, according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment services program provided for in 53-6-101; and

(b) routine immunizations according to the schedule for immunizations recommended by the immunization practices advisory committee of the U.S. department of health and human services.

(3) Minimum benefits may be limited to one visit payable to one provider for all of the services

provided at each visit cited in this section.

(4) This section does not apply to disability income, specified disease, medicare supplement, or hospital indemnity policies.

(5) For purposes of this section:

(a) "well-child care" means the services described in subsection (2) and delivered by a physician or a health care professional supervised by a physician; and

(b) "developmental assessment" and "anticipatory guidance" mean the services described in the Guidelines for Health Supervision II, published by the American academy of pediatrics.

(6) When a policy of disability insurance or a certificate issued under the policy provides coverage or benefits to a resident of this state, it is considered to be delivered in this state within the meaning of this section, whether the insurer that issued or delivered the policy or certificate is located inside or outside of this state."

Section 62. Section 33-22-504, MCA, is amended to read:

"**33-22-504. Newborn infant coverage.** (1) ~~No~~ A group disability policy or certificate of insurance ~~which, in addition to covering persons in the insured group, also covers members of such person's family~~ delivered or issued for delivery in this state may not be issued or amended in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of persons covered under the policy from and after the moment of birth.

(2) ~~If the~~ A policy or certificate ~~issued thereunder, in addition to covering persons in the insured group, also covers members of such person's family, it shall~~ subject to this section, must contain ~~an additional~~ a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any person covered under the policy.

(3) The coverage for newborn infants ~~shall~~ must be the same as provided by the policy for other covered persons~~;~~. ~~provided, however~~ However, ~~that~~ for newborn infants there ~~shall~~ may not be ~~no~~ waiting or elimination periods. A deductible or reduction in benefits applicable to the coverage for newborn infants is not permissible unless it conforms and is consistent with the deductible or reduction in benefits applicable to all other covered persons.

(4) This section does not apply to medicare supplement policies issued by reason of age.

(5) When a group disability policy or certificate issued under the policy provides for coverage or

benefits for a resident of this state, the policy or certificate is considered delivered in this state within the meaning of this section regardless of whether the insurer issuing the policy or certificate is located in this state.

(6) The policy or certificate may require notification of the birth of a child and payment of a required premium or subscription fee to be furnished to the insurer or nonprofit or indemnity corporation within 31 days of the birth in order to have the coverage extend beyond 31 days."

Section 63. Section 33-22-508, MCA, is amended to read:

"**33-22-508. Conversion on termination of eligibility.** (1) A group disability insurance policy or certificate of insurance delivered or issued for delivery or renewed after October 1, 1981, must contain a provision that if the insurance or any portion of it on a person~~, his~~ or the person's dependents~~,~~ or family members covered under the policy ceases because of termination of ~~his~~ the person's employment or ~~of his~~ membership in the class or classes eligible for coverage under the policy or as a result of ~~his~~ the person's employer discontinuing ~~his~~ business or as a result of ~~his~~ the employer discontinuing the group disability insurance policy and not providing for any other group disability insurance or plan and if the person had been insured for a period of 3 months and ~~he~~ is not insured under another major medical disability insurance policy or plan, ~~he~~ the person is entitled to have issued ~~to him~~ by the insurer, without evidence of insurability, group coverage or an individual policy ~~issued by the insurer~~ or, in the absence of an individual policy issued by the insurer, a group policy issued by the insurer, of hospital or medical service insurance on ~~himself~~ the person~~, his~~ and the person's dependents~~,~~ or family members if application for the individual policy is made and the first premium tendered to the insurer within 31 days after the termination of group coverage.

(2) The individual policy or group policy, at the option of the insured, may be on any form then customarily issued by the insurer to individual or group policyholders, with the exception of a policy the eligibility for which is determined by affiliation other than by employment with a common entity.

(3) The premium on the individual policy or group policy must be at the insurer's then customary rate applicable to the coverage of the individual or group policy."

Section 64. Section 33-22-1120, MCA, is amended to read:

"**33-22-1120. Extraterritorial jurisdiction.** A group long-term care insurance policy or certificate

may not be delivered or issued for delivery to a resident of Montana under a group policy issued in another state ~~to a group described in 33-22-1107(3)(d)~~ unless it is approved by:

(1) the commissioner; ~~or~~ and

(2) the insurance regulatory official of a state that has statutory and regulatory long-term care insurance requirements substantially similar to those adopted in Montana."

Section 65. Section 33-22-1803, MCA, is amended to read:

"**33-22-1803. Definitions.** As used in this part, the following definitions apply:

(1) "Actuarial certification" means a written statement by a member of the American academy of actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of 33-22-1809, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with a specified entity or person.

(3) "Assessable carrier" means all individual carriers of disability insurance and all carriers of group disability insurance, excluding the state group benefits plan provided for in Title 2, chapter 18, part 8, the Montana university system health plan, and any self-funded disability insurance plan provided by a political subdivision of the state.

(4) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

(5) "Basic health benefit plan" means a lower cost health benefit plan developed pursuant to 33-22-1812.

(6) "Board" means the board of directors of the program established pursuant to 33-22-1818.

(7) "Carrier" means any person who provides a health benefit plan in this state subject to state insurance regulation. The term includes but is not limited to an insurance company, a fraternal benefit society, a health service corporation, a health maintenance organization, and, to the extent permitted by the Employee Retirement Income Security Act of 1974, a multiple-employer welfare arrangement. For

purposes of this part, companies that are affiliated companies or that are eligible to file a consolidated tax return must be treated as one carrier, except that the following may be considered as separate carriers:

(a) an insurance company or health service corporation that is an affiliate of a health maintenance organization located in this state;

(b) a health maintenance organization located in this state that is an affiliate of an insurance company or health service corporation; or

(c) a health maintenance organization that operates only one health maintenance organization in an established geographic service area of this state.

(8) "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, provided that gender, claims experience, health status, and duration of coverage are not case characteristics for purposes of this part.

(9) "Class of business" means all or a separate grouping of small employers established pursuant to 33-22-1808.

(10) "Committee" means the health benefit plan committee created pursuant to 33-22-1812.

(11) "Dependent" means:

(a) a spouse or an unmarried child under 19 years of age;

(b) an unmarried child, under 23 years of age, who is a full-time student and who is financially dependent on the insured;

(c) a child of any age who is disabled and dependent upon the parent as provided in 33-22-506 and 33-30-1003; or

(d) any other individual defined ~~to be~~ as a dependent in the health benefit plan covering the employee.

(12) "Eligible employee" means an employee who works on a full-time basis and who has a normal workweek of 30 hours or more. The term includes a sole proprietor, a partner of a partnership, and an independent contractor if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer. The term does not include an employee who works on a part-time, temporary, or substitute basis.

(13) "Established geographic service area" means a geographic area, as approved by the commissioner and based on the carrier's certificate of authority to transact insurance in this state, within

which the carrier is authorized to provide coverage.

(14) "Health benefit plan" means any hospital or medical policy or certificate providing for physical and mental health care issued by an insurance company, a fraternal benefit society, or a health service corporation or issued under a health maintenance organization subscriber contract. Health benefit plan does not include:

(a) accident-only, credit, dental, vision, specified disease, medicare supplement, long-term care, or disability income insurance;

(b) coverage issued as a supplement to liability insurance, workers' compensation insurance, or similar insurance; or

(c) automobile medical payment insurance.

(15) "Index rate" means, for each class of business for a rating period for small employers with similar case characteristics, the average of the applicable base premium rate and the corresponding highest premium rate.

(16) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual was entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period was a period of at least 30 days. However, an eligible employee or dependent may not be considered a late enrollee if:

(a) the individual requests enrollment within 30 days after termination of the qualifying previous coverage and ~~meets each of the following conditions~~:

(i) the individual was covered under qualifying previous coverage at the time of the initial enrollment; or

(ii) the individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, the death of a spouse, or divorce; ~~and~~

~~(iii) the individual requests enrollment within 30 days after termination of the qualifying previous coverage;~~

(b) the individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

(c) a court has ordered that coverage be provided for a spouse, minor, or dependent child under

a covered employee's health benefit plan and a request for enrollment is made within 30 days after issuance of the court order.

(17) "New business premium rate" means, for each class of business for a rating period, the lowest premium rate charged or offered or that could have been charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(18) "Plan of operation" means the operation of the program established pursuant to 33-22-1818.

(19) "Premium" means all money paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

(20) "Program" means the Montana small employer health reinsurance program created by 33-22-1818.

(21) "Qualifying previous coverage" means benefits or coverage provided under:

(a) medicare or medicaid;

(b) an employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan; or

(c) an individual health insurance policy, including coverage issued by an insurance company, a fraternal benefit society, a health service corporation, or a health maintenance organization that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided that the policy has been in effect for a period of at least 1 year.

(22) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

(23) "Reinsuring carrier" means a small employer carrier participating in the reinsurance program pursuant to 33-22-1819.

(24) "Restricted network provision" means a provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to Title 33, chapter 22, part 17, or Title 33, chapter 31, to provide health care services to covered individuals.

(25) "Small employer" means a person, firm, corporation, partnership, or association that is actively engaged in business and that, on at least 50% of its working days during the preceding calendar quarter,

employed at least 3 but not more than 25 eligible employees, the majority of whom were employed within this state or were residents of this state. In determining the number of eligible employees, companies are considered one employer if they:

(a) are affiliated companies;

(b) are eligible to file a combined tax return for purposes of state taxation; or

(c) are members of an association that:

(i) has been in existence for 1 year prior to January 1, 1994;

(ii) provides a health benefit plan to employees of its members as a group; and

(iii) does not deny coverage to any member of its association or any employee of its members who applies for coverage as part of a group.

(26) "Small employer carrier" means a carrier that offers health benefit plans that cover eligible employees of one or more small employers in this state.

(27) "Standard health benefit plan" means a health benefit plan developed pursuant to 33-22-1812."

Section 66. Section 33-22-1819, MCA, is amended to read:

"**33-22-1819. Program plan of operation -- treatment of losses -- exemption from taxation.** (1) Within 180 days after the appointment of the initial board, the board shall submit to the commissioner a plan of operation and may at any time submit amendments to the plan necessary or suitable to ensure the fair, reasonable, and equitable administration of the program. The commissioner may, after notice and hearing, approve the plan of operation if the commissioner determines it to be suitable to ensure the fair, reasonable, and equitable administration of the program and if the plan of operation provides for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation is effective upon written approval by the commissioner.

(2) If the board fails to submit a suitable plan of operation within 180 days after its appointment, the commissioner shall, after notice and hearing, promulgate and adopt a temporary plan of operation. The commissioner shall amend or rescind any temporary plan adopted under this subsection at the time a plan of operation is submitted by the board and approved by the commissioner.

(3) The plan of operation must:

(a) establish procedures for the handling and accounting of program assets and money and for an

annual fiscal reporting to the commissioner;

(b) establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;

(c) establish procedures for reinsuring risks in accordance with the provisions of this section;

(d) establish procedures for collecting assessments from assessable carriers to fund claims incurred by the program;

(e) establish procedures for allocating a portion of premiums collected from reinsuring carriers to fund administrative expenses incurred or to be incurred by the program; and

(f) provide for any additional matters necessary for the implementation and administration of the program.

(4) The program has the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals. In addition, the program may:

(a) enter into contracts as are necessary or proper to carry out the provisions and purposes of this part, including the authority, with the approval of the commissioner, to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(b) sue or be sued, including taking any legal actions necessary or proper to recover any premiums and penalties for, on behalf of, or against the program or any reinsuring carriers;

(c) take any legal action necessary to avoid the payment of improper claims against the program;

(d) define the health benefit plans for which reinsurance will be provided and to issue reinsurance policies in accordance with the requirements of this part;

(e) establish conditions and procedures for reinsuring risks under the program;

(f) establish actuarial functions as appropriate for the operation of the program;

(g) appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in operation of the program, policy and other contract design, and any other function within the authority of the program;

(h) to the extent permitted by federal law and in accordance with subsection (8)(c), make annual fiscal yearend assessments against assessable carriers and make interim assessments to fund claims incurred by the program; and

(i) borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default are legal investments for carriers and may be carried as admitted assets.

(5) A reinsuring carrier may reinsure with the program as provided for in this subsection (5):

(a) With respect to a basic health benefit plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a basic or standard health benefit plan.

(b) A small employer carrier may reinsure an entire employer group within 60 days of the commencement of the group's coverage under a health benefit plan.

(c) A reinsuring carrier may reinsure an eligible employee or dependent within a period of 60 days following the commencement of coverage with the small employer. A newly eligible employee or dependent of the reinsured small employer may be reinsured within 60 days of the commencement of coverage.

(d) (i) The program may not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the carrier has incurred an initial level of claims for the employee or dependent of $5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier is responsible for 20% of the next $100,000 of benefit payments during a calendar year and the program shall reinsure the remainder. A reinsuring carrier's liability under this subsection (d)(i) may not exceed a maximum limit of $25,000 in any calendar year with respect to any reinsured individual.

(ii) The board annually shall adjust the initial level of claims and maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment may not be less than the annual change in the medical component of the consumer price index for all urban consumers of the United States department of labor, bureau of labor statistics, unless the board proposes and the commissioner approves a lower adjustment factor.

(e) A small employer carrier may terminate reinsurance with the program for one or more of the reinsured employees or dependents of a small employer on any anniversary of the health benefit plan.

(f) A small employer group health benefit plan in effect before January 1, 1994, may not be reinsured by the program until January 1, 1997, and then only if the board determines that sufficient funding sources are available.

(g) A reinsuring carrier shall apply all managed care and claims-handling techniques, including utilization review, individual case management, preferred provider provisions, and other managed care

provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

(6) (a) As part of the plan of operation, the board shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology must include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology must provide for the development of base reinsurance premium rates that must be multiplied by the factors set forth in subsection (6)(b) to determine the premium rates for the program. The base reinsurance premium rates must be established by the board, subject to the approval of the commissioner, and must be set at levels that reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard health benefit plan, adjusted to reflect retention levels required under this part.

(b) Premiums for the program are as follows:

(i) An entire small employer group may be reinsured for a rate that is one and one-half times the base reinsurance premium rate for the group established pursuant to this subsection (6).

(ii) An eligible employee or dependent may be reinsured for a rate that is five times the base reinsurance premium rate for the individual established pursuant to this subsection (6).

(c) The board periodically shall review the methodology established under subsection (6)(a), including the system of classification and any rating factors, to ensure that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology that are subject to the approval of the commissioner.

(d) The board may consider adjustments to the premium rates charged by the program to reflect the use of effective cost containment and managed care arrangements.

(7) If a health benefit plan for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued must meet the requirements relating to premium rates set forth in 33-22-1809.

(8) (a) Prior to March 1 of each year, the board shall determine and report to the commissioner the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(b) To the extent permitted by federal law, each assessable carrier shall share in any net loss of the program for the year in an amount equal to the ratio of the total premiums earned in the previous

calendar year from health benefit plans delivered or issued for delivery by each assessable carrier divided by the total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery by all assessable carriers in the state.

(c) The board shall make an annual determination in accordance with this section of each assessable carrier's liability for its share of the net loss of the program and, except as otherwise provided by this section, make an annual fiscal yearend assessment against each assessable carrier to the extent of that liability. If approved by the commissioner, the board may also make interim assessments against assessable carriers to fund claims incurred by the program. Any interim assessment must be credited against the amount of any fiscal yearend assessment due or to be due from an assessable carrier. Payment of a fiscal yearend or interim assessment is due within 30 days of receipt by the assessable carrier of written notice of the assessment. An assessable carrier that ceases doing business within the state is liable for assessments until the end of the calendar year in which the assessable carrier ceased doing business. The board may determine not to assess an assessable carrier if the assessable carrier's liability determined in accordance with this section does not exceed $10.

(9) The participation in the program as reinsuring carriers; the establishment of rates, forms, or procedures; or any other joint collective action required by this part may not be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers, either jointly or separately.

(10) The board, as part of the plan of operation, shall develop standards setting forth the minimum levels of compensation to be paid to producers for the sale of basic and standard health benefit plans. In establishing the standards, the board shall take into consideration the need to ensure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide ongoing service to small employers, the levels of compensation currently used in the industry, and the overall costs of coverage to small employers selecting these plans.

(11) The program is exempt from taxation.

(12) On or before March 1 of each year, the commissioner shall evaluate the operation of the program and report to the governor and the legislature in writing the results of the evaluation. The report must include an estimate of future costs of the program, assessments necessary to pay those costs, the appropriateness of premiums charged by the program, the level of insurance retention under the program, the cost of coverage of small employers, and any recommendations for change to the plan of operation.

(13) All premiums and other money paid to the small employer carrier reinsurance program and all property and securities acquired through the use of money and interest and dividends earned on money belonging to the small employer carrier reinsurance program are solely the property of the program and must be used exclusively for the operations and obligations of the program. Money collected by the program is not subject to legislative appropriation."

Section 67. Section 33-30-102, MCA, is amended to read:

"**33-30-102. Application of this chapter -- construction of other related laws.** (1) All health service corporations ~~heretofore or hereafter organized~~ are subject to the provisions of this chapter. In addition to the provisions contained in this chapter, other chapters and provisions of this title apply to health service corporations as follows: ~~33-17-212~~ 33-17-101; ~~through 33-17-214~~ Title 33, chapter 17, parts 2 and 10 through 12; ~~and~~ Title 33, chapters 1, 15, 18, 19, and 22, except 33-22-111; and [sections 78 through 81].

(2) A law of this state other than the provisions of this chapter applicable to health service corporations ~~shall~~ must be construed in accordance with the fundamental nature of a health service corporation, and in the event of a conflict ~~between that law and~~ the provisions of this chapter~~, the latter shall~~ prevail."

Section 68. Section 33-30-107, MCA, is amended to read:

"**33-30-107. Annual statement.** (1) On or before March 1 of each year, ~~Every~~ each health service corporation shall file an annual statement for the preceding year on ~~a form containing substantially the same information as that contained in~~ form No. 13 N.A.I.C. with the commissioner of insurance. This annual statement must be completed in accordance with the national association of insurance commissioners' annual statement instructions.

(2) The health service corporation shall file a statement containing any other information concerning its financial affairs that may be reasonably requested by the commissioner.

(3) (a) Each health service corporation shall file electronic diskette versions of its annual and quarterly financial statements with the national association of insurance commissioners. The filing date for submission of the annual statement diskette is March 1. The filing dates for the other three quarterly statements are as follows:

(i) the first quarter statement is due May 15;

(ii) the second quarter statement is due August 15; and

(iii) the third quarter statement is due November 15.

(b) The commissioner may exempt health service corporations operating only in Montana from these filing requirements."

Section 69. Section 33-30-108, MCA, is amended to read:

"**33-30-108. License required.** (1) ~~No~~ A person may not act as a health service corporation and ~~no~~ a health service corporation may not conduct business in this state except as authorized by a license issued by the commissioner.

(2) ~~Such~~ A license may be issued by the commissioner only after the person has complied with the applicable provisions of this title.

(3) A health service corporation is entitled to a continuation of its license upon payment of the annual continuation fee specified in 33-30-204~~(1)(i)~~ on or before March 1 of each year and upon continued compliance with the provisions of this title.

(4) A license issued or continued under this section may be revoked or suspended by the commissioner for violation of this title."

Section 70. Section 33-30-202, MCA, is amended to read:

"**33-30-202. Annual report by certified public accountant.** (1) All corporations subject to the provisions of this chapter shall ~~make and~~ file annually with the commissioner, on or before ~~March~~ June 1 ~~of each year~~, a ~~report under oath setting forth:~~ financial statement audited by a certified public accountant pursuant to rules promulgated by the commissioner.

~~(1) the name of the corporation;~~

~~(2) the address of its registered office in this state and the name of its registered agent at that address;~~

~~(3) the names and addresses of its directors and officers;~~

~~(4) a brief statement of the character of the affairs which the corporation is actually conducting;~~

~~(5) the amount of all dues or fees collected from members in the last fiscal year, the amounts actually paid during that year for health services for the members or beneficiaries, and the amounts placed in reserves;~~

~~(6) a balance sheet and statement of income and expenditures for the most recent fiscal year of the corporation, prepared and verified by two officers of the corporation and certified by a certified public accountant;~~

~~(7) a statement of any other facts or information concerning the financial affairs of the health service corporation which may be reasonably required by the commissioner.~~

(2) (a) The commissioner may establish rules governing the content and preparation of the report required by subsection (1).

(b) The report must include:

(i) the corporation's financial statements for the most recent calendar year;

(ii) an opinion by the certified public accountant concerning the accuracy and fairness of the corporation's representation of its financial statements; and

(iii) other information that the commissioner specifies by rule."

Section 71. Section 33-30-204, MCA, is amended to read:

"**33-30-204. Fees.** (1) Every health service corporation subject to the provisions of this chapter shall pay the following fees to the commissioner for enforcement of the provisions of this chapter:

~~(a) insurance producer's license:~~

~~(i) application for original license and issuance of license ..... $15~~

~~(ii) annual renewal ..... $15~~

~~(iii) examination for license, for each examination ..... $15~~

~~(b)~~(a) filing any ~~other~~ statement or report $1

~~(c)~~(b) for a certified copy of any document or other paper filed in the office of the commissioner, per page ..... $.50

~~(d)~~(c) for ~~the~~ a certificate ~~and for affixing the~~ with affixed seal ~~thereto~~ $10

~~(e)~~(d) filing of a membership contract $25

~~(f)~~(e) filing of a membership contract package $100

~~(g)~~(f) filing annual report, other than as part of application for original license $25

~~(h)~~(g) issuance of health service corporation license $300

~~(i)~~(h) annual continuation of health service corporation license $300

(2) The commissioner shall promptly deposit with the state treasurer, to the credit of the general

fund, all fees and license fees received ~~by him~~ under this section."

Section 72. Section 33-30-311, MCA, is amended to read:

"**33-30-311. Insurance producer.** ~~(1)~~ A person who, for compensation, solicits membership in a prepayment health service plan offered by a corporation subject to the provisions of this chapter is an insurance producer of that corporation and is subject to the provisions of 33-2-708 and Title 33, chapter 17.

~~(2) The definitions of insurance producer as defined in this chapter do not include an individual:~~

~~(a) employed and used by insurance producers for the performance of clerical, stenographic, and similar office duties;~~

~~(b) employed and used for incidental taking of an application for coverage from time to time in the office of the employing insurance producer;~~

~~(c) who secures and forwards information for the purpose of an existing group contractor for enrolling individuals under an existing group contract.~~"

Section 73. Section 33-30-1001, MCA, is amended to read:

"**33-30-1001. Newborn infants covered by insurance by health service corporation.** ~~No~~ A disability insurance plan or group disability insurance plan issued by a health service corporation may not be issued or amended in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of the persons insured from and after the moment of birth. Each ~~such~~ policy ~~shall~~ must contain a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any insured person. ~~If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within 31 days after the date of birth in order to have the coverage continue beyond such 31 day period.~~ The policy or contract may require notification of the birth of a child and payment of a required premium or subscription fee to be furnished to the insurer or nonprofit or indemnity corporation within 31 days of the birth in order to have the coverage extend beyond 31 days."

Section 74. Section 33-31-311, MCA, is amended to read:

"**33-31-311. Insurance producer license required -- application, issuance, renewal, fees -- penalty.** (1) ~~No~~ An individual, partnership, or corporation may not act as or ~~hold himself out~~ represent to the public to be an insurance producer of a health maintenance organization unless ~~he~~ the individual, partnership, or corporation is:

(a) licensed as a disability insurance producer by the commissioner pursuant to chapter 17, parts 1, 2, and 4 of this title or licensed as an insurance producer under 33-30-311 ~~through 33-30-313~~; and

(b) appointed or authorized by the health maintenance organization to solicit health care service agreements on its behalf.

(2) Application, appointment and qualification for a health maintenance organization insurance producer license, fees applicable to and the issuance of a health maintenance organization insurance producer license, and renewal of a health maintenance organization insurance producer license must be in accordance with the provisions of chapter 17 that apply to a disability insurance producer.

(3) An individual, partnership, or corporation who holds a disability insurance producer license on October 1, 1987, need not requalify by an examination to be licensed as a health maintenance organization insurance producer.

(4) The commissioner may, in accordance with 33-1-313, 33-1-317, 33-17-411, and chapter 17, part 10, suspend, revoke, refuse to issue or renew a health maintenance organization insurance producer license, or impose a fine upon the licensee.

(5) The provisions of this section do not exempt a health maintenance organization from material transaction disclosure requirements under [sections 78 through 81]. A health maintenance organization must be considered an insurer for the purposes of [sections 78 through 81]."

NEW SECTION. **Section 75. Notice of right to return policy.** Each life or disability insurance policy, except a single-premium nonrenewable disability policy, issued for delivery in this state or issued after January 1, 1996, must contain a notice stating in substance that if the person to whom the policy is issued is not satisfied for any reason, the person may return the policy within 10 days of its delivery or a longer period if provided by the policy and have refunded directly to the person the premium paid. A policy returned pursuant to this section is void from the beginning.

NEW SECTION. **Section 76. Reserve calculation -- indeterminate premium plans -- minimum standards for disability plans.** (1) In the case of a plan of life insurance that provides for future premium determination, the amounts of which are to be determined by the insurer based on then estimates of future experience, or in the case of a plan of life insurance or annuity that is of such a nature that the minimum reserves cannot be determined by the methods described in 33-2-525 and 33-2-526(3), the reserves that are held under the plan must:

(a) be appropriate in relation to the benefits and the pattern of premiums for that plan; and

(b) be computed by a method that is consistent with the principles of 33-2-521 through 33-2-529, as determined by rules promulgated by the commissioner.

(2) The commissioner shall promulgate a rule containing the minimum standards applicable to the valuation of disability plans.

NEW SECTION. **Section 77. Dating of insurance applications -- antedating prohibited.** An application for issuance of an insurance policy may not be antedated by any person in order to obtain or provide coverage for losses or injuries incurred prior to the date of application.

NEW SECTION. **Section 78. Short title.** [Sections 78 through 81] may be cited as the "Disclosure of Material Transactions Act".

NEW SECTION. **Section 79. Report.** (1) An insurer domiciled in this state shall file a report with the commissioner disclosing material acquisitions and dispositions of assets or material nonrenewals, cancellations, or revisions of ceded reinsurance agreements unless the acquisitions and dispositions of assets or material nonrenewals, cancellations, or revisions have been submitted to the commissioner for review or approval or for information purposes pursuant to other provisions of the insurance code, laws, or regulations or other requirements.

(2) The report required in subsection (1) is due within 15 days after the end of the calendar month in which any of the transactions in subsection (1) occur.

(3) One complete copy of the report, including any exhibits or other attachments, must be filed with:

(a) the insurance department of the state in which the insurer is domiciled; and

(b) the national association of insurance commissioners.

(4) All reports obtained by or disclosed to the commissioner pursuant to [sections 78 through 81] must be treated confidentially, may not be subject to subpoena, and may not be made public by the commissioner, the national association of insurance commissioners, or any other person, except to insurance departments of other states, without the prior consent of the insurer to which it pertains unless the commissioner, after giving the insurer notice and an opportunity to be heard, determines that the interest of policyholders, shareholders, or the public will be served by publication, in which event the commissioner may publish all or any part of the report in the manner the commissioner chooses.

NEW SECTION. **Section 80. Acquisitions and dispositions of assets.** (1) Acquisitions or dispositions of assets that are not material are not required to be reported pursuant to [section 79] if the acquisitions or dispositions are not material. For purposes of [sections 78 through 81], a material acquisition or the aggregate of any series of related acquisitions during any 30-day period or a disposition or the aggregate of any series of related dispositions during any 30-day period is one that is nonrecurring and not in the ordinary course of business and involves more than 5% of the reporting insurer's total admitted assets as reported in its most recent statutory statement filed with the insurance department of the insurer's state of domicile.

(2) Asset acquisitions subject to [sections 78 through 81] include every purchase, lease, exchange, merger, consolidation, succession, or other acquisition, other than the construction or development of real property, by or for the reporting insurer or the acquisition of materials for this purpose.

(3) Asset dispositions subject to [sections 78 through 81] include each sale, lease, exchange, merger, consolidation, mortgage, hypothecation, assignment, whether for the benefit of creditors or otherwise, abandonment, destruction, or other disposition.

(4) The following information is required to be disclosed in any report of a material acquisition or disposition of assets:

(a) the date of the transaction;

(b) the manner of acquisition or disposition;

(c) the description of the assets involved;

(d) the nature and amount of the consideration given or received;

(e) the purpose or reason for the transaction;

(f) the manner by which the amount of consideration was determined;

(g) the gain or loss recognized or realized as a result of the transaction; and

(h) the names of the persons from whom the assets were acquired or to whom they were disposed.

(5) An insurer is required to report material acquisitions and dispositions on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers that uses a pooling arrangement or 100% reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed business to the pool. An insurer cedes substantially all of its direct and assumed business to a pool if the insurer has less than $1 million total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than 5% of the insurer's capital and surplus.

NEW SECTION. **Section 81. Nonrenewals, cancellations, or revisions of ceded reinsurance agreements.** (1) A nonrenewal, cancellation, or revision of a ceded reinsurance agreement need not be reported pursuant to [section 79] if the nonrenewal, cancellation, or revision is not material. For purposes of [sections 78 through 81], a material nonrenewal, cancellation, or revision is one that affects:

(a) property and casualty business, including disability business written by a property and casualty insurer, so that:

(i) more than 50% of the insurer's total ceded written premium is affected; or

(ii) more than 50% of the insurer's total ceded indemnity and loss adjustment reserves are affected;

(b) life, annuity, and disability business, so that more than 50% of the total reserve credit taken for business ceded, on an annualized basis, as indicated in the insurer's most recent annual statement is affected;

(c) either property and casualty or life, annuity, and disability business and causes either of the following events that constitutes a material revision that must be reported:

(i) an authorized reinsurer representing more than 10% of a total cession is replaced by one or more unauthorized reinsurers; or

(ii) previously established collateral requirements have been reduced or waived as respects one

or more unauthorized reinsurers representing collectively more than 10% of a total cession.

(2) However, a filing is not required if:

(a) with respect to property and casualty business, including disability business written by a property and casualty insurer, the insurer's total ceded written premium represents, on an annualized basis, less than 10% of its total written premium for direct and assumed business; or

(b) with respect to life, annuity, and disability business, the total reserve credit taken for business ceded represents, on an annualized basis, less than 10% of the statutory reserve requirement prior to any cession.

(3) The following information is required to be disclosed in any report of a material nonrenewal, cancellation, or revision of ceded reinsurance agreements:

(a) the effective date of the nonrenewal, cancellation, or revision;

(b) the description of the transaction with an identification of the initiator of the transaction;

(c) the purpose or reason for the transaction; and

(d) if applicable, the identity of the replacement reinsurers.

(4) Insurers are required to report all material nonrenewals, cancellations, or revisions of ceded reinsurance agreements on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers that uses a pooling arrangement or 100% reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed business to the pool. An insurer is considered to have ceded substantially all of its direct and assumed business to a pool if the insurer has less than $1 million total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than 5% of the insurer's capital and surplus.

NEW SECTION. **Section 82. Short title.** [Sections 82 through 94] constitute and may be referred to as "The Risk-Based Capital For Insurers Act".

NEW SECTION. **Section 83. Definitions.** As used in [sections 82 through 94], the following definitions apply:

(1) "Adjusted RBC report" means an RBC report that has been adjusted by the commissioner in accordance with [section 84(5)].

(2) "Corrective order" means an order issued by the commissioner specifying corrective actions that the commissioner has determined are required.

(3) "Domestic insurer" means any insurance company domiciled in this state.

(4) "Foreign insurer" means any insurance company licensed to do business in this state under 33-2-116 but not domiciled in this state.

(5) "Life or disability insurer" means:

(a) any insurance company licensed under 33-2-116 and engaged in the business of entering into contracts of disability insurance as described in 33-1-207 or life insurance as described in 33-1-208; or

(b) a licensed property and casualty insurer writing only disability insurance.

(6) "NAIC" means the national association of insurance commissioners.

(7) "Negative trend" means, with respect to a life or health insurer, a negative trend over a period of time, as determined in accordance with the trend test calculation included in the RBC instructions.

(8) (a) "Property and casualty insurer" means any insurance company licensed under 33-2-116 and engaged in the business of entering into contracts of property insurance as described in 33-1-210 or casualty insurance as described in 33-1-206.

(b) The term does not include monoline mortgage guaranty insurers, financial guaranty insurers, and title insurers.

(9) "RBC instructions" means the RBC report including risk-based capital instructions adopted by the NAIC, as the RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

(10) "RBC level" means an insurer's authorized control level RBC, company action level RBC, mandatory control level RBC, or regulatory action level RBC, where:

(a) "authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions;

(b) "company action level RBC" means, with respect to any insurer, the product of 2 and its authorized control level RBC;

(c) "mandatory control level RBC" means the product of 0.70 and the authorized control level RBC; and

(d) "regulatory action level RBC" means the product of 1.5 and its authorized control level RBC.

(11) "RBC plan" means a comprehensive financial plan containing the elements specified in [section 85(2)]. If the commissioner rejects the RBC plan and it is revised by the insurer, with or without the commissioner's recommendation, the plan must be called a revised RBC plan.

(12) "RBC report" means the report required in [section 84].

(13) "Total adjusted capital" means the sum of:

(a) an insurer's statutory capital and surplus; and

(b) other items, if any, as the RBC instructions may provide.

NEW SECTION. **Section 84. RBC reports.** (1) Each domestic insurer shall, on or before each March 1 filing date, prepare and submit to the commissioner a report of its RBC levels as of the end of the previous calendar year in a form and containing information as required by the RBC instructions. In addition, each domestic insurer shall file its RBC report:

(a) with the NAIC in accordance with the RBC instructions; and

(b) with the insurance commissioner in any state in which the insurer is authorized to do business if that insurance commissioner has notified the insurer of the request in writing, in which case the insurer shall file its RBC report not later than the later of:

(i) 15 days from the receipt of notice to file its RBC report with that state; or

(ii) the March 1 filing date.

(2) A life and disability insurer's RBC must be determined in accordance with the formula set forth in the RBC instructions. The formula must take into account and may adjust for the covariance between:

(a) the risk with respect to the insurer's assets;

(b) the risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

(c) the interest rate risk with respect to the insurer's business; and

(d) all other business risks and other relevant risks as are set forth in the RBC instructions and determined in each case by applying the factors in the manner set forth in the RBC instructions.

(3) A property and casualty insurer's RBC must be determined in accordance with the formula set forth in the RBC instructions. The formula shall take into account and may adjust for the covariance

between:

(a) asset risk;

(b) credit risk;

(c) underwriting risk; and

(d) all other business risks and other relevant risks that are set forth in the RBC instructions and determined in each case by applying the factors in the manner set forth in the RBC instructions.

(4) An excess of capital over the amount produced by the risk-based capital requirements contained in [sections 82 through 94] and the formulas, schedules, and instructions referenced in [sections 87 through 94] is desirable in the business of insurance. Accordingly, insurers should seek to maintain capital above the RBC levels required by [sections 82 through 94]. Additional capital is used and useful in the insurance business and helps to secure an insurer against various risks inherent in or affecting the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in [sections 82 through 94].

(5) If a domestic insurer files an RBC report that in the judgment of the commissioner is inaccurate, the commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice must contain a statement of the reason for the adjustment. An RBC report so adjusted is referred to as an adjusted RBC report.

NEW SECTION. **Section 85. Company action level event.** (1) "Company action level event" means any of the following events:

(a) the filing of an RBC report by an insurer which indicates that:

(i) the insurer's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC; or

(ii) for a life or disability insurer, the insurer has total adjusted capital that is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 2.5 and that has a negative trend;

(b) the notification by the commissioner to the insurer of an adjusted RBC report that indicates an event in subsection (1)(a) if the insurer does not challenge the adjusted RBC report under [section 89] or if the commissioner has rejected the insurer's challenge.

(2) In the event of a company action level event, the insurer shall prepare and submit to the

commissioner an RBC plan that must:

(a) identify the conditions that contribute to the company action level event;

(b) contain proposals of corrective actions that the insurer intends to take and that would be expected to result in the elimination of the company action level event;

(c) provide projections of the insurer's financial results in the current year and at least the next 4 years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital, and surplus. The projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense, and benefit component.

(d) identify the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and

(e) identify the quality of and problems associated with the insurer's business, including but not limited to its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance, if any, in each case.

(3) The RBC plan must be submitted:

(a) within 45 days of the company action level event; or

(b) if the insurer challenges an adjusted RBC report pursuant to [section 89], within 45 days after notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(4) Within 60 days after the submission by an insurer of an RBC plan to the commissioner, the commissioner shall notify the insurer as to whether the RBC plan may be implemented or is unsatisfactory in the judgment of the commissioner. If the commissioner determines that the RBC plan is unsatisfactory, the notification to the insurer must set forth the reasons for the determination and may set forth proposed revisions that will render the RBC plan satisfactory in the judgment of the commissioner. Upon notification from the commissioner, the insurer shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by the commissioner, and shall submit the revised RBC plan to the commissioner:

(a) within 45 days after the notification from the commissioner; or

(b) if the insurer challenges the notification from the commissioner under [section 89], within 45 days after a notification to the insurer that the commissioner has, after a hearing, rejected the

insurer's challenge.

(5) In the event of a notification by the commissioner to an insurer that the insurer's RBC plan or revised RBC plan is unsatisfactory, the commissioner may at the commissioner's discretion, subject to the insurer's right to a hearing under [section 89], specify in the notification that the notification constitutes a regulatory action level event.

(6) Each domestic insurer that files an RBC plan or revised RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in any state in which the insurer is authorized to do business if:

(a) the state has an RBC provision substantially similar to [section 90(1)]; and

(b) the insurance commissioner of that state has notified the insurer in writing of its request for the filing, in which case the insurer shall file a copy of the RBC plan or revised RBC plan in that state by the later of:

(i) 15 days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with that state; or

(ii) the date on which the RBC plan or revised RBC plan is filed under [section 85(3) and (4)].

NEW SECTION. **Section 86. Regulatory action level event.** (1) "Regulatory action level event" means, with respect to any insurer, any of the following events:

(a) the filing of an RBC report by the insurer that indicates that the insurer's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC;

(b) the notification by the commissioner to an insurer of an adjusted RBC report that indicates the event in subsection (1)(a) if the insurer does not challenge the adjusted RBC report under [section 89] or the commissioner rejects the insurer's challenge;

(c) the failure of the insurer to file an RBC report by the filing date, unless the insurer has provided an explanation for the failure that is satisfactory to the commissioner and has cured the failure within 10 days after the filing date;

(d) the failure of the insurer to submit an RBC plan to the commissioner within the time period set forth in [section 85(3)];

(e) notification by the commissioner to the insurer that:

(i) the RBC plan or revised RBC plan submitted by the insurer is unsatisfactory in the judgment of the commissioner; and

(ii) the notification constitutes a regulatory action level event with respect to the insurer if the insurer has not challenged the determination under [section 89];

(f) if, pursuant to [section 89], the insurer challenges a determination by the commissioner, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the challenge;

(g) notification by the commissioner to the insurer that the insurer has failed to adhere to its RBC plan or revised RBC plan, but only if the failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event in accordance with its RBC plan or revised RBC plan and the commissioner has so stated in the notification and if the insurer has not challenged the determination under [section 89] or the commissioner has not rejected the insurer's challenge.

(2) In the event of a regulatory action level event, the commissioner shall:

(a) require the insurer to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(b) perform an examination or analysis as the commissioner considers necessary of the assets, liabilities, and operations of the insurer including a review of its RBC plan or revised RBC plan; and

(c) subsequent to the examination or analysis, issue a corrective order specifying corrective actions that the commissioner determines are required.

(3) In determining corrective actions, the commissioner may take into account factors considered relevant with respect to the insurer based upon the commissioner's examination or analysis of the assets, liabilities, and operations of the insurer, including but not limited to the results of any sensitivity tests undertaken pursuant to the RBC instructions. The RBC plan or revised RBC plan must be submitted:

(a) within 45 days after the occurrence of the regulatory action level event;

(b) if the insurer challenges an adjusted RBC report pursuant to [section 89] and the challenge is not frivolous in the judgment of the commissioner, within 45 days after the notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge; or

(c) if the insurer challenges a revised RBC plan pursuant to [section 89] and the challenge is not frivolous in the judgment of the commissioner, within 45 days after the notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(4) The commissioner may retain actuaries and investment experts and other consultants that may be necessary in the judgment of the commissioner to review the insurer's RBC plan or revised RBC plan, to examine or analyze the assets, liabilities, and operations of the insurer, and to formulate the corrective order with respect to the insurer. The fees, costs, and expenses relating to consultants must be borne by the affected insurer or such other party as directed by the commissioner.

NEW SECTION. **Section 87. Authorized control level event.** (1) "Authorized control level event" means any of the following events:

(a) the filing of an RBC report by the insurer that indicates that the insurer's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC;

(b) the notification by the commissioner to the insurer of an adjusted RBC report that indicates the event in subsection (1)(a) if the insurer does not challenge the adjusted RBC report under [section 89] or the commissioner rejects the insurer's challenge;

(c) the failure of the insurer to respond, in a manner satisfactory to the commissioner, to a corrective order if the insurer has not challenged the corrective order under [section 89]; or

(d) if the insurer has challenged a corrective order under [section 89] and the commissioner has, after a hearing, rejected the challenge or modified the corrective order, the failure of the insurer to respond, in a manner satisfactory to the commissioner, to the corrective order subsequent to rejection or modification by the commissioner.

(2) In the event of an authorized control level event with respect to an insurer, the commissioner shall:

(a) take the actions required under [section 86] regarding an insurer with respect to which a regulatory action level event has occurred; or

(b) if the commissioner considers it to be in the best interests of the policyholders and creditors of the insurer and of the public, take the actions necessary to cause the insurer to be placed under regulatory control under Title 33, chapter 2, part 13. In the event that the commissioner places the insurer under regulatory control, the authorized control level event must be considered sufficient grounds for the commissioner to take action under Title 33, chapter 2, part 13, and the commissioner shall have the rights, powers, and duties with respect to the insurer as are set forth in Title 33, chapter

2, part 13. In the event that the commissioner takes an action under this subsection pursuant to an adjusted RBC report, the insurer is entitled to the protections afforded to insurers under the provisions of 33-2-1321 through 33-2-1323 pertaining to summary proceedings.

NEW SECTION. **Section 88. Mandatory control level event.** (1) "Mandatory control level event" means any of the following events:

(a) the filing of an RBC report that indicates that the insurer's total adjusted capital is less than its mandatory control level RBC;

(b) notification by the commissioner to the insurer of an adjusted RBC report that indicates the event in subsection (1)(a) if the insurer does not challenge the adjusted RBC report under [section 89] or the commissioner rejects the insurer's challenge.

(2) In the event of a mandatory control level event:

(a) with respect to a life insurer, the commissioner shall take the actions that are necessary to place the insurer under regulatory control under Title 33, chapter 2, part 13. In that event, the mandatory control level event must be considered sufficient grounds for the commissioner to take action under Title 33, chapter 2, part 13, and the commissioner shall have the rights, powers, and duties with respect to the insurer as are set forth in Title 33, chapter 2, part 13. If the commissioner takes an action pursuant to an adjusted RBC report, the insurer is entitled to the protections of 33-2-1321 through 33-2-1323 pertaining to summary proceedings. Notwithstanding any of the foregoing, the commissioner may forego action for up to 90 days after the mandatory control level event if the commissioner finds that there is a reasonable expectation that the mandatory control level event may be eliminated within the 90-day period.

(b) with respect to a property and casualty insurer, the commissioner shall take the actions necessary to place the insurer under regulatory control under Title 33, chapter 2, part 13, or, in the case of an insurer that is not writing business and that is running-off its existing business, may allow the insurer to continue its runoff under the supervision of the commissioner. In either event, the mandatory control level event must be considered sufficient grounds for the commissioner to take action under Title 33, chapter 2, part 13, and the commissioner shall have the rights, powers, and duties with respect to the insurer as are set forth in Title 33, chapter 2, part 13. If the commissioner takes an action pursuant to an adjusted RBC report, the insurer is entitled to the protections of

33-2-1321 through 33-2-1323 pertaining to summary proceedings. Notwithstanding any of the foregoing, the commissioner may forego action for up to 90 days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the 90-day period.

NEW SECTION. **Section 89. Notification and hearing.** (1) An insurer has the right to a hearing before the department upon notification by the commissioner:

(a) of an adjusted RBC report or unsatisfactory RBC plan or revised RBC plan that constitutes a regulatory action level event with respect to the insurer;

(b) that the insurer has failed to adhere to its RBC plan or revised RBC plan and that the failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event with respect to the insurer in accordance with its RBC plan or revised RBC plan; or

(c) of a corrective order with respect to the insurer.

(2) The insurer shall notify the commissioner of its request for a hearing within 5 days after the notification by the commissioner under subsection (1). Upon receipt of the insurer's request for a hearing, the commissioner shall set a date for the hearing, which may not be less than 10 or more than 30 days after the date of the insurer's request.

NEW SECTION. **Section 90. Confidentiality -- prohibition on announcements -- prohibition on use in ratemaking.** (1) With respect to a domestic insurer or a foreign insurer, all RBC reports, to the extent the information in the reports is not required to be set forth in a publicly available annual statement schedule, and all RBC plans, including the results or report of any examination or analysis of an insurer performed pursuant to [sections 82 through 94] and any corrective order issued by the commissioner pursuant to the examination or analysis, that are filed with the commissioner constitute information that might be damaging to the insurer if made available to its competitors and must be kept confidential by the commissioner. This information may not be made public and is not subject to subpoena other than by the commissioner and then only for the purpose of enforcement actions taken by the commissioner pursuant to [sections 82 through 94] or any other provision of the insurance laws of this state.

(2) It is the intent of the legislature that the comparison of an insurer's total adjusted capital

to any of its RBC levels is a regulatory tool that may indicate the need for possible corrective action with respect to the insurer and that it is not intended as a means to rank insurers generally. Except as otherwise required under the provisions of [sections 92 through 94], the making, publishing, disseminating, circulating, or placing before the public or causing, directly or indirectly to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, in the form of a notice, circular, pamphlet, letter, or poster, over any radio or television station, or in any other way, an advertisement, announcement, or statement containing an assertion, representation, or statement with regard to the RBC levels of any insurer or of any component derived in the calculation that is by any insurer, producer, or other person engaged in any manner in the insurance business would be misleading and is prohibited. However, if any materially false statement with respect to the comparison regarding an insurer's total adjusted capital to its RBC levels or an inappropriate comparison of any other amount to the insurer's RBC levels is published in any written publication and the insurer is able to demonstrate to the commissioner, with substantial proof, the falsity of the statement or the inappropriateness, as the case may be, the insurer may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

(3) It is the further intent of the legislature that the RBC instructions, RBC reports, adjusted RBC reports, RBC plans, and revised RBC plans are intended solely for use by the commissioner in monitoring the solvency of insurers and the need for possible corrective action with respect to insurers and may not be used by the commissioner for ratemaking or considered or introduced as evidence in any rate proceeding or used by the commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance that an insurer or any affiliate is authorized to write.

NEW SECTION. **Section 91. Supplemental provisions -- rules -- exemption.** (1) The provisions of [sections 82 through 94] are supplemental to any other provisions of the laws of this state and do not preclude or limit any other powers or duties of the commissioner under the law, including but not limited to Title 33, chapter 2, part 13.

(2) The commissioner may adopt reasonable rules necessary for the implementation of [sections 82 through 94].

(3) The commissioner may exempt from the application of [sections 82 through 94] any domestic property and casualty insurer that:

(a) writes direct business only in this state;

(b) writes direct annual premiums of $2 million or less; and

(c) does not assume reinsurance in excess of 5% of direct premium written.

NEW SECTION. **Section 92. Foreign insurers.** (1) A foreign insurer shall, upon the written request of the commissioner, submit to the commissioner an RBC report for the previous calendar year on the later of:

(a) the date that an RBC report would be required to be filed by a domestic insurer under [section 84]; or

(b) 15 days after the request is received by the foreign insurer.

(2) A foreign insurer shall, at the written request of the commissioner, promptly submit to the commissioner a copy of any RBC plan that is filed with the insurance commissioner of any other state.

(3) In the event of a company action level event, regulatory action level event, or authorized control level event, with respect to any foreign insurer as determined under the RBC statute applicable in the state of domicile of the insurer or, if an RBC statute is not in force in that state, under the provisions of [sections 82 through 94], if the insurance commissioner of the state of domicile of the foreign insurer fails to require the foreign insurer to file an RBC plan in the manner specified under that state's RBC statute or, if an RBC statute is not in force in that state, under [section 85], the commissioner may require the foreign insurer to file an RBC plan with the commissioner. In that event, the failure of the foreign insurer to file an RBC plan with the commissioner is grounds to order the insurer to cease and desist from writing new insurance business in this state.

(4) In the event of a mandatory control level event with respect to any foreign insurer, if a domiciliary receiver has not been appointed with respect to the foreign insurer under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign insurer, the commissioner may make application to a district court of this state permitted under 33-2-1380 with respect to the liquidation of property of foreign insurers found in this state, and the occurrence of the mandatory control level event must be considered adequate grounds for the application.

NEW SECTION. **Section 93. Applicability for 1995.** (1) For RBC reports required to be filed by property and casualty insurers with respect to 1995, the following requirements apply in lieu of the provisions of [sections 85 through 88]:

(a) In the event of a company action level event with respect to a domestic insurer, the commissioner will not take regulatory action under [sections 82 through 94].

(b) In the event of a regulatory action level event under [section 86(1)(a), (1)(b), or (1)(c)], the commissioner shall take the actions required under [section 86(2)].

(c) In the event of a regulatory action level event under [section 86(1)(d), (1)(e), (1)(f), or (1)(g)] or an authorized control level event, the commissioner shall take the actions required under [section 86(2) and (3)] with respect to the insurer.

(4) In the event of a mandatory control level event with respect to an insurer, the commissioner shall take the actions required under [section 88].

NEW SECTION. **Section 94. Notices.** All notices by the commissioner to an insurer that may result in regulatory action are effective on dispatch if transmitted by certified mail or, in the case of any other transmission, are effective on the insurer's receipt of the notice.

NEW SECTION. **Section 95. Repealer.** Sections 33-30-312 and 33-30-313, MCA, are repealed.

NEW SECTION. **Section 96. Codification instruction.** (1) [Section 75] is intended to be codified as an integral part of Title 33, chapter 15, and the provisions of Title 33, chapter 15, apply to [section 75].

(2) [Section 76] is intended to be codified as an integral part of Title 33, chapter 2, part 5, and the provisions of Title 33, chapter 2, part 5, apply to [section 76].

(3) [Section 77] is intended to be codified as an integral part of Title 33, chapter 15, part 4, and the provisions of Title 33, chapter 15, part 4, apply to [section 77].

(4) [Sections 78 through 81] are intended to be codified as an integral part of Title 33, chapter 3, and the provisions of Title 33, chapter 3, apply to [sections 78 through 81].

(5) [Sections 82 through 94] are intended to be codified as an integral part of Title 33, chapter

2, and the provisions of Title 33, chapter 2, apply to [sections 82 through 94].

NEW SECTION. **Section 97. Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

-END-

APPROVED BY COMMITTEE
ON BUSINESS AND LABOR

House BILL NO. 556

INTRODUCED BY Simon Bennett

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING STATE INSURANCE LAWS; PROVIDING FOR THE DISCLOSURE OF MATERIAL TRANSACTIONS; CREATING A RISK-BASED CAPITAL FOR INSURERS ACT; AMENDING SECTIONS 2-6-109, 33-1-207, 33-1-208, 33-1-209, 33-1-311, 33-1-501, 33-2-117, 33-2-301, 33-2-302, 33-2-305, 33-2-307, 33-2-501, 33-2-521, 33-2-523, 33-2-525, 33-2-526, 33-2-528, 33-2-529, 33-2-531, 33-2-701, 33-2-705, 33-2-708, 33-2-803, 33-2-806, 33-2-820, 33-2-1111, 33-2-1201, 33-2-1216, 33-2-1217, 33-2-1218, 33-2-1510, 33-2-1605, 33-3-431, 33-4-202, 33-4-203, 33-5-401, 33-7-117, 33-10-201, 33-10-202, 33-11-102, 33-11-104, 33-11-108, 33-14-304, 33-15-301, 33-15-303, 33-16-202, 33-16-235, 33-17-102, 33-17-211, 33-17-405, 33-17-503, 33-17-603, 33-17-1001, 33-18-212, 33-18-301, 33-22-131, 33-22-132, 33-22-201, 33-22-202, 33-22-301, 33-22-303, 33-22-504, 33-22-508, 33-22-1120, 33-22-1803, 33-22-1819, 33-30-102, 33-30-107, 33-30-108, 33-30-202, 33-30-204, 33-30-311, 33-30-1001, AND 33-31-311, MCA; AND REPEALING SECTIONS 33-30-312 AND 33-30-313, MCA."

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

THERE ARE NO CHANGES IN THIS BILL AND IT WILL NOT BE REPRINTED. PLEASE REFER TO INTRODUCED COPY (WHITE) FOR COMPLETE TEXT.

House BILL NO. 556

INTRODUCED BY Simon Rosenblatt

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING STATE INSURANCE LAWS; PROVIDING FOR THE DISCLOSURE OF MATERIAL TRANSACTIONS; CREATING A RISK-BASED CAPITAL FOR INSURERS ACT; AMENDING SECTIONS 2-6-109, 33-1-207, 33-1-208, 33-1-209, 33-1-311, 33-1-501, 33-2-117, 33-2-301, 33-2-302, 33-2-305, 33-2-307, 33-2-501, 33-2-521, 33-2-523, 33-2-525, 33-2-526, 33-2-528, 33-2-529, 33-2-531, 33-2-701, 33-2-705, 33-2-708, 33-2-803, 33-2-806, 33-2-820, 33-2-1111, 33-2-1201, 33-2-1216, 33-2-1217, 33-2-1218, 33-2-1510, 33-2-1605, 33-3-431, 33-4-202, 33-4-203, 33-5-401, 33-7-117, 33-10-201, 33-10-202, 33-11-102, 33-11-104, 33-11-108, 33-14-304, 33-15-301, 33-15-303, 33-16-202, 33-16-235, 33-17-102, 33-17-211, 33-17-405, 33-17-503, 33-17-603, 33-17-1001, 33-18-212, 33-18-301, 33-22-131, 33-22-132, 33-22-201, 33-22-202, 33-22-301, 33-22-303, 33-22-504, 33-22-508, 33-22-1120, 33-22-1803, 33-22-1819, 33-30-102, 33-30-107, 33-30-108, 33-30-202, 33-30-204, 33-30-311, 33-30-1001, AND 33-31-311, MCA; AND REPEALING SECTIONS 33-30-312 AND 33-30-313, MCA."

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

THERE ARE NO CHANGES IN THIS BILL AND IT WILL NOT BE REPRINTED. PLEASE REFER TO SECOND READING COPY (YELLOW) FOR COMPLETE TEXT.

SENATE STANDING COMMITTEE REPORT

March 2, 1995

MR. PRESIDENT:

We, your committee on Business and Industry having had under consideration HB 556 (third reading copy -- blue), respectfully report that HB 556 be amended as follows and as so amended be concurred in.

Signed: John Hertel
Senator John R. Hertel, Chair

That such amendments read:

1. Title, line 10.
Following: "33-2-1218,"
Insert: "33-2-1394,"

2. Title, line 13.
Strike: "33-17-1001,"

3. Title, line 14.
Following: "33-22-1803,"
Insert: "33-22-1811,"

4. Title, line 15.
Strike: "33-31-311"
Insert: "33-31-111"

5. Title, line 15.
Following: "MCA;"
Strike: "AND"

6. Title, line 16.
Following: "MCA"
Insert: "; AND PROVIDING EFFECTIVE DATES"

7. Page 6, line 20.
Following: "payment"
Insert: "on or"

8. Page 8, line 13.
Following: "insurers"
Insert: "or, in the case of a renewal, the line of insurance has not become available from an authorized insurer"

9. Page 8, line 20.
Following: "~~and~~"
Insert: "and"

Amd. Coord.
Sec. of Senate

Sen. Steve Benedict
Senator Carrying Bill

HB556
SENATE
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10. Page 8, line 21.
Strike: subsection (5) in its entirety
Renumber: subsequent subsection

11. Page 15, line 17.
Strike: "1995"
Insert: "1996"

12. Page 17, line 1.
Following: "~~such~~"
Insert: "all other"

13. Page 42, line 4.
Insert: "**Section 31.** Section 33-2-1394, MCA, is amended to read:

"**33-2-1394. Settlement of actions against rehabilitator, liquidator, and employees -- court approval -- applicability.** (1) If any legal action against an employee for which indemnity may be available under this section is settled prior to final adjudication on the merits, the insurer shall pay the settlement amount on behalf of the employee or indemnify the employee for the settlement amount unless the commissioner determines:

(a) that the claim did not arise out of or by reason of the employee's duties or employment; or

(b) that the claim was caused by the intentional or willful and wanton misconduct of the employee.

(2) In a legal action in which the rehabilitator or liquidator is a defendant, that portion of any settlement relating to the alleged act, error, or omission of the rehabilitator or liquidator is subject to the approval of the court before which the delinquency proceeding is pending. The court may not approve that portion of the settlement if it determines:

(a) that the claim did not arise out of or by reason of the rehabilitator's or liquidator's duties or employment; or

(b) that the claim was caused by the intentional or willful and wanton misconduct of the rehabilitator or liquidator.

(3) This section may not be construed to deprive the rehabilitator, liquidator, or employee of immunity, indemnity, benefit of law, right, or defense available under any provision of law, including, without limitation, the provisions of Title 2, chapter 9.

(4) (a) ~~A~~ Except as otherwise provided, a legal action by a third party does not lie against the rehabilitator, liquidator, or employee based in whole or in part on any alleged act, error, or omission that took place prior to October 1, 1993, unless suit is filed and valid service of process is obtained by October 1, 1994. A legal action that is pending on or filed after September 30, 1993, by a liquidator or a liquidation estate will lie

against a former special deputy liquidator or any employee, agent, or independent contractor retained by a special deputy liquidator without regard to when the alleged act, error, or omission occurred.

(b) Subsections (1) through (3) apply to any suit that is pending on or filed after October 1, 1993, without regard to when the alleged act, error, or omission took place.""
Renumber: subsequent sections

14. Page 43, lines 18 and 19.
Strike: "The" on line 18 through "fees" on line 19
Insert: "A limit on the controlling producer's writings in relation to the controlled insurer's surplus and total writings"

15. Page 68, line 18 through page 69, line 18.
Strike: section 53 in its entirety
Renumber: subsequent sections

16. Page 71, line 14.
Strike: "hospital indemnity,"

17. Page 88, line 27.
Strike: "report" through "license"
Insert: "statement"

18. Page 90, lines 1 through 22.
Strike: section 74 in its entirety
Insert: "**Section 74.** Section 33-31-111, MCA, is amended to read:

"33-31-111. Statutory construction and relationship to other laws. (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to any health maintenance organization authorized to transact business under this chapter. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives may not be construed as a violation of any law relating to solicitation or advertising by health professionals.

(3) A health maintenance organization authorized under this chapter may not be considered to be practicing medicine and is exempt from Title 37, chapter 3, relating to the practice of medicine.

(4) The provisions of this chapter do not exempt a health maintenance organization from the applicable certificate of need

requirements under Title 50, chapter 5, parts 1 and 3.

(5) The provisions of this section do not exempt a health maintenance organization from material transaction disclosure requirements under [sections 78 through 81]. A health maintenance organization must be considered an insurer for the purposes of [sections 78 through 81]."

19. Page 90, line 24.
Following: "Each"
Insert: "individual"

20. Page 106, line 17.
Insert: "**Section 95.** Section 33-22-1811, MCA, is amended to read:

"**33-22-1811. Availability of coverage -- required plans.** (1) (a) As a condition of transacting business in this state with small employers, each small employer carrier shall offer to small employers at least two health benefit plans. One plan must be a basic health benefit plan, and one plan must be a standard health benefit plan.

(b) (i) A small employer carrier shall issue a basic health benefit plan or a standard health benefit plan to any eligible small employer that applies for either plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this part.

(ii) In the case of a small employer carrier that establishes more than one class of business pursuant to 33-22-1808, the small employer carrier shall maintain and offer to eligible small employers at least one basic health benefit plan and at least one standard health benefit plan in each established class of business. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business, provided that:

(A) the criteria are not intended to discourage or prevent acceptance of small employers applying for a basic or standard health benefit plan;

(B) the criteria are not related to the health status or claims experience of the small employers' employees;

(C) the criteria are applied consistently to all small employers that apply for coverage in that class of business; and

(D) the small employer carrier provides for the acceptance of all eligible small employers into one or more classes of business.

(iii) The provisions of subsection (1)(b)(ii) may not be applied to a class of business into which the small employer carrier is no longer enrolling new small businesses.

(c) The provisions of this section are effective 180 days

after the commissioner's approval of the basic health benefit plan and the standard health benefit plan developed pursuant to 33-22-1812, provided that if the program created pursuant to 33-22-1818 is not yet operative on that date, the provisions of this section are effective on the date that the program begins operation.

(2) (a) A small employer carrier shall, pursuant to 33-1-501, file the basic health benefit plans and the standard health benefit plans to be used by the small employer carrier.

(b) The commissioner may at any time, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a basic or standard health benefit plan on the grounds that the plan does not meet the requirements of this part.

(3) Health benefit plans covering small employers must comply with the following provisions:

(a) A health benefit plan may not, because of a preexisting condition, deny, exclude, or limit benefits for a covered individual for losses incurred more than 12 months following the effective date of the individual's coverage. A health benefit plan may not define a preexisting condition more restrictively than 33-22-110, except that the condition may be excluded for a maximum of 12 months.

(b) A health benefit plan must waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to those services if the qualifying previous coverage was continuous to a date not ~~less~~ more than 30 days prior to the submission of an application for new coverage. This subsection (3)(b) does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

(c) A health benefit plan may exclude coverage for late enrollees for 18 months or for an 18-month preexisting condition exclusion, provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period may not exceed 18 months from the date the individual enrolls for coverage under the health benefit plan.

(d) (i) Requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, must be applied uniformly among all small employers that have the same number of eligible employees and that apply for coverage or receive coverage from the small employer carrier.

(ii) A small employer carrier may vary the application of

minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(e) (i) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier may not offer coverage only to certain individuals in a small employer group or only to part of the group, except in the case of late enrollees as provided in subsection (3)(c).

(ii) A small employer carrier may not modify a basic or standard health benefit plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

(4) (a) A small employer carrier may not be required to offer coverage or accept applications pursuant to subsection (1) in the case of the following:

(i) to a small employer when the small employer is not physically located in the carrier's established geographic service area;

(ii) to an employee when the employee does not work or reside within the carrier's established geographic service area; or

(iii) within an area where the small employer carrier reasonably anticipates and demonstrates to the satisfaction of the commissioner that it will not have the capacity within its established geographic service area to deliver service adequately to the members of a group because of its obligations to existing group policyholders and enrollees.

(b) A small employer carrier may not be required to provide coverage to small employers pursuant to subsection (1) for any period of time for which the commissioner determines that requiring the acceptance of small employers in accordance with the provisions of subsection (1) would place the small employer carrier in a financially impaired condition.""
Renumber: subsequent sections

21. Page 107, line 7.
Insert: "NEW SECTION. **Section 99. Effective dates.** (1) [Section 31 and this section] are effective on passage and approval.

(2) [Sections 1 through 30 and 32 through 98] are effective October 1, 1995."

-END-

SENATE COMMITTEE OF THE WHOLE AMENDMENT

March 8, 1995 1:09 pm

Mr. Chairman: I move to amend HB 556 (third reading copy -- blue).

ADOPT

REJECT

Signed: Jergeson
Senator Jergeson

That such amendments read:

1. Title, line 7.
Following: "33-1-311,"
Insert: "33-1-413,"

2. Page 106, line 17.
Insert: "**Section 96.** Section 33-1-413, MCA, is amended to read:
"**33-1-413. Examination expense -- lien.** (1) Upon presentation of a detailed account of ~~such~~ charges and expenses by the commissioner or pursuant to ~~his~~ the commissioner's written authorization, each person ~~so~~ examined, other than ~~as to~~ examinations pursuant to 33-1-402, shall pay the actual travel expenses, a reasonable living expense allowance, and a per diem as compensation of examiners as necessarily incurred on account of the examination, all at reasonable rates ~~customary therefor and~~ as established or adopted by the commissioner. ~~Such an~~ An account may be ~~so~~ presented periodically during the course of the examination or at the termination of the examination as the commissioner ~~deems~~ considers proper. ~~No~~ A person ~~shall~~ may not pay and ~~no~~ an examiner ~~shall~~ may not accept any additional emolument on account of ~~any such~~ an examination.
(2) The commissioner shall pay to the state treasurer to the credit of the ~~general~~ state special revenue fund all ~~moneys~~ money received pursuant to subsection (1) ~~above~~.
(3) If ~~any such~~ a person fails to pay the charges and expenses, as referred to in subsection (1) ~~above~~, ~~they shall~~ the charges and expenses must be paid out of the funds of the commissioner in the same manner as other disbursements of ~~such~~ the funds. The amount ~~so~~ paid ~~shall be~~ is a first lien upon all of the assets and property in this state of ~~such~~ the person and may be recovered by suit by the attorney general on behalf of the state of Montana and restored to the appropriate fund.""
Renumber: subsequent sections

3. Page 6 of the Senate standing committee report amendment no. 21 is amended as follows:
Strike: "[Sections 1 through 30 and 32 through 98] are"
Insert: "Except as provided in subsection (1), [this act] is"

-END-

HB 556

SENATE

Amd. Coord.

HOUSE BILL NO. 556

INTRODUCED BY SIMON, BENEDICT

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING STATE INSURANCE LAWS; PROVIDING FOR THE DISCLOSURE OF MATERIAL TRANSACTIONS; CREATING A RISK-BASED CAPITAL FOR INSURERS ACT; AMENDING SECTIONS 2-6-109, 33-1-207, 33-1-208, 33-1-209, 33-1-311, 33-1-413, 33-1-501, 33-2-117, 33-2-301, 33-2-302, 33-2-305, 33-2-307, 33-2-501, 33-2-521, 33-2-523, 33-2-525, 33-2-526, 33-2-528, 33-2-529, 33-2-531, 33-2-701, 33-2-705, 33-2-708, 33-2-803, 33-2-806, 33-2-820, 33-2-1111, 33-2-1201, 33-2-1216, 33-2-1217, 33-2-1218, 33-2-1394, 33-2-1510, 33-2-1605, 33-3-431, 33-4-202, 33-4-203, 33-5-401, 33-7-117, 33-10-201, 33-10-202, 33-11-102, 33-11-104, 33-11-108, 33-14-304, 33-15-301, 33-15-303, 33-16-202, 33-16-235, 33-17-102, 33-17-211, 33-17-405, 33-17-503, 33-17-603, ~~33-17-1001,~~ 33-18-212, 33-18-301, 33-22-131, 33-22-132, 33-22-201, 33-22-202, 33-22-301, 33-22-303, 33-22-504, 33-22-508, 33-22-1120, 33-22-1803, 33-22-1811, 33-22-1819, 33-30-102, 33-30-107, 33-30-108, 33-30-202, 33-30-204, 33-30-311, 33-30-1001, AND ~~33-31-311~~ 33-31-111, MCA; ~~AND~~ REPEALING SECTIONS 33-30-312 AND 33-30-313, MCA; AND PROVIDING EFFECTIVE DATES."

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

Section 1. Section 2-6-109, MCA, is amended to read:

"2-6-109. Prohibition on distribution or sale of mailing lists -- exceptions -- penalty. (1) Except as provided in subsections (3) through (7), in order to protect the privacy of those who deal with state and local government:

(a) ~~no~~ an agency may not distribute or sell for use as a mailing list any list of persons without first securing the permission of those on the list; and

(b) ~~no~~ a list of persons prepared by the agency may not be used as a mailing list except by the agency or another agency without first securing the permission of those on the list.

(2) As used in this section, "agency" means any board, bureau, commission, department, division, authority, or officer of the state or a local government.

(3) Except as provided in 30-9-403, this section does not prevent an individual from compiling a mailing list by examination of original documents or applications which are otherwise open to public inspection.

(4) This section does not apply to the lists of registered electors and the new voter lists provided for in 13-2-115 and 13-38-103, to lists of the names of employees governed by Title 39, chapter 31, or to lists of persons holding driver's licenses provided for under 61-5-126.

(5) This section ~~shall~~ does not prevent an agency from providing a list to persons providing prelicensing or continuing educational courses subject to Title 20, chapter 30, or specifically exempted ~~therefrom~~ as provided in 20-30-102, or subject to Title 33, chapter 17.

(6) This section does not apply to the right of access either by Montana law enforcement agencies or, by purchase or otherwise, of public records dealing with motor vehicle registration.

(7) This section does not apply to a corporate information list developed by the secretary of state containing the name, address, registered agent, officers, and directors of business, nonprofit, religious, professional, and close corporations authorized to do business in this state.

(8) A person violating the provisions of subsection (1)(b) is guilty of a misdemeanor."

Section 2. Section 33-1-207, MCA, is amended to read:

"**33-1-207. Disability insurance.** (1) Disability insurance, including credit disability insurance, is insurance of human beings: (a) against bodily injury, disablement, or death by accident or accidental means or the medical expense ~~thereof~~ or indemnity involved; or

(b) against disablement or medical expense or indemnity resulting from sickness ~~and every insurance appertaining thereto~~.

(2) Transaction of disability insurance does not include workers' compensation insurance."

Section 3. Section 33-1-208, MCA, is amended to read:

"**33-1-208. Life insurance.** Life insurance, including credit life insurance, is insurance on human lives. The transaction of life insurance includes ~~also~~ the granting of endowment benefits, additional benefits in event of death or dismemberment by accident or accidental means, additional benefits in event of the insured's disability, benefits that provide reimbursement or payment for long-term home health care or long-term care in a nursing home or other related institution, and optional modes of settlement of proceeds

of life insurance. Transaction of life insurance does not include workers' compensation insurance."

Section 4. Section 33-1-209, MCA, is amended to read:

"**33-1-209. Marine protection and indemnity and wet marine insurance.** (1) ~~Marine insurance includes marine protection and indemnity insurance, meaning insurance against, or against legal liability of the insured for, loss, damage, or expense arising out of or incident to the ownership, operation, chartering, maintenance, use, repair, or construction of any vessel, craft, or instrumentality in use in ocean or inland waterways, including liability of the insured for personal injury, illness, or death or for loss of or damage to the property of another person.~~ Marine and transportation insurance means insurance against loss of or damage to:

(a) vessels, craft, aircraft, vehicles, goods, freights, cargoes, merchandise, effects, disbursements, profits, money, securities, choses in action, evidences of debt, valuable papers, bottomry, respondentia, and any interest therein, with respect to risks and perils, including war risks, marine builder's risks, and personal property floater risks, of navigation and transportation or while being assembled, packed, crated, baled, compressed, or similarly prepared for shipment, while awaiting shipment, or during any delays, storage, transshipment, or reshipment;

(b) person or property in connection with marine, transit, or transportation insurance, including liability for loss or damage to either person or property incident to the construction, repair, operation, maintenance, or use of the subject matter of the insurance, but not including life insurance, surety bonds, or insurance against bodily injury arising out of the ownership, maintenance, or use of an automobile;

(c) jewels, jewelry, or precious metals, whether in the course of transportation or otherwise; and

(d) bridges; tunnels; and other instrumentalities of transportation and communication, excluding buildings and their furnishings, fixed contents, and supplies held in storage (unless fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot, or civil commotion are the only hazards to be covered); piers; wharves; docks; slips; and other aids to navigation and transportation, including drydocks, marina railways, and dams and appurtenant facilities for the control of waterways.

(2) Marine protection and indemnity insurance means insurance against liability of the insured for loss, damage, or expense incident to ownership, operation, charter, maintenance, use, repair, or construction of any vessel, craft, or instrumentality for use in ocean or inland waterways. The term includes insurance against the liability of the insured for personal injury, illness, death, or loss or damage

of the property of another person.

~~(2)~~(3) For the purposes of this code, wet marine and transportation insurance is that part of marine insurance ~~which~~ that includes only:

(a) insurance upon vessels, crafts, and hulls and of interests ~~therein or with relation thereto~~ in or relating to the vessels, crafts, and hulls;

(b) insurance of marine builders' risks, marine war risks, and contracts of marine protection and indemnity insurance;

(c) insurance of freights and disbursements pertaining to a subject of insurance ~~coming within~~ subject to this subsection; and

(d) insurance of personal property and interests ~~therein~~ in the personal property, in the course of exportation from or importation into any country and in the course of transportation coastwise or on inland waters, including transportation by land, water, or air from point of origin to final destination, ~~in~~ with respect to~~, appertaining to, or in connection with any and all~~ risks or perils of navigation, transit, or transportation or while being prepared for ~~and~~ or ~~while~~ awaiting shipment ~~and~~ or during any delays, storage, transshipment, or reshipment incident ~~thereto~~ to preparation or shipment."

Section 5. Section 33-1-311, MCA, is amended to read:

"**33-1-311. General powers and duties.** (1) The commissioner shall enforce the applicable provisions of ~~this code~~ the laws of this state and shall execute the duties imposed on the commissioner by ~~this code~~ the laws of this state.

(2) The commissioner ~~shall have~~ has the powers and authority expressly conferred upon the commissioner by or reasonably implied from the provisions of ~~this code~~ the laws of this state.

(3) The commissioner shall administer the department to ensure that the interests of insurance consumers are protected.

(4) The commissioner may conduct examinations and investigations of insurance matters, in addition to examinations and investigations expressly authorized, as the commissioner considers proper, to determine whether any person has violated any provision of ~~this code~~ the laws of this state or to secure information useful in the lawful administration of any provision. The cost of additional examinations and investigations must be borne by the state.

~~(5) The commissioner has additional powers and duties as provided by other laws of this state.~~

~~(6)~~(5) The department is a criminal justice agency as defined in 44-5-103."

Section 6. Section 33-1-501, MCA, is amended to read:

"**33-1-501. Filing and approval of forms.** (1) (a) An insurance policy or annuity contract form, certificate, enrollment form, application form, printed rider or endorsement form, or form of renewal certificate may not be delivered or issued for delivery in Montana unless the form has been filed with and approved by the commissioner and, if required, the regulatory official of the state of domicile of the insurer, ~~if required~~. This provision does not apply to surety bonds or policies, riders, endorsements, or forms of unique character designed for and used with relation to insurance upon a particular subject or that relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or disability insurance policies and are used at the request of the individual policyholder, contract holder, or certificate holder. Forms for use in property, marine, ~~(~~other than ocean marine and foreign trade coverages~~)~~, casualty, and surety insurance coverages may be filed by a rating organization on behalf of its members and subscribers or by a member or subscriber on its own behalf.

(b) The approval of an insurance policy or annuity contract form, certificate, enrollment form, application form, or other related insurance form by the state of domicile may be waived by the commissioner if the commissioner considers the requirements of subsection (1)(a) unnecessary for the protection of Montana insurance consumers. If the requirement is waived, an insurer shall notify the commissioner in writing within 10 days of disapproval, denial, or withdrawal of approval of a form by the state of domicile.

(2) The filing must be made not less than 60 days in advance of delivery. Approval of a form by the commissioner constitutes a waiver of any unexpired portion of the waiting period. The commissioner may extend by not more than an additional 60 days the period within which the commissioner may approve or disapprove a form by giving notice of the extension before expiration of the initial 60-day period. The commissioner may at any time, after notice and for cause shown, withdraw any approval.

(3) ~~An order of~~ Notice by the commissioner disapproving a form or withdrawing a previous approval must state the grounds for disapproval or withdrawal in sufficient detail to inform the insurer.

(4) The commissioner may exempt from the requirements of this section, for so long as the commissioner considers proper, an insurance document, form, or type of document or form ~~specified~~ to which, in the commissioner's opinion, this section may not practicably be applied or the filing and approval

of which are~~, in the commissioner's opinion,~~ not desirable or necessary for the protection of the public.

(5) This section applies to a form used by a domestic insurer for delivery in a jurisdiction outside Montana if the insurance supervisory official of the jurisdiction informs the commissioner that the form is not subject to approval or disapproval by the official and upon the commissioner's order requiring the form to be submitted to the commissioner for the purpose. The same standards apply to these forms as apply to forms for domestic use.

(6) This section and 33-1-502 do not apply to:

(a) reinsurance;

(b) policies or contracts not issued for delivery in Montana or delivered in Montana, except as provided in subsection (5);

(c) ocean marine and foreign trade insurances.

(7) Except as provided in chapter 21, group certificates that are delivered or issued for delivery in Montana for group insurance policies effectuated and delivered outside Montana but covering persons resident in Montana must be filed with the commissioner upon request. The certificates must meet the minimum provisions mandated by Montana if Montana law prevails over conflicting provisions of other state law."

Section 7. Section 33-2-117, MCA, is amended to read:

"**33-2-117. Continuance, expiration, reinstatement, and amendment of certificate of authority.** (1) Certificates of authority issued or renewed under this code ~~shall~~ must continue in force as long as the insurer is entitled thereto under this code and until suspended or revoked or otherwise terminated~~;. subject, however,~~ A certificate is subject to continuance ~~of the certificate~~ by the insurer each year by payment ON OR prior to ~~May 15~~ March 1 of the continuation fee provided in 33-2-708.

(2) If not ~~so~~ continued by the insurer, ~~its~~ the certificate of authority ~~shall expire~~ expires at midnight on May 31 ~~next~~ following ~~such~~ failure of the insurer ~~so~~ to continue it in force. The commissioner shall promptly notify the insurer of ~~the occurrence of any such failure resulting in impending~~ its failure to pay the continuation fee that can result in the expiration of its certificate of authority.

(3) The commissioner may~~, in his discretion,~~ reinstate a certificate of authority ~~which~~ that the insurer has inadvertently permitted to expire~~,~~ after the insurer ~~has fully cured all its~~ cures any failures ~~which resulted~~ resulting in ~~such~~ expiration and upon payment ~~by the insurer~~ of the fee for reinstatement in

addition to the current continuation fee, as provided in 33-2-708. Otherwise, the insurer ~~shall~~ may be granted another certificate of authority only after filing an application ~~therefor~~ and meeting all other requirements ~~as~~ for an original certificate of authority in this state.

(4) The commissioner may amend a certificate of authority at any time to accord with changes in the insurer's charter of insuring powers."

Section 8. Section 33-2-301, MCA, is amended to read:

"**33-2-301. Short title -- purpose -- definitions.** (1) This part constitutes and may be referred to as "The Surplus Lines Insurance Law".

(2) This part must be applied to:

(a) protect persons seeking insurance in this state;

(b) permit surplus lines insurance to be placed with reputable and financially sound unauthorized insurers and to be exported from this state pursuant to this part;

(c) establish a system of regulation that will permit orderly access to surplus lines insurance in this state and encourage authorized insurers to provide new and innovative types of insurance to consumers in this state; and

(d) protect revenues of this state.

(3) As used in this part, the following definitions apply:

(a) "Authorized insurer" means an insurer authorized pursuant to 33-2-101 to transact insurance in this state.

(b) "Eligible surplus lines insurer" means an unauthorized insurer with which a surplus lines insurance producer may place surplus lines insurance under 33-2-307.

(c) "Export" means to place surplus lines insurance with an unauthorized insurer.

~~(d) "Kind of insurance" means one of the types of insurance required to be reported in the annual statement filed with the commissioner by an authorized insurer.~~

~~(e)~~(d) "Producing insurance producer" means the individual insurance producer dealing directly with the person seeking insurance.

~~(f)~~(e) "Surplus lines insurance" means any insurance ~~(~~on risks resident, located, or to be performed in this state~~)~~ permitted to be placed through a surplus lines insurance producer with an unauthorized insurer eligible to accept the insurance. The term does not include the kinds of insurance exempted under

33-2-317.

~~(g)~~(f) "Surplus lines insurance producer" means an individual, partnership, or corporation licensed under 33-2-305 to place surplus lines insurance ~~(~~on risks resident, located, or to be performed in this state~~)~~ with unauthorized insurers eligible to accept ~~such~~ the insurance.

~~(h)~~(g) "Unauthorized insurer" means an insurer not authorized pursuant to 33-2-101 to transact insurance in this state. The term includes insurance exchanges authorized under the laws of other states."

Section 9. Section 33-2-302, MCA, is amended to read:

"33-2-302. Conditions precedent to sale of surplus lines insurance. ~~Insurance may be procured through a licensed surplus lines insurance producer from~~ A producing insurance producer may request a surplus lines insurance producer to place or a surplus lines insurance producer may place a contract of insurance with an unauthorized insurer if:

(1) the insurer is an eligible surplus lines insurer;

(2) the line of insurance or the full amount of the line of insurance cannot be obtained from authorized insurers OR, IN THE CASE OF A RENEWAL, THE LINE OF INSURANCE HAS NOT BECOME AVAILABLE FROM AN AUTHORIZED INSURER;

(3) the producing insurance producer makes a diligent effort to place the business with a minimum of three insurers authorized and actually transacting that line of business in this state. If fewer than three insurers are authorized and actually transacting the line of business in this state, diligent effort must be met by searching this lesser market.

(4) the insurance is not procured for the purpose of securing:

(a) a lower premium rate than would be accepted by an authorized insurer; or

(b) an advantage in terms of the insurance contract; ~~and~~ AND

~~(5) in case of renewal, the line has not become available from an authorized insurer; and~~

~~(5)(6)~~(5) all other requirements of this part are met."

Section 10. Section 33-2-305, MCA, is amended to read:

"33-2-305. Licensing of surplus lines insurance producer -- fee and bond. (1) A person may not ~~procure~~ place a contract of surplus lines insurance with an unauthorized insurer unless the person is licensed as a property and casualty insurance producer and possesses a current surplus lines insurance

license issued by the commissioner.

(2) The commissioner shall issue a surplus lines insurance license to any qualified holder of a current property and casualty insurance producer license only if the insurance producer has:

(a) remitted to the commissioner the annual fee prescribed by 33-2-708;

(b) submitted to the commissioner a completed license application on a form supplied by the commissioner;

(c) been licensed as a property and casualty insurance producer continuously for 5 years or more; and

(d) filed with the commissioner and, for as long as the license remains in effect, kept in force a bond in favor of the state of Montana in the amount of $10,000, with authorized corporate sureties approved by the commissioner. The bond must be conditioned that the insurance producer will conduct business under the license in accordance with the provisions of The Surplus Lines Insurance Law and that the insurance producer will promptly remit the taxes provided in 33-2-311. The bond may not be terminated unless the surety gives the surplus lines insurance producer, the producing insurance producer, and the commissioner at least 30 days' prior written notice of termination.

(3) The license expires on April 1 after its date of issue. A surplus lines insurance producer shall renew the license on or before March 1 of each year upon payment of the annual renewal fee prescribed in 33-2-708. A surplus lines insurance producer who fails to apply for a renewal of the license on or before March 1 shall pay a fine of $100 before the commissioner renews the license.

(4) A corporation is eligible to be licensed as a surplus lines insurance producer if:

(a) the corporate license lists the individuals within the corporation who have satisfied the requirements of this part to become surplus lines insurance producers; and

(b) only those individuals listed on the corporate license transact surplus lines insurance.

(5) This section may not be construed to require agents, producers, or brokers acting as intermediaries between a surplus lines insurance producer and an unauthorized insurer under this part to hold a valid Montana surplus lines insurance producer's license."

Section 11. Section 33-2-307, MCA, is amended to read:

"**33-2-307. Requirements for eligible surplus lines insurers.** (1) A surplus lines insurance producer may not place insurance with an unauthorized insurer unless, at the time of placement, the unauthorized

insurer:

(a) has established satisfactory evidence of good reputation and financial integrity; and

(b) is qualified under one of the following subsections:

(i) the insurer maintains capital and surplus or its equivalent under the laws of its state of domicile, which equals the greater of:

(A) the minimum capital and surplus requirements of 33-2-109 and 33-2-110; or

(B) ~~$3~~ $7 million. An insurer possessing less than ~~$4~~ $6 million capital and surplus may satisfy the requirements of this subsection upon an affirmative finding of acceptability by the commissioner. The commissioner's finding must be based upon such factors as quality of management, capital, and surplus of a parent company; company underwriting profit and investment income trends; and company record and reputation within the industry. The commissioner may not make an affirmative finding of acceptability when the surplus lines insurer's capital and surplus is less than ~~$3~~ $6 million.

(ii) in the case of Lloyd's or another similar ~~unincorporated~~ group ~~of~~ including incorporated and unincorporated alien ~~individual~~ insurers, the insurer maintains a trust fund of not less than $50 million as security to the full amount of capital and surplus for all policyholders and creditors in the United States of each member of the group. The incorporated members of the group may not engage in any business other than underwriting as a member of the group and must be subject to the same level of solvency regulation and control by the groups of domiciliary regulators as are the unincorporated members. The trust must comply with the terms and conditions established in subsection (1)(b)(iv) for alien insurers.

(iii) in the case of an insurance exchange created by the laws of individual states, the insurer maintains capital and surplus, or their substantial equivalent, of not less than $15 million in the aggregate. For an insurance exchange that maintains funds for the protection of each insurance exchange policyholder, each individual syndicate shall maintain minimum capital and surplus, or their substantial equivalent, of not less than $1.5 million. If the insurance exchange does not maintain funds for the protection of each insurance exchange policyholder, each individual syndicate shall meet the minimum capital and surplus requirements of subsection (1)(b)(i).

(iv) in the case of an alien insurer, the insurer maintains in the United States an irrevocable trust fund in either a national bank or a member of the federal reserve system, in an amount not less than $1.5 million, for the protection of all its policyholders in the United States and the trust fund consists of cash, securities, or letters of credit or of investments of substantially the same character and quality as those

which are eligible investments for the capital and statutory reserves of insurers authorized to write like kinds of insurance in this state. The trust fund, which must be included in any calculation of capital and surplus or its equivalent, must have an expiration date that may not at any time be less than 5 years. In addition, the alien insurer must appear on the national association of insurance commissioners' Non-Admitted Insurers Quarterly Listing.

(c) has provided the commissioner a copy of its current annual statement, certified by the insurer no more than 6 months after the close of the period reported upon, ~~(~~or quarterly if considered necessary by the commissioner~~)~~, and which is either:

(i) filed with and approved by the regulatory authority in the state of domicile of the unauthorized insurer; or

(ii) certified by an accounting or auditing firm licensed in the jurisdiction of the insurer's state of domicile.

(2) In the case of an insurance exchange, the statement required by subsection (1)(c) may be an aggregate combined statement of all underwriting syndicates operating during the period reported.

(3) In addition to meeting the requirements in subsection (1), an insurer is an eligible surplus lines insurer only if it appears on the most recent list of eligible surplus lines insurers published at least semiannually by the commissioner. This subsection does not require the commissioner to place or maintain the name of any unauthorized insurer on the list of eligible surplus lines insurers. An action may not lie against the commissioner or an employee of the commissioner for anything said in issuing the list of eligible surplus lines insurers referred to in this subsection.

(4) (a) The commissioner may declare an eligible surplus lines insurer ineligible if at any time the commissioner has reason to believe that it:

(i) is in unsound financial condition;

(ii) is no longer eligible under subsections (1) through (3);

(iii) has willfully violated the laws of this state; or

(iv) does not make reasonably prompt payment of just losses and claims in this state or elsewhere.

(b) The commissioner shall promptly mail notice of all declarations to each surplus lines insurance producer.

(5) As used in this section, the following definitions apply:

(a) "Capital", as used in the financial requirements of this section, means funds invested in for

stocks or other evidences of ownership.

(b) "Surplus", as used in the financial requirements of this section, means funds over and above liabilities and capital of the insurer for the protection of policyholders."

Section 12. Section 33-2-501, MCA, is amended to read:

"**33-2-501. Assets allowed.** In any determination of the financial condition of an insurer, there must be allowed as assets only assets that are owned by the insurer and that consist of:

(1) cash in the possession of the insurer or in transit under its control and including the true balance of any deposit in a solvent bank or trust company;

(2) investments, securities, properties, and loans acquired or held in accordance with this code and in connection therewith the following items:

(a) interest due or accrued on any bond or evidence of indebtedness which is not in default and which is not valued on a basis including accrued interest;

(b) declared and unpaid dividends on stock and shares unless the amount has otherwise been allowed as an asset;

(c) interest due or accrued upon a collateral loan in an amount not to exceed 1 year's interest on the loan;

(d) interest due or accrued on deposits in solvent banks and trust companies and interest due or accrued on other assets, if the interest is in the judgment of the commissioner a collectible asset;

(e) interest due or accrued on a mortgage loan in an amount not exceeding in any event the amount, if any, of the excess of the value of the property less delinquent taxes on the property over the unpaid principal. Interest accrued for a period in excess of 18 months may not be allowed as an asset.

(f) rent due or accrued on real property if the rent is not in arrears for more than 3 months and rent more than 3 months in arrears if the payment of the rent is adequately secured by property held in the name of the tenant and conveyed to the insurer as collateral;

(g) the unaccrued portion of taxes paid prior to the due date on real property;

(3) premium notes, policy loans, and other policy assets and liens on policies and certificates of life insurance and annuity contracts and accrued interest, in an amount not exceeding the legal reserve and other policy liabilities carried on each individual policy;

(4) the net amount of uncollected and deferred premiums and annuity considerations in the case

of a life insurer;

(5) premiums in the course of collection, other than for life insurance, not more than 3 months past due, less commissions payable on the premiums. The limitation in this subsection does not apply to premiums payable directly or indirectly by the United States government or by any of its instrumentalities.

(6) installment premiums other than life insurance premiums to the extent of the unearned premium reserve carried on the policy to which premiums apply;

(7) notes and like written obligations not past due, taken for premiums other than life insurance premiums, on policies permitted to be issued on that basis, to the extent of the unearned premium reserves carried on the policies;

(8) the full amount of reinsurance recoverable by a ceding insurer from a solvent reinsurer and which reinsurance is authorized under chapter 2, part 12;

(9) amounts receivable by an assuming insurer representing funds withheld by a solvent ceding insurer under a reinsurance treaty;

(10) deposits or equities recoverable from underwriting associations, syndicates, and reinsurance funds or from any suspended banking institution, to the extent considered by the commissioner available for the payment of losses and claims and at values to be determined by the commissioner;

(11) electronic data processing equipment if the cost of the equipment is ~~at least $100,000, which cost must be~~ amortized in full over a period of not to exceed ~~10~~ 8 calendar years. However, ~~with regard to life insurers, the equipment must be allowed as an asset if the cost of the equipment is at least $25,000, which cost must be amortized in full over a period of not to exceed 5 calendar years, and~~ the amount of the asset allowed may not exceed 1% of the total of the other allowable assets of the insurer.

(12) all assets, whether or not consistent with the provisions of this section, as may be allowed pursuant to the annual statement form approved by the commissioner for the kinds of insurance to be reported upon in the annual statement;

(13) other assets, not inconsistent with the provisions of this section, considered by the commissioner to be available for the payment of losses and claims, at values to be determined by the commissioner."

Section 13. Section 33-2-521, MCA, is amended to read:

"33-2-521. Standard valuation of reserve liabilities law -- life insurance. (1) The commissioner

shall annually value or cause to be valued the reserve liabilities (~~hereinafter called~~ reserves) for all outstanding life insurance policies and annuity and pure endowment contracts of every life insurer doing business in this state and may certify the amount of any ~~such~~ reserves, specifying the mortality table or tables, rate or rates of interest, and methods (net level premium method or other) used in the calculation of ~~such~~ reserves. In calculating ~~such~~ the reserves, ~~he~~ the commissioner may use group methods and approximate averages for fractions of a year or otherwise. ~~In the case of an alien insurer, such valuation shall be limited to its insurance transactions in the United States.~~

(2) ~~For the purpose of making such valuation, the commissioner may employ a competent actuary who shall be paid by the insurer for which the service is rendered; but a domestic insurer may make such valuation and it may be received by the commissioner upon satisfactory proof of its correctness.~~ In lieu of the valuation of the reserves ~~herein~~ required in this section of any foreign or alien insurer, the commissioner may accept any valuation made or caused to be made by the insurance supervisory official of any state or other jurisdiction when ~~such~~ the valuation complies with the minimum standard ~~herein~~ provided in this section and if the official of ~~such~~ the other state or jurisdiction accepts as sufficient and valid for all legal purposes the certificate of valuation of the commissioner when ~~such~~ the certificate states the valuation to have been made in a specified manner according to which the aggregate reserves would be at least as large as if they had been computed in the manner prescribed by the law of that state or jurisdiction.

(3) Any insurer ~~which at any time shall have~~ that has adopted any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard ~~herein~~ provided in this section may, with the approval of the commissioner, adopt any lower standard of valuation but not lower than the minimum ~~herein provided~~ in this section. For the purposes of this section, the holding of additional reserves previously determined by a qualified actuary to be necessary to render the opinion required in subsection (4) may not be considered to be the adoption of a higher standard of valuation.

(4) (a) Each life insurer doing business in this state shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by rule are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this state. The commissioner by rule shall define the specifics of this opinion and add any other items considered necessary to its scope.

(b) Each life insurer, except as exempted by or pursuant to regulation, shall also annually include

in the opinion required by subsection (4)(a) an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by rule, when considered in light of the assets held by the insurer with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the insurer's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts.

(c) The commissioner may provide by rule for a transition period for establishing any higher reserves that the qualified actuary may consider necessary in order to render the opinion required by this subsection (4).

(d) Each opinion required by this subsection (4) must be governed by the following provisions:

(i) A memorandum, in form and substance acceptable to the commissioner as specified by rule, must be prepared to support each actuarial opinion.

(ii) If the insurer fails to provide a supporting memorandum at the request of the commissioner within a period specified by rule or if the commissioner determines that the supporting memorandum provided by the insurer fails to meet the standards prescribed by the rules or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the insurer to review the opinion and the basis for the opinion and to prepare any supporting memorandum as is required by the commissioner.

(iii) The opinion must be submitted with the annual statement reflecting the valuation of the reserve liabilities for each year ending on or after December 31, ~~1995~~ 1996.

(iv) The opinion must apply to all business in force, including individual and group health insurance plans, in form and substance acceptable to the commissioner as specified by rule.

(v) The opinion must be based on standards adopted from time to time by the actuarial standards board and on additional standards as the commissioner may prescribe by rule.

(vi) In the case of an opinion required to be submitted by a foreign or alien insurer, the commissioner may accept the opinion filed by that insurer with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.

(vii) Except in cases of fraud or willful misconduct, the qualified actuary is not liable for damages

to any person, other than the insurer and the commissioner, for any act, error, omission, decision, or conduct with respect to the actuary's opinion.

(viii) Disciplinary action by the commissioner against the insurer or the qualified actuary must be defined in rules by the commissioner.

(ix) Any memorandum in support of the opinion and any other material provided by the insurer to the commissioner in connection with those items must be kept confidential by the commissioner, may not be made public, and is subject to subpoena, other than for the purpose of defending an action seeking damages from any person by reason of any action required by this subsection (4) or by rules promulgated under this subsection (4). However, the memorandum or other material may otherwise be released by the commissioner:

(A) with the written consent of the insurer; or

(B) to the American academy of actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the commissioner for preserving the confidentiality of the memorandum or other material. Once any portion of the confidential memorandum is cited by the insurer in its marketing, is cited before any governmental agency other than a state insurance department, or is released by the insurer to the news media, all portions of the confidential memorandum are no longer confidential.

(5) For purposes of this section, "qualified actuary" means a member in good standing of the American academy of actuaries who meets the requirements set forth in the academy's rules."

Section 14. Section 33-2-523, MCA, is amended to read:

"**33-2-523. Contracts on or after the operative date of 33-20-213 -- valuation.** (1) This section ~~shall apply~~ applies to only those policies and contracts issued on or after the operative date of 33-20-213, except as otherwise provided in 33-2-524 for group annuity and pure endowment contracts issued prior to that date.

(2) Except as otherwise provided in 33-2-524, ~~and~~ 33-2-525, and [section 76(2)], the minimum standard for the valuation of all ~~such~~ the policies and contracts issued prior to October 1, 1995, ~~shall~~ must be the standard provided by the laws in effect prior to October 1, 1995. Except as otherwise provided in 33-2-524, 33-2-525, and [section 76(2)], the minimum standard for the valuation of all policies and contracts must be the commissioner's reserve valuation methods defined in 33-2-525, ~~and~~ 32-2-526(3), ~~and~~

and (4), and [section 76], 5% interest for group annuity and pure endowment contracts, and 3 1/2% interest for all other ~~such~~ policies and contracts or, in the case of life insurance policies and contracts other than annuity and pure endowment contracts issued on or after March 17, 1973, 4% interest for ~~such~~ all other policies issued prior to July 1, 1979, 5 1/2% interest for single-premium life insurance policies, and 4 1/2% interest for ~~such~~ ALL OTHER policies issued on or after July 1, 1979, and the following tables:

(a) for all ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in ~~such~~ the policies~~,~~:

(i) the commissioner's 1941 standard ordinary mortality table~~:~~

~~(i)~~ for ~~such~~ policies issued prior to the operative date of 33-20-206, as amended, and the commissioner's 1958 standard ordinary mortality table for ~~such~~ policies issued on or after that operative date but prior to January 1, 1989, except that for any category of ~~such~~ the policies issued on female risks, modified net premiums and present values, referred to in 33-2-525 and 33-2-526, may be calculated, at the option of the insurer, with the approval of the commissioner, according to an age younger than the actual age of the insured; or

(ii) for ~~such~~ policies issued on or after January 1, 1989:

(A) the commissioner's 1980 standard ordinary mortality table;

(B) at the election of the company for any one or more specified plans of life insurance, the commissioner's 1980 standard ordinary mortality table with 10-year select mortality factors; or

(C) any ordinary mortality table adopted after 1980 by the national association of insurance commissioners that is approved by the commissioner by rule for use in determining the minimum standard of valuation for ~~such~~ policies;

(b) for all industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in ~~such~~ the policies, the 1941 standard industrial mortality table for ~~such~~ policies issued prior to the operative date of 33-20-207~~, as amended,~~ and~~,~~ for ~~such~~ policies issued on or after that operative date, the commissioner's 1961 standard industrial mortality table or any industrial mortality table adopted after 1980 by the national association of insurance commissioners that is approved by the commissioner by rule for use in determining the minimum standard of valuation for ~~such~~ the policies;

(c) for individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in ~~such~~ the policies, the 1937 standard annuity mortality table or, at the option of the insurer, the annuity mortality table for 1949, ultimate, or any modification of either of these tables approved

by the commissioner;

(d) for group annuity and pure endowment contracts, excluding any disability and accidental death benefits in ~~such~~ the policies, the group annuity mortality table for 1951, any modification of ~~such~~ the table approved by the commissioner, or, at the option of the insurer, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts;

(e) (i) for total and permanent disability benefits in or supplementary to ordinary policies or contracts:

(A) for policies or contracts issued on or after January 1, 1966, the tables of period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 disability study of the society of actuaries, with due regard to the type of benefit, or any tables of disablement rates and termination rates adopted after 1980 by the national association of insurance commissioners that are approved by the commissioner by rule for use in determining the minimum standard of valuation for ~~such~~ the policies;

(B) for policies or contracts issued on or after January 1, 1961, and prior to January 1, 1966, either ~~such~~ the tables or, at the option of the insurer, the class 3 disability table (1926); and

(C) for policies issued prior to January 1, 1961, the class 3 disability table (1926);

(ii) any ~~such~~ table ~~shall~~ must, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies;

(f) (i) for accidental death benefits in or supplementary to policies:

(A) for policies issued on or after January 1, 1966, the 1959 accidental death benefits table or any accidental death benefits table adopted after 1980 by the national association of insurance commissioners that is approved by the commissioner by rule for use in determining the minimum standard of valuation for ~~such~~ the policies;

(B) for policies issued on or after January 1, 1961, and prior to January 1, 1966, either such table or, at the option of the insurer, the intercompany double indemnity mortality table; and

(C) for policies issued prior to January 1, 1961, the intercompany double indemnity mortality table;

(ii) either table ~~shall~~ must be combined with a mortality table permitted for calculating the reserves for life insurance policies;

(g) for group life insurance, life insurance issued on the substandard basis, and other special benefits, ~~such~~ the tables as may be approved by the commissioner."

Section 15. Section 33-2-525, MCA, is amended to read:

"**33-2-525. Commissioner's reserve valuation method.** (1) Except as otherwise provided in subsection (4) of this section, ~~and~~ 33-2-526(3) and (4), and [section 76(2)], reserves according to the commissioner's reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums, ~~shall~~ must be the excess, if any, of the present value, at the date of valuation, of ~~such~~ future guaranteed benefits provided for by ~~such~~ the policies, over the then present value of any future modified net premiums ~~therefor~~. The modified net premiums for any ~~such~~ policy ~~shall~~ must be ~~such~~ the uniform percentage of the respective contract premiums for ~~such~~ the benefits that the present value, at the date of issue of the policy, of all ~~such~~ modified net premiums ~~shall~~ must be equal to the sum of the then present value of ~~such~~ the benefits provided for by the policy and the excess of (a) over (b), as follows:

(a) a net level annual premium equal to the present value, at the date of issue, of ~~such~~ benefits provided for after the first policy year, divided by the present value, at the date of issue of an annuity of one per annum payable on the first and each subsequent anniversary of ~~such~~ the policy on which a premium falls due~~;~~. ~~provided, however~~ However, ~~that such~~ the net level annual premium ~~shall~~ may not exceed the net level annual premium on the 19-year premium whole life plan for insurance of the same amount at an age 1 year higher than the age at issue of ~~such~~ the policy;

(b) a net 1-year term premium for ~~such~~ benefits provided for in the first policy year.

(2) (a) For ~~every~~ each life insurance policy issued on or after January 1, 1987, for which the contract premium in the first policy year exceeds that of the second year, for which ~~no~~ a comparable additional benefit is not provided in the first year for ~~such~~ the excess, and that provides an endowment benefit, a cash surrender value, or a combination of both in an amount greater than ~~such~~ the excess premium, the reserve according to the commissioner's reserve valuation method, as of any policy anniversary occurring on or before the assumed ending date as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than ~~such~~ the excess premium, is, except as otherwise provided in 33-2-526, the greater of the reserve as of ~~such~~ the policy anniversary calculated as described in subsection (1) or the reserve as of ~~such~~ the policy anniversary calculated as described in subsection (1) with the following exceptions:

(i) the value defined in subsection (1)(a) is reduced by 15% of the amount of ~~such~~ the excess first-year premium;

(ii) all present values of benefits and premiums are determined without reference to premiums or benefits provided for in the policy after the assumed ending date;

(iii) the policy is assumed to mature on ~~such~~ the assumed ending date as an endowment; and

(iv) the cash surrender value provided on ~~such~~ the assumed ending date is considered an endowment benefit.

(b) In making the comparisons in subsection (2)(a), the mortality and interest bases stated in 33-2-523 and 33-2-527 must be used.

(3) Reserves according to the commissioner's reserve valuation method for the following ~~shall~~ must be calculated by a method consistent with the principles of this section, except that any extra premiums charged because of impairments or special hazards ~~shall~~ must be disregarded in the determination of modified net premiums:

(a) life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums;

(b) group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, ~~(~~including a partnership or sole proprietorship~~)~~, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the Internal Revenue Code, as ~~now or hereafter~~ amended;

(c) disability and accidental death benefits in all policies and contracts; and

(d) all other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts.

(4) (a) Subsection (4)(b) applies to any annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation established or maintained by an employer, ~~(~~including a partnership or sole proprietorship~~)~~, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the Internal Revenue Code, as ~~now or hereafter~~ amended.

(b) Reserves according to the commissioner's annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in ~~such~~ the contracts, ~~shall~~ must be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by ~~such~~ the contracts

at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations required by the terms of ~~such~~ the contract that become payable prior to the end of ~~such~~ the respective contract year. The future guaranteed benefits ~~shall~~ must be determined by using the mortality table, if any, and the interest rate or rates specified in ~~such~~ the contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of ~~such~~ the contracts to determine nonforfeiture values."

Section 16. Section 33-2-526, MCA, is amended to read:

"**33-2-526. Limits -- options -- minimum reserves.** (1) ~~In no event shall an~~ An insurer's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits issued on or after October 1, 1995, may not be less than the aggregate reserves calculated in accordance with the methods set forth in 33-2-525, ~~and~~ subsection (3) of this section, [section 76(2)] and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for ~~such~~ the policies.

(2) Reserves for all policies and contracts issued prior to October 1, 1995, may be calculated, at the option of the insurer, according to standards that produce greater aggregate reserves for those policies and contracts than the minimum reserves required by the laws in effect immediately prior to October 1, 1995. Reserves for any category of policies, contracts, or benefits as established by the commissioner, issued on or after October 1, 1995, may be calculated at the option of the insurer according to any standards which produce greater aggregate reserves for ~~such~~ a category than those calculated according to the minimum standard ~~herein~~ provided in this section, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, ~~shall~~ may not be higher than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided for ~~therein~~ a category.

(3) If in any contract year the gross premium charged by any life insurer on any policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve ~~thereon~~ on the policy or contract but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for ~~such~~ the policy or contract ~~shall~~ must be the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for ~~such~~ the policy or contract or the reserve calculated by the method actually used for ~~such~~

the policy or contract but using the minimum standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this section are those standards stated in 33-2-524 and 33-2-527.

(4) For every life insurance policy issued after December 30, 1986, for which the gross premium in the first policy year exceeds that of the second year, for which ~~no~~ a comparable additional benefit is not provided in the first year for ~~such~~ an excess, and that provides an endowment benefit, a cash surrender value, or a combination of both in an amount greater than ~~such~~ the excess premium, subsections (1) through (3) of this section must be applied as if the method actually used in calculating the reserve for ~~such~~ the policy were the method described in 33-2-525(1). The minimum reserve at each policy anniversary of ~~such a~~ the policy must be the greater of the minimum reserve calculated in accordance with 33-2-525 and the minimum reserve calculated in accordance with this section."

Section 17. Section 33-2-528, MCA, is amended to read:

"**33-2-528. Interest rate weighting factor.** (1) The weighting factors referred to in the formulas stated in 33-2-527 are as follows:

(a) (i) for life insurance:

Guarantee Duration in Years	Weighting Factors
10 or less	.50
More than 10 but not more than 20	.45
More than 20	.35

(ii) for life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values, or both, that are guaranteed in the original policy;

(b) .80 for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options;

(c) for other annuities and for guaranteed interest contracts, except as stated in subsection (1)(b), according to the guarantee duration established in ~~subsection (2)~~ subsections (1)(c)(i) through (1)(c)(iii) and

the ~~type of plan~~ rules and definitions established in established in ~~subsection~~ subsections (2), (3), and (4):

(i) for annuities and guaranteed interest contracts valued on an issue year basis:

Guarantee Duration in Years	Weighting Factor for Plan Type		
	A	B	C
5 or less	.80	.60	.50
More than 5 but not more than 10	.75	.60	.50
More than 10 but not more than 20	.65	.50	.45
More than 20	.45	.35	.35

(ii) for annuities and guaranteed interest contracts valued on a change-in-fund basis, the factors shown in subsection (1)(c)(i) increased by:

	Plan Type		
	A	B	C
	.15	.25	.05

(iii) for annuities and guaranteed interest contracts valued on an issue year basis, ~~(~~other than those ~~with no~~ without cash settlement options~~)~~, that do not guarantee interest on considerations received more than 1 year after issue or purchase and for annuities and guaranteed interest contracts valued on a change-in-fund basis that do not guarantee interest rates on considerations received more than 12 months beyond the valuation date, the factors set forth in subsection (1)(c)(i) or derived in subsection (1)(c)(ii) increased by:

	Plan Type		
	A	B	C
	.05	.05	.05

(2) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of 20 years. For other annuities ~~with no~~ without cash settlement options and for guaranteed interest contracts ~~with no~~ without cash settlement options, the guarantee duration is the

number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.

(3) Plan types used in subsection (1)(c) are:

(a) Plan Type A--No withdrawal is permitted or at any time policyholder may withdraw funds only:

(i) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company;

(ii) without ~~such~~ an adjustment but in installments over 5 years or more; or

(iii) as an immediate life annuity.

(b) Plan Type B--(i) Before expiration of the interest rate guarantee, no withdrawal is permitted or a policyholder may withdraw funds only:

(A) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company;

(B) without ~~such~~ an adjustment but in installments over 5 years or more.

(ii) At the end of the interest rate guarantee, funds may be withdrawn without ~~such~~ an adjustment in a single sum or installments over less than 5 years.

(c) Plan Type C--A policyholder may withdraw funds before expiration of the interest rate guarantee in a single sum or installments over less than 5 years either:

(i) without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company; or

(ii) subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

(4) (a) An insurer may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue year basis or on a change-in-fund basis. Guaranteed interest contracts ~~with no~~ without cash settlement options and other annuities ~~with no~~ without cash settlement options must be valued on an issue year basis.

(b) As used in subsection (4):

(i) issue year basis of valuation is a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract; and

(ii) change-in-fund basis of valuation is a valuation basis under which the interest rate used to

determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund."

Section 18. Section 33-2-529, MCA, is amended to read:

"**33-2-529. Reference interest rate.** (1) The reference interest rate referred to in the formulas in 33-2-527 is:

(a) for all life insurance, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year next preceding the year of issue, of Moody's ~~corporate bond yield average~~ monthly average ~~corporates~~ composite yield on seasoned corporate bonds;

(b) for single-premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of Moody's ~~corporate bond yield average~~ monthly average ~~corporates~~ composite yield on seasoned corporate bonds;

(c) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options valued on a year-of-issue basis, except as stated in subsection (1)(b), with guarantee duration in excess of 10 years, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of Moody's ~~corporate bond yield average~~ monthly average ~~corporates~~ composite yield on seasoned corporate bonds;

(d) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options valued on a year-of-issue basis, except as stated in subsection (1)(b), with guarantee duration of 10 years or less, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of Moody's ~~corporate bond yield average~~ monthly average ~~corporates~~ composite yield on seasoned corporate bonds;

(e) for other annuities ~~with no~~ without cash settlement options and for guaranteed interest contracts ~~with no~~ without cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of Moody's ~~corporate bond yield average~~ monthly average ~~corporates~~ composite yield on seasoned corporate bonds; or

(f) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options valued on a change-in-fund basis, except as stated in subsection (1)(b), the average over a period of 12 months, ending on June 30 of the calendar year of the change in the fund, of Moody's ~~corporate bond yield average~~ monthly average ~~corporates~~ composite yield on seasoned corporate bonds.

(2) If Moody's ~~corporate bond yield average~~ monthly average ~~corporates~~ composite yield on seasoned corporate bonds is no longer published by Moody's investors service, inc., or if the national association of insurance commissioners determines that Moody's ~~corporate bond yield average~~ monthly average ~~corporates~~ composite yield on seasoned corporate bonds, as published by Moody's investors service, inc., is no longer appropriate for the determination of the reference interest rate, then an alternative method for determination of the reference interest rate adopted by the national association of insurance commissioners and approved by rule promulgated by the commissioner may be substituted."

Section 19. Section 33-2-531, MCA, is amended to read:

"**33-2-531. Deposit of reserves -- domestic life insurers.** (1) Domestic life insurers shall deposit and maintain on deposit, in securities and assets, with depositaries and subject to conditions as provided for in part 6 of this chapter, an amount not less than the reserves on its outstanding life insurance policies and annuity contracts, as valued under 33-2-521 through 33-2-526, minus policy loans.

(2) Annually on or before April 1, the insurer shall ~~so~~ deposit any additional ~~such~~ securities or assets required under subsection (1) and related to the increase of ~~such~~ the reserves, minus policy loans, during the calendar year next preceding, as determined from the insurer's annual statement as at December 31 of ~~such~~ the preceding year.

(3) A domestic stock life insurer may credit toward ~~such~~ the deposit the amount of any other deposit of the insurer held under part 6 of this chapter for the protection of its policyholders or of its policyholders and creditors.

(4) Deposits of the reserves of a domestic life insurer under this section ~~shall~~ must consist of securities and assets acquired and valued in accordance with parts 5 and 8 of this chapter.

(5) Real estate mortgage loans~~,~~ and chattel mortgage loans~~, and policy loans~~ may be made a part of the deposit by filing a verified statement of the loans with the commissioner~~, which statement shall be~~. The statement is subject to audit at all times by the commissioner. Nonnegotiable securities ~~where~~ deposited with the commissioner ~~shall~~ must be accompanied by transfer powers in due form. If the insurer

uses real estate acquired under 33-2-832 as a deposit, then a deed of trust, mortgage, or other instrument sufficient to convey a security interest in ~~such~~ the real estate, in a form acceptable to the commissioner, ~~shall~~ must be completed in due form and recorded prior to being deposited with the commissioner.

(6) If default occurs in the payment of interest or principal of any deposited security and ~~such~~ the default continues for a period of 120 days, the commissioner may declare ~~such~~ the security no longer eligible for deposit under this section."

Section 20. Section 33-2-701, MCA, is amended to read:

"**33-2-701. Annual statement -- revocation or fine for failure to file -- penalty for perjury.** (1) Each authorized insurer shall annually on or before March 1 file with the commissioner a full and true statement of its financial condition, transactions, and affairs as of the preceding December 31 ~~preceding~~. The statement must be in the general form and context as is required or not disapproved by the commissioner, as is in current use for similar reports to states in general with respect to the type of insurer and kinds of insurance to be reported upon, and as supplemented for additional information required by the commissioner. The statement must be completed in accordance with the annual statement instructions and the accounting practices and procedures manual of the national association of insurance commissioners. The statement must be accompanied by an actuarial opinion attesting to the adequacy of the insurer's reserves. The statement must be verified by the oath of the insurer's president or vice-president and secretary or, if a reciprocal insurer, by the oath of the attorney-in-fact or its like officers if a corporation. The commissioner may waive the verification under oath.

(2) (a) Each domestic insurer shall file electronic diskette versions of its annual and quarterly financial statements with the national association of insurance commissioners. The filing date for submission of the annual statement diskette is March 1. The filing dates for the quarterly statement diskettes are as follows:

(i) the first calendar quarter filing is due May 15;

(ii) the second calendar quarter filing is due August 15; and

(iii) the third calendar quarter filing is due November 15.

(b) The commissioner may exempt insurers that operate only in Montana from these filing requirements.

~~(2)~~(3) The statement of an alien insurer must relate only to its transactions and affairs in the United

States unless the commissioner requires otherwise. If the commissioner requires a statement as to an alien insurer's affairs throughout the world, the insurer shall file the statement with the commissioner as soon as reasonably possible. The statement must be verified by the insurer's United States manager or other authorized officer.

~~(3)~~(4) The commissioner may refuse to accept the fee for continuance of the insurer's certificate of authority, as provided in 33-2-117, or may suspend or revoke the certificate of authority of any insurer failing to file its annual statement when due or within an extension of time that the commissioner may grant.

~~(4)~~(5) Any director, officer or insurance producer, or employee of any company who subscribes to, makes, or concurs in making or publishing any annual statement or any other statement required by law knowing that the ~~same to contain~~ statement contains any material statement which is false shall be punished by a fine of not more than $1,000.

~~(5)~~(6) At time of filing, the insurer shall pay to the commissioner the fee for filing its statement as prescribed in 33-2-708.

~~(6)~~(7) The commissioner may impose a fine not to exceed $100 a day for each day after March 1 that an insurer fails to file the annual statement referred to in subsection (1). The fine may not exceed a maximum of $1,000."

Section 21. 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 received while an authorized insurer in this state shall file with the commissioner, on or before March 1 each year, a report in a form 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 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 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 the 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 the policies. As to title insurance, "premium" includes the total charge for the insurance. A deduction may not be made of the cash surrender values of policies. Considerations received on annuity contracts may not be included in total direct premium income and are not subject to tax.

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

(3) That portion of the tax paid under this section by an insurer on account of premiums received for fire insurance must be separately specified in the report as required by the commissioner, for apportionment as provided by law. When insurance against fire is included with insurance of property against other perils at an undivided premium, the insurer shall make a reasonable allocation from the entire premium to the fire portion of the coverage as must be stated in the report and as may be approved or accepted by the commissioner.

(4) With respect to authorized insurers, the premium tax provided by this section must 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~~ that 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 plus interest on the delinquent amount at the annual interest rate ~~established in 31-1-107~~ of 12%.

(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 tax liability is accrued."

Section 22. 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 when 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, electronically filed 10.00

(iii) appointment of insurance producer, each insurer, nonelectronically filed 15.00

(iv) temporary license 15.00

(v) amendment of license, ~~(~~excluding additions to license~~)~~, or reissuance of master license 15.00

(vi) termination of insurance producer, each insurer, electronically filed 10.00

(vii) termination of insurance producer, each insurer, nonelectronically filed 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, electronically filed 10.00

(iii) appointment of insurance producer, each insurer, nonelectronically filed 15.00

(iv) annual renewal of license 10.00

(v) amendment of license, ~~(~~excluding additions to license~~)~~, or reissuance of master license 15.00

(vi) termination of insurance producer, each insurer, electronically filed 10.00

(vii) termination of insurance producer, each insurer, nonelectronically filed 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) motor club representative's license:

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

(ii) annual renewal of license 15.00

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

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

~~(m)~~(n) policy forms:

(i) filing each policy form 25.00

(ii) filing each application, certificate, enrollment form, 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, provided that all additional forms relate to the same policy 100.00

~~(n)~~(o) applications for approval of prelicensing education courses:

(i) reviewing initial application 150.00

(ii) periodic review 50.00

(2) The commissioner shall establish by rule fees commensurate with costs for filing documents and conducting the course reviews required by 33-17-1204 and 33-17-1205.

(3) The commissioner shall establish by rule an annual accreditation fee to be paid by each domestic and foreign insurer when it submits a fee for annual continuation of its certificate of authority.

(4)(a) Except as provided in subsection (4)(b), 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 the commissioner pursuant to Title 33 and the rules adopted under Title 33, except that all fees for filing documents and conducting the course reviews required by 33-17-1204 and 33-17-1205 must be deposited in the state special revenue fund pursuant to 33-17-1207.

(b) The accreditation fee required by subsection (3) must be turned over promptly to the state treasurer who shall deposit the money in the state special revenue fund to the credit of the commissioner's office. The accreditation fee funds must be used only to pay the expenses of the commissioner's office in discharging the administrative and regulatory duties that are required to meet the minimum financial regulatory standards established by the national association of insurance commissioners, subject to the applicable laws relating to the appropriation of state funds and to the deposit and expenditure of money. The commissioner is responsible for the proper expenditure of the accreditation money.

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

Section 23. Section 33-2-803, MCA, is amended to read:

"33-2-803. General qualifications of investments. (1) ~~No~~ A security or investment, other than real and personal property acquired under 33-2-832, ~~shall be~~ is not eligible for acquisition unless it is interest bearing or interest accruing or dividend or income paying, if not then in default in any respect, and the insurer is entitled to receive for its exclusive account and benefit the interest or income accruing ~~thereon~~ on the security or investment. However, up to 3% of a company's total assets may be invested in nondividend-paying common stock as described in 33-2-820.

(2) ~~No~~ A security or investment ~~shall be~~ is not eligible for purchase at a price above its market value.

(3) ~~No~~ A provision of this part ~~shall~~ may not prohibit the acquisition by an insurer of other or

additional securities or property if received as a dividend or as a lawful distribution of assets or under a lawful and bona fide agreement of bulk reinsurance, merger, or consolidation. Any investment ~~so~~ acquired ~~which~~ that is not otherwise eligible under this part ~~shall~~ must be disposed of pursuant to 33-2-842 if personal property or securities or pursuant to 33-2-841 if real property."

Section 24. Section 33-2-806, MCA, is amended to read:

"**33-2-806. Diversification of investments.** An insurer shall invest in or hold as admitted assets categories of investments only within applicable limits as follows:

(1) An insurer ~~shall~~ may not, except with the consent of the commissioner, have at any one time any combination of investments in or loans upon the security of the obligations, property, or securities of any one person or insurer aggregating an amount exceeding 5% of the insurer's assets. This restriction ~~shall~~ does not apply as to general obligations of the United States of America or of any state or include policy loans made under 33-2-825.

(2) An insurer ~~shall~~ may not invest in or hold at any one time more than 10% of the outstanding voting stock of any corporation, except with the consent of the commissioner given with respect to voting rights of preference stock during default of dividends. This provision does not apply as to stock of a wholly-owned subsidiary of the insurer or to controlling stock of an insurer acquired under 33-2-821.

(3) An insurer, other than title insurer, shall invest and maintain invested funds not less in amount than the minimum paid-in capital stock required under this code of a domestic stock insurer transacting like kinds of insurance, only in cash and the securities provided for under the following sections: 33-2-811(1), 33-2-812, and 33-2-830.

(4) A life insurer shall also invest and keep invested its funds in an amount not less than the reserves under its life insurance policies and annuity contracts, other than variable annuities, in force in cash, ~~and/or the~~ in securities, in both cash and securities, or in investments provided for under 33-2-531.

(5) Except with the commissioner's consent, an insurer ~~shall~~ may not have invested at any one time more than 20% of its assets in the class of securities described in 33-2-818, exclusive of obligations of public utilities.

(6) An insurer may not invest and have invested at any one time in aggregate amount ~~not~~ more than ~~10%~~ 15% of its assets in all stocks under 33-2-820 and 33-2-821. Determination of the amount ~~which~~ that an insurer has invested in common stocks for the purposes of this provision ~~shall~~ must be based

on the cost of ~~such~~ the stocks to the insurer. This provision ~~shall~~ does not apply as to stock of a controlled or subsidiary insurance corporation or other corporations under 33-2-821 and 33-2-822.

(7) Except with the commissioner's consent, an insurer may not have invested at any one time more than 5% of its assets in securities allowed under 33-2-824.

(8) Except with the commissioner's consent, an insurer ~~shall~~ may not have invested at any one time more than 10% of its assets in the class of securities described in any one of the following sections: 33-2-814, 33-2-819, and 33-2-823.

(9) Limits as to investments in the category of real estate shall be as provided in 33-2-832. Other specific limits ~~shall~~ apply as stated in the sections dealing with other respective kinds of investments."

Section 25. Section 33-2-820, MCA, is amended to read:

"**33-2-820. Common stocks.** An insurer may invest in nonassessable common stocks, other than insurance stocks, of any solvent corporation existing under the laws of the United States of America or of Canada or any state or province ~~thereof if cash or stock dividends have been earned and paid on its common stock in each of the 5 fiscal years preceding such acquisition and if, further, all prior obligations or preference stock of such corporation, if any, are eligible for investment under this part. If the issuing corporation has not been in legal existence for the whole of the 5 preceding fiscal years but was formed as a consolidation or merger of two or more businesses, the test of eligibility for investment of its common stock under this section shall be based upon consolidation pro forma statements of the predecessor or constituent institutions~~."

Section 26. Section 33-2-1111, MCA, is amended to read:

"**33-2-1111. Registration of insurers -- requisites -- termination.** (1) ~~Every~~ An insurer ~~which is~~ authorized to do business in this state ~~and which~~ that is a member of an insurance holding company system shall register with the commissioner, except that a foreign insurer subject to disclosure requirements and standards adopted by statute or regulation in the jurisdiction of its domicile ~~which~~ that are substantially similar to those contained in this section is not required to register. Any insurer ~~which is~~ subject to registration under this section shall register within 15 days after ~~it becomes~~ becoming subject to registration, unless the commissioner for good cause ~~shown~~ extends the time for registration~~, and then within the extended time~~. The commissioner may require any authorized insurer ~~which~~ that is a member

of a holding company system ~~which~~ that is not subject to registration under this section to furnish a copy of the registration statement or other information filed by the insurance company with the insurance regulatory authority ~~of domiciliary~~ in the jurisdiction where the company is domiciled.

(2) ~~Every~~ An insurer subject to registration shall file with the commissioner, on or before April 30 each year, a registration statement on a form provided by the commissioner~~, which~~ that must contain current information about:

(a) the capital structure, general financial condition, ownership, and management of the insurer and any person controlling the insurer;

(b) the identity of every member of the insurance holding company system;

(c) ~~the following agreements in force,~~ existing relationships ~~subsisting~~, ~~and~~ transactions currently outstanding between the insurer and its affiliates, and the following agreements that are in force:

(i) loans, other investments, or purchases, sales, or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates;

(ii) purchases, sales, or exchanges of assets;

(iii) transactions not in the ordinary course of business;

(iv) guaranties or undertakings for the benefit of an affiliate ~~which~~ that result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business;

(v) ~~all~~ management and service contracts and ~~all~~ cost-sharing arrangements~~, other than cost allocation arrangements based upon generally accepted accounting principles~~;

(vi) reinsurance agreements covering all or substantially all of one or more lines of insurance of the ceding company;

(vii) dividends and other distributions to shareholders; and

(viii) consolidated tax allocation agreements;

(d) ~~any~~ a pledge of the insurer's stock, including stock of a subsidiary or controlling affiliate for a loan made to a member of the insurance holding company system;

(e) all matters concerning transactions between registered insurers and any affiliates as may be included from time to time in ~~any~~ registration forms adopted or approved by the commissioner.

(3) A registration statement must contain a summary outlining each item in the current registration statement that represents a change from the prior registration statement.

(4) Information need not be disclosed on the registration statement filed pursuant to subsection (2) if the information is not material for the purposes of this section. Unless the commissioner by rule or order provides otherwise, sales, purchases, exchanges, loans or extensions of credit, or investments involving 1/2 of 1% or less of an insurer's admitted assets as of the prior December 31 ~~next preceding~~ are not material for purposes of this section.

(5) A person within an insurance holding company system subject to registration shall provide complete and accurate information to an insurer if the information is reasonably necessary to enable the insurer to comply with Title 33, chapter 2, part 11.

(6) Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions on amendment forms provided by the commissioner within 15 days after the end of the month in which it learns of each change or addition.

(7) The commissioner shall terminate the registration of any insurer ~~which~~ that demonstrates that it no longer is a member of an insurance holding company system.

(8) The commissioner may require or allow two or more affiliated insurers subject to registration under this section to file a consolidated registration statement or consolidated reports amending their consolidated registration statement or their individual registration statements.

(9) The commissioner may allow an insurer ~~which~~ that is authorized to do business in this state and ~~which~~ that is part of an insurance holding company system to register on behalf of any affiliated insurer which is required to register under subsection (1) and to file all information and material required to be filed under this section."

Section 27. Section 33-2-1201, MCA, is amended to read:

"**33-2-1201. Limit of risk.** (1) An insurer may not retain any risk on any one subject of insurance, whether located or to be performed in this state or elsewhere, in an amount exceeding 10% of its surplus to policyholders.

(2) A "subject of insurance" for the purposes of this section, as to insurance against fire and hazards other than windstorm, earthquake, or other catastrophe hazards, includes all properties insured by the same insurer which are customarily considered by underwriters to be subject to loss or damage from the same fire or the same occurrence of the other hazard insured against.

(3) Reinsurance ceded as authorized by this part must be deducted in determining risk retained.

As to surety risks, deduction must also be made of the amount assumed by any established incorporated cosurety and the value of any security deposited, pledged, or held subject to the surety's consent and for the surety's protection.

(4) As to alien insurers, this section only relates to risks and surplus to policyholders of the insurer's United States branch.

(5) "Surplus to policyholders" for the purposes of this section, in addition to the insurer's capital and surplus, is considered to include any voluntary reserves which are not required pursuant to law and are determined from the last sworn statement of the insurer on file with the commissioner or by the last report of examination of the insurer, whichever is the more recent at time of assumption of risk.

(6) This section does not apply to life or disability insurance, title insurance, insurance of wet marine and transportation risks, workers' compensation insurance, employer's liability coverages, ~~sprinklered risks,~~ or any policy or type of coverage as to which the maximum possible loss to the insurer is not readily ascertainable on issuance of the policy."

Section 28. Section 33-2-1216, MCA, is amended to read:

"**33-2-1216. Credit allowed domestic ceding insurer.** (1) Credit for reinsurance is allowed to a domestic ceding insurer as either an asset or a deduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of subsection (2), (3), (4), (5), or (6). If the requirements of subsection (4) or (5) are met, the requirements of subsection (7) must also be met.

(2) Credit must be allowed when the reinsurance is ceded to an assuming insurer that is licensed to transact insurance or reinsurance in this state.

(3) Credit must be allowed when the reinsurance is ceded to an assuming insurer that is accredited as a reinsurer in this state. Credit may not be allowed a domestic ceding insurer if the assuming insurer's accreditation has been revoked by the commissioner after notice and hearing. An accredited reinsurer is one that:

(a) files with the commissioner evidence of its submission to this state's jurisdiction;

(b) submits to this state's authority to examine its books and records;

(c) is licensed to transact insurance or reinsurance in at least one state or, in the case of a United States branch of an alien assuming insurer, is entered through and licensed to transact insurance or reinsurance in at least one state;

(d) files annually with the commissioner a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement and either:

(i) maintains a surplus with regard to policyholders in an amount that is not less than $20 million and whose accreditation has not been denied by the commissioner within 90 days of its submission; or

(ii) maintains a surplus with regard to policyholders in an amount less than $20 million and whose accreditation has been approved by the commissioner.

(4) (a) Subject to subsection (4)(b), credit must be allowed when:

(i) the reinsurance is ceded to an assuming insurer that is domiciled and licensed in or, in the case of a United States branch of an alien assuming insurer, is entered through a state that employs standards regarding credit for reinsurance substantially similar to those applicable under this statute; and

(ii) the assuming insurer or the United States branch of an alien assuming insurer:

(A) maintains a surplus with regard to policyholders in an amount not less than $20 million; and

(B) submits to the authority of this state to examine its books and records.

(b) The requirement of subsection (4)(a)(i) does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

(5) (a) Credit must be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund in a qualified United States financial institution for the payment of the valid claims of its United States policyholders and ceding insurers and their assigns and successors in interest. The assuming insurer shall report annually to the commissioner information substantially the same as that required to be reported on the NAIC annual statement form by licensed insurers to enable the commissioner to determine the sufficiency of the trust fund.

(b) (i) In the case of a single assuming insurer, the trust must consist of a trusteed account representing the assuming insurer's liabilities attributable to business written in the United States, and in addition, the assuming insurer shall maintain a surplus with the trustee of not less than $20 million.

(ii) In the case of a group, ~~of~~ including incorporated and individual unincorporated underwriters, the trust must consist of a trusteed account representing the group's liabilities attributable to business written in the United States, and in addition, the group shall maintain a surplus with the trustee of which $100 million must be held jointly for the benefit of United States ceding insurers of any member of the group.

(iii) The incorporated members of the group, as group members, may not be engaged in a business

other than underwriting as members of the group and are subject to the same level of solvency regulation and control by the insurance regulator as the unincorporated members. The group shall make available to the commissioner an annual certification of the solvency of each underwriter by the ~~group's domiciliary~~ insurance regulator and the independent public accountants in the jurisdiction where the underwriter is domiciled ~~and its independent public accountants~~.

~~(iii)~~(iv) In the case of a group of incorporated insurers under common administration:

(A) the provisions of subsection ~~(5)(b)(iii)(B)~~ (5)(b)(iv)(B) apply~~,~~ to the group that:

(I) complies with the reporting requirements contained in subsection (5)(a);

(II) has continuously transacted an insurance business outside the United States for at least 3 years immediately prior to making application for accreditation;

(III) submits to this state's authority to examine its books and records and bears the expense of the examination; and

(IV) has aggregate policyholders' surplus of $10 billion;

(B) (I) the trust must be in an amount equal to the group's several liabilities attributable to business ceded by United States ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of the group;

(II) the group shall maintain a joint surplus with a trustee of which $100 million is held jointly for the benefit of United States ceding insurers of any member of the group as additional security for any liabilities; and

(III) each member of the group shall make available to the commissioner an annual certification of the member's solvency by the ~~member's domiciliary regulator and its independent public accountant~~ insurance regulator and the independent public accountants in the jurisdiction where the underwriter is domiciled.

(c) The trust must be established in a form approved by the commissioner. The trust instrument must provide that contested claims are valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust must vest legal title to its assets in the trustees of the trust for its United States policyholders and ceding insurers and their assigns and successors in interest. The trust and the assuming insurer are subject to examination as determined by the commissioner. The trust described in this subsection (c) must remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust.

(d) No later than February 28 of each year, the trustees of the trust shall report to the commissioner in writing setting forth the balance of the trust and listing the trust's investments at the end of the preceding year. The trustees shall certify the date of termination of the trust, if planned, or certify that the trust may not expire prior to the following December 31.

(6) Credit must be allowed when the reinsurance is ceded to an assuming insurer that does not meet the requirements of subsection (2), (3), (4), or (5) but only with respect to the insurance of risks located in a jurisdiction in which the reinsurance is required by applicable law or regulation of that jurisdiction.

(7) (a) If the assuming insurer is not licensed or accredited to transact insurance or reinsurance in this state, the credit permitted by subsections (4) and (5) may not be allowed unless the assuming insurer agrees in the reinsurance agreements:

(i) that in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, will:

(A) submit to the jurisdiction of any court of competent jurisdiction in any state of the United States;

(B) comply with all requirements necessary to give the court jurisdiction; and

(C) abide by the final decision of the court or of any appellate court in the event of an appeal; and

(ii) to designate the commissioner or a designated attorney as its attorney upon whom may be served any lawful process in any action, suit, or proceeding instituted by or on behalf of the ceding company.

(b) Subsection (7)(a)(i) is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes if an obligation is created in the agreement."

Section 29. Section 33-2-1217, MCA, is amended to read:

"**33-2-1217. Reduction of liability for reinsurance ceded by domestic insurer to assuming insurer -- definition.** A reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of 33-2-1216 must be allowed in an amount not exceeding the liabilities carried by the ceding insurer. The reduction must be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer:

(1) under a reinsurance contract with the assuming insurer as security for the payment of

obligations under the contract if the security is held in the United States subject to withdrawal solely by and under the exclusive control of the ceding insurer; or

(2) in the case of a trust, in a qualified United States financial institution. This security may be in the form of:

(a) cash;

(b) securities listed by the securities valuation office of the NAIC and qualifying as admitted assets;

(c) clean, irrevocable, unconditional letters of credit that are issued or confirmed by a qualified United States financial institution no later than December 31 of the year for which filing is being made and that are in the possession of the ceding company on or before the filing date of its annual statement. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation must, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification, or amendment, whichever occurs first.

(d) any other form of security acceptable to the commissioner.

(3) For the purposes of subsection (2)(c), a "qualified United States financial institution" means an institution that:

(a) is organized or, in the case of a United States office of a foreign banking organization, licensed under the laws of the United States or any of its states;

(b) is regulated, supervised, and examined by United States federal or state authorities with regulatory authority over banks and trust companies; and

(c) has been determined by either the commissioner or the securities valuation office of the national association of insurance commissioners to meet the standards of financial condition and standing that are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner.

(4) For the purposes of this part, except for subsection (2)(c), "qualified United States financial institution" means, with respect to institutions eligible to act as a fiduciary of a trust, an institution that:

(a) is organized or, in the case of a United States branch or agency office of a foreign banking corporation, licensed under the laws of the United States or any of its states and that has been granted authority to operate with fiduciary powers; and

(b) is regulated, supervised, and examined by federal or state authorities having regulatory authority

over banks and trust companies.

(5) The commissioner may adopt rules implementing the provisions of 33-2-307, 33-2-708, and 33-2-806."

Section 30. Section 33-2-1218, MCA, is amended to read:

"**33-2-1218. Reinsurance agreements affected.** Sections 33-2-1216 and 33-2-1217 apply to all cessions after October 1, 1993, under reinsurance agreements that have had an inception, anniversary, or renewal date on or ~~before~~ after April 1, 1993."

SECTION 31. SECTION 33-2-1394, MCA, IS AMENDED TO READ:

"**33-2-1394. Settlement of actions against rehabilitator, liquidator, and employees -- court approval -- applicability.** (1) If any legal action against an employee for which indemnity may be available under this section is settled prior to final adjudication on the merits, the insurer shall pay the settlement amount on behalf of the employee or indemnify the employee for the settlement amount unless the commissioner determines:

(a) that the claim did not arise out of or by reason of the employee's duties or employment; or

(b) that the claim was caused by the intentional or willful and wanton misconduct of the employee.

(2) In a legal action in which the rehabilitator or liquidator is a defendant, that portion of any settlement relating to the alleged act, error, or omission of the rehabilitator or liquidator is subject to the approval of the court before which the delinquency proceeding is pending. The court may not approve that portion of the settlement if it determines:

(a) that the claim did not arise out of or by reason of the rehabilitator's or liquidator's duties or employment; or

(b) that the claim was caused by the intentional or willful and wanton misconduct of the rehabilitator or liquidator.

(3) This section may not be construed to deprive the rehabilitator, liquidator, or employee of immunity, indemnity, benefit of law, right, or defense available under any provision of law, including, without limitation, the provisions of Title 2, chapter 9.

(4) (a) ~~A~~ Except as otherwise provided, a legal action by a third party does not lie against the rehabilitator, liquidator, or employee based in whole or in part on any alleged act, error, or omission that

took place prior to October 1, 1993, unless suit is filed and valid service of process is obtained by October 1, 1994. A legal action that is pending on or filed after September 30, 1993, by a liquidator or a liquidation estate will lie against a former special deputy liquidator or any employee, agent, or independent contractor retained by a special deputy liquidator without regard to when the alleged act, error, or omission occurred.

(b) Subsections (1) through (3) apply to any suit that is pending on or filed after October 1, 1993, without regard to when the alleged act, error, or omission took place."

Section 32. Section 33-2-1510, MCA, is amended to read:

"**33-2-1510. Minimum standards.** Unless there is a written contract between a controlling producer and a controlled insurer specifying the responsibilities of each party, the controlled insurer may not accept business from the controlling producer and the controlling producer may not place business with the controlled insurer. The contract must be approved by the board of directors of the controlled insurer and must contain the following minimum provisions:

(1) The controlled insurer may terminate the contract for cause, upon written notice to the controlling producer. The controlled insurer shall suspend the authority of the controlling producer to write business during the pendency of any dispute regarding the cause for the termination.

(2) The controlling producer shall render to the controlled insurer accounts detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by or owing to the controlling producer.

(3) On at least a monthly basis, the controlling producer shall remit to the controlled insurer all funds due under the terms of the contract. The due date must be fixed so that premiums or installments of premiums collected must be remitted no later than 90 days after the effective date of any policy placed with the controlled insurer under the contract.

(4) In accordance with the provisions of this title, all funds collected for the controlled insurer's account must be held by the controlling producer in a fiduciary capacity, in one or more appropriately identified bank accounts in banks that are members of the federal reserve system. However, funds of a controlling producer not required to be licensed in this state must be maintained in compliance with the requirements of the jurisdiction in which the controlling ~~producer's domiciliary jurisdiction~~ producer is domiciled.

(5) The controlling producer shall maintain separately identifiable records of business written for

the controlled insurer.

(6) The contract may not be assigned in whole or in part by the controlling producer.

(7) The controlled insurer shall provide the controlling producer with its underwriting standards, rules, procedures, manuals setting forth the rates to be charged, and the conditions for the acceptance or rejection of risks. The controlling producer shall adhere to the standards, rules, procedures, rates, and conditions. The standards, rules, procedures, rates, and conditions must be the same as those applicable to comparable business placed with the controlled insurer by a producer other than the controlling producer.

(8) The rates and terms of the controlling producer's commissions, charges, or other fees and the purposes of those commissions, charges, or fees must be contained in the contract. The rates of the controlling producer's commissions, charges, and other fees may not be greater than those applicable to comparable business placed with the controlled insurer by producers other than controlling producers. For purposes of subsection (7) and this subsection, examples of "comparable business" include the same lines of insurance, same kinds of insurance, same kinds of risks, similar policy limits, and similar quality of business.

(9) If the contract provides that on insurance business placed with the controlled insurer, the controlling producer is to be compensated contingent upon the controlled insurer's profits on that business, then the compensation may not be determined and paid until at least 5 years after the premiums on liability insurance are earned and at least 1 year after the premiums are earned on any other insurance. The commissions may not be paid until the adequacy of the controlled insurer's reserves on remaining claims has been independently verified pursuant to 33-2-1512.

(10) ~~The rates and terms of the controlling producer's commissions, charges, or other fees and the purposes of those commissions, charges, or fees~~ A LIMIT ON THE CONTROLLING PRODUCER'S WRITINGS IN RELATION TO THE CONTROLLED INSURER'S SURPLUS AND TOTAL WRITINGS must be contained in the contract. The controlled insurer may establish a different limit for each line or subline of business. The controlled insurer shall notify the controlling producer when the applicable limit is approached and may not accept business from the controlling producer if the limit is reached. The controlling producer may not place business with the controlled insurer if it has been notified by the controlled insurer that the limit has been reached.

(11) The controlling producer may negotiate but may not bind reinsurance on behalf of the controlled insurer on business that the controlling producer places with the controlled insurer, except that

the controlling producer may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the controlled insurer contains underwriting guidelines. For reinsurance assumed and ceded, the guidelines must include a list of reinsurers with which the automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured, and commission schedules."

Section 33. Section 33-2-1605, MCA, is amended to read:

"**33-2-1605. Penalties and liabilities.** (1) If, after a hearing conducted in accordance with Title 33, chapter 1, part 7, the commissioner finds that a person has violated any provision of this part, the commissioner may order:

(a) a penalty in an amount of $5,000 for each separate violation;

(b) revocation or suspension of the producer's license; and

(c) the managing general agent to reimburse the insurer, the rehabilitator, or a liquidator of the insurer for any losses incurred by the insurer caused by a violation of this part committed by the managing general agent.

(2) An order of the commissioner pursuant to subsection (1) is subject to judicial review pursuant to 33-1-711.

(3) This section does not limit the power of the commissioner to impose any other penalty provided in this title.

(4) This part does not limit the rights of policyholders, claimants, or ~~auditors~~ creditors."

Section 34. 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, to provide it with surplus funds, or for any purpose of its business~~,~~ upon a written agreement that ~~such~~ the money is required to be repaid only out of the insurer's surplus in excess of that stipulated in ~~such~~ the agreement. The agreement may provide for interest at a rate ~~no~~ not 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~~ and whether the interest constitutes a liability of the insurer must be stipulated in the agreement. ~~No~~ A commission or promotion expense ~~shall~~ may not be paid in connection with ~~any such~~ a loan of the type described in this section.

(2) Money ~~so~~ borrowed, together with the interest ~~thereon~~ if ~~so~~ stipulated in the agreement, ~~shall~~ does 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~~ However, until the money or interest, or both, are repaid, financial statements filed or published by the insurer ~~shall~~ must show as a footnote ~~thereto~~ the amount ~~thereof~~ then unpaid together with any interest ~~thereon~~ accrued but unpaid.

(3) ~~Any such~~ A loan of this type to a mutual or stock insurer ~~shall be~~ is 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~~ are approved unless within 15 days after ~~date of such~~ filing the insurer is notified of the commissioner's disapproval and ~~the reasons therefor~~ reasons for the disapproval. The commissioner shall disapprove any proposed loan or agreement if ~~he~~ the commissioner 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~~ A loan to a mutual or stock insurer or a substantial portion ~~thereof~~ of the loan ~~shall~~ must be repaid by the insurer when it is no longer reasonably necessary for the purpose originally intended. ~~No repayment of such loan shall~~ Repayment of either principal or interest on the loan may not be made by a mutual or stock insurer unless ~~in advance~~ approved in advance by the commissioner.

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

Section 35. Section 33-4-202, MCA, is amended to read:

"33-4-202. Declaration of intention to incorporate -- articles of incorporation -- fee. (1) The individuals proposing to form a farm mutual insurer as referred to in 33-4-201 shall file with the commissioner:

(a) a declaration of their intention to form ~~such a~~ the corporation~~, which declaration shall be~~ signed by at least 100 incorporators if a proposed state mutual insurer or by at least 25 incorporators if a proposed county mutual insurer; and

(b) proposed articles of incorporation executed in ~~quadruplicate~~ triplicate by three or more of the incorporators and acknowledged by each before a person authorized to take and verify acknowledgments

of conveyance of real property.

(2) The articles of incorporation ~~shall~~ must state:

(a) the name of the corporation. If a state mutual insurer, the words "farm mutual" must be a part of the name; if a county mutual insurer, the name ~~shall~~ must contain the words "farm mutual" or "rural mutual" together with the name of the county ~~wherein is to be located~~ in which its principal place of business is to be located. The name ~~shall~~ may not be so similar to one already used by a corporation in this state as to be misleading.

(b) if a county mutual insurer, the name of the county or counties in which the corporation is to transact insurance and the address where its principal business office will be located;

(c) if a state mutual insurer, the location of its principal business office, which ~~office~~ must be located in this state;

(d) the objects and purposes for which the corporation is formed;

(e) whether it intends to transact business on the cash premium plan or the assessment plan;

(f) the duration of its existence, which may be perpetual;

(g) the number of its directors, which ~~shall~~ may not be less than 5 or more than 11~~; also~~, and the names and addresses of the members of the initial board of directors appointed to manage the affairs of the corporation until the first annual meeting of the members and ~~until their~~ successors are elected and qualified;

(h) ~~such~~ other provisions, not inconsistent with law, ~~deemed~~ considered appropriate by the incorporators;

(i) the names, residences, and addresses of the incorporators and the value of ~~the~~ their property ~~desired~~ to be insured ~~owned by each~~ in the county or counties where the operations of the corporation are to be carried on.

(3) At the time of filing of the articles of incorporation as provided in subsection (1) ~~above~~, the incorporators shall pay to the commissioner a filing fee of $10. The commissioner shall deposit ~~all such~~ the fees with the state treasurer to the credit of the general fund ~~of this state~~."

Section 36. Section 33-4-203, MCA, is amended to read:

"33-4-203. Approval of articles -- commencement of corporate existence. (1) ~~Upon receipt of proposed articles of incorporation, the commissioner shall forward the proposed articles of incorporation~~

~~to the attorney general for examination.~~ If the ~~attorney general~~ commissioner finds the proposed articles of incorporation to be in accordance with the provisions of this chapter and not in conflict with the constitution and laws of the United States of America or of this state, the ~~attorney general~~ commissioner shall make a certificate of the facts ~~and return it with the proposed articles to the commissioner~~.

(2) If the commissioner considers the name of the proposed corporation to be so similar to one already appropriated by another company or corporation as to be likely to mislead the public, the commissioner shall reject the name applied for and shall notify the incorporators of the rejection.

(3) When the proposed articles of incorporation have been approved by the ~~attorney general~~ commissioner, the commissioner shall ~~likewise~~ endorse the commissioner's approval upon each set of the articles and forward ~~four~~ three sets of articles to the incorporators. The incorporators shall file one of the sets of articles with the secretary of state, one set with the commissioner bearing the certification of the secretary of state, and one set with the county clerk of the county in which the principal place of business of the corporation is located and shall pay to the secretary of state and the county clerk the customary filing fees. The remaining set of articles must be made a part of the corporation's records.

(4) The corporation has legal existence upon the approval of the articles by the ~~attorney general and the~~ commissioner and completion of the filings referred to in subsection (3), but it may not transact business as an insurer until it has fulfilled the requirements for and has obtained a certificate of authority as provided in 33-4-505."

Section 37. Section 33-5-401, MCA, is amended to read:

"**33-5-401. Surplus funds required.** (1) A domestic reciprocal insurer ~~hereunder formed~~ subject to this part, if it has otherwise complied with the applicable provisions of this code, may be authorized to transact insurance if it has and ~~thereafter~~ maintains surplus funds as follows:

(a) to transact property insurance, surplus funds of not less than $400,000;

(b) to transact casualty insurance~~; other than workers' compensation, surplus funds of not less than $400,000.~~

(i) including authority for workers' compensation insurance, surplus funds of not less than $600,000; or

(ii) excluding authority for workers' compensation insurance, surplus funds of not less than $400,000.

(2) In addition to surplus funds required to be maintained under subsection (1) ~~above~~, the insurer ~~shall~~ must have, when first ~~so~~ authorized, expendable surplus in the same amount as required of a like foreign reciprocal insurer under 33-2-110.

(3) A domestic reciprocal insurer may be authorized to transact additional kinds of insurance if it has otherwise complied with the provisions of this code ~~therefor~~ for the additional kinds of insurance and ~~possesses and so~~ maintains surplus funds in an amount equal to the minimum capital stock required of a stock insurer for authority to transact a like combination of kinds of insurance."

Section 38. Section 33-7-117, MCA, is amended to read:

"**33-7-117. Scope -- provisions applicable.** (1) Except as provided in subsection (2), societies are governed by this chapter and are exempt from all other provisions of the insurance laws of this state, not only in governmental relations with the state but for every other purpose. The provisions of a law enacted after January 1, 1992, do not apply to fraternal benefit societies unless expressly made applicable by the provisions of the law.

(2) In addition to the provisions of this chapter, the provisions of chapter 1, parts 1 through 4 and 7; 33-2-104; 33-2-107; 33-2-112; chapter 2, part 13; 33-3-308; 33-15-502; ~~and~~ chapters 17, 18, 20, and 22; and [sections 78 through 81] apply to fraternal benefit societies to the extent applicable and to the extent not in conflict with the provisions of this chapter and the reasonable implications of this chapter."

Section 39. Section 33-10-201, MCA, is amended to read:

"**33-10-201. Short title, purpose, scope, and construction.** (1) This part ~~shall be known and~~ may be cited as the "Montana Life and Health Insurance Guaranty Association Act".

(2) The purpose of this part is to protect policyowners, insureds, beneficiaries, annuitants, payees, and assignees of life insurance policies, health insurance policies, annuity contracts, and supplemental contracts, subject to certain limitations, against failure in the performance of contractual obligations due to the impairment of the insurer issuing the policies or contracts.

(3) To provide this protection:

(a) an association of insurers is created to enable the guaranty of payment of benefits and of continuation of coverages;

(b) members of the association are subject to assessment to provide funds to carry out the purpose

of this part; and

(c) the association is authorized to assist the commissioner, in the prescribed manner, in the detection and prevention of insurer impairments.

(4) This part applies to direct, nongroup life, health, annuity, and supplemental policies or contracts, to certificates under direct group policies and contracts, and to unallocated annuity contracts issued by member insurers, except as limited by this part. Annuity contracts and certificates under group annuity contracts include but are not limited to guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement agreements, lottery contracts, and any immediate or deferred annuity contracts.

(5) This part provides coverage for ~~covered~~ policies and contracts specified in subsection (6):

(a) to persons who are owners of or certificate holders under covered policies or, in the case of unallocated annuity contracts, to the persons who are contract holders ~~and who~~ if the persons:

(i) are residents; or

(ii) are not residents, but only under all of the following conditions:

(A) the insurers that issued the policies are domiciled in this state;

(B) the insurers have not held a license or certificate of authority in the state in which the persons reside;

(C) the state has an association similar to the association created under this part; and

(D) the persons are not eligible for coverage by that association; and

(b) to persons who, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees, or payees of the persons covered under subsection (5)(a).

(6) This part covers persons specified in subsection (5)(a) for direct, nongroup life, health, annuity, and supplemental policies and contracts, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by this part. Annuity contracts and certificates under group annuity contracts include but are not limited to guaranteed investment contracts, deposit administration contracts, allocated and unallocated funding agreements, structured settlement agreements, lottery contracts, and immediate or deferred annuity contracts. This part does not apply to:

(a) ~~any~~ policies or contracts or any part of the policies or contracts under which the risk is borne

by the policyholder;

(b) ~~any~~ a policy or contract or part of the policy or contract assumed by the impaired insurer under a contract of reinsurance, other than reinsurance for which assumption certificates have been issued;

(c) any portion of a policy or contract to the extent that the rate of interest on which it is based:

(i) averaged over the period of 4 years prior to the date on which the association becomes obligated with respect to the policy or contract, exceeds a rate of interest determined by subtracting 2 percentage points from Moody's corporate bond yield average averaged for that same 4-year period or for the lesser period if the policy or contract was issued less than 4 years before the association became obligated; and

(ii) on and after the date on which the association becomes obligated with respect to the policy or contract, exceeds the rate of interest determined by subtracting 3 percentage points from Moody's corporate bond yield average as is most recently available;

(d) any plan or program of an employer, association, or similar entity to provide life, health, or annuity benefits to its employees or members to the extent that the plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association, or similar entity under:

(i) a multiple employer welfare arrangement, as defined in section 514 of the Employee Retirement Income Security Act of 1974, as amended;

(ii) a minimum premium group insurance plan;

(iii) a stop-loss group insurance plan; or

(iv) an administrative services only contract;

(e) any portion of a policy or contract to the extent that it provides dividends or experience rating credits or provides that any fees or allowances be paid to any person, including the policy or contract holder, in connection with the service to or administration of the policy or contract;

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

(g) any unallocated annuity contract issued to an employee benefit plan that is protected under the federal pension benefit guaranty corporation; and

(h) any portion of any unallocated annuity contract that is not issued to or in connection with a specific employee, union, or association of natural persons benefit plan or a government lottery.

(7) This part must be liberally construed to effect the purpose under subsections (2) and (3), which

constitute an aid and guide to interpretation.

(8) This part may not be construed to reduce the liability for unpaid assessments of the insureds of an impaired insurer operating under a plan with assessment liability."

Section 40. Section 33-10-202, MCA, is amended to read:

"**33-10-202. Definitions.** As used in this part, the following definitions apply:

(1) "Account" means any of the three accounts created under 33-10-203.

(2) "Association" means the Montana life and health insurance guaranty association created under 33-10-203.

(3) "Contractual obligation" means any obligation under covered policies.

(4) "Covered policy" means any policy or contract within the scope of this part under subsections (4) through (6) of 33-10-201.

(5) "Impaired insurer" means:

(a) an insurer which after July 1, 1974, becomes insolvent and is placed under a final order of liquidation, rehabilitation, or supervision by a court of competent jurisdiction; or

(b) an insurer considered by the commissioner after July 1, 1974, to be unable or potentially unable to fulfill its contractual obligations.

(6) (a) "Member insurer" means any ~~person authorized to transact in this state any kind of insurance to which this part applies under subsections (4) and (6) of 33-10-201~~ insurer that is licensed or that holds a certificate of authority to transact any kind of insurance in this state for which coverage is provided under 33-2-201 and includes any insurer whose license or certificate of authority may have been suspended, revoked, not renewed, or voluntarily withdrawn.

(b) The term does not include:

(i) a health service corporation;

(ii) a health maintenance organization;

(iii) a fraternal benefit society;

(iv) a mandatory state pooling plan;

(v) a mutual assessment company or any entity that operates on an assessment basis;

(vi) an insurance exchange; or

(vii) an entity similar to any of the entities listed in subsections (6)(b)(i) through (6)(b)(vi).

(7) "Person" means any individual, corporation, partnership, association, or voluntary organization.

(8) "Premiums" means direct gross insurance premiums and annuity considerations written on covered policies, less return premiums and considerations on premiums and dividends paid or credited to policyholders on the direct business. "Premiums" do not include premiums and considerations on contracts between insurers and reinsurers. As used in 33-10-227, "premiums" are those for the calendar year preceding the determination of impairment.

(9) "Resident" means any person who resides in this state at the time the impairment is determined and to whom contractual obligations are owed.

(10) "Unallocated annuity contract" means an annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of annuity benefits guaranteed to an individual by the insurer under the contract or certificate."

Section 41. Section 33-11-102, MCA, is amended to read:

"**33-11-102. Definitions.** As used in this part, the following definitions apply:

(1) "Completed operations liability" means:

(a) liability arising out of the installation, maintenance, or repair of any product at a site that is not owned or controlled by:

(i) a person who performs that work; or

(ii) a person who hires an independent contractor to perform that work; and

(b) liability for activities that are completed or abandoned before the date of the occurrence giving rise to the liability.

(2) "Domicile", for purposes of determining the state where a purchasing group is domiciled, means:

(a) for a corporation, the state where the purchasing group is incorporated; and

(b) for an unincorporated entity, the state of its principal place of business.

~~(2)~~(3) "Hazardous financial condition" means that, based on its present or reasonably anticipated financial condition, a risk retention group, although not yet financially impaired or insolvent, is unlikely to be able to:

(a) meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

(b) pay other obligations in the normal course of business.

~~(3)~~(4) "Insurance" means primary insurance, excess insurance, reinsurance, surplus line insurance, and any other arrangement for shifting and distributing risk that is determined to be insurance under the laws of this state.

~~(4)~~(5) (a) "Liability" means legal liability for damages, including costs of defense, legal costs and fees, and other claims expenses, because of injuries to other persons, damage to their property, or other damage or loss to other persons resulting from or arising out of:

(i) a business, whether profit or nonprofit, trade, product, service (including professional service), premises, or operation; or

(ii) an activity of any state or local government or an agency or political subdivision ~~thereof~~ of state or local government.

(b) The term does not include personal risk liability or an employer's liability with respect to its employees other than legal liability under the federal Employers' Liability Act, ~~(~~45 U.S.C. 51 through 60~~)~~. As used in this subsection, "personal risk liability" means liability for damages because of injury to any person, damage to property, or other loss or damage resulting from personal, familial, or household responsibilities or activities rather than from responsibilities or activities referred to in subsection ~~(4)(a)~~ (5)(a).

~~(5)~~(6) "Plan of operation or a feasibility study" means an analysis that presents the expected activities and results of a risk retention group, including at a minimum:

(a) the coverages, deductibles, coverage limits, rates, and rating classification systems for each line of insurance the group intends to offer;

(b) historical and expected loss experience of the proposed members and national experience of similar exposures to the extent this experience is reasonably available;

(c) pro forma financial statements and projections;

(d) appropriate opinions by a qualified independent casualty actuary, including a determination of minimum premium or participation levels required to commence operations and to prevent a hazardous financial condition;

(e) identification of management, underwriting procedures, managerial oversight methods, and investment policies; and

(f) other matters as may be prescribed by the commissioner for liability insurance companies

authorized by the insurance laws of the state where the risk retention group is chartered.

~~(6)~~(7) "Purchasing group" means a group that:

(a) has as one of its purposes the purchase of liability insurance on a group basis;

(b) purchases liability insurance only for its group members and only to cover their similar or related liability exposure, as described in subsection ~~(6)(c)~~ (7)(c);

(c) is composed of members whose businesses or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar, or common business, trade, product, service, premises, or operation; and

(d) is domiciled in any state.

~~(7)~~(8) "Risk retention group" means a corporation or other limited liability association formed under the laws of any state, Bermuda, or the Cayman Islands:

(a) whose primary activity consists of assuming and spreading all or any portion of the liability exposure of its group members;

(b) that is organized for the primary purpose of conducting the activity described under subsection ~~(7)(a)~~ (8)(a);

(c) (i) that is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state; or

(ii) that, before January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before that date, had certified to the insurance regulatory official of at least one state that it satisfied the capitalization requirements of that state. However, ~~such~~ the group is considered to be a risk retention group only if it has been engaged in business continuously since January 1, 1985, and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability.

~~(A) For purposes of this subsection (7), "completed operations liability" means liability arising out of the installation, maintenance, or repair of any product at a site which is not owned or controlled by a person who performs that work or hires an independent contractor to perform that work and includes liability for activities which are completed or abandoned before the date of the occurrence giving rise to the liability.~~

~~(B)~~ For purposes of this subsection ~~(7)~~ (8), "product liability" means liability for damages because of any personal injury, death, emotional harm, consequential economic damage, or property damage,

~~(~~including damages resulting from the loss of use of property~~)~~, arising out of the manufacture, design, importation, distribution, packaging, labeling, lease, or sale of a product but does not include the liability of any person for those damages if the product involved was in the possession of that person when the incident giving rise to the claim occurred.

(d) that does not exclude any person from membership in the group solely to provide to members of the group a competitive advantage over ~~such~~ the person;

(e) (i) that has as its members only persons who have an ownership interest in the group and that has as its owners only persons who are members and who are provided insurance by the risk retention group; or

(ii) that has as its sole member and sole owner an organization that is owned by persons who are provided insurance by the risk retention group;

(f) whose members are engaged in businesses or activities that are similar or related with respect to the liability to which the members are exposed by virtue of any related, similar, or common business, trade, product, service, premises, or operation;

(g) whose activities do not include the provision of insurance other than:

(i) liability insurance for assuming and spreading all or any portion of the liability of its group members; and

(ii) reinsurance with respect to the liability of any other risk retention group or member of ~~such~~ the other group that is engaged in businesses or activities so that ~~such~~ the group or member meets the requirement described in subsection ~~(7)(f)~~ (8)(f) for membership in the risk retention group that provides the reinsurance; and

(h) whose name includes the phrase "risk retention group".

~~(8)~~(9) "State" means any state of the United States or the District of Columbia."

Section 42. Section 33-11-104, MCA, is amended to read:

"**33-11-104. Risk retention groups not chartered in this state.** A risk retention group chartered in a state other than this state and seeking to do business as a risk retention group in this state must observe and abide by the laws of this state as follows:

(1) Before offering insurance in this state, a risk retention group shall submit to the commissioner:

(a) a statement identifying the state or states where the risk retention group is chartered and

authorized as a casualty insurer, date of chartering, its principal place of business, and other information, including information on its membership, as the commissioner requires to verify that the risk retention group is qualified under 33-11-102~~(7)~~(8);

(b) a copy of its plan of operation or a feasibility study and revisions of the plan or study submitted to its state of domicile. However, this provision relating to the submission of a plan of operation or a feasibility study does not apply with respect to any line or classification of liability insurance that was defined in the federal Product Liability Risk Retention Act of 1981 (15 U.S.C. 3901 through 3904) before it was amended by P.L. 99-563, approved on October 27, 1986, and that was offered before that date by a risk retention group that had been chartered and operated for not less than 3 years before that date; and

(c) a statement of registration that designates the commissioner as its agent for the purpose of receiving service of legal documents or process.

(2) A risk retention group doing business in this state shall submit to the commissioner:

(a) a copy of the group's financial statement submitted to its state of domicile, which must be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American academy of actuaries or by a qualified loss reserve specialist under criteria established by the national association of insurance commissioners;

(b) a copy of each examination of the risk retention group as certified by the insurance regulatory official of the state in which the examination was conducted or public official conducting the examination;

(c) upon request by the commissioner, a copy of any audit performed with respect to the risk retention group; and

(d) any information as may be required to verify the group's continuing qualification as a risk retention group under 33-11-102~~(7)~~(8).

(3) (a) Each risk retention group is liable for the payment of premium taxes and taxes on premiums of direct business for risks resident or located within this state and shall report to the commissioner the net premiums written for risks resident or located within this state. The risk retention group is subject to taxation and any applicable interest, fines, and penalties for nonpayment that apply to foreign admitted insurers.

(b) To the extent that an insurance producer is used, the insurance producer shall report to the commissioner the premiums of direct business for risks resident or located within this state that the licensees have placed with or on behalf of a risk retention group not chartered in this state.

(c) To the extent that an insurance producer is used, the insurance producer shall keep a complete and separate record of all policies procured from each risk retention group. The record is open to examination by the commissioner, as provided in 33-1-408. The records must, for each policy and each kind of insurance provided under the policy, include the limit of liability, the time period covered, the effective date, the name of the risk retention group that issued the policy, the gross premium charged, and the amount of return premiums, if any.

(4) Each risk retention group, its insurance producers, and its representatives shall comply with Title 33, chapter 18, part 2.

(5) Each risk retention group shall comply with the provisions of Title 33, chapter 18, part 2, regarding deceptive, false, or fraudulent acts or practices. However, if the commissioner seeks an injunction regarding the risk retention group's conduct, the injunction must be obtained from a court of competent jurisdiction.

(6) Each risk retention group shall submit to an examination by the commissioner to determine its financial condition if the insurance regulatory official of the jurisdiction where the group is chartered has not initiated an examination or does not initiate an examination within 60 days after a request by the commissioner. The examination must be coordinated to avoid unjustified repetition and be conducted in an expeditious manner in accordance with the national association of insurance commissioners examiners handbook.

(7) Each policy issued by a risk retention group must contain, in 10-point type on the front page and the declaration page, the following notice:

"NOTICE

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group."

(8) The following acts by a risk retention group are prohibited:

(a) the solicitation or sale of insurance by a risk retention group to any person who is not eligible for membership in the group; and

(b) the solicitation or sale of insurance by or operation of a risk retention group that is in a hazardous financial condition or is financially impaired.

(9) A risk retention group is not allowed to do business in this state if an insurer is directly or

indirectly a member or owner of the risk retention group, other than in the case of a risk retention group all of whose members are insurers.

(10) A risk retention group may not offer insurance policy coverage declared unlawful by the Montana supreme court.

(11) A risk retention group not chartered in this state and doing business in this state shall comply with a lawful order issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by the insurance regulatory official of any state if there has been a finding of financial impairment after an examination under subsection (6).

(12) Upon completion of registration requirements, the commissioner shall issue to the risk retention group a proper certificate of registration.

(13) A risk retention group that violates any provision of this chapter is subject to fines and penalties, including revocation of the right to do business in this state, applicable to licensed insurers generally."

Section 43. Section 33-11-108, MCA, is amended to read:

"**33-11-108. Notice and registration requirements of purchasing groups.** (1) A purchasing group that intends to do business in this state shall furnish notice to the commissioner that:

(a) identifies the state where the group is domiciled and all other states in which the group intends to do business;

(b) specifies the lines and classifications of liability insurance that the purchasing group intends to purchase;

(c) identifies the insurer from which the purchasing group intends to purchase its insurance and the domicile of ~~the~~ that insurer;

(d) identifies the Montana-licensed insurance producer or Montana-licensed surplus lines insurance producer through which the purchasing group intends to place its business;

(e) identifies the principal place of business of the purchasing group; ~~and~~

(f) provides information required by the commissioner to verify that the purchasing group is qualified under 33-11-102~~(6)~~(7)~~.~~; and

(g) identifies the person or persons controlling the activities of the group and includes biographical information on the person or persons.

(2) The purchasing group shall register with and designate the commissioner as its agent solely for the purpose of receiving service of legal documents or process. However, the requirements do not apply in the case of a purchasing group:

(a) (i) that was domiciled before April 2, 1986, in any state of the United States; and

(ii) that was domiciled on and after October 27, 1986, in any state of the United States;

(b) (i) that, before October 27, 1986, purchased insurance from an insurer licensed in any state; and

(ii) that, since October 27, 1986, purchased its insurance from an insurer licensed in any state;

(c) that was a purchasing group under the requirements of the federal Product Liability Risk Retention Act of 1981 (15 U.S.C. 3901 through 3904) before it was amended by P.L. 99-563, approved on October 27, 1986; and

(d) that does not purchase insurance that was not authorized for purposes of an exemption under the federal Product Liability Risk Retention Act of 1981, as in effect before October 27, 1986.

(3) Upon completion of registration requirements, the commissioner shall issue a proper certificate of registration to the purchasing group."

Section 44. Section 33-14-304, MCA, is amended to read:

"**33-14-304. Cancellation of insurance upon default.** (1) When a premium finance agreement contains a power of attorney or other authority enabling the insurance premium finance company to cancel any insurance contract listed in the agreement, the insurance contract or contracts may not be canceled by the premium finance company unless ~~such~~ the cancellation is effectuated in accordance with this section.

(2) ~~Not less than 10 days' written~~ Written notice must be mailed to the insured setting forth the intent of the insurance premium finance company to cancel the insurance contract unless the default is cured prior to the date stated in the notice. The written notice must be mailed at least 10 days prior to the date stated in the notice. The insurance producer ~~or broker~~ indicated on the premium finance agreement ~~shall~~ must also be mailed 10 days' notice of this action.

(3) Pursuant to the power of attorney or other authority referred to above, the insurance premium finance company may cancel on behalf of the insured by mailing to the insurer written notice stating when ~~thereafter~~ the cancellation ~~shall be~~ will become effective, and the insurance contract ~~shall~~ must be canceled

as if ~~such~~ the notice of cancellation had been submitted by the insured ~~himself~~ but without requiring the return of the insurance contract. If the insurer or its insurance producer does not provide the insurance premium finance company with a specific mailing address for the purpose of receipt of the ~~above~~ notice, mailing by the insurance premium finance company to the insurer at the address that is on file ~~and of record~~ with the commissioner is considered sufficient notice under this section. The insurance premium finance company shall also mail a notice of cancellation to the insured at ~~his~~ the insured's last-known address and to the insurance producer ~~or broker~~ indicated on the premium finance agreement.

(4) All statutory, regulatory, and contractual restrictions providing that the insurance contract may not be canceled unless notice is given to a governmental agency, mortgagee, or other third party apply whenever cancellation is effected under the provisions of this section. The insurer shall give the prescribed notice in behalf of itself or the insured to any governmental agency, mortgagee, or other third party on or before the second business day after the day it receives the notice of cancellation from the premium finance company and shall determine the effective date of cancellation taking into consideration the number of days' notice required to complete the cancellation."

Section 45. Section 33-15-301, MCA, is amended to read:

"**33-15-301. Requiring standard provisions -- waiver.** (1) Insurance contracts ~~shall~~ must contain ~~such~~ the standard or uniform provisions ~~as are~~ and benefits required by the applicable provisions of this code pertaining to contracts of particular kinds of insurance. The commissioner may waive ~~the required use of~~ a particular provision in a particular insurance policy form if:

(a) ~~he~~ the commissioner finds ~~such~~ the provision or benefit unnecessary for the protection of the insured and inconsistent with the purposes of the policy; and

(b) the policy is otherwise approved by ~~him~~ the commissioner.

(2) ~~No~~ A policy or certificate ~~shall~~ may not contain any provision or benefit inconsistent with or contradictory to any standard or uniform provision or benefit used or required to be used, but the commissioner may approve any substitute provision or benefit ~~which~~ that is, in ~~his~~ the commissioner's opinion, not less favorable in any particular to the insured or beneficiary than the provisions otherwise required.

(3) In lieu of the provisions required by this code for contracts for particular kinds of insurance, substantially similar provisions required by the law of the domicile of a foreign or alien insurer may be used

when approved by the commissioner.

(4) ~~No such~~ A provision, if required to be contained in the policy, ~~can~~ may not be waived by agreement between the insurer and any other person."

Section 46. Section 33-15-303, MCA, is amended to read:

"**33-15-303. Contents of policies in general -- identification.** (1) ~~Every~~ Each policy ~~shall~~ must specify:

(a) the names of the parties to the contract;

(b) the subject of the insurance;

(c) the risks insured against;

(d) the time when the insurance under the policy takes effect and the period during which the insurance is to continue;

(e) the premium;

(f) the conditions pertaining to the insurance.

(2) If under the policy the exact amount of premium is determinable only at stated intervals or termination of the contract, a statement of the basis and rates upon which the premium is to be determined and paid must be included.

(3) All policies and annuity contracts issued by insurers and the forms of policies and annuity contracts filed with the commissioner must have printed on the policy or annuity contract an appropriate designating letter or figure, combination of letters or figures, or terms identifying the respective forms of policies or contracts~~, together with the year of adoption of the form~~. Each form, including riders and endorsements, must be identified by a designating letter or figure placed in a lower, preferably left-hand, corner of the first page of the form. Whenever any change is made in any form, the designating letters, figures, or terms ~~and year of adoption~~ on the form must be correspondingly changed and the revision date must be noted next to the designating letters."

Section 47. Section 33-16-202, MCA, is amended to read:

"**33-16-202. Recording and reporting of loss and expense experience.** (1) The commissioner ~~shall~~ may promulgate and may modify reasonable rules and statistical plans, reasonably adapted to each of the rating systems used, ~~and~~ which ~~shall~~ must ~~thereafter~~ be used by each insurer in the recording and reporting

of its loss and countrywide expense experience, in order that the experience of all insurers may be made available at least annually in ~~such~~ form and detail as ~~may be~~ necessary to aid ~~him~~ the commissioner in determining whether rates comply with the applicable standards of this chapter. ~~Such~~ The rules and plans may also provide for the recording and reporting of expense experience items ~~which~~ that are specially applicable to this state and are not susceptible of determination by a prorating of countrywide expense experience.

(2) In promulgating ~~such~~ rules and plans, the commissioner shall give ~~due~~ consideration to the rating systems in use in this state and, in order that ~~such~~ the rules and plans may be as uniform as is practicable among the several states, to the rules and to the form of the plans used for ~~such~~ rating systems in other states. ~~No~~ An insurer ~~shall~~ may not be required to record or report its loss experience on a classification basis that is inconsistent with the rating system used by it.

(3) The commissioner may designate one or more rating organizations or other agencies to assist ~~him~~ in gathering ~~such~~ and making compilations of loss and expense experience ~~and making compilations thereof~~, and ~~such~~ the compilations ~~shall~~ must be made available, subject to reasonable rules promulgated by the commissioner, to insurers and rating organizations."

Section 48. Section 33-16-235, MCA, is amended to read:

"33-16-235. Data reporting -- rules. (1) An insurer that has transacted a line of insurance designated as noncompetitive or volatile ~~shall~~ may report once a year to the commissioner, on forms prescribed by the commissioner, information including:

(a) reported and estimated ultimate exposure, by year of exposure to loss;

(b) reported and estimated ultimate premiums, by year of exposure to loss;

(c) losses paid, by year incurred;

(d) loss adjustment expense paid, by year incurred;

(e) reported and ultimately incurred losses and loss adjustment expenses, by year incurred; and

(f) any other information required by the commissioner.

(2) An insurer transacting a line of insurance designated as noncompetitive or volatile shall provide to the commissioner information concerning at least 5 years of experience, with information evaluated as of the end of each calendar year. In addition to the latest reported information for each year, the insurer shall document any adjustments, including but not limited to development factors and trend adjustments,

made to the reported data in projecting losses.

(3) The commissioner ~~shall~~ may adopt by rule reasonable development factors and trend adjustments to be applied to the reported data."

Section 49. 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~~.~~; or

(d) licensed third-party administrator 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~~ these coverages.

(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~~ the person's 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~~ the person, ~~his~~ or the person's 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~~ chapter, the term "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~~ has the same meaning as set forth in 33-2-1501.

(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 50. Section 33-17-211, MCA, is amended to read:

"**33-17-211. General qualifications -- application for license.** (1) An individual applying for a license shall apply on a form specified by the commissioner and declare under penalty of refusal, suspension, or revocation of the license that statements made in the application are true, correct, and complete to the best of the individual's knowledge and belief. Before approving the application, the commissioner shall verify that the individual:

(a) is 18 years of age or older;

(b) has not committed an act that is a ground for refusal, suspension, or revocation as set forth in 33-17-1001;

(c) has paid the license fees stated in 33-2-708;

(d) has successfully passed the examinations for each kind of insurance for which the individual has applied within 12 months of application;

(e) is a resident of this state or of another state that grants similar privileges to residents of this state. Licenses issued based upon Montana state residency terminate if the licensee relocates to another state;

(f) is competent, trustworthy, and of good reputation;

(g) has experience or training or otherwise is qualified in the kind or kinds of insurance for which ~~he~~ the applicant applies to be licensed and is reasonably familiar with the provisions of this code which govern ~~his~~ the applicant's operations as an insurance producer; and

(h) if applying for a license as to life or disability insurance:

(i) is not a funeral director, undertaker, or mortician operating in this or any other state;

(ii) is not an officer, employee, or representative of a funeral director, undertaker, or mortician operating in this or any other state; or

(iii) does not hold an interest in or benefit from a business of a funeral director, undertaker, or mortician operating in this or any other state.

(2) A person acting as an insurance producer shall obtain a license. A person shall apply for a license on a form specified by the commissioner. Before approving the application, the commissioner shall verify that:

(a) the person meets the requirements listed in subsection (1);

(b) the person has paid the licensing fees stated in 33-2-708 for each individual licensed in conjunction with the person's license. A licensed person shall promptly notify the commissioner of each change relating to an individual listed in the license.

(c) the person has designated a licensed officer responsible for compliance by the person with the insurance laws and rules of this state;

(d) each member and employee of a partnership and each officer, director, stockholder, or employee of a corporation who is acting as an insurance producer in this state has obtained a license;

(e) (i) if the person is a partnership or corporation, the transaction of insurance business is within the purposes stated in the partnership agreement or the articles of incorporation; and

(ii) if the person is a corporation, the secretary of state has issued a certificate of existence or authorization under 35-1-1312 or filed articles of incorporation under ~~35-2-214~~ 35-1-220.

(3) The commissioner may license as a resident insurance producer an association of licensed Montana insurance producers, whether or not incorporated, formed and existing substantially for purposes

other than insurance. The license must be used solely for the purpose of enabling the association to place, as a resident insurance producer, insurance of the properties, interests, and risks of the state of Montana and of other public agencies, bodies, and institutions and to receive the customary commission for the placement. The president and secretary of the association shall apply for the license in the name of the association, and the commissioner shall issue the license to the association in its name alone. The fee for the license is the same as that required by 33-2-708 for the license of an insurance producer. The commissioner may, after a hearing with notice to the association, revoke the license if ~~he~~ the commissioner finds that continuation of the license is not in the public interest or that a ground listed in 33-17-1001 exists.

(4) An insurance producer using an assumed business name shall register the name with the commissioner before using it."

Section 51. Section 33-17-405, MCA, is amended to read:

"**33-17-405. Service of process -- commissioner as agent.** ~~A nonresident person shall file with the commissioner the required forms appointing the~~ The commissioner ~~and his successors in office~~ shall act as ~~the~~ a nonresident person's agent upon whom process in a legal proceeding against the nonresident person may be served. ~~and shall agree that such~~ Service of process on the commissioner ~~process has~~ has the same legal force and validity as personal service of process upon the nonresident person. The commissioner shall, within 3 working days after receiving process, forward by certified mail, ~~at~~ to the nonresident person's address of record, a copy of the process ~~by certified mail to the person for whom he has received the process~~."

Section 52. Section 33-17-503, MCA, is amended to read:

"**33-17-503. Application -- fee -- expiration.** (1) Before a consultant license is issued or renewed, the prospective licensee shall:

(a) properly file in the office of the commissioner a written application on forms the commissioner prescribes; and

(b) pay a fee of $50, which the commissioner shall deposit with the state treasurer to be credited to the state's general fund.

(2) Each consultant license ~~expires on May 31 next following the date of issue~~ must be renewed

each year by the consultant paying a continuation fee on or before May 31, and the license continues in force unless suspended, revoked, or otherwise terminated."

Section 53. 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~~ represent to the public that the person is an administrator in this state unless ~~he~~ the person 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~~ the commissioner 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~~ A certificate of registration ~~is renewable annually on July 1. A request for renewal must be accompanied by a renewal fee of $100~~ must be renewed each year by the administrator paying a continuation fee of $100 on or before July 1. Upon payment, the license continues in force unless suspended, revoked, or otherwise terminated. The commissioner shall deposit the fee with the state treasurer to be credited to the general fund.

(4) ~~The~~ A 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~~ a 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 53.** Section 33-17-1001, MCA, is amended to read:~~

~~"**33-17-1001. Suspension, revocation, or refusal of license.** (1) Except as provided in 33-17-411, after a hearing, which must be held no less than 10 days after advance notice by certified mail, on charges given under 33-1-314(3), the commissioner may suspend for up to 5 years, revoke, refuse to continue, or deny a license issued under this chapter if the commissioner finds that the licensee or applicant has:~~

~~(a) engaged or is about to engage in an act or practice for which issuance of the license could have been refused;~~

~~(b) obtained or attempted to obtain a license through misrepresentation or fraud;~~

~~(c) violated or failed to comply with a provision of this code or has violated a rule, subpoena, or order of the commissioner or of the commissioner of any other state;~~

~~(d) improperly withheld, misappropriated, or converted to the licensee's or applicant's own use money or property belonging to policyholders, insurers, beneficiaries, or others and received in conduct of business under the license;~~

~~(e) been convicted of a felony;~~

~~(f) in the conduct of the affairs under the license, used fraudulent, coercive, or dishonest practices or the licensee or applicant is incompetent, untrustworthy, financially irresponsible, or a source of injury and loss to the public;~~

~~(g) made a materially untrue statement in the license application or in the continuing education affidavit;~~

~~(h) misrepresented the terms of an actual or proposed insurance contract;~~

~~(i) been found guilty of an unfair trade practice or fraud prohibited by Title 33, chapter 18;~~

~~(j) had a similar license suspended or revoked in any other state;~~

~~(k) forged another's name to an application for insurance;~~

~~(l) cheated on an examination for a license; or~~

~~(m) knowingly accepted insurance business from a person who is not licensed.~~

~~(2) The license of a partnership or corporation may be suspended, revoked, refused, or denied if a reason listed in subsection (1) applies to an individual designated in the license to exercise its powers~~ or ~~to a partner or officer in the partnership or corporation~~.

~~(3) The commissioner may suspend, revoke, or refuse to continue a license under subsection (1)(c) without conducting an investigation pursuant to 37-1-203 or making a written finding pursuant to 37-1-204."~~

Section 54. Section 33-18-212, MCA, is amended to read:

"**33-18-212. Illegal dealing in premiums -- improper charges for insurance.** (1) A person may not willfully collect any sum as a premium or charge for insurance~~, which insurance~~ that is not then provided or is not in due course to be provided, ~~(~~subject to acceptance of the risk by the insurer~~)~~, by an insurance policy issued by an insurer as authorized by this code.

(2) A person may not willfully collect as a premium or charge for insurance any sum in excess of or less than the premium or charge applicable to ~~such~~ the insurance and, as specified in the policy, in accordance with the applicable classifications and rates ~~as~~ filed with ~~and~~ or approved by the commissioner; or in cases ~~where~~ in which classifications, premiums, or rates are not required by this code to be ~~so~~ filed ~~and~~ or approved, ~~such~~ the premiums and charges may not be in excess of or less than those specified in the policy and as fixed by the insurer. This provision may not ~~be deemed to~~ prohibit the charging and collection, by surplus lines insurance producers licensed under chapter 2, part 3, of the amount of applicable state and federal taxes in addition to the premium required by the insurer. ~~It~~ This provision may not ~~be considered to~~ prohibit the charging and collection, by a life insurer, of amounts actually to be expended for medical examination of an applicant for life insurance or for reinstatement of a life insurance policy.

(3) Each violation of this section is punishable under 33-1-104."

Section 55. Section 33-18-301, MCA, is amended to read:

"**33-18-301. Prohibited relations with mortuaries.** (1) ~~No~~ A life insurer and its officers, employees, or representatives may not own, manage, supervise, operate, or maintain any mortuary, funeral, or undertaking establishment ~~or permit its officers, employees, or representatives to own, operate, maintain, or be employed in any such business~~ in Montana.

(2) ~~No~~ A life insurer may not contract or agree with any funeral director, mortuary, or undertaker ~~to the effect~~ that ~~such~~ the funeral director, undertaker, or mortuary shall conduct the funeral or be named beneficiary of any person insured by ~~such~~ the insurer. This subsection does not prohibit a life insurer from making insurance, designated as funeral insurance, available.

(3) A funeral insurance policy and any solicitation material for the policy must clearly indicate that:

(a) the policy is a life insurance product;

(b) the applicant may designate the beneficiary, provided that there is an appropriate and insurable interest;

(c) the beneficiary may use the proceeds for any purpose; and

(d) any attempt by the insurer or its representative to have the insured designate a specific beneficiary, including but not limited to a funeral director, mortuary, or undertaker, constitutes a violation of this section punishable as a misdemeanor pursuant to subsection (4).

~~(3)~~(4) Each violation of this section constitutes a misdemeanor punishable by a fine of not more than $1,000 or by imprisonment for not more than 6 months or ~~by~~ both ~~such fine and imprisonment~~."

Section 56. Section 33-22-131, MCA, is amended to read:

"**33-22-131. Coverage for phenylketonuria treatment.** (1) Each group or individual medical expense disability policy, certificate of insurance, and membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide coverage for the treatment of phenylketonuria.

(2) For purposes of this section, "treatment" means licensed professional medical services under the supervision of a physician and a dietary formula product to achieve and maintain normalized blood levels of phenylalanine and adequate nutritional status.

(3) These services are subject to the terms of the applicable group or individual disability policy, certificate, or membership contract that establishes durational limits, dollar limits, deductibles, and copayment provisions as long as the terms are not less favorable than for physical illness generally.

(4) This section does not apply to disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, or specified disease policies."

Section 57. Section 33-22-132, MCA, is amended to read:

"**33-22-132. Coverage for mammography examinations.** (1) Each group or individual medical expense, cancer, ~~hospital indemnity,~~ and blanket disability policy, certificate of insurance, and membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide minimum mammography examination coverage.

(2) For the purpose of this section, "minimum mammography examination" means:

(a) one baseline mammogram for a woman who is 35 years of age or older and under 40 years of age;

(b) a mammogram every 2 years for any woman who is 40 years of age or older and under 50 years of age or more frequently if recommended by the woman's physician; and

(c) a mammogram each year for a woman who is 50 years of age or older.

(3) A minimum $70 payment or the actual charge if the charge is less than $70 must be made for each mammography examination performed before the application of the terms of the applicable group or

individual disability policy, certificate of insurance, or membership contract that establish durational limits, deductibles, and copayment provisions as long as the terms are not less favorable than for physical illness generally.

(4) This section does not apply to disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, or specified disease policies."

Section 58. Section 33-22-201, MCA, is amended to read:

"**33-22-201. Format and content.** ~~A~~ An individual policy of disability insurance may not be delivered or issued for delivery to any person in this state unless it otherwise complies with this code and complies with the following:

(1) The entire money and other considerations for the policy must be expressed in the policy.

(2) The time when the insurance takes effect and terminates must be expressed in the policy.

(3) The policy may insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who is the policyholder, any two or more eligible members of that family, including husband, wife, dependent children or any children under a specified age that may not exceed ~~19~~ 25 years, and any other person dependent upon the policyholder.

(4) The style, arrangement, and overall appearance of the policy may not give undue prominence to any portion of the text, and every printed portion of the text of the policy and of any endorsements or attached papers must be plainly printed in lightfaced type of a style in general use, the size of which must be uniform and not less than 10 point with a lowercase, unspaced alphabet length not less than 120 point.

(5) The "text" must include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions.

(6) The exceptions and reductions of indemnity must be set forth in the policy and, other than those contained in 33-22-204 through 33-22-215 and ~~33-22-217~~ 33-22-221 through 33-22-231, must be printed, at the insurer's option, either included with the benefit provision to which they apply or under an appropriate caption such as "Exceptions" or "Exceptions and Reductions", except that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction must be included with the benefit provision to which it applies.

~~(7) Each form, including riders and endorsements, must be identified by a form number in the lower~~

~~left-hand corner of the first page of the form.~~

~~(8)~~(7) The policy may not contain a provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless the portion is set forth in full in the policy, except in the case of the incorporation of or reference to a statement of rates or classification of risks or short-rate table filed with the commissioner.

~~(9) Each individual disability policy, except for a single premium nonrenewable policy, issued for delivery in this state on or after January 1, 1980, must contain a notice stating in substance that if the person to whom the policy is issued is not satisfied for any reason, the person is permitted to return the policy within 10 days of its delivery, or a longer period as the policy may provide, and to have refunded the amount of the premium paid. A policy returned pursuant to this subsection is void from the beginning.~~"

Section 59. Section 33-22-202, MCA, is amended to read:

"**33-22-202. Required provisions -- captions -- omissions -- substitutions -- order.** (1) Except as provided in subsection (2), each policy delivered or issued for delivery to any person in this state must contain the provisions specified in 33-22-204 through 33-22-215, ~~in the words in which the~~ as those provisions appear, except that the insurer may, at its option, substitute for one or more of the provisions corresponding provisions of different wording approved by the commissioner ~~which are in each instance~~ and not less favorable in any respect to the insured or the beneficiary. Each provision must be preceded ~~individually~~ by the applicable caption shown or, at the option of the insurer, by the appropriate individual or group captions or subcaptions as the commissioner may approve.

(2) If any provision is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the commissioner, shall omit from the policy any inapplicable provision or part of a provision and shall modify any inconsistent provision or part of a provision in a manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

(3) The provisions that are the subject of 33-22-204 through 33-22-215 and ~~33-22-217~~ 33-22-221 through 33-22-232 or any corresponding provisions which are used in accordance with the cited sections must be printed in the consecutive order of the provisions in the sections or, at the option of the insurer, any provision may appear as a unit in any part of the policy with other provisions to which it may be logically related, provided that the resulting policy is not in whole or in part unintelligible, uncertain,

ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered, or issued."

Section 60. Section 33-22-301, MCA, is amended to read:

"**33-22-301. Coverage of newborn under disability policy.** (1) Each policy of disability insurance or certificate issued ~~thereunder shall~~ must contain a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any insured.

(2) The coverage for newborn infants must be the same as provided by the policy for the other covered persons~~;~~. ~~provided, however~~ However, that for newborn infants there ~~shall be no~~ may not be waiting or elimination periods. A deductible or reduction in benefits applicable to the coverage for newborn infants is not permissible unless it conforms and is consistent with the deductible or reduction in benefits applicable to all other covered persons.

(3) ~~No~~ A policy or certificate of insurance may not be issued or amended in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an insured from and after the moment of birth.

(4) ~~If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within 31 days after the date of birth in order to have the coverage continue beyond such 31 day period.~~ The policy or contract may require notification of the birth of a child and payment of a required premium or subscription fee to be furnished to the insurer or nonprofit or indemnity corporation within 31 days of the birth in order to have the coverage extend beyond 31 days."

Section 61. Section 33-22-303, MCA, is amended to read:

"**33-22-303. Coverage for well-child care.** (1) Each medical expense policy of disability insurance or certificate issued under the policy that is delivered, issued for delivery, renewed, extended, or modified in this state by a disability insurer and that provides coverage for a family member of the insured or subscriber must provide coverage for well-child care for children from the moment of birth through 2 years of age. Benefits provided under this coverage are exempt from any deductible provision that may be in force in the policy or certificate issued under the policy.

(2) Coverage for well-child care under subsection (1) must include:

(a) a history, physical examination, developmental assessment, anticipatory guidance, and laboratory tests, according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment services program provided for in 53-6-101; and

(b) routine immunizations according to the schedule for immunizations recommended by the immunization practices advisory committee of the U.S. department of health and human services.

(3) Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit cited in this section.

(4) This section does not apply to disability income, specified disease, medicare supplement, or hospital indemnity policies.

(5) For purposes of this section:

(a) "well-child care" means the services described in subsection (2) and delivered by a physician or a health care professional supervised by a physician; and

(b) "developmental assessment" and "anticipatory guidance" mean the services described in the Guidelines for Health Supervision II, published by the American academy of pediatrics.

(6) When a policy of disability insurance or a certificate issued under the policy provides coverage or benefits to a resident of this state, it is considered to be delivered in this state within the meaning of this section, whether the insurer that issued or delivered the policy or certificate is located inside or outside of this state."

Section 62. Section 33-22-504, MCA, is amended to read:

"**33-22-504. Newborn infant coverage.** (1) ~~No~~ A group disability policy or certificate of insurance ~~which, in addition to covering persons in the insured group, also covers members of such person's family~~ delivered or issued for delivery in this state may not be issued or amended in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of persons covered under the policy from and after the moment of birth.

(2) ~~If the~~ A policy or certificate ~~issued thereunder, in addition to covering persons in the insured group, also covers members of such person's family, it shall~~ subject to this section, must contain ~~an additional~~ a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any person covered under the policy.

(3) The coverage for newborn infants ~~shall~~ must be the same as provided by the policy for other

covered persons~~;~~. ~~provided, however~~ However, ~~that~~ for newborn infants there ~~shall~~ may not be ~~no~~ waiting or elimination periods. A deductible or reduction in benefits applicable to the coverage for newborn infants is not permissible unless it conforms and is consistent with the deductible or reduction in benefits applicable to all other covered persons.

(4) This section does not apply to medicare supplement policies issued by reason of age.

(5) When a group disability policy or certificate issued under the policy provides for coverage or benefits for a resident of this state, the policy or certificate is considered delivered in this state within the meaning of this section regardless of whether the insurer issuing the policy or certificate is located in this state.

(6) The policy or certificate may require notification of the birth of a child and payment of a required premium or subscription fee to be furnished to the insurer or nonprofit or indemnity corporation within 31 days of the birth in order to have the coverage extend beyond 31 days."

Section 63. Section 33-22-508, MCA, is amended to read:

"**33-22-508. Conversion on termination of eligibility.** (1) A group disability insurance policy or certificate of insurance delivered or issued for delivery or renewed after October 1, 1981, must contain a provision that if the insurance or any portion of it on a person~~, his~~ or the person's dependents~~,~~ or family members covered under the policy ceases because of termination of ~~his~~ the person's employment or ~~of his~~ membership in the class or classes eligible for coverage under the policy or as a result of ~~his~~ the person's employer discontinuing ~~his~~ business or as a result of ~~his~~ the employer discontinuing the group disability insurance policy and not providing for any other group disability insurance or plan and if the person had been insured for a period of 3 months and ~~he~~ is not insured under another major medical disability insurance policy or plan, ~~he~~ the person is entitled to have issued ~~to him~~ by the insurer, without evidence of insurability, group coverage or an individual policy ~~issued by the insurer~~ or, in the absence of an individual policy issued by the insurer, a group policy issued by the insurer, of hospital or medical service insurance on ~~himself~~ the person~~, his~~ and the person's dependents~~,~~ or family members if application for the individual policy is made and the first premium tendered to the insurer within 31 days after the termination of group coverage.

(2) The individual policy or group policy, at the option of the insured, may be on any form then customarily issued by the insurer to individual or group policyholders, with the exception of a policy the

eligibility for which is determined by affiliation other than by employment with a common entity.

(3) The premium on the individual policy or group policy must be at the insurer's then customary rate applicable to the coverage of the individual or group policy."

Section 64. Section 33-22-1120, MCA, is amended to read:

"**33-22-1120. Extraterritorial jurisdiction.** A group long-term care insurance policy or certificate may not be delivered or issued for delivery to a resident of Montana under a group policy issued in another state ~~to a group described in 33-22-1107(3)(d)~~ unless it is approved by:

(1) the commissioner; ~~or~~ and

(2) the insurance regulatory official of a state that has statutory and regulatory long-term care insurance requirements substantially similar to those adopted in Montana."

Section 65. Section 33-22-1803, MCA, is amended to read:

"**33-22-1803. Definitions.** As used in this part, the following definitions apply:

(1) "Actuarial certification" means a written statement by a member of the American academy of actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of 33-22-1809, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with a specified entity or person.

(3) "Assessable carrier" means all individual carriers of disability insurance and all carriers of group disability insurance, excluding the state group benefits plan provided for in Title 2, chapter 18, part 8, the Montana university system health plan, and any self-funded disability insurance plan provided by a political subdivision of the state.

(4) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

(5) "Basic health benefit plan" means a lower cost health benefit plan developed pursuant to

33-22-1812.

(6) "Board" means the board of directors of the program established pursuant to 33-22-1818.

(7) "Carrier" means any person who provides a health benefit plan in this state subject to state insurance regulation. The term includes but is not limited to an insurance company, a fraternal benefit society, a health service corporation, a health maintenance organization, and, to the extent permitted by the Employee Retirement Income Security Act of 1974, a multiple-employer welfare arrangement. For purposes of this part, companies that are affiliated companies or that are eligible to file a consolidated tax return must be treated as one carrier, except that the following may be considered as separate carriers:

(a) an insurance company or health service corporation that is an affiliate of a health maintenance organization located in this state;

(b) a health maintenance organization located in this state that is an affiliate of an insurance company or health service corporation; or

(c) a health maintenance organization that operates only one health maintenance organization in an established geographic service area of this state.

(8) "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, provided that gender, claims experience, health status, and duration of coverage are not case characteristics for purposes of this part.

(9) "Class of business" means all or a separate grouping of small employers established pursuant to 33-22-1808.

(10) "Committee" means the health benefit plan committee created pursuant to 33-22-1812.

(11) "Dependent" means:

(a) a spouse or an unmarried child under 19 years of age;

(b) an unmarried child, under 23 years of age, who is a full-time student and who is financially dependent on the insured;

(c) a child of any age who is disabled and dependent upon the parent as provided in 33-22-506 and 33-30-1003; or

(d) any other individual defined ~~to be~~ as a dependent in the health benefit plan covering the employee.

(12) "Eligible employee" means an employee who works on a full-time basis and who has a normal

workweek of 30 hours or more. The term includes a sole proprietor, a partner of a partnership, and an independent contractor if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer. The term does not include an employee who works on a part-time, temporary, or substitute basis.

(13) "Established geographic service area" means a geographic area, as approved by the commissioner and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

(14) "Health benefit plan" means any hospital or medical policy or certificate providing for physical and mental health care issued by an insurance company, a fraternal benefit society, or a health service corporation or issued under a health maintenance organization subscriber contract. Health benefit plan does not include:

(a) accident-only, credit, dental, vision, specified disease, medicare supplement, long-term care, or disability income insurance;

(b) coverage issued as a supplement to liability insurance, workers' compensation insurance, or similar insurance; or

(c) automobile medical payment insurance.

(15) "Index rate" means, for each class of business for a rating period for small employers with similar case characteristics, the average of the applicable base premium rate and the corresponding highest premium rate.

(16) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual was entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period was a period of at least 30 days. However, an eligible employee or dependent may not be considered a late enrollee if:

(a) the individual requests enrollment within 30 days after termination of the qualifying previous coverage and ~~meets each of the following conditions~~:

(i) the individual was covered under qualifying previous coverage at the time of the initial enrollment; or

(ii) the individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, the death of a

spouse, or divorce; ~~and~~

~~(iii) the individual requests enrollment within 30 days after termination of the qualifying previous coverage;~~

(b) the individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

(c) a court has ordered that coverage be provided for a spouse, minor, or dependent child under a covered employee's health benefit plan and a request for enrollment is made within 30 days after issuance of the court order.

(17) "New business premium rate" means, for each class of business for a rating period, the lowest premium rate charged or offered or that could have been charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(18) "Plan of operation" means the operation of the program established pursuant to 33-22-1818.

(19) "Premium" means all money paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

(20) "Program" means the Montana small employer health reinsurance program created by 33-22-1818.

(21) "Qualifying previous coverage" means benefits or coverage provided under:

(a) medicare or medicaid;

(b) an employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan; or

(c) an individual health insurance policy, including coverage issued by an insurance company, a fraternal benefit society, a health service corporation, or a health maintenance organization that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided that the policy has been in effect for a period of at least 1 year.

(22) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

(23) "Reinsuring carrier" means a small employer carrier participating in the reinsurance program pursuant to 33-22-1819.

(24) "Restricted network provision" means a provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to Title 33, chapter 22, part 17, or Title 33, chapter 31, to provide health care services to covered individuals.

(25) "Small employer" means a person, firm, corporation, partnership, or association that is actively engaged in business and that, on at least 50% of its working days during the preceding calendar quarter, employed at least 3 but not more than 25 eligible employees, the majority of whom were employed within this state or were residents of this state. In determining the number of eligible employees, companies are considered one employer if they:

(a) are affiliated companies;

(b) are eligible to file a combined tax return for purposes of state taxation; or

(c) are members of an association that:

(i) has been in existence for 1 year prior to January 1, 1994;

(ii) provides a health benefit plan to employees of its members as a group; and

(iii) does not deny coverage to any member of its association or any employee of its members who applies for coverage as part of a group.

(26) "Small employer carrier" means a carrier that offers health benefit plans that cover eligible employees of one or more small employers in this state.

(27) "Standard health benefit plan" means a health benefit plan developed pursuant to 33-22-1812."

Section 66. Section 33-22-1819, MCA, is amended to read:

"33-22-1819. Program plan of operation -- treatment of losses -- exemption from taxation. (1) Within 180 days after the appointment of the initial board, the board shall submit to the commissioner a plan of operation and may at any time submit amendments to the plan necessary or suitable to ensure the fair, reasonable, and equitable administration of the program. The commissioner may, after notice and hearing, approve the plan of operation if the commissioner determines it to be suitable to ensure the fair, reasonable, and equitable administration of the program and if the plan of operation provides for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation is effective upon written approval by the commissioner.

(2) If the board fails to submit a suitable plan of operation within 180 days after its appointment, the commissioner shall, after notice and hearing, promulgate and adopt a temporary plan of operation. The commissioner shall amend or rescind any temporary plan adopted under this subsection at the time a plan of operation is submitted by the board and approved by the commissioner.

(3) The plan of operation must:

(a) establish procedures for the handling and accounting of program assets and money and for an annual fiscal reporting to the commissioner;

(b) establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;

(c) establish procedures for reinsuring risks in accordance with the provisions of this section;

(d) establish procedures for collecting assessments from assessable carriers to fund claims incurred by the program;

(e) establish procedures for allocating a portion of premiums collected from reinsuring carriers to fund administrative expenses incurred or to be incurred by the program; and

(f) provide for any additional matters necessary for the implementation and administration of the program.

(4) The program has the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals. In addition, the program may:

(a) enter into contracts as are necessary or proper to carry out the provisions and purposes of this part, including the authority, with the approval of the commissioner, to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(b) sue or be sued, including taking any legal actions necessary or proper to recover any premiums and penalties for, on behalf of, or against the program or any reinsuring carriers;

(c) take any legal action necessary to avoid the payment of improper claims against the program;

(d) define the health benefit plans for which reinsurance will be provided and to issue reinsurance policies in accordance with the requirements of this part;

(e) establish conditions and procedures for reinsuring risks under the program;

(f) establish actuarial functions as appropriate for the operation of the program;

(g) appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in operation of the program, policy and other contract design, and any other function within the authority of the program;

(h) to the extent permitted by federal law and in accordance with subsection (8)(c), make annual fiscal yearend assessments against assessable carriers and make interim assessments to fund claims incurred by the program; and

(i) borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default are legal investments for carriers and may be carried as admitted assets.

(5) A reinsuring carrier may reinsure with the program as provided for in this subsection (5):

(a) With respect to a basic health benefit plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a basic or standard health benefit plan.

(b) A small employer carrier may reinsure an entire employer group within 60 days of the commencement of the group's coverage under a health benefit plan.

(c) A reinsuring carrier may reinsure an eligible employee or dependent within a period of 60 days following the commencement of coverage with the small employer. A newly eligible employee or dependent of the reinsured small employer may be reinsured within 60 days of the commencement of coverage.

(d) (i) The program may not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the carrier has incurred an initial level of claims for the employee or dependent of $5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier is responsible for 20% of the next $100,000 of benefit payments during a calendar year and the program shall reinsure the remainder. A reinsuring carrier's liability under this subsection (d)(i) may not exceed a maximum limit of $25,000 in any calendar year with respect to any reinsured individual.

(ii) The board annually shall adjust the initial level of claims and maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment may not be less than the annual change in the medical component of the consumer price index for all urban consumers of the United States department of labor, bureau of labor statistics, unless the board proposes and the commissioner approves a lower adjustment factor.

(e) A small employer carrier may terminate reinsurance with the program for one or more of the

reinsured employees or dependents of a small employer on any anniversary of the health benefit plan.

(f) A small employer group health benefit plan in effect before January 1, 1994, may not be reinsured by the program until January 1, 1997, and then only if the board determines that sufficient funding sources are available.

(g) A reinsuring carrier shall apply all managed care and claims-handling techniques, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

(6) (a) As part of the plan of operation, the board shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology must include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology must provide for the development of base reinsurance premium rates that must be multiplied by the factors set forth in subsection (6)(b) to determine the premium rates for the program. The base reinsurance premium rates must be established by the board, subject to the approval of the commissioner, and must be set at levels that reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard health benefit plan, adjusted to reflect retention levels required under this part.

(b) Premiums for the program are as follows:

(i) An entire small employer group may be reinsured for a rate that is one and one-half times the base reinsurance premium rate for the group established pursuant to this subsection (6).

(ii) An eligible employee or dependent may be reinsured for a rate that is five times the base reinsurance premium rate for the individual established pursuant to this subsection (6).

(c) The board periodically shall review the methodology established under subsection (6)(a), including the system of classification and any rating factors, to ensure that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology that are subject to the approval of the commissioner.

(d) The board may consider adjustments to the premium rates charged by the program to reflect the use of effective cost containment and managed care arrangements.

(7) If a health benefit plan for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued must meet the

requirements relating to premium rates set forth in 33-22-1809.

(8) (a) Prior to March 1 of each year, the board shall determine and report to the commissioner the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(b) To the extent permitted by federal law, each assessable carrier shall share in any net loss of the program for the year in an amount equal to the ratio of the total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery by each assessable carrier divided by the total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery by all assessable carriers in the state.

(c) The board shall make an annual determination in accordance with this section of each assessable carrier's liability for its share of the net loss of the program and, except as otherwise provided by this section, make an annual fiscal yearend assessment against each assessable carrier to the extent of that liability. If approved by the commissioner, the board may also make interim assessments against assessable carriers to fund claims incurred by the program. Any interim assessment must be credited against the amount of any fiscal yearend assessment due or to be due from an assessable carrier. Payment of a fiscal yearend or interim assessment is due within 30 days of receipt by the assessable carrier of written notice of the assessment. An assessable carrier that ceases doing business within the state is liable for assessments until the end of the calendar year in which the assessable carrier ceased doing business. The board may determine not to assess an assessable carrier if the assessable carrier's liability determined in accordance with this section does not exceed $10.

(9) The participation in the program as reinsuring carriers; the establishment of rates, forms, or procedures; or any other joint collective action required by this part may not be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers, either jointly or separately.

(10) The board, as part of the plan of operation, shall develop standards setting forth the minimum levels of compensation to be paid to producers for the sale of basic and standard health benefit plans. In establishing the standards, the board shall take into consideration the need to ensure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide ongoing service to small employers, the levels of compensation currently used in the industry, and the overall costs of coverage to small employers selecting these plans.

(11) The program is exempt from taxation.

(12) On or before March 1 of each year, the commissioner shall evaluate the operation of the program and report to the governor and the legislature in writing the results of the evaluation. The report must include an estimate of future costs of the program, assessments necessary to pay those costs, the appropriateness of premiums charged by the program, the level of insurance retention under the program, the cost of coverage of small employers, and any recommendations for change to the plan of operation.

(13) All premiums and other money paid to the small employer carrier reinsurance program and all property and securities acquired through the use of money and interest and dividends earned on money belonging to the small employer carrier reinsurance program are solely the property of the program and must be used exclusively for the operations and obligations of the program. Money collected by the program is not subject to legislative appropriation."

Section 67. Section 33-30-102, MCA, is amended to read:

"**33-30-102. Application of this chapter -- construction of other related laws.** (1) All health service corporations ~~heretofore or hereafter organized~~ are subject to the provisions of this chapter. In addition to the provisions contained in this chapter, other chapters and provisions of this title apply to health service corporations as follows: ~~33-17-212~~ 33-17-101; ~~through 33-17-214~~ Title 33, chapter 17, parts 2 and 10 through 12; ~~and~~ Title 33, chapters 1, 15, 18, 19, and 22, except 33-22-111; and [sections 78 through 81].

(2) A law of this state other than the provisions of this chapter applicable to health service corporations ~~shall~~ must be construed in accordance with the fundamental nature of a health service corporation, and in the event of a conflict ~~between that law and~~ the provisions of this chapter~~, the latter shall~~ prevail."

Section 68. Section 33-30-107, MCA, is amended to read:

"**33-30-107. Annual statement.** (1) On or before March 1 of each year, ~~Every~~ each health service corporation shall file an annual statement for the preceding year on ~~a form containing substantially the same information as that contained in~~ form No. 13 N.A.I.C. with the commissioner of insurance. This annual statement must be completed in accordance with the national association of insurance commissioners' annual statement instructions.

(2) The health service corporation shall file a statement containing any other information concerning

its financial affairs that may be reasonably requested by the commissioner.

(3) (a) Each health service corporation shall file electronic diskette versions of its annual and quarterly financial statements with the national association of insurance commissioners. The filing date for submission of the annual statement diskette is March 1. The filing dates for the other three quarterly statements are as follows:

(i) the first quarter statement is due May 15;

(ii) the second quarter statement is due August 15; and

(iii) the third quarter statement is due November 15.

(b) The commissioner may exempt health service corporations operating only in Montana from these filing requirements."

Section 69. Section 33-30-108, MCA, is amended to read:

"**33-30-108. License required.** (1) ~~No~~ A person may not act as a health service corporation and ~~no~~ a health service corporation may not conduct business in this state except as authorized by a license issued by the commissioner.

(2) ~~Such~~ A license may be issued by the commissioner only after the person has complied with the applicable provisions of this title.

(3) A health service corporation is entitled to a continuation of its license upon payment of the annual continuation fee specified in 33-30-204~~(1)(i)~~ on or before March 1 of each year and upon continued compliance with the provisions of this title.

(4) A license issued or continued under this section may be revoked or suspended by the commissioner for violation of this title."

Section 70. Section 33-30-202, MCA, is amended to read:

"**33-30-202. Annual report by certified public accountant.** (1) All corporations subject to the provisions of this chapter shall ~~make and~~ file annually with the commissioner, on or before ~~March~~ June 1 ~~of each year~~, a ~~report under oath setting forth:~~ financial statement audited by a certified public accountant pursuant to rules promulgated by the commissioner.

~~(1) the name of the corporation;~~

~~(2) the address of its registered office in this state and the name of its registered agent at that~~

~~address;~~

~~(3) the names and addresses of its directors and officers;~~

~~(4) a brief statement of the character of the affairs which the corporation is actually conducting;~~

~~(5) the amount of all dues or fees collected from members in the last fiscal year, the amounts actually paid during that year for health services for the members or beneficiaries, and the amounts placed in reserves;~~

~~(6) a balance sheet and statement of income and expenditures for the most recent fiscal year of the corporation, prepared and verified by two officers of the corporation and certified by a certified public accountant;~~

~~(7) a statement of any other facts or information concerning the financial affairs of the health service corporation which may be reasonably required by the commissioner.~~

(2) (a) The commissioner may establish rules governing the content and preparation of the report required by subsection (1).

(b) The report must include:

(i) the corporation's financial statements for the most recent calendar year;

(ii) an opinion by the certified public accountant concerning the accuracy and fairness of the corporation's representation of its financial statements; and

(iii) other information that the commissioner specifies by rule."

Section 71. Section 33-30-204, MCA, is amended to read:

"**33-30-204. Fees.** (1) Every health service corporation subject to the provisions of this chapter shall pay the following fees to the commissioner for enforcement of the provisions of this chapter:

~~(a) insurance producer's license:~~

~~(i) application for original license and issuance of license ..... $15~~

~~(ii) annual renewal ..... $15~~

~~(iii) examination for license, for each examination ..... $15~~

~~(b)~~(a) filing any ~~other~~ statement or report $1

~~(c)~~(b) for a certified copy of any document or other paper filed in the office of the commissioner, per page ..... $.50

~~(d)~~(c) for ~~the~~ a certificate ~~and for affixing the~~ with affixed seal ~~thereto~~ $10

~~(e)~~(d) filing of a membership contract $25

~~(f)~~(e) filing of a membership contract package $100

~~(g)~~(f) filing annual ~~report, other than as part of application for original license~~ STATEMENT $25

~~(h)~~(g) issuance of health service corporation license $300

~~(i)~~(h) annual continuation of health service corporation license $300

(2) The commissioner shall promptly deposit with the state treasurer, to the credit of the general fund, all fees and license fees received ~~by him~~ under this section."

Section 72. Section 33-30-311, MCA, is amended to read:

"**33-30-311. Insurance producer.** ~~(1)~~ A person who, for compensation, solicits membership in a prepayment health service plan offered by a corporation subject to the provisions of this chapter is an insurance producer of that corporation and is subject to the provisions of 33-2-708 and Title 33, chapter 17.

~~(2) The definitions of insurance producer as defined in this chapter do not include an individual:~~

~~(a) employed and used by insurance producers for the performance of clerical, stenographic, and similar office duties;~~

~~(b) employed and used for incidental taking of an application for coverage from time to time in the office of the employing insurance producer;~~

~~(c) who secures and forwards information for the purpose of an existing group contractor for enrolling individuals under an existing group contract.~~"

Section 73. Section 33-30-1001, MCA, is amended to read:

"**33-30-1001. Newborn infants covered by insurance by health service corporation.** ~~No~~ A disability insurance plan or group disability insurance plan issued by a health service corporation may not be issued or amended in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of the persons insured from and after the moment of birth. Each ~~such~~ policy ~~shall~~ must contain a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any insured person. ~~If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fees~~

~~must be furnished to the insurer or nonprofit service or indemnity corporation within 31 days after the date of birth in order to have the coverage continue beyond such 31-day period.~~ The policy or contract may require notification of the birth of a child and payment of a required premium or subscription fee to be furnished to the insurer or nonprofit or indemnity corporation within 31 days of the birth in order to have the coverage extend beyond 31 days."

~~**Section 74.** Section 33-31-311, MCA, is amended to read:~~

~~"33-31-311. Insurance producer license required -- application, issuance, renewal, fees -- penalty.~~ ~~(1) No~~ An individual, partnership, or corporation may ~~not~~ act as or ~~hold himself out~~ ~~represent to the public to be an insurance producer of a health maintenance organization unless he~~ the individual, partnership, or ~~corporation~~ is:

~~(a) licensed as a disability insurance producer by the commissioner pursuant to chapter 17, parts 1, 2, and 4 of this title or licensed as an insurance producer under 33-30-311 through 33-30-313; and~~

~~(b) appointed or authorized by the health maintenance organization to solicit health care service agreements on its behalf.~~

~~(2) Application, appointment and qualification for a health maintenance organization insurance producer license, fees applicable to and the issuance of a health maintenance organization insurance producer license, and renewal of a health maintenance organization insurance producer license must be in accordance with the provisions of chapter 17 that apply to a disability insurance producer.~~

~~(3) An individual, partnership, or corporation who holds a disability insurance producer license on October 1, 1987, need not requalify by an examination to be licensed as a health maintenance organization insurance producer.~~

~~(4) The commissioner may, in accordance with 33-1-313, 33-1-317, 33-17-411, and chapter 17, part 10, suspend, revoke, refuse to issue or renew a health maintenance organization insurance producer license, or impose a fine upon the licensee.~~

~~(5) The provisions of this section do not exempt a health maintenance organization from material transaction disclosure requirements under [sections 78 through 81]. A health maintenance organization must be considered an insurer for the purposes of [sections 78 through 81].~~"

SECTION 74. SECTION 33-31-111, MCA, IS AMENDED TO READ:

"**33-31-111. Statutory construction and relationship to other laws.** (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to any health maintenance organization authorized to transact business under this chapter. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives may not be construed as a violation of any law relating to solicitation or advertising by health professionals.

(3) A health maintenance organization authorized under this chapter may not be considered to be practicing medicine and is exempt from Title 37, chapter 3, relating to the practice of medicine.

(4) The provisions of this chapter do not exempt a health maintenance organization from the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

(5) The provisions of this section do not exempt a health maintenance organization from material transaction disclosure requirements under [sections 78 through 81]. A health maintenance organization must be considered an insurer for the purposes of [sections 78 through 81]."

NEW SECTION. **Section 75. Notice of right to return policy.** Each INDIVIDUAL life or disability insurance policy, except a single-premium nonrenewable disability policy, issued for delivery in this state or issued after January 1, 1996, must contain a notice stating in substance that if the person to whom the policy is issued is not satisfied for any reason, the person may return the policy within 10 days of its delivery or a longer period if provided by the policy and have refunded directly to the person the premium paid. A policy returned pursuant to this section is void from the beginning.

NEW SECTION. **Section 76. Reserve calculation -- indeterminate premium plans -- minimum standards for disability plans.** (1) In the case of a plan of life insurance that provides for future premium determination, the amounts of which are to be determined by the insurer based on then estimates of future experience, or in the case of a plan of life insurance or annuity that is of such a nature that the minimum reserves cannot be determined by the methods described in 33-2-525 and 33-2-526(3), the reserves that are held under the plan must:

(a) be appropriate in relation to the benefits and the pattern of premiums for that plan; and

(b) be computed by a method that is consistent with the principles of 33-2-521 through 33-2-529, as determined by rules promulgated by the commissioner.

(2) The commissioner shall promulgate a rule containing the minimum standards applicable to the valuation of disability plans.

NEW SECTION. **Section 77. Dating of insurance applications -- antedating prohibited.** An application for issuance of an insurance policy may not be antedated by any person in order to obtain or provide coverage for losses or injuries incurred prior to the date of application.

NEW SECTION. **Section 78. Short title.** [Sections 78 through 81] may be cited as the "Disclosure of Material Transactions Act".

NEW SECTION. **Section 79. Report.** (1) An insurer domiciled in this state shall file a report with the commissioner disclosing material acquisitions and dispositions of assets or material nonrenewals, cancellations, or revisions of ceded reinsurance agreements unless the acquisitions and dispositions of assets or material nonrenewals, cancellations, or revisions have been submitted to the commissioner for review or approval or for information purposes pursuant to other provisions of the insurance code, laws, or regulations or other requirements.

(2) The report required in subsection (1) is due within 15 days after the end of the calendar month in which any of the transactions in subsection (1) occur.

(3) One complete copy of the report, including any exhibits or other attachments, must be filed with:

(a) the insurance department of the state in which the insurer is domiciled; and

(b) the national association of insurance commissioners.

(4) All reports obtained by or disclosed to the commissioner pursuant to [sections 78 through 81] must be treated confidentially, may not be subject to subpoena, and may not be made public by the commissioner, the national association of insurance commissioners, or any other person, except to insurance departments of other states, without the prior consent of the insurer to which it pertains unless the commissioner, after giving the insurer notice and an opportunity to be heard, determines that the

interest of policyholders, shareholders, or the public will be served by publication, in which event the commissioner may publish all or any part of the report in the manner the commissioner chooses.

NEW SECTION. **Section 80. Acquisitions and dispositions of assets.** (1) Acquisitions or dispositions of assets that are not material are not required to be reported pursuant to [section 79] if the acquisitions or dispositions are not material. For purposes of [sections 78 through 81], a material acquisition or the aggregate of any series of related acquisitions during any 30-day period or a disposition or the aggregate of any series of related dispositions during any 30-day period is one that is nonrecurring and not in the ordinary course of business and involves more than 5% of the reporting insurer's total admitted assets as reported in its most recent statutory statement filed with the insurance department of the insurer's state of domicile.

(2) Asset acquisitions subject to [sections 78 through 81] include every purchase, lease, exchange, merger, consolidation, succession, or other acquisition, other than the construction or development of real property, by or for the reporting insurer or the acquisition of materials for this purpose.

(3) Asset dispositions subject to [sections 78 through 81] include each sale, lease, exchange, merger, consolidation, mortgage, hypothecation, assignment, whether for the benefit of creditors or otherwise, abandonment, destruction, or other disposition.

(4) The following information is required to be disclosed in any report of a material acquisition or disposition of assets:

(a) the date of the transaction;

(b) the manner of acquisition or disposition;

(c) the description of the assets involved;

(d) the nature and amount of the consideration given or received;

(e) the purpose or reason for the transaction;

(f) the manner by which the amount of consideration was determined;

(g) the gain or loss recognized or realized as a result of the transaction; and

(h) the names of the persons from whom the assets were acquired or to whom they were disposed.

(5) An insurer is required to report material acquisitions and dispositions on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers that uses a pooling arrangement or 100% reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer

ceded substantially all of its direct and assumed business to the pool. An insurer cedes substantially all of its direct and assumed business to a pool if the insurer has less than $1 million total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than 5% of the insurer's capital and surplus.

NEW SECTION. **Section 81. Nonrenewals, cancellations, or revisions of ceded reinsurance agreements.** (1) A nonrenewal, cancellation, or revision of a ceded reinsurance agreement need not be reported pursuant to [section 79] if the nonrenewal, cancellation, or revision is not material. For purposes of [sections 78 through 81], a material nonrenewal, cancellation, or revision is one that affects:

(a) property and casualty business, including disability business written by a property and casualty insurer, so that:

(i) more than 50% of the insurer's total ceded written premium is affected; or

(ii) more than 50% of the insurer's total ceded indemnity and loss adjustment reserves are affected;

(b) life, annuity, and disability business, so that more than 50% of the total reserve credit taken for business ceded, on an annualized basis, as indicated in the insurer's most recent annual statement is affected;

(c) either property and casualty or life, annuity, and disability business and causes either of the following events that constitutes a material revision that must be reported:

(i) an authorized reinsurer representing more than 10% of a total cession is replaced by one or more unauthorized reinsurers; or

(ii) previously established collateral requirements have been reduced or waived as respects one or more unauthorized reinsurers representing collectively more than 10% of a total cession.

(2) However, a filing is not required if:

(a) with respect to property and casualty business, including disability business written by a property and casualty insurer, the insurer's total ceded written premium represents, on an annualized basis, less than 10% of its total written premium for direct and assumed business; or

(b) with respect to life, annuity, and disability business, the total reserve credit taken for

business ceded represents, on an annualized basis, less than 10% of the statutory reserve requirement prior to any cession.

(3) The following information is required to be disclosed in any report of a material nonrenewal, cancellation, or revision of ceded reinsurance agreements:

(a) the effective date of the nonrenewal, cancellation, or revision;

(b) the description of the transaction with an identification of the initiator of the transaction;

(c) the purpose or reason for the transaction; and

(d) if applicable, the identity of the replacement reinsurers.

(4) Insurers are required to report all material nonrenewals, cancellations, or revisions of ceded reinsurance agreements on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers that uses a pooling arrangement or 100% reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed business to the pool. An insurer is considered to have ceded substantially all of its direct and assumed business to a pool if the insurer has less than $1 million total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than 5% of the insurer's capital and surplus.

NEW SECTION. **Section 82. Short title.** [Sections 82 through 94] constitute and may be referred to as "The Risk-Based Capital For Insurers Act".

NEW SECTION. **Section 83. Definitions.** As used in [sections 82 through 94], the following definitions apply:

(1) "Adjusted RBC report" means an RBC report that has been adjusted by the commissioner in accordance with [section 84(5)].

(2) "Corrective order" means an order issued by the commissioner specifying corrective actions that the commissioner has determined are required.

(3) "Domestic insurer" means any insurance company domiciled in this state.

(4) "Foreign insurer" means any insurance company licensed to do business in this state under 33-2-116 but not domiciled in this state.

(5) "Life or disability insurer" means:

(a) any insurance company licensed under 33-2-116 and engaged in the business of entering into contracts of disability insurance as described in 33-1-207 or life insurance as described in 33-1-208; or

(b) a licensed property and casualty insurer writing only disability insurance.

(6) "NAIC" means the national association of insurance commissioners.

(7) "Negative trend" means, with respect to a life or health insurer, a negative trend over a period of time, as determined in accordance with the trend test calculation included in the RBC instructions.

(8) (a) "Property and casualty insurer" means any insurance company licensed under 33-2-116 and engaged in the business of entering into contracts of property insurance as described in 33-1-210 or casualty insurance as described in 33-1-206.

(b) The term does not include monoline mortgage guaranty insurers, financial guaranty insurers, and title insurers.

(9) "RBC instructions" means the RBC report including risk-based capital instructions adopted by the NAIC, as the RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

(10) "RBC level" means an insurer's authorized control level RBC, company action level RBC, mandatory control level RBC, or regulatory action level RBC, where:

(a) "authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions;

(b) "company action level RBC" means, with respect to any insurer, the product of 2 and its authorized control level RBC;

(c) "mandatory control level RBC" means the product of 0.70 and the authorized control level RBC; and

(d) "regulatory action level RBC" means the product of 1.5 and its authorized control level RBC.

(11) "RBC plan" means a comprehensive financial plan containing the elements specified in [section 85(2)]. If the commissioner rejects the RBC plan and it is revised by the insurer, with or without the commissioner's recommendation, the plan must be called a revised RBC plan.

(12) "RBC report" means the report required in [section 84].

(13) "Total adjusted capital" means the sum of:

(a) an insurer's statutory capital and surplus; and

(b) other items, if any, as the RBC instructions may provide.

NEW SECTION. **Section 84. RBC reports.** (1) Each domestic insurer shall, on or before each March 1 filing date, prepare and submit to the commissioner a report of its RBC levels as of the end of the previous calendar year in a form and containing information as required by the RBC instructions. In addition, each domestic insurer shall file its RBC report:

(a) with the NAIC in accordance with the RBC instructions; and

(b) with the insurance commissioner in any state in which the insurer is authorized to do business if that insurance commissioner has notified the insurer of the request in writing, in which case the insurer shall file its RBC report not later than the later of:

(i) 15 days from the receipt of notice to file its RBC report with that state; or

(ii) the March 1 filing date.

(2) A life and disability insurer's RBC must be determined in accordance with the formula set forth in the RBC instructions. The formula must take into account and may adjust for the covariance between:

(a) the risk with respect to the insurer's assets;

(b) the risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

(c) the interest rate risk with respect to the insurer's business; and

(d) all other business risks and other relevant risks as are set forth in the RBC instructions and determined in each case by applying the factors in the manner set forth in the RBC instructions.

(3) A property and casualty insurer's RBC must be determined in accordance with the formula set forth in the RBC instructions. The formula shall take into account and may adjust for the covariance between:

(a) asset risk;

(b) credit risk;

(c) underwriting risk; and

(d) all other business risks and other relevant risks that are set forth in the RBC instructions and determined in each case by applying the factors in the manner set forth in the RBC instructions.

(4) An excess of capital over the amount produced by the risk-based capital requirements contained in [sections 82 through 94] and the formulas, schedules, and instructions referenced in [sections 87 through 94] is desirable in the business of insurance. Accordingly, insurers should seek to maintain capital above the RBC levels required by [sections 82 through 94]. Additional capital is used and useful in the insurance business and helps to secure an insurer against various risks inherent in or affecting the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in [sections 82 through 94].

(5) If a domestic insurer files an RBC report that in the judgment of the commissioner is inaccurate, the commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice must contain a statement of the reason for the adjustment. An RBC report so adjusted is referred to as an adjusted RBC report.

NEW SECTION. **Section 85. Company action level event.** (1) "Company action level event" means any of the following events:

(a) the filing of an RBC report by an insurer which indicates that:

(i) the insurer's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC; or

(ii) for a life or disability insurer, the insurer has total adjusted capital that is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 2.5 and that has a negative trend;

(b) the notification by the commissioner to the insurer of an adjusted RBC report that indicates an event in subsection (1)(a) if the insurer does not challenge the adjusted RBC report under [section 89] or if the commissioner has rejected the insurer's challenge.

(2) In the event of a company action level event, the insurer shall prepare and submit to the commissioner an RBC plan that must:

(a) identify the conditions that contribute to the company action level event;

(b) contain proposals of corrective actions that the insurer intends to take and that would be expected to result in the elimination of the company action level event;

(c) provide projections of the insurer's financial results in the current year and at least the next 4 years, both in the absence of proposed corrective actions and giving effect to the proposed corrective

actions, including projections of statutory operating income, net income, capital, and surplus. The projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense, and benefit component.

(d) identify the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and

(e) identify the quality of and problems associated with the insurer's business, including but not limited to its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance, if any, in each case.

(3) The RBC plan must be submitted:

(a) within 45 days of the company action level event; or

(b) if the insurer challenges an adjusted RBC report pursuant to [section 89], within 45 days after notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(4) Within 60 days after the submission by an insurer of an RBC plan to the commissioner, the commissioner shall notify the insurer as to whether the RBC plan may be implemented or is unsatisfactory in the judgment of the commissioner. If the commissioner determines that the RBC plan is unsatisfactory, the notification to the insurer must set forth the reasons for the determination and may set forth proposed revisions that will render the RBC plan satisfactory in the judgment of the commissioner. Upon notification from the commissioner, the insurer shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by the commissioner, and shall submit the revised RBC plan to the commissioner:

(a) within 45 days after the notification from the commissioner; or

(b) if the insurer challenges the notification from the commissioner under [section 89], within 45 days after a notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(5) In the event of a notification by the commissioner to an insurer that the insurer's RBC plan or revised RBC plan is unsatisfactory, the commissioner may at the commissioner's discretion, subject to the insurer's right to a hearing under [section 89], specify in the notification that the notification constitutes a regulatory action level event.

(6) Each domestic insurer that files an RBC plan or revised RBC plan with the commissioner

shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in any state in which the insurer is authorized to do business if:

(a) the state has an RBC provision substantially similar to [section 90(1)]; and

(b) the insurance commissioner of that state has notified the insurer in writing of its request for the filing, in which case the insurer shall file a copy of the RBC plan or revised RBC plan in that state by the later of:

(i) 15 days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with that state; or

(ii) the date on which the RBC plan or revised RBC plan is filed under [section 85(3) and (4)].

NEW SECTION. **Section 86. Regulatory action level event.** (1) "Regulatory action level event" means, with respect to any insurer, any of the following events:

(a) the filing of an RBC report by the insurer that indicates that the insurer's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC;

(b) the notification by the commissioner to an insurer of an adjusted RBC report that indicates the event in subsection (1)(a) if the insurer does not challenge the adjusted RBC report under [section 89] or the commissioner rejects the insurer's challenge;

(c) the failure of the insurer to file an RBC report by the filing date, unless the insurer has provided an explanation for the failure that is satisfactory to the commissioner and has cured the failure within 10 days after the filing date;

(d) the failure of the insurer to submit an RBC plan to the commissioner within the time period set forth in [section 85(3)];

(e) notification by the commissioner to the insurer that:

(i) the RBC plan or revised RBC plan submitted by the insurer is unsatisfactory in the judgment of the commissioner; and

(ii) the notification constitutes a regulatory action level event with respect to the insurer if the insurer has not challenged the determination under [section 89];

(f) if, pursuant to [section 89], the insurer challenges a determination by the commissioner, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the

challenge;

(g) notification by the commissioner to the insurer that the insurer has failed to adhere to its RBC plan or revised RBC plan, but only if the failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event in accordance with its RBC plan or revised RBC plan and the commissioner has so stated in the notification and if the insurer has not challenged the determination under [section 89] or the commissioner has not rejected the insurer's challenge.

(2) In the event of a regulatory action level event, the commissioner shall:

(a) require the insurer to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(b) perform an examination or analysis as the commissioner considers necessary of the assets, liabilities, and operations of the insurer including a review of its RBC plan or revised RBC plan; and

(c) subsequent to the examination or analysis, issue a corrective order specifying corrective actions that the commissioner determines are required.

(3) In determining corrective actions, the commissioner may take into account factors considered relevant with respect to the insurer based upon the commissioner's examination or analysis of the assets, liabilities, and operations of the insurer, including but not limited to the results of any sensitivity tests undertaken pursuant to the RBC instructions. The RBC plan or revised RBC plan must be submitted:

(a) within 45 days after the occurrence of the regulatory action level event;

(b) if the insurer challenges an adjusted RBC report pursuant to [section 89] and the challenge is not frivolous in the judgment of the commissioner, within 45 days after the notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge; or

(c) if the insurer challenges a revised RBC plan pursuant to [section 89] and the challenge is not frivolous in the judgment of the commissioner, within 45 days after the notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(4) The commissioner may retain actuaries and investment experts and other consultants that may be necessary in the judgment of the commissioner to review the insurer's RBC plan or revised RBC plan, to examine or analyze the assets, liabilities, and operations of the insurer, and to formulate the corrective order with respect to the insurer. The fees, costs, and expenses relating to consultants must be borne by the affected insurer or such other party as directed by the commissioner.

NEW SECTION. **Section 87. Authorized control level event.** (1) "Authorized control level event" means any of the following events:

(a) the filing of an RBC report by the insurer that indicates that the insurer's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC;

(b) the notification by the commissioner to the insurer of an adjusted RBC report that indicates the event in subsection (1)(a) if the insurer does not challenge the adjusted RBC report under [section 89] or the commissioner rejects the insurer's challenge;

(c) the failure of the insurer to respond, in a manner satisfactory to the commissioner, to a corrective order if the insurer has not challenged the corrective order under [section 89]; or

(d) if the insurer has challenged a corrective order under [section 89] and the commissioner has, after a hearing, rejected the challenge or modified the corrective order, the failure of the insurer to respond, in a manner satisfactory to the commissioner, to the corrective order subsequent to rejection or modification by the commissioner.

(2) In the event of an authorized control level event with respect to an insurer, the commissioner shall:

(a) take the actions required under [section 86] regarding an insurer with respect to which a regulatory action level event has occurred; or

(b) if the commissioner considers it to be in the best interests of the policyholders and creditors of the insurer and of the public, take the actions necessary to cause the insurer to be placed under regulatory control under Title 33, chapter 2, part 13. In the event that the commissioner places the insurer under regulatory control, the authorized control level event must be considered sufficient grounds for the commissioner to take action under Title 33, chapter 2, part 13, and the commissioner shall have the rights, powers, and duties with respect to the insurer as are set forth in Title 33, chapter 2, part 13. In the event that the commissioner takes an action under this subsection pursuant to an adjusted RBC report, the insurer is entitled to the protections afforded to insurers under the provisions of 33-2-1321 through 33-2-1323 pertaining to summary proceedings.

NEW SECTION. **Section 88. Mandatory control level event.** (1) "Mandatory control level event" means any of the following events:

(a) the filing of an RBC report that indicates that the insurer's total adjusted capital is less than its mandatory control level RBC;

(b) notification by the commissioner to the insurer of an adjusted RBC report that indicates the event in subsection (1)(a) if the insurer does not challenge the adjusted RBC report under [section 89] or the commissioner rejects the insurer's challenge.

(2) In the event of a mandatory control level event:

(a) with respect to a life insurer, the commissioner shall take the actions that are necessary to place the insurer under regulatory control under Title 33, chapter 2, part 13. In that event, the mandatory control level event must be considered sufficient grounds for the commissioner to take action under Title 33, chapter 2, part 13, and the commissioner shall have the rights, powers, and duties with respect to the insurer as are set forth in Title 33, chapter 2, part 13. If the commissioner takes an action pursuant to an adjusted RBC report, the insurer is entitled to the protections of 33-2-1321 through 33-2-1323 pertaining to summary proceedings. Notwithstanding any of the foregoing, the commissioner may forego action for up to 90 days after the mandatory control level event if the commissioner finds that there is a reasonable expectation that the mandatory control level event may be eliminated within the 90-day period.

(b) with respect to a property and casualty insurer, the commissioner shall take the actions necessary to place the insurer under regulatory control under Title 33, chapter 2, part 13, or, in the case of an insurer that is not writing business and that is running-off its existing business, may allow the insurer to continue its runoff under the supervision of the commissioner. In either event, the mandatory control level event must be considered sufficient grounds for the commissioner to take action under Title 33, chapter 2, part 13, and the commissioner shall have the rights, powers, and duties with respect to the insurer as are set forth in Title 33, chapter 2, part 13. If the commissioner takes an action pursuant to an adjusted RBC report, the insurer is entitled to the protections of 33-2-1321 through 33-2-1323 pertaining to summary proceedings. Notwithstanding any of the foregoing, the commissioner may forego action for up to 90 days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the 90-day period.

NEW SECTION. **Section 89. Notification and hearing.** (1) An insurer has the right to a hearing

before the department upon notification by the commissioner:

(a) of an adjusted RBC report or unsatisfactory RBC plan or revised RBC plan that constitutes a regulatory action level event with respect to the insurer;

(b) that the insurer has failed to adhere to its RBC plan or revised RBC plan and that the failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event with respect to the insurer in accordance with its RBC plan or revised RBC plan; or

(c) of a corrective order with respect to the insurer.

(2) The insurer shall notify the commissioner of its request for a hearing within 5 days after the notification by the commissioner under subsection (1). Upon receipt of the insurer's request for a hearing, the commissioner shall set a date for the hearing, which may not be less than 10 or more than 30 days after the date of the insurer's request.

NEW SECTION. **Section 90. Confidentiality -- prohibition on announcements -- prohibition on use in ratemaking.** (1) With respect to a domestic insurer or a foreign insurer, all RBC reports, to the extent the information in the reports is not required to be set forth in a publicly available annual statement schedule, and all RBC plans, including the results or report of any examination or analysis of an insurer performed pursuant to [sections 82 through 94] and any corrective order issued by the commissioner pursuant to the examination or analysis, that are filed with the commissioner constitute information that might be damaging to the insurer if made available to its competitors and must be kept confidential by the commissioner. This information may not be made public and is not subject to subpoena other than by the commissioner and then only for the purpose of enforcement actions taken by the commissioner pursuant to [sections 82 through 94] or any other provision of the insurance laws of this state.

(2) It is the intent of the legislature that the comparison of an insurer's total adjusted capital to any of its RBC levels is a regulatory tool that may indicate the need for possible corrective action with respect to the insurer and that it is not intended as a means to rank insurers generally. Except as otherwise required under the provisions of [sections 92 through 94], the making, publishing, disseminating, circulating, or placing before the public or causing, directly or indirectly to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, in the form of a notice, circular, pamphlet, letter, or poster, over any radio or television

station, or in any other way, an advertisement, announcement, or statement containing an assertion, representation, or statement with regard to the RBC levels of any insurer or of any component derived in the calculation that is by any insurer, producer, or other person engaged in any manner in the insurance business would be misleading and is prohibited. However, if any materially false statement with respect to the comparison regarding an insurer's total adjusted capital to its RBC levels or an inappropriate comparison of any other amount to the insurer's RBC levels is published in any written publication and the insurer is able to demonstrate to the commissioner, with substantial proof, the falsity of the statement or the inappropriateness, as the case may be, the insurer may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

(3) It is the further intent of the legislature that the RBC instructions, RBC reports, adjusted RBC reports, RBC plans, and revised RBC plans are intended solely for use by the commissioner in monitoring the solvency of insurers and the need for possible corrective action with respect to insurers and may not be used by the commissioner for ratemaking or considered or introduced as evidence in any rate proceeding or used by the commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance that an insurer or any affiliate is authorized to write.

NEW SECTION. **Section 91. Supplemental provisions -- rules -- exemption.** (1) The provisions of [sections 82 through 94] are supplemental to any other provisions of the laws of this state and do not preclude or limit any other powers or duties of the commissioner under the law, including but not limited to Title 33, chapter 2, part 13.

(2) The commissioner may adopt reasonable rules necessary for the implementation of [sections 82 through 94].

(3) The commissioner may exempt from the application of [sections 82 through 94] any domestic property and casualty insurer that:

(a) writes direct business only in this state;

(b) writes direct annual premiums of $2 million or less; and

(c) does not assume reinsurance in excess of 5% of direct premium written.

NEW SECTION. **Section 92. Foreign insurers.** (1) A foreign insurer shall, upon the written request of the commissioner, submit to the commissioner an RBC report for the previous calendar year on the later of:

(a) the date that an RBC report would be required to be filed by a domestic insurer under [section 84]; or

(b) 15 days after the request is received by the foreign insurer.

(2) A foreign insurer shall, at the written request of the commissioner, promptly submit to the commissioner a copy of any RBC plan that is filed with the insurance commissioner of any other state.

(3) In the event of a company action level event, regulatory action level event, or authorized control level event, with respect to any foreign insurer as determined under the RBC statute applicable in the state of domicile of the insurer or, if an RBC statute is not in force in that state, under the provisions of [sections 82 through 94], if the insurance commissioner of the state of domicile of the foreign insurer fails to require the foreign insurer to file an RBC plan in the manner specified under that state's RBC statute or, if an RBC statute is not in force in that state, under [section 85], the commissioner may require the foreign insurer to file an RBC plan with the commissioner. In that event, the failure of the foreign insurer to file an RBC plan with the commissioner is grounds to order the insurer to cease and desist from writing new insurance business in this state.

(4) In the event of a mandatory control level event with respect to any foreign insurer, if a domiciliary receiver has not been appointed with respect to the foreign insurer under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign insurer, the commissioner may make application to a district court of this state permitted under 33-2-1380 with respect to the liquidation of property of foreign insurers found in this state, and the occurrence of the mandatory control level event must be considered adequate grounds for the application.

NEW SECTION. **Section 93. Applicability for 1995.** (1) For RBC reports required to be filed by property and casualty insurers with respect to 1995, the following requirements apply in lieu of the provisions of [sections 85 through 88]:

(a) In the event of a company action level event with respect to a domestic insurer, the commissioner will not take regulatory action under [sections 82 through 94].

(b) In the event of a regulatory action level event under [section 86(1)(a), (1)(b), or (1)(c)], the

commissioner shall take the actions required under [section 86(2)].

(c) In the event of a regulatory action level event under [section 86(1)(d), (1)(e), (1)(f), or (1)(g)] or an authorized control level event, the commissioner shall take the actions required under [section 86(2) and (3)] with respect to the insurer.

(4) In the event of a mandatory control level event with respect to an insurer, the commissioner shall take the actions required under [section 88].

NEW SECTION. **Section 94. Notices.** All notices by the commissioner to an insurer that may result in regulatory action are effective on dispatch if transmitted by certified mail or, in the case of any other transmission, are effective on the insurer's receipt of the notice.

SECTION 95. SECTION 33-22-1811, MCA, IS AMENDED TO READ:

"**33-22-1811. Availability of coverage -- required plans.** (1) (a) As a condition of transacting business in this state with small employers, each small employer carrier shall offer to small employers at least two health benefit plans. One plan must be a basic health benefit plan, and one plan must be a standard health benefit plan.

(b) (i) A small employer carrier shall issue a basic health benefit plan or a standard health benefit plan to any eligible small employer that applies for either plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this part.

(ii) In the case of a small employer carrier that establishes more than one class of business pursuant to 33-22-1808, the small employer carrier shall maintain and offer to eligible small employers at least one basic health benefit plan and at least one standard health benefit plan in each established class of business. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business, provided that:

(A) the criteria are not intended to discourage or prevent acceptance of small employers applying for a basic or standard health benefit plan;

(B) the criteria are not related to the health status or claims experience of the small employers' employees;

(C) the criteria are applied consistently to all small employers that apply for coverage in that

commissioner shall take the actions required under [section 86(2)].

(c) In the event of a regulatory action level event under [section 86(1)(d), (1)(e), (1)(f), or (1)(g)] or an authorized control level event, the commissioner shall take the actions required under [section 86(2) and (3)] with respect to the insurer.

(2) In the event of a mandatory control level event with respect to an insurer, the commissioner shall take the actions required under [section 88].

NEW SECTION. **Section 94. Notices.** All notices by the commissioner to an insurer that may result in regulatory action are effective on dispatch if transmitted by certified mail or, in the case of any other transmission, are effective on the insurer's receipt of the notice.

SECTION 95. SECTION 33-22-1811, MCA, IS AMENDED TO READ:

"**33-22-1811. Availability of coverage -- required plans.** (1) (a) As a condition of transacting business in this state with small employers, each small employer carrier shall offer to small employers at least two health benefit plans. One plan must be a basic health benefit plan, and one plan must be a standard health benefit plan.

(b) (i) A small employer carrier shall issue a basic health benefit plan or a standard health benefit plan to any eligible small employer that applies for either plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this part.

(ii) In the case of a small employer carrier that establishes more than one class of business pursuant to 33-22-1808, the small employer carrier shall maintain and offer to eligible small employers at least one basic health benefit plan and at least one standard health benefit plan in each established class of business. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business, provided that:

(A) the criteria are not intended to discourage or prevent acceptance of small employers applying for a basic or standard health benefit plan;

(B) the criteria are not related to the health status or claims experience of the small employers' employees;

(C) the criteria are applied consistently to all small employers that apply for coverage in that

class of business; and

(D) the small employer carrier provides for the acceptance of all eligible small employers into one or more classes of business.

(iii) The provisions of subsection (1)(b)(ii) may not be applied to a class of business into which the small employer carrier is no longer enrolling new small businesses.

(c) The provisions of this section are effective 180 days after the commissioner's approval of the basic health benefit plan and the standard health benefit plan developed pursuant to 33-22-1812, provided that if the program created pursuant to 33-22-1818 is not yet operative on that date, the provisions of this section are effective on the date that the program begins operation.

(2) (a) A small employer carrier shall, pursuant to 33-1-501, file the basic health benefit plans and the standard health benefit plans to be used by the small employer carrier.

(b) The commissioner may at any time, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a basic or standard health benefit plan on the grounds that the plan does not meet the requirements of this part.

(3) Health benefit plans covering small employers must comply with the following provisions:

(a) A health benefit plan may not, because of a preexisting condition, deny, exclude, or limit benefits for a covered individual for losses incurred more than 12 months following the effective date of the individual's coverage. A health benefit plan may not define a preexisting condition more restrictively than 33-22-110, except that the condition may be excluded for a maximum of 12 months.

(b) A health benefit plan must waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to those services if the qualifying previous coverage was continuous to a date not ~~less~~ more than 30 days prior to the submission of an application for new coverage. This subsection (3)(b) does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

(c) A health benefit plan may exclude coverage for late enrollees for 18 months or for an 18-month preexisting condition exclusion, provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period may not exceed 18 months from the date the individual enrolls for coverage under the health benefit plan.

(d) (i) Requirements used by a small employer carrier in determining whether to provide

coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, must be applied uniformly among all small employers that have the same number of eligible employees and that apply for coverage or receive coverage from the small employer carrier.

(ii) A small employer carrier may vary the application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(e) (i) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier may not offer coverage only to certain individuals in a small employer group or only to part of the group, except in the case of late enrollees as provided in subsection (3)(c).

(ii) A small employer carrier may not modify a basic or standard health benefit plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

(4) (a) A small employer carrier may not be required to offer coverage or accept applications pursuant to subsection (1) in the case of the following:

(i) to a small employer when the small employer is not physically located in the carrier's established geographic service area;

(ii) to an employee when the employee does not work or reside within the carrier's established geographic service area; or

(iii) within an area where the small employer carrier reasonably anticipates and demonstrates to the satisfaction of the commissioner that it will not have the capacity within its established geographic service area to deliver service adequately to the members of a group because of its obligations to existing group policyholders and enrollees.

(b) A small employer carrier may not be required to provide coverage to small employers pursuant to subsection (1) for any period of time for which the commissioner determines that requiring the acceptance of small employers in accordance with the provisions of subsection (1) would place the small employer carrier in a financially impaired condition."

SECTION 96. SECTION 33-1-413, MCA, IS AMENDED TO READ:

"**33-1-413. Examination expense -- lien.** (1) Upon presentation of a detailed account of ~~such~~ charges and expenses by the commissioner or pursuant to ~~his~~ the commissioner's written authorization, each person ~~so~~ examined, other than ~~as to~~ examinations pursuant to 33-1-402, shall pay the actual travel expenses, a reasonable living expense allowance, and a per diem as compensation of examiners as necessarily incurred on account of the examination, all at reasonable rates ~~customary therefor and~~ as established or adopted by the commissioner. ~~Such an~~ An account may be ~~so~~ presented periodically during the course of the examination or at the termination of the examination as the commissioner ~~deems~~ considers proper. ~~No~~ A person ~~shall~~ may not pay and ~~no~~ an examiner ~~shall~~ may not accept any additional emolument on account of ~~any such~~ an examination.

(2) The commissioner shall pay to the state treasurer to the credit of the ~~general~~ state special revenue fund all ~~moneys~~ money received pursuant to subsection (1) ~~above~~.

(3) If ~~any such~~ a person fails to pay the charges and expenses, as referred to in subsection (1) ~~above~~, ~~they shall~~ the charges and expenses must be paid out of the funds of the commissioner in the same manner as other disbursements of ~~such~~ the funds. The amount ~~so~~ paid ~~shall be~~ is a first lien upon all of the assets and property in this state of ~~such~~ the person and may be recovered by suit by the attorney general on behalf of the state of Montana and restored to the appropriate fund."

NEW SECTION. **Section 97. Repealer.** Sections 33-30-312 and 33-30-313, MCA, are repealed.

NEW SECTION. **Section 98. Codification instruction.** (1) [Section 75] is intended to be codified as an integral part of Title 33, chapter 15, and the provisions of Title 33, chapter 15, apply to [section 75].

(2) [Section 76] is intended to be codified as an integral part of Title 33, chapter 2, part 5, and the provisions of Title 33, chapter 2, part 5, apply to [section 76].

(3) [Section 77] is intended to be codified as an integral part of Title 33, chapter 15, part 4, and the provisions of Title 33, chapter 15, part 4, apply to [section 77].

(4) [Sections 78 through 81] are intended to be codified as an integral part of Title 33, chapter 3, and the provisions of Title 33, chapter 3, apply to [sections 78 through 81].

(5) [Sections 82 through 94] are intended to be codified as an integral part of Title 33, chapter

2, and the provisions of Title 33, chapter 2, apply to [sections 82 through 94].

NEW SECTION. **Section 99. Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **SECTION 100. EFFECTIVE DATES.** (1) [SECTION 31 AND THIS SECTION] ARE EFFECTIVE ON PASSAGE AND APPROVAL.

(2) ~~[SECTIONS 1 THROUGH 30 AND 32 THROUGH 98] ARE~~ EXCEPT AS PROVIDED IN SUBSECTION (1), [THIS ACT] IS EFFECTIVE OCTOBER 1, 1995.

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