HOUSE BILL NO. 131

INTRODUCED BY SIMON

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING STATE INSURANCE LAWS; PROVIDING FOR UNIFORM HEALTH INSURANCE CLAIM FORMS; PROVIDING A STATUTE OF LIMITATIONS FOR ACTIONS BROUGHT BY THE COMMISSIONER OF INSURANCE; PROVIDING PENALTIES FOR MISREPRESENTATIONS MADE TO THE COMMISSIONER; REQUIRING THAT CREDIT LIFE AND DISABILITY INSURANCE APPLICATIONS BE SIGNED BY THE INSURANCE PRODUCER EFFECTING THE SALE; DEFINING "SERVICE CONTRACT INSURANCE"; AMENDING SECTIONS 18-8-103, 33-2-307, 33-2-317, 33-2-514, 33-2-517, 33-2-537, 33-2-704, 33-2-806, 33-2-1359, 33-2-1902, 33-3-303, 33-3-307, 33-4-202, 33-4-203, 33-4-204, 33-4-313, 33-4-314, 33-5-402, 33-10-202, 33-15-1106, 33-16-1027, 33-17-102, 33-17-212, 33-17-301, 33-17-1203, 33-18-210, 33-18-301, 33-20-101, 33-22-107, 33-22-508, 33-22-903, 33-22-907, 33-22-910, 33-22-1803, 33-22-1819, 33-22-1820, 33-22-1828, 33-30-102, 33-30-107, 33-31-111, AND 33-31-211, MCA; AND REPEALING SECTIONS 33-2-515, 33-2-536, 33-2-721, 33-2-722, 33-2-723, 33-4-404, 33-4-409, 33-22-1201, 33-22-1202, 33-22-1203, 33-22-1204, AND 33-22-1205, MCA."

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

Section 1. Section 18-8-103, MCA, is amended to read:

"**18-8-103. Exemptions.** This part does not apply to employment of:

(1) registered professional engineers, surveyors, real estate appraisers, or registered architects;

(2) physicians, dentists, or other medical, dental, or health care providers;

(3) expert witnesses hired for use in litigation, hearings officers hired in rulemaking and contested case proceedings under the Montana Administrative Procedure Act, or attorneys as specified by executive order of the governor;

(4) consulting actuaries to the public retirement boards, ~~or~~ the state compensation insurance fund, or the commissioner of insurance;

(5) private consultants employed by the student associations of the university system with money

raised from student activity fees designated for use by those student associations; or

(6) private consultants employed by the Montana state lottery."

Section 2. 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) $7 million. An insurer possessing less than ~~$6~~ $7 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 ~~$6~~ $7 million.

(ii) in the case of Lloyd's or another similar group including incorporated and unincorporated alien 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~~ not 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 3. Section 33-2-317, MCA, is amended to read:

"**33-2-317. Exemptions.** The Surplus Lines Insurance Law does not apply to reinsurance or to the following kinds of insurance when placed by a licensed insurance producer of this state:

(1) wet marine ~~and transportation insurances~~ insurance;

(2) insurance on subjects located, residing, or to be performed wholly outside of this state or on vehicles or aircraft owned and principally garaged outside this state;

(3) insurance on property or operations of railroads engaged in interstate commerce; and

(4) insurance of aircraft owned or operated by manufacturers of aircraft or aircraft operated in scheduled interstate flight or cargo of the aircraft or against liability, other than workers' compensation and employers' liability, arising out of the ownership, maintenance, or use of the aircraft."

Section 4. Section 33-2-514, MCA, is amended to read:

"**33-2-514. Reserve for disability insurance.** (1) For all disability insurance policies, the insurer shall maintain an active life reserve ~~which shall place~~ that places a sound value on its liabilities under ~~such~~ the policies and that may not be ~~not~~ less than ~~the reserve according to appropriate standards set forth in regulations issued by the commissioner and, in no event, less in the aggregate than~~ the pro rata gross unearned premiums for ~~such~~ the policies.

(2) The commissioner may promulgate rules to define additional standards for reserve requirements."

Section 5. Section 33-2-517, MCA, is amended to read:

"**33-2-517. Title insurance reserves.** (1) In addition to an adequate reserve as to outstanding losses as required under 33-2-511, a title insurer shall maintain a guaranty fund or unearned premium reserve of not less than an amount computed as follows:

(a) Ten percent of the total amount of the risk premiums written in the calendar year for title insurance contracts ~~shall~~ must be assigned originally to the reserve.

(b) During each of the 20 years next following the year in which the title insurance contract was issued, the reserve applicable to the contract ~~shall~~ must be reduced by 5% of the original amount of ~~such~~ the reserve.

(2) The reserve sums ~~herein~~ required ~~to be reserved~~ by subsection (1) for unearned premiums on contracts of title insurance ~~shall~~ must at all times and for all purposes be considered and constitute unearned portions of the original premiums and ~~shall~~ must be held in trust for the benefit of policyholders.

(3) The reduction of the unearned premium reserve required by subsection (1)(b) ~~of this section shall~~ must be made for all title insurance contracts issued after December 31, 1958, with respect to which 10% of the risk premiums have been assigned to the reserve pursuant to subsection (1)(a) ~~of this section~~. ~~In the event that any title insurer has not in accordance with subsection (1)(b) of this section reduced the amount of its unearned premium reserve by 5% of the amount originally assigned to the reserve pursuant to subsection (1)(a) of this section for years ending after December 31, 1958, and before January 1, 1977, the insurer shall effect such reduction for such prior years during its accounting year which includes December 31, 1976.~~ If the insurer has not reduced the amount of its unearned premium reserves pursuant to subsection (1)(b) for a previous year or years, the insurer shall make the reduction for the prior year or years in its next accounting year."

Section 6. Section 33-2-537, MCA, is amended to read:

"**33-2-537. 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~~ may promulgate a rule containing the minimum standards applicable to the valuation of disability plans."

Section 7. Section 33-2-704, MCA, is amended to read:

"**33-2-704. Insured lives reporting requirement.** On or before ~~February 15~~ March 1 of each year, each insurer providing disability insurance shall, on a form prescribed by the commissioner, report the number of Montana residents insured on February 1 under any policy of individual or group disability insurance, including excess of loss or stop loss insurance policies covering disability insurance."

Section 8. 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 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 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 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~~ 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:~~ in 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, in securities, in both cash and securities, or in investments provided for ~~under~~ in 33-2-531.

(5) Except with the commissioner's consent, an insurer 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) Except with the commissioner's consent, an ~~An~~ insurer may not invest and have invested at any one time in aggregate amount more than 15% of its assets in all stocks ~~under~~ provided for in 33-2-820 and 33-2-821. Determination of the amount that an insurer has invested in common stocks for the purposes of this provision must be based on the cost of the stocks to the insurer. This provision does not apply ~~as~~ to stock of a controlled or subsidiary insurance corporation or other corporations ~~under~~ provided for in 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~~ in 33-2-824. Money market funds, as defined by the commissioner by rule, are exempt from the 5% limitation of this subsection.

(8) Except with the commissioner's consent, an insurer 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~~ of investments in ~~the category of~~ real estate ~~shall~~ must be as provided in 33-2-832. Other specific limits apply as stated in the sections dealing with other respective kinds of investments."

Section 9. Section 33-2-1359, MCA, is amended to read:

"**33-2-1359. Setoffs and counterclaims.** (1) Mutual debts or mutual credits between the insurer and another person in connection with any action or proceeding under this part ~~shall~~ must be set off and the balance only ~~shall be~~ allowed or paid, except as provided in ~~subsection (2) and~~ 33-2-1362 and subsection (2) of this section.

(2) ~~No~~ A setoff or counterclaim may not be allowed in favor of any person when:

(a) the obligation of the insurer to the person would not at the date of the filing of a petition for liquidation entitle the person to share as a claimant in the assets of the insurer;

(b) the obligation of the insurer to the person was purchased by or transferred to the person with a view to its being used as a setoff; or

(c) the obligation of the person is to pay an assessment levied against the members or subscribers of the insurer or is to pay a balance upon a subscription to the capital stock of the insurer or is in any other way in the nature of a capital contribution.; ~~or~~

~~(d) the obligation of the person is to pay premiums, whether earned or unearned, to the insurer.~~"

Section 10. Section 33-2-1902, MCA, is amended to read:

"**33-2-1902. Definitions.** As used in this part, the following definitions apply:

(1) "Adjusted RBC report" means an RBC report that has been adjusted by the commissioner in accordance with 33-2-1903(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; or

(c) any insurer engaged solely in the business of reinsurance of life or disability contracts.

(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 :

(i) 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;

(ii) any insurance company engaged solely in the business of reinsurance of property and casualty contracts; or

(iii) any insurance company engaged in the business of surety and marine insurance.

(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 33-2-1904(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 33-2-1903.

(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."

Section 11. Section 33-3-303, MCA, is amended to read:

"**33-3-303. Meetings of stockholders or members.** (1) Meetings of stockholders or members of a domestic insurer ~~shall~~ must be held in the city or town of its principal office or place of business in this state.

(2) ~~No~~ A meeting of stockholders or members ~~shall~~ may not amend the insurer's articles of incorporation unless the proposal ~~so~~ to amend was included in the notice of the meeting.

(3) Except with the commissioner's consent, each ~~Each~~ insurer shall, during the first 6 months of each calendar year, hold the annual meeting of its stockholders or members to fill vacancies existing or occurring in the board of directors, must receive and shall consider reports of the insurer's officers as to its affairs, and shall transact ~~such~~ other business ~~as may~~ properly ~~be~~ brought before it. Not less than 20

days' notice ~~shall~~ must be given of ~~such~~ the meeting in the manner provided in the bylaws, except ~~where~~ when notice of the annual meeting of a mutual insurer is contained in its policies.

(4) Special meetings of the stockholders or members may be called at any time for any purpose by the board of directors upon not less than 10 days' notice, with notice given as provided in the bylaws. The notice ~~shall~~ must state the purpose of the meeting, and ~~no~~ business for which notice was not given may not ~~shall~~ be transacted at the meeting ~~of which notice was not so given~~.

(5) If more than 15 months are allowed to elapse without an annual stockholders' or members' meeting being held, any stockholder or member may call ~~such a~~ for an annual meeting to be held. At any time, upon written request of any director or of any stockholders or members holding in the aggregate one-fifth of the voting power of all stockholders or members, it ~~shall be~~ is the duty of the secretary to call a special meeting of stockholders or members to be held at ~~such~~ the time ~~as~~ that the secretary may fix, not less than 10 or more than 30 days after the receipt of the request. If the secretary fails to issue ~~such~~ a call, the director, stockholders, or members making the request may do so.

(6) A stockholders' or members' meeting duly held ~~can~~ may be organized for the transaction of business whenever a quorum is present. Except as otherwise provided by law or the articles of incorporation:

(a) the presence, in person or by proxy, of the holders of a majority of the voting power of all stockholders or of all members ~~shall constitute~~ constitutes a quorum;

(b) the stockholders or members present at a duly organized meeting ~~can~~ may continue to do business until adjournment, notwithstanding the withdrawal of enough stockholders or members to leave less than a quorum;

(c) if any necessary officer fails to attend ~~such~~ a meeting, any stockholder or member present may be elected to act temporarily in lieu of ~~any such~~ the absent officer;

(d) if a meeting cannot be ~~organized~~ held because a quorum ~~has not attended~~ is not present, those present may adjourn the meeting to ~~such~~ a time ~~as~~ that they ~~may~~ determine, but in the case of any meeting called for the election of any director, the adjournment must be to the next day and those who attend the second ~~of such adjourned meetings~~ meeting, although less than a quorum as fixed in this section or in the articles of incorporation, ~~shall nevertheless~~ constitute a quorum for the purpose of electing any director; and

(e) an annual or special meeting of stockholders or members may be adjourned to another date

without new notice being given."

Section 12. Section 33-3-307, MCA, is amended to read:

"**33-3-307. Bond of officers.** (1) The president, secretary, and treasurer of ~~every~~ each mutual insurer or stock insurer shall each file with the commissioner and ~~thereafter~~ maintain in force so long as ~~he~~ that individual is ~~such~~ an officer a fidelity bond in ~~the sum of $10,000~~ an amount set by the commissioner by rule and issued by an authorized corporate surety in favor of the insurer. The commissioner shall consider the insurer's exposure, total assets, and total income in determining the bond amount. In lieu of individual bonds, ~~all such~~ officers may be covered under a blanket bond for the same respective amounts~~,~~ ~~and which~~ The blanket bond ~~shall likewise~~ must be filed with the commissioner.

(2) The premium for the bond ~~shall~~ must be payable by the insurer.

(3) ~~No such~~ A bond ~~shall~~ is not ~~be~~ subject to cancellation except upon written notice to both the insurer and the commissioner, delivered not less than 30 days in advance of the effective date of ~~such~~ the cancellation.

(4) The insurer shall provide for the bonding by authorized corporate surety of all other officers in any way responsible for the handling of the funds of the insurer.

(5) This section ~~shall~~ may not be ~~deemed~~ considered to limit the amount of bonded protection ~~which~~ that the insurer may carry as to any officer."

Section 13. 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 the corporation 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) four copies of proposed articles of incorporation executed ~~in 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~~ The signatures of the incorporators must be notarized.

(2) The articles of incorporation 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 must contain the words "farm mutual" or "rural mutual" together with the name of the county in which its principal place of business is to be located. The name 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 must be located in this state;

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

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

(f) the duration of ~~its~~ the corporation's existence, which may be perpetual;

(g) the number of its directors, which may not be less than 5 or more than 11, 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~~ at which time successors are elected and qualified;

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

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

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

Section 14. Section 33-4-203, MCA, is amended to read:

"**33-4-203. Approval of articles -- commencement of corporate existence.** (1) If the 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 commissioner shall make a certificate of the facts.

(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 commissioner, the

commissioner shall endorse the ~~commissioner's~~ approval upon each set of the articles and forward ~~three~~ four 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 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 15. Section 33-4-204, MCA, is amended to read:

"**33-4-204. Amendment of articles.** A farm mutual insurer may, by a vote of two-thirds of its members present at any annual meeting or at any special meeting ~~of members~~ called for that purpose, amend its articles of incorporation to extend its corporate duration or ~~in~~ any other particular within the scope of this chapter by causing amended articles to be filed in the same form and manner as required for original articles of incorporation. The commissioner shall review the amended articles for compliance with this title. The amended articles of incorporation ~~shall~~ may be signed only by the president and secretary of the corporation and attested by the corporate seal. Notice of the proposed amendment ~~shall~~ must be contained in the notice ~~given~~ of ~~any such~~ the annual or special meeting."

Section 16. Section 33-4-313, MCA, is amended to read:

"**33-4-313. Annual statement ~~—report—filing~~.** ~~(1)~~ The president and secretary of ~~every~~ each insurer, on or before March 1 each year, shall prepare, affirm under oath, affix the corporate seal ~~thereto~~ to, and file with the commissioner, on forms ~~as~~ prescribed and furnished by ~~him~~ the commissioner, an annual statement for the preceding calendar year showing the condition of ~~such~~ the insurer as of December 31 of ~~such~~ the preceding year and exhibiting the following facts:

~~(a)~~(1) the names of the president and secretary;

~~(b)~~(2) the date of the annual meeting;

~~(c)~~(3) the amount of insurance in force;

~~(d)~~(4) the number of members;

~~(e)~~(5) the number of assessments made during the year;

~~(f)~~(6) the amount paid in losses during the year;

~~(g)~~(7) the amount of the losses claimed and not paid, with the reason for nonpayment;

~~(h)~~(8) the number of members withdrawn, suspended, and expelled during the year;

~~(i)~~(9) the number of new members admitted during the year;

~~(j)~~(10) the expenses during the year;

~~(k)~~(11) the amount of money on hand;

~~(l)~~(12) the amount and character of the insurer's assets;

~~(m)~~(13) the amount of the insurer's liabilities, including any reserves required to be established under this chapter; and

~~(n)~~(14) ~~such~~ other information concerning the insurer's affairs ~~as~~ that the commissioner may reasonably require.

~~(2) A report of an insurer's expenditures for educational purposes, if any, for the preceding year must be filed with the commissioner at the same time and in conjunction with the annual report of such insurer, as required under 33-4-404.~~"

Section 17. Section 33-4-314, MCA, is amended to read:

"**33-4-314. Annual statement -- exclusive report -- penalty for failure to file.** (1) ~~No~~ A report, statement, or return of any nature ~~shall~~ may not be required of any farm mutual insurer other than those required by 33-4-313.

(2) The commissioner may:

(a) suspend or revoke the certificate of authority of any insurer failing to file its annual statement as required; or

(b) impose a fine of up to $100 a day for each day that an insurer is late in filing its annual statement, with the aggregate penalty not to exceed $1,000."

Section 18. Section 33-5-402, MCA, is amended to read:

"**33-5-402. Contributions to insurer.** The attorney or other parties may advance to a domestic reciprocal insurer upon reasonable terms ~~such~~ funds ~~as~~ that it may require from time to time in its operations. Sums ~~so~~ advanced ~~shall~~ may not be treated as a liability of the insurer, ~~and, except~~ Except upon

liquidation of the insurer, ~~shall not be withdrawn or repaid except out of the insurer's realized earned surplus in excess of its minimum required surplus~~ during any calendar year, the total of withdrawals and repayments of the advanced sums may not exceed the lesser of the insured's realized earned surplus or 10% of the sums advanced as of the previous December 31. ~~No such~~ A withdrawal or repayment ~~shall~~ may not be made without the advance approval of the commissioner. This section does not apply to bank loans or to loans for which security is given."

Section 19. 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~~ 33-10-201(4) through (6) ~~of 33-10-201~~.

(5) "Impaired insurer" means:

(a) an insurer ~~which after July 1, 1974,~~ that 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 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~~ 33-10-201 and 33-10-224 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) (a) "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.

(b) ~~"Premiums" do~~ The term does not include premiums and considerations on contracts between insurers and reinsurers.

(c) As used in 33-10-227, ~~"premiums"~~ 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 that 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 20. Section 33-15-1106, MCA, is amended to read:

"**33-15-1106. Renewal with altered terms.** (1) If an insurer offers or purports to renew a policy but on less favorable terms, at a higher rate, or at a higher rating plan, the new terms, rate, or rating plan take effect on the policy renewal date only if the insurer has mailed or delivered notice of the new terms, rate, or rating plan to the insured at least 30 days before the expiration date. ~~If the insured has not been so notified, he may cancel the renewal policy within 30 days after receiving the notice. The insurer shall continue coverage for a period of not less than 30 days after mailing or delivery of the notice. If the insured terminates the policy within the 30-day period, the insurer shall calculate the earned premium pro rata based upon the prior policy's rate. The new rate is effective only after the required 30-day notification period has been met. If the insured does not terminate the policy, the premium increase and other changes are effective the day following the prior policy's expiration or anniversary date.~~

(2) This section does not apply if the increase in the rate or the rating plan, or both, results from a classification change based on the altered nature or extent of the risk insured against."

Section 21. Section 33-16-1027, MCA, is amended to read:

"**33-16-1027. Rate filing review.** (1) The commissioner shall review each insurance filing to ensure compliance with the following guidelines:

(a) The effective date of each workers' compensation insurer or advisory organization filing must be the date specified in the filing. The effective date of the filing may not be earlier than 30 days after the date on which the filing is received by the commissioner or the date of receipt of the information furnished in support of the filing, if the supporting information is required by the commissioner.

(b) Upon written application of the insurer or advisory organization, the commissioner may authorize a filing that becomes effective before the expiration of the period described in subsection (1)(a).

(c) A filing is considered to have met the requirements of this part unless disapproved by the commissioner within the period described in subsection (1)(a) or any extension of the period.

(2) Whenever a filing is not accompanied by the information required under this section, the commissioner shall inform the filer of the deficiency within ~~10~~ 30 days of the initial filing. The filing is considered made when the required information is furnished or when the filer certifies to the commissioner that the additional information requested by the commissioner is not maintained or cannot be provided."

Section 22. 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;

(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 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 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~~.~~; or

(xii) a person appointed as a managing general agent in this state whose activities are limited

exclusively to those described in 33-2-1501(10) and Title 33, chapter 2, part 16.

(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 the person or the person's spouse, employer, or 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 chapter, the term "managing general agent" 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 23. Section 33-17-212, MCA, is amended to read:

"**33-17-212. Examination required -- exceptions -- fees.** (1) Except as provided in subsection (7), an individual applying for a license shall pass a written examination. The examination must test the knowledge of the individual concerning each kind of insurance listed in subsection (6) for which application is made, the duties and responsibilities of an insurance producer, and the insurance laws and rules of this state. The examination must be developed and conducted under rules adopted by the commissioner.

(2) The commissioner may conduct the examination or make arrangements, including contracting with an outside testing service, for administering the examination and collecting the fees required by 33-2-708. The commissioner may arrange for the testing service to recover the cost of the examination from the applicant.

(3) Each individual applying for an examination shall remit the fees required by 33-2-708.

(4) An individual who fails to appear for the examination as scheduled or fails to pass the examination may reapply for an examination and shall remit all required fees and forms before being rescheduled for another examination.

(5) If the applicant is a partnership or corporation, each individual who is to be named in the license as having authority to act for the applicant in its insurance transactions under the license shall take the examination.

(6) Examination of an applicant for a license must cover all of the kinds of insurance for which the applicant has applied to be licensed, as constituted by any one or more of the following classifications:

(a) life insurance;

(b) disability insurance;

(c) property insurance. For the purposes of this provision, property insurance includes marine insurance.

(d) casualty insurance;

(e) surety insurance;

(f) credit life and disability insurance;

(g) title insurance.

(7) This section does not apply to and an examination is not required of:

(a) an individual lawfully licensed as an insurance producer as to the kind or kinds of insurance to be transacted as of or immediately prior to January 1, 1961, and ~~thereafter continuing~~ who continues to be licensed;

(b) an applicant for a license covering the same kind or kinds of insurance as to which the applicant was licensed in this state, other than under a temporary license, within the 12 months immediately preceding the date of application unless the commissioner has suspended, revoked, or refused to continue the previous license, except that this subsection (7)(b) does not apply to a title insurance producer, as defined in 33-25-105;

(c) an applicant for a license as a nonresident insurance producer;

(d) an applicant for a license to sell all-risk federal crop insurance if the applicant provides certification from an appropriate governmental agency to the commissioner that ~~he~~ the applicant is qualified to sell the insurance;

(e) transportation ticket agents of common carriers applying for a license to solicit and sell only:

(i) accident insurance ticket policies; or

(ii) insurance of personal effects while being carried as baggage on a common carrier, as incidental to their duties as transportation ticket agents;

(f) an association applying for a license under 33-17-211;

(g) a mechanical breakdown insurance producer~~.~~;

(h) a service contract insurance producer; or

~~(h)~~(i) an individual who, within 60 days of cancellation of a license issued by the state of the individual's residence, files with the commissioner a current letter of clearance certifying that the individual has passed an examination and held an insurance license in good standing in the individual's state of licensure, except that the individual shall take an examination pertaining to this state's law and each kind of insurance for which the individual has applied for a license and ~~which~~ that is not covered under the license held in the other state."

Section 24. Section 33-17-301, MCA, is amended to read:

"**33-17-301. Adjuster license -- qualifications -- catastrophe adjustments -- public adjuster.** (1) A person may not ~~in this state~~ act as or hold ~~himself~~ the person out to be an adjuster in this state unless licensed as an adjuster under this chapter. A person shall apply for an adjuster license to the commissioner according to forms that the commissioner prescribes and furnishes. The commissioner shall issue the adjuster license to individuals qualified to be licensed as an adjuster upon payment of the license fee provided in 33-2-708.

(2) To be licensed as an adjuster, the applicant:

(a) must be an individual 18 years of age or more;

(b) must be a resident of Montana or resident of another state that will permit residents of Montana regularly to act as adjusters in the other state;

(c) must be a full-time salaried employee of a licensed adjuster or a graduate of a recognized law school or have had experience or special education or training as to the handling of loss claims under insurance contracts of sufficient duration and extent reasonably to make ~~him~~ the applicant competent to fulfill the responsibilities of an adjuster;

(d) must be trustworthy and of good character and reputation; and

(e) ~~shall~~ must have and shall maintain in this state an office accessible to the public and shall keep in the office for not less than 5 years the usual and customary records pertaining to transactions under the license. This provision does not prohibit maintenance of the office in the home of the licensee.

(3) A partnership or corporation, whether or not organized under the laws of this state, may be licensed as an adjuster if each individual who is to exercise the adjuster license powers is separately licensed or is named in the partnership or corporation adjuster license and is qualified for an individual adjuster license. An additional full license fee must be paid for each individual in excess of one named in the partnership or corporation adjuster license to exercise its powers.

(4) An adjuster license or qualifications are not required for an adjuster who is sent into this state by and on behalf of an insurer or adjusting partnership or corporation for the purpose of investigating or making adjustments of a particular loss under an insurance policy or for the adjustment of a series of losses resulting from a catastrophe common to all losses.

(5) An adjuster license continues in force until expired, suspended, revoked, or terminated. The license is subject to annual payment to the commissioner of the renewal fee required by 33-2-708, accompanied by a written request for renewal.

(6) The commissioner may adopt rules providing for the examination, licensure, bonding, and regulation of public adjusters."

Section 25. Section 33-17-1203, MCA, is amended to read:

"**33-17-1203. Continuing education -- basic requirements -- exceptions.** (1) Unless exempt under subsection (4):

(a) a person licensed to act as an insurance producer for property, casualty, surety, or title insurance or as a consultant for general insurance shall, during each calendar year, complete at least 10 credit hours of approved continuing education;

(b) a person licensed to act as an insurance producer for life or disability insurance or as a consultant for life insurance shall, during each calendar year, complete at least 10 credit hours of approved continuing education;

(c) a person holding multiple licenses shall, during each calendar year, complete at least 15 credit hours of approved continuing education;

(d) a person licensed to act as an insurance producer only for credit life and disability insurance shall, during each calendar year, complete 5 credit hours of approved continuing education in the areas of insurance law, ethics, or credit life and disability insurance;

(e) a person licensed as an insurance producer or consultant shall, during each biennium, complete at least 1 credit hour of approved continuing education on changes in Montana insurance statutes and administrative rules.

(2) If a person licensed as an insurance producer or consultant completes more credit hours of approved continuing education in a year than the minimum required in subsection (1), the excess credit hours may be carried forward and applied to the continuing education requirements of the next year.

(3) The commissioner may, for good cause ~~shown~~, grant an extension of time, not to exceed 1 year, during which the requirements imposed by subsection (1) may be completed.

(4) The minimum continuing education requirements do not apply to:

(a) a person licensed to sell any kind of insurance for which an examination is not required under 33-17-212(7)(d) through ~~(7)(g)~~ (7)(h);

(b) a person holding a temporary license issued under 33-17-216;

(c) a nonresident licensee who must meet continuing education requirements in the licensee's state of residence if that state ~~accords~~ grants substantially similar privileges to and has similar requirements ~~of~~ for residents of this state;

(d) a newly licensed insurance producer or consultant during the calendar year in which the licensee first received a license; or

(e) an insurance producer or consultant otherwise exempted by the commissioner."

Section 26. Section 33-18-210, MCA, is amended to read:

"**33-18-210. Unfair discrimination and rebates prohibited -- property, casualty, and surety insurances.** (1) A title, property, casualty, or surety insurer or an employee, representative, or insurance producer of an insurer may not, as an inducement to purchase insurance or after insurance has been effected, pay, allow, ~~or~~ give, or offer to pay, allow, or give, directly or indirectly, a:

(a) rebate, discount, abatement, credit, or reduction of the premium named in the insurance policy;

(b) special favor or advantage in the dividends or other benefits to accrue on the policy; or

(c) valuable consideration or inducement not specified in the policy, except to the extent provided for in an applicable filing with the commissioner as provided by law.

(2) An insured named in a policy or an employee of the insured may not knowingly receive or accept, directly or indirectly, a:

(a) rebate, discount, abatement, credit, or reduction of premium;

(b) special favor or advantage; or

(c) valuable consideration or inducement.

(3) An insurer may not make or permit unfair discrimination in the premium or rates charged for insurance, in the dividends or other benefits payable on insurance, or in any other of the terms and conditions of the insurance either between insureds or property having like insuring or risk characteristics or between insureds because of race, color, creed, religion, or national origin.

(4) This section may not be construed as prohibiting the payment of commissions or other compensation to duly licensed insurance producers or as prohibiting an insurer from allowing or returning lawful dividends, savings, or unabsorbed premium deposits to its participating policyholders, members, or subscribers.

(5) An insurer may not make or permit unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, canceling, or limiting the amount of insurance coverage on a property or casualty risk because of the geographic location of the risk, unless:

(a) the refusal, cancellation, or limitation is for a business purpose that is not a mere pretext for unfair discrimination; or

(b) the refusal, cancellation, or limitation is required by law or regulatory mandate.

(6) An insurer may not make or permit unfair discrimination between individuals or risks of the

same class and of essentially the same hazards by refusing to issue, refusing to renew, canceling, or limiting the amount of insurance coverage on a residential property risk or on the personal property contained in the residential property, because of the age of the residential property, unless:

(a) the refusal, cancellation, or limitation is for a business purpose that is not a mere pretext for unfair discrimination; or

(b) the refusal, cancellation, or limitation is required by law or regulatory mandate.

(7) An insurer may not refuse to insure, refuse to continue to insure, or limit the amount of coverage available to an individual because of the sex or marital status of the individual. However, an insurer may take marital status into account for the purpose of defining persons eligible for dependents' benefits.

(8) An insurer may not terminate or modify coverage or refuse to issue or refuse to renew a property or casualty policy or contract of insurance solely because the applicant or insured or any employee of either is mentally or physically impaired. However, this subsection does not apply to accident and health insurance sold by a casualty insurer, and this subsection may not be interpreted to modify any other provision of law relating to the termination, modification, issuance, or renewal of any insurance policy or contract.

(9) An insurer may not refuse to insure, ~~refuse to continue to insure,~~ charge higher rates, or limit the amount of coverage available to an individual based solely on adverse information contained in a driving record that is 3 years old or older. However, an insurer may provide discounts to an insured based on favorable aspects of an insured's claims history that is 3 years old or older.

(10) An insurer may not charge points on, refuse to issue, refuse to renew, remove an existing discount on, or surcharge a private passenger motor vehicle policy because of a claim submitted under the insured's policy if the insured was not at fault.

(11) (a) For the purposes of this subsection (11), "credit history" means that portion of a credit report or background report that addresses the applicant's or insured's debt payment history or lack of history but does not include public information including convictions, lawsuits, bankruptcies, or similar public information.

(b) An insurer writing automobile or homeowner insurance may not refuse to insure, refuse to continue to insure, charge higher rates, or limit the scope or amount of coverage or benefits available to an individual based solely on the insurer's knowledge of the individual's credit history unless:

(i) the insurer possesses substantial documentation that credit history is significantly correlated with the types of risks insured or to be insured;

(ii) the insurer sends written communication to the individual disclosing that the insurance coverage was declined, not renewed, or limited in scope or amount of coverage or benefits because of credit information relating to the applicant or the insured; and

(iii) upon subsequent request of the individual, mailed within 10 days of receipt of the denial, nonrenewal, or limitation, the insurer provides the individual with a copy of the credit report at issue or the name and address of a third party from whom the individual may obtain a copy of the credit report, within 10 days of receipt of the request.

(c) The provisions of this subsection (11) are not intended to conflict with any disclosure provisions of state law or the federal Truth in Lending Act applicable to lending institutions, credit bureaus, or other credit service organizations that maintain or distribute credit histories on insurance applicants or policyholders."

Section 27. Section 33-18-301, MCA, is amended to read:

"**33-18-301. Prohibited relations with mortuaries.** (1) A life insurer and its officers, employees, or representatives may not own, manage, supervise, operate, or maintain any mortuary, funeral, or undertaking establishment in Montana.

(2) A life insurer may not contract or agree with any funeral director, mortuary, or undertaker that the funeral director, undertaker, or mortuary shall conduct the funeral or be named beneficiary of any person insured by 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; and

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

~~(d)~~(4) ~~any~~ 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)~~ (6).

(5) An insured may designate a funeral director, mortuary, or undertaker as a specific beneficiary only when the cash value of the policy adversely affects the insured's financial condition for the purpose of determining the availability of medicaid benefits.

~~(4)~~(6) 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 both."

Section 28. Section 33-20-101, MCA, is amended to read:

"**33-20-101. Scope.** (1) Except as provided in subsection (2), parts 1 through 5 of this chapter apply only to contracts of life insurance and annuities, other than reinsurance, group life insurance, and group annuities.

(2) Sections 33-20-114 and 33-20-131 also apply to group life insurance and group annuities."

Section 29. Section 33-22-107, MCA, is amended to read:

"**33-22-107. Premium increase restriction -- exception.** (1) An insurer or a health service corporation that issues a policy, certificate, or membership contract covering a resident of this state may not increase a premium in an individual's or an ~~individual group's~~ individual's group disability insurance policy more frequently than once during a 12-month period unless failure to increase the premium more frequently than once during the 12-month period would:

(a) place the insurer in violation of the laws of this state; or

(b) cause the financial impairment of the insurer to the extent that further transaction of insurance by the insurer injures or is hazardous to its policyholders or to the public.

(2) Subsection (1) does not apply to a premium increase necessitated by a state or federal law, court decision, or rule adopted by an agency of competent jurisdiction of the state or federal government."

Section 30. 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 or the person's dependents or family members covered under the policy ceases because of termination of the person's employment or of the person's membership in the class or classes eligible for coverage under the policy or as a result of a

person's employer discontinuing the employer's business or as a result of a person's 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 the person is not insured under another major medical disability insurance policy or plan, the person is entitled to have issued to the person by the insurer, without evidence of insurability, group coverage or an individual policy 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 the person or 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. In addition, the insurer shall make available a conversion policy as required by subsection (4).

(3) The premium on the individual policy or group policy must be at no more than 200% of the insurer's then customary rate applicable to the coverage of the individual or group policy. The customary rate is that rate that is normally issued for medically underwritten policies without discount for healthy lifestyles.

(4) The insurer shall also make available ~~an individual~~ a conversion policy, certificate, or membership contract that provides at least the level of benefits provided by the insurer's lowest cost basic health benefit plan, as defined in 33-22-1803. If the insurer is not a small employer carrier under part 18, the insurer shall make available ~~an individual~~ a conversion policy, certificate, or membership contract that provides equivalent benefits to a basic health benefit plan. The conversion rate may not exceed 150% of the highest rate charged for that plan."

Section 31. Section 33-22-903, MCA, is amended to read:

"33-22-903. Definitions. As used in this part, the following definitions apply:

(1) "Applicant" means:

(a) in the case of an individual medicare supplement policy, the person who seeks to contract for insurance benefits; and

(b) in the case of a group medicare supplement policy, the proposed certificate holder.

(2) "Certificate" means a certificate delivered or issued for delivery in this state under a group

medicare supplement policy.

(3) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(4) "Entity" means an insurer as defined in 33-1-201, a health service corporation as defined in 33-30-101, and a health maintenance organization as defined in 33-31-102.

(5) "Health care expenses":

(a) means expenses of a health maintenance organization associated with the delivery of health care services that are analogous to incurred losses of an insurer;

(b) does not include home office and overhead costs, advertising costs, commissions and other acquisition costs, taxes, capital costs, administrative costs, or claims processing costs.

(6) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any entity delivering or issuing for delivery in this state medicare supplement policies or certificates.

(7) "Medicare" means Health Insurance for the Aged, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

(8) "Medicare supplement policy" means a group or individual policy of disability insurance or a subscriber contract of a health service corporation, other than a policy issued pursuant to a contract under ~~42 U.S.C. 1395l or 1395mm~~ 42 U.S.C. 1395ss(g)(1), or a policy issued under a demonstration project authorized pursuant to amendments to the federal Social Security Act, that is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare. The term does not include:

(a) a policy or contract of one or more employers or labor organizations or of the trustees of a fund established by one or more employers or labor organizations, or a combination of employers, organizations, and trustees, for employees or former employees, or a combination of current and former employees, or for members or former members, or a combination of current and former members, of the labor organizations; or

(b) individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when the group or individual policy or contract includes provisions that are inconsistent with the requirements of this part or policies issued to employees or members as additions to franchise plans in existence on April 8, 1981.

(9) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer."

Section 32. Section 33-22-907, MCA, is amended to read:

"**33-22-907. Disclosure standards -- informational brochure -- rules.** (1) In order to provide for full and fair disclosure in the sale of medicare supplement policies and certificates, a medicare supplement policy may not be delivered or issued for delivery in this state and a certificate may not be delivered pursuant to a group medicare supplement policy delivered or issued for delivery in this state unless an outline of coverage is delivered to the applicant at the time that application is made. The outline of coverage must be filed with the commissioner as required by 33-1-501. The filing must be made at least 60 days in advance of the date that the outline of coverage is delivered to any resident of this state.

(2) (a) The commissioner shall prescribe the format and content of the outline of coverage required by subsection (1).

(b) For purposes of this section, "format" means style, arrangements, and overall appearance, including such items as the size, color, and prominence of type and the arrangement of text and captions.

(c) The outline of coverage must include:

(i) a description of the principal benefits and coverage provided in the policy or certificate;

(ii) a statement of the exceptions, reductions, and limitations contained in the policy or certificate;

(iii) a statement of the renewal provisions, including any reservation by the issuer of a right to change premiums and disclosure of the existence of any automatic renewal premium increases based on the policyholder's or certificate holder's age;

(iv) a statement that the outline of coverage is a summary of the policy or certificate issued or applied for and that the policy or certificate should be consulted to determine governing contractual provisions.

(3) The commissioner may prescribe by rule a standard form and the contents of an informational brochure for persons eligible for medicare, which is intended to improve the buyer's ability to select the most appropriate coverage and to improve the buyer's understanding of medicare. Except in the case of direct response insurance policies, the commissioner may require by rule that the information brochure be provided to any prospective insureds eligible for medicare at the same time that the outline of coverage is delivered. With respect to direct response insurance policies, the commissioner may require by rule that the

prescribed brochure be provided upon request, but not later than the time of policy delivery, to any prospective insureds eligible for medicare.

(4) The commissioner may adopt reasonable rules for captions or notice requirements, determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not medicare supplement coverages, for all accident and sickness insurance policies sold to persons eligible for medicare, other than:

(a) medicare supplement policies or certificates; or

(b) disability income policies~~;~~

~~(c) basic, catastrophic, or major medical expense policies;~~

~~(d) single premium, nonrenewable policies; or~~

~~(e) other policies excepted in 33-22-903(8)~~.

(5) The commissioner may further adopt reasonable rules to govern the full and fair disclosure of the information in connection with the replacement of accident and sickness policies or certificates by persons eligible for medicare.

(6) As soon as practicable, but no later than 30 days before the annual effective date of a medicare benefit change, every entity providing medicare supplement insurance or benefits to a resident of this state shall notify its policyholders and certificate holders, in a format that the commissioner prescribes by rule, of the changes that it has made to the medicare supplement policy or certificate."

Section 33. Section 33-22-910, MCA, is amended to read:

"**33-22-910. Filing requirements for advertising.** Every issuer of medicare supplement policies or certificates in this state shall provide to the commissioner for the commissioner's ~~review or~~ approval a copy of any medicare supplement advertising intended for use in this state, whether through written, radio, or television medium."

Section 34. 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 carriers of disability insurance, including excess of loss and stop loss disability insurance.

(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 health benefit plan, except a uniform health benefit plan, developed by a small employer carrier, that has a lower benefit value than the small employer carrier's standard benefit plan and that provides the benefits required by 33-22-1827.

(6) "Benefit equivalency" means a method developed by the small employer carrier for comparing the types of health care services and articles covered under a health benefit plan with the types of health care services required to be covered under a uniform, basic, or standard health benefit plan.

(7) "Benefit value" means an actuarially based method developed by the small employer carrier for comparing the value of determinable contingencies covered under a health benefit plan with the value of determinable contingencies required under a uniform, basic, or standard health benefit plan.

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

(9) "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, and a health maintenance organization. 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.

(10) "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.

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

(12) "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 as a dependent in the health benefit plan covering the employee.

(13) "Eligible employee" means an employee who works on a full-time basis with a normal workweek of 30 hours or more, except that at the sole discretion of the employer, the term may include an employee who works on a full-time basis with a normal workweek of between 20 and 40 hours as long as this eligibility criteria is applied uniformly among all of the employer's employees. 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.

(14) "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.

(15) "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 or any other limited benefit plan;

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

(c) automobile medical payment insurance.

(16) "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.

(17) "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:

(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;

(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.

(18) "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.

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

(20) "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.

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

(22) "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 minimum 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 minimum basic health benefit plan, provided that the policy has been in effect for a period of at least 1 year.

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

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

(25) "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.

(26) "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 small employer member of its association or any employee of

its small employer members who applies for coverage as part of a group.

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

(28) "Standard health benefit plan" means a health benefit plan that is developed by a small employer carrier and that contains the provisions required pursuant to 33-22-1828."

Section 35. 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 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 the premiums necessary to recover one-half of the expenses for the

calendar year. For purposes of this section, expenses include administrative expenses, one-half of the program net loss for the previous calendar year, and the actuarially anticipated claims to be incurred, 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 shall annually review the methodology established under subsection (6)(a), including the system of classification and any rating factors, to ensure that it is actuarially sound and 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, and the actuarially anticipated losses for the calendar year. The sum of one-half of the program net loss for the previous calendar year plus the anticipated net loss for the calendar year must equal the total assessment amount. If the program net loss for the previous calendar year is zero or less, the total assessment amount must equal the actuarially anticipated losses for the calendar year.

(b) (i) Each assessable carrier shall share in the program in an amount determined by multiplying the total assessment amount by a fraction, the numerator of which is the number of individuals in this state covered under disability insurance by the assessable carrier and the denominator of which is the number of all individuals in this state covered under disability insurance by all assessable carriers.

(ii) The board shall make a reasonable effort to ensure that each insured individual is counted only once for the purpose of assessment. The board shall require each assessable carrier that provides excess

of loss or stop loss insurance to include in its count of insured individuals all individuals whose coverage is reinsured in whole or in part, including coverage under excess of loss or stop loss insurance. The board shall allow an assessable carrier who is an excess of loss or stop loss insurer to exclude from its count of insured individuals those who have been counted by a primary disability insurer or by a primary reinsurer.

(iii) ~~The board shall base each assessable carrier's assessment on reports filed with the commissioner as required by 33-22-1820.~~ The board may use any reasonable method of estimating the number of individuals insured by an assessable carrier if the specific number is unknown.

(c) The board shall make an annual determination in accordance with this section of each assessable carrier's liability for its share of the contribution to the program and, except as otherwise provided by this section, make an annual assessment against each assessable carrier to the extent of that liability. Payment of an 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.

(d) The board may establish and maintain program reserves not to exceed five times the actuarially anticipated losses for the calendar year.

(e) If the sum of the reinsurance premiums and assessments in any calendar year exceeds the sum of the administrative expenses and incurred claims for that year, the board may proportionately credit the excess to assessable carriers or it may place the excess in program reserves, subject to the limits in subsection (8)(d).

(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 36. Section 33-22-1820, MCA, is amended to read:

"**33-22-1820. Periodic market evaluation -- report.** The ~~board shall~~ commissioner may study and report at least every 3 years to the ~~commissioner~~ governor or other interested persons on the effectiveness of this part. The report must analyze the effectiveness of this part in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the small employer health insurance markets. The report must address whether carriers and producers are fairly and actively marketing or issuing health benefit plans to small employers in fulfillment of the purposes of this part. The report may contain recommendations for market conduct or other regulatory standards or action."

Section 37. Section 33-22-1828, MCA, is amended to read:

"**33-22-1828. Benefits required in standard benefit plan.** (1) The minimum benefits must be equal to at least 75% of the covered expenses in excess of an annual deductible that does not exceed $500 per person or $1,000 per family. The coverage must include a limitation of $2,000 per person or $4,000 per family on the total annual out-of-pocket expenses for services covered. The coverage may be subject to a maximum lifetime benefit, but a maximum, if any, may not be less than $1 million.

(2) The commissioner may not require coverage in a standard health benefit plan for any benefit

unless other provisions of Title 33, chapter 22, 30, or 31, specifically require coverage for the benefit. A small employer carrier may offer coverage for additional services and articles.

(3) A standard health benefit plan provided by a health maintenance organization or a basic health benefit plan with a restricted network provision must provide a comparable level of benefits to those required by subsection (1), as determined by the ~~benefit equivalency and~~ benefit value."

Section 38. 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 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: 33-3-308; 33-3-701 through 33-3-704; 33-17-101; 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 33-3-701 through 33-3-704~~.

(2) A law of this state other than the provisions of this chapter applicable to health service corporations must be construed in accordance with the fundamental nature of a health service corporation, and in the event of a conflict the provisions of this chapter prevail."

Section 39. Section 33-30-107, MCA, is amended to read:

"**33-30-107. Annual statement.** (1) On or before March 1 of each year, each health service corporation shall file an annual statement for the preceding year on 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.

(4) The commissioner may, after notice and hearing, suspend or revoke a health maintenance organization's license or impose a fine not to exceed $100 a day and not to exceed $1,000 upon a health maintenance organization that fails to file an annual statement as required by this part."

Section 40. 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 the prohibition of pecuniary interest under 33-3-308 or the material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance organization must be considered an insurer for the purposes of 33-3-308 and 33-3-701 through 33-3-704."

Section 41. Section 33-31-211, MCA, is amended to read:

"**33-31-211. Annual statement -- revocation for failure to file -- penalty for false swearing.** (1) Unless it is operated by an insurer or a health service corporation as a plan, each authorized health maintenance organization 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. The

statement must be in the general form and content required by the commissioner. The statement must be verified by the oath of at least two principal officers of the health maintenance organization. The commissioner may ~~in his discretion~~ waive any verification under oath.

(2) At the time of filing its annual statement, the health maintenance organization shall pay the commissioner the fee for filing its statement as prescribed in 33-31-212. The commissioner may refuse to accept the fee for continuance of the insurer's certificate of authority, as provided in 33-31-212, may impose a penalty of $100, or may ~~in his discretion~~ suspend or revoke the certificate of authority of a health maintenance organization that fails to file an annual statement when due. Each day that the insurer fails to file its annual statement constitutes a separate violation. The total penalty may not exceed $1,000.

(3) The commissioner may, after notice and hearing, impose a fine not to exceed $5,000 ~~per~~ for each violation upon a director, officer, partner, member, insurance producer, or employee of a health maintenance organization who knowingly subscribes to or concurs in making or publishing an annual statement required by law that contains a material statement ~~which~~ that is false.

(4) The commissioner may require ~~such~~ reports ~~as he~~ that the commissioner considers reasonably necessary and appropriate to enable ~~him~~ the commissioner to carry out ~~his~~ the commissioner's duties under this chapter, including but not limited to a statement of operations, transactions, and affairs of a health maintenance organization operated by an insurer or a health service corporation as a plan."

NEW SECTION. **Section 42. Uniform claim forms and procedures.** (1) The commissioner of insurance, after consultation with the health care advisory council, may adopt by rule uniform health insurance claim forms and uniform standards and procedures for the use of the forms and processing of claims, including the submission of claims by means of an electronic claims processing system.

(2) The commissioner may contract with a private or public entity to administer and operate an electronic claims processing system. If the commissioner elects to contract for administration and operation of the system, the commissioner shall award a contract according to Title 18, chapter 4.

NEW SECTION. **Section 43. Statute of limitations.** The period prescribed for the commencement of a civil or administrative action by the commissioner for alleged violation of Title 33 is within 2 years of the commissioner's discovery of the facts constituting the alleged violation.

NEW SECTION. **Section 44. Filing or making false statements.** (1) A person may not purposely or knowingly make or cause to be made, in any document filed with the commissioner or in any proceeding before the commissioner, any statement that is, at the time and in the light of the circumstances under which it is made, false or misleading in any material respect.

(2) A person found to have willfully violated subsection (1) is subject to a fine of up to $5,000 and, if applicable, may be subject to the criminal laws of this state.

NEW SECTION. **Section 45. Credit life and disability applications.** (1) The insurance producer who effects the sale of a policy or certificate of credit life and disability insurance shall sign the application.

(2) An insurance company may not accept an application for credit life and disability insurance unless the application is signed by the insurance producer who effected the sale.

(3) This section does not apply to policies or certificates subject to the provisions of 33-21-204.

NEW SECTION. **Section 46. Service contract insurance.** (1) Service contract insurance is a contract or agreement for a separately stated consideration or for a specific duration to:

(a) perform the repair, replacement, or maintenance of property; or

(b) indemnify for repair, replacement, or maintenance of property.

(2) Service contract insurance does not include contracts or agreements that:

(a) are indemnified only by the seller or manufacturer; and

(b) insure only the inherent quality of the product.

NEW SECTION. **Section 47. Loss and loss expense reserves for property and casualty insurance.** (1) (a) In determining the financial condition of a property and casualty insurer for the purpose of applying the provisions of this chapter and in any financial statement or report of an insurer, loss reserves and loss expense reserves at least equal to the amounts required under the provisions of this section must be included in the insurer's liabilities. The date from which the determination, statement, or report is made is, for the purpose of this part, the date of determination.

(b) Accepted actuarial standards as adopted by the actuarial standards board must be taken into consideration for the purpose of determining the loss reserves and loss expense reserves.

(2) Except as provided in subsections (3) and (4), the reserves for all outstanding losses and loss

expenses must include the following:

(a) the aggregate estimated amounts due or to become due on account of all known losses, claims, and loss expenses incurred but not paid, including the estimated liability on any notice received by the insurer of the occurrence of any event that may result in a loss; and

(b) the aggregate amounts of liability for all losses and loss expenses incurred for which notice has not been received, estimated in accordance with the insurer's prior experience, if any, or otherwise in accordance with Montana industry data. The estimated liabilities for losses under all bonds, policies, or contracts of fidelity insurance may not be less than 10% of the net premiums in force, and the estimated liabilities for all of those losses under all the insurer's surety contracts may not be less than 5% of the net premiums in force.

(3) Except as provided in subsection (4), tabular reserves for outstanding losses under policies of workers' compensation insurance may be actuarially calculated for both indemnity and medical payments. The loss adjustment expenses are not eligible for discounting. Tabular reserves are those reserves that are:

(a) calculated using discounts determined with reference to actuarial tables, which incorporate mortality, interest, not to exceed 4%, remarriage, and other contingencies applied to a reasonably determinable payment stream associated with lifetime benefit cases; or

(b) annuities certain, such as those arising from structured settlements.

(4) Whenever, in the judgment of the commissioner, the loss and loss expense reserves of any property and casualty insurer doing business in this state, calculated in accordance with the provisions of this section, are inadequate or excessive, the commissioner may prescribe any other method that will produce adequate and reasonable reserves.

(5) The excess, if any, of statutory reserves over statement reserves must be calculated in accordance with the annual statement instructions adopted by the national association of insurance commissioners.

NEW SECTION. **Section 48. Repealer.** Sections 33-2-515, 33-2-536, 33-2-721, 33-2-722, 33-2-723, 33-4-404, 33-4-409, 33-22-1201, 33-22-1202, 33-22-1203, 33-22-1204, and 33-22-1205, MCA, are repealed.

NEW SECTION. **Section 49. Codification instruction.** (1) [Section 42] is intended to be codified

as an integral part of Title 50, chapter 4, part 5, and the provisions of Title 50, chapter 4, part 5, apply to [section 42].

(2) [Sections 43 and 44] are intended to be codified as an integral part of Title 33, chapter 1, part 3, and the provisions of Title 33, chapter 1, part 3, apply to [sections 43 and 44].

(3) [Section 45] is intended to be codified as an integral part of Title 33, chapter 21, part 1, and the provisions of Title 33, chapter 21, part 1, apply to [section 45].

(4) [Section 46] is intended to be codified as an integral part of Title 33, chapter 1, part 2, and the provisions of Title 33, chapter 1, part 2, apply to [section 46].

(5) [Section 47] 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 47].

NEW SECTION. **Section 50. 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-

STATE OF MONTANA - FISCAL NOTE

Fiscal Note for HB0131, as introduced

DESCRIPTION OF PROPOSED LEGISLATION:

An act generally revising state insurance laws.

ASSUMPTIONS:

1. This is the general house cleaning bill for the State Auditor's Office. There is no fiscal impact associated with this bill.

FISCAL IMPACT:

Passage of HB0131 will have no fiscal impact on the state.

Dave Lewis 1-9-97

DAVE LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

BRUCE SIMON, PRIMARY SPONSOR DATE
Fiscal Note for HB0131, as introduced

HB 131

APPROVED BY COM ON
BUSINESS & LABOR

HOUSE BILL NO. 131

INTRODUCED BY SIMON

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING STATE INSURANCE LAWS; PROVIDING FOR UNIFORM HEALTH INSURANCE CLAIM FORMS; PROVIDING A STATUTE OF LIMITATIONS FOR ACTIONS BROUGHT BY THE COMMISSIONER OF INSURANCE; PROVIDING PENALTIES FOR MISREPRESENTATIONS MADE TO THE COMMISSIONER; REQUIRING THAT CREDIT LIFE AND DISABILITY INSURANCE APPLICATIONS BE SIGNED BY THE INSURANCE PRODUCER EFFECTING THE SALE; DEFINING "SERVICE CONTRACT INSURANCE"; AMENDING SECTIONS 18-8-103, 33-2-307, 33-2-317, 33-2-514, 33-2-517, 33-2-537, 33-2-704, 33-2-806, 33-2-1359, 33-2-1902, 33-3-303, 33-3-307, 33-4-202, 33-4-203, 33-4-204, 33-4-313, 33-4-314, 33-5-402, 33-10-202, 33-15-1106, 33-16-1027, 33-17-102, 33-17-212, 33-17-301, 33-17-1203, 33-18-210, ~~33-18-301,~~ 33-20-101, 33-22-107, 33-22-508, 33-22-903, 33-22-907, 33-22-910, 33-22-1803, 33-22-1819, 33-22-1820, 33-22-1828, 33-30-102, 33-30-107, 33-31-111, AND 33-31-211, MCA; AND REPEALING SECTIONS 33-2-515, 33-2-536, 33-2-721, 33-2-722, 33-2-723, 33-4-404, 33-4-409, 33-22-1201, 33-22-1202, 33-22-1203, 33-22-1204, AND 33-22-1205, MCA."

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

Section 1. Section 18-8-103, MCA, is amended to read:

"**18-8-103. Exemptions.** This part does not apply to employment of:

(1) registered professional engineers, surveyors, real estate appraisers, or registered architects;

(2) physicians, dentists, or other medical, dental, or health care providers;

(3) expert witnesses hired for use in litigation, hearings officers hired in rulemaking and contested case proceedings under the Montana Administrative Procedure Act, or attorneys as specified by executive order of the governor;

(4) consulting actuaries to the public retirement boards, ~~or~~ the state compensation insurance fund, or the commissioner of insurance;

(5) private consultants employed by the student associations of the university system with money

raised from student activity fees designated for use by those student associations; or

(6) private consultants employed by the Montana state lottery."

Section 2. 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) $7 million. An insurer possessing less than ~~$6~~ $7 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 ~~$6~~ $7 million.

(ii) in the case of Lloyd's or another similar group including incorporated and unincorporated alien 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~~ not 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 3. Section 33-2-317, MCA, is amended to read:

"**33-2-317. Exemptions.** The Surplus Lines Insurance Law does not apply to reinsurance or to the following kinds of insurance when placed by a licensed insurance producer of this state:

(1) wet marine ~~and transportation insurances~~ insurance;

(2) insurance on subjects located, residing, or to be performed wholly outside of this state or on vehicles or aircraft owned and principally garaged outside this state;

(3) insurance on property or operations of railroads engaged in interstate commerce; and

(4) insurance of aircraft owned or operated by manufacturers of aircraft or aircraft operated in scheduled interstate flight or cargo of the aircraft or against liability, other than workers' compensation and employers' liability, arising out of the ownership, maintenance, or use of the aircraft."

Section 4. Section 33-2-514, MCA, is amended to read:

"**33-2-514. Reserve for disability insurance.** (1) For all disability insurance policies, the insurer shall maintain an active life reserve ~~which shall place~~ that places a sound value on its liabilities under ~~such~~ the policies and that may not be ~~not~~ less than ~~the reserve according to appropriate standards set forth in regulations issued by the commissioner and, in no event, less in the aggregate than~~ the pro rata gross unearned premiums for ~~such~~ the policies.

(2) The commissioner may promulgate rules to define additional standards for reserve requirements."

Section 5. Section 33-2-517, MCA, is amended to read:

"33-2-517. Title insurance reserves. (1) In addition to an adequate reserve as to outstanding losses as required under 33-2-511, a title insurer shall maintain a guaranty fund or unearned premium reserve of not less than an amount computed as follows:

(a) Ten percent of the total amount of the risk premiums written in the calendar year for title insurance contracts ~~shall~~ must be assigned originally to the reserve.

(b) During each of the 20 years next following the year in which the title insurance contract was issued, the reserve applicable to the contract ~~shall~~ must be reduced by 5% of the original amount of ~~such~~ the reserve.

(2) The reserve sums ~~herein~~ required ~~to be reserved~~ by subsection (1) for unearned premiums on contracts of title insurance ~~shall~~ must at all times and for all purposes be considered and constitute unearned portions of the original premiums and ~~shall~~ must be held in trust for the benefit of policyholders.

(3) The reduction of the unearned premium reserve required by subsection (1)(b) ~~of this section~~ ~~shall~~ must be made for all title insurance contracts issued after December 31, 1958, with respect to which 10% of the risk premiums have been assigned to the reserve pursuant to subsection (1)(a) ~~of this section~~. ~~In the event that any title insurer has not in accordance with subsection (1)(b) of this section reduced the amount of its unearned premium reserve by 5% of the amount originally assigned to the reserve pursuant to subsection (1)(a) of this section for years ending after December 31, 1958, and before January 1, 1977, the insurer shall effect such reduction for such prior years during its accounting year which includes December 31, 1976.~~ If the insurer has not reduced the amount of its unearned premium reserves pursuant to subsection (1)(b) for a previous year or years, the insurer shall make the reduction for the prior year or years in its next accounting year."

Section 6. Section 33-2-537, MCA, is amended to read:

"33-2-537. 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~~ may promulgate a rule containing the minimum standards applicable to the valuation of disability plans."

Section 7. Section 33-2-704, MCA, is amended to read:

"**33-2-704. Insured lives reporting requirement.** On or before ~~February 15~~ March 1 of each year, each insurer providing disability insurance shall, on a form prescribed by the commissioner, report the number of Montana residents insured on February 1 under any policy of individual or group disability insurance, including excess of loss or stop loss insurance policies covering disability insurance."

Section 8. 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 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 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 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~~ 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:~~ in 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, in securities, in both cash and securities, or in investments provided for ~~under~~ in 33-2-531.

(5) Except with the commissioner's consent, an insurer 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) Except with the commissioner's consent, an ~~An~~ insurer may not invest and have invested at any one time in aggregate amount more than 15% of its assets in all stocks ~~under~~ provided for in 33-2-820 and 33-2-821. Determination of the amount that an insurer has invested in common stocks for the purposes of this provision must be based on the cost of the stocks to the insurer. This provision does not apply ~~as~~ to stock of a controlled or subsidiary insurance corporation or other corporations ~~under~~ provided for in 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~~ in 33-2-824. Money market funds, as defined by the commissioner by rule, are exempt from the 5% limitation of this subsection.

(8) Except with the commissioner's consent, an insurer 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~~ of investments in ~~the category of~~ real estate ~~shall~~ must be as provided in 33-2-832. Other specific limits apply as stated in the sections dealing with other respective kinds of investments."

Section 9. Section 33-2-1359, MCA, is amended to read:

"33-2-1359. Setoffs ~~and counterclaims~~. (1) Mutual debts or mutual credits between the insurer and another person in connection with any action or proceeding under this part ~~shall~~ must be set off and the balance only ~~shall be~~ allowed or paid, except as provided in ~~subsection (2) and~~ 33-2-1362 and subsection (2) of this section.

(2) ~~No~~ A setoff ~~or counterclaim~~ may not be allowed in favor of any person when:

(a) the obligation of the insurer to the person would not at the date of the filing of a petition for liquidation entitle the person to share as a claimant in the assets of the insurer;

(b) the obligation of the insurer to the person was purchased by or transferred to the person with a view to its being used as a setoff; or

(c) the obligation of the person is to pay an assessment levied against the members or subscribers of the insurer or is to pay a balance upon a subscription to the capital stock of the insurer or is in any other way in the nature of a capital contribution.~~; or~~

~~(d) the obligation of the person is to pay premiums, whether earned or unearned, to the insurer.~~"

Section 10. Section 33-2-1902, MCA, is amended to read:

"**33-2-1902. Definitions.** As used in this part, the following definitions apply:

(1) "Adjusted RBC report" means an RBC report that has been adjusted by the commissioner in accordance with 33-2-1903(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; or

(c) any insurer engaged solely in the business of reinsurance of life or disability contracts.

(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 :

(i) 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;

(ii) any insurance company engaged solely in the business of reinsurance of property and casualty contracts; or

(iii) any insurance company engaged in the business of surety and marine insurance.

(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 33-2-1904(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 33-2-1903.

(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."

Section 11. Section 33-3-303, MCA, is amended to read:

"**33-3-303. Meetings of stockholders or members.** (1) Meetings of stockholders or members of a domestic insurer ~~shall~~ must be held in the city or town of its principal office or place of business in this state.

(2) ~~No~~ A meeting of stockholders or members ~~shall~~ may not amend the insurer's articles of incorporation unless the proposal ~~so~~ to amend was included in the notice of the meeting.

(3) Except with the commissioner's consent, each ~~Each~~ insurer shall, during the first 6 months of each calendar year, hold the annual meeting of its stockholders or members to fill vacancies existing or occurring in the board of directors, must receive and shall consider reports of the insurer's officers as to its affairs, and shall transact ~~such~~ other business ~~as may~~ properly ~~be~~ brought before it. Not less than 20

days' notice ~~shall~~ must be given of ~~such~~ the meeting in the manner provided in the bylaws, except ~~where~~ when notice of the annual meeting of a mutual insurer is contained in its policies.

(4) Special meetings of the stockholders or members may be called at any time for any purpose by the board of directors upon not less than 10 days' notice, with notice given as provided in the bylaws. The notice ~~shall~~ must state the purpose of the meeting, and ~~no~~ business for which notice was not given may not ~~shall~~ be transacted at the meeting ~~of which notice was not so given~~.

(5) If more than 15 months are allowed to elapse without an annual stockholders' or members' meeting being held, any stockholder or member may call ~~such a~~ for an annual meeting to be held. At any time, upon written request of any director or of any stockholders or members holding in the aggregate one-fifth of the voting power of all stockholders or members, it ~~shall be~~ is the duty of the secretary to call a special meeting of stockholders or members to be held at ~~such~~ the time ~~as~~ that the secretary may fix, not less than 10 or more than 30 days after the receipt of the request. If the secretary fails to issue ~~such~~ a call, the director, stockholders, or members making the request may do so.

(6) A stockholders' or members' meeting duly held ~~can~~ may be organized for the transaction of business whenever a quorum is present. Except as otherwise provided by law or the articles of incorporation:

(a) the presence, in person or by proxy, of the holders of a majority of the voting power of all stockholders or of all members ~~shall constitute~~ constitutes a quorum;

(b) the stockholders or members present at a duly organized meeting ~~can~~ may continue to do business until adjournment, notwithstanding the withdrawal of enough stockholders or members to leave less than a quorum;

(c) if any necessary officer fails to attend ~~such~~ a meeting, any stockholder or member present may be elected to act temporarily in lieu of ~~any such~~ the absent officer;

(d) if a meeting cannot be ~~organized~~ held because a quorum ~~has not attended~~ is not present, those present may adjourn the meeting to ~~such~~ a time ~~as~~ that they ~~may~~ determine, but in the case of any meeting called for the election of any director, the adjournment must be to the next day and those who attend the second ~~of such adjourned meetings~~ meeting, although less than a quorum as fixed in this section or in the articles of incorporation, ~~shall nevertheless~~ constitute a quorum for the purpose of electing any director; and

(e) an annual or special meeting of stockholders or members may be adjourned to another date

without new notice being given."

Section 12. Section 33-3-307, MCA, is amended to read:

"**33-3-307. Bond of officers.** (1) The president, secretary, and treasurer of ~~every~~ each mutual insurer or stock insurer shall each file with the commissioner and ~~thereafter~~ maintain in force so long as ~~he~~ that individual is ~~such~~ an officer a fidelity bond in ~~the sum of $10,000~~ an amount set by the commissioner by rule and issued by an authorized corporate surety in favor of the insurer. The commissioner shall consider the insurer's exposure, total assets, and total income in determining the bond amount. In lieu of individual bonds, ~~all such~~ officers may be covered under a blanket bond for the same respective amounts~~,~~ ~~and which~~ The blanket bond ~~shall likewise~~ must be filed with the commissioner.

(2) The premium for the bond ~~shall~~ must be payable by the insurer.

(3) ~~No such~~ A bond ~~shall~~ is not ~~be~~ subject to cancellation except upon written notice to both the insurer and the commissioner, delivered not less than 30 days in advance of the effective date of ~~such~~ the cancellation.

(4) The insurer shall provide for the bonding by authorized corporate surety of all other officers in any way responsible for the handling of the funds of the insurer.

(5) This section ~~shall~~ may not be ~~deemed~~ considered to limit the amount of bonded protection ~~which~~ that the insurer may carry as to any officer."

Section 13. 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 the corporation 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) four copies of proposed articles of incorporation executed ~~in 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~~ The signatures of the incorporators must be notarized.

(2) The articles of incorporation 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 must contain the words "farm mutual" or "rural mutual" together with the name of the county in which its principal place of business is to be located. The name 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 must be located in this state;

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

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

(f) the duration of ~~its~~ the corporation's existence, which may be perpetual;

(g) the number of its directors, which may not be less than 5 or more than 11, 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~~ at which time successors are elected and qualified;

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

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

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

Section 14. Section 33-4-203, MCA, is amended to read:

"33-4-203. Approval of articles -- commencement of corporate existence. (1) If the 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 commissioner shall make a certificate of the facts.

(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 commissioner, the

commissioner shall endorse the ~~commissioner's~~ approval upon each set of the articles and forward ~~three~~ four 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 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 15. Section 33-4-204, MCA, is amended to read:

"33-4-204. Amendment of articles. A farm mutual insurer may, by a vote of two-thirds of its members present at any annual meeting or at any special meeting ~~of members~~ called for that purpose, amend its articles of incorporation to extend its corporate duration or ~~in~~ any other particular within the scope of this chapter by causing amended articles to be filed in the same form and manner as required for original articles of incorporation. The commissioner shall review the amended articles for compliance with this title. The amended articles of incorporation ~~shall~~ may be signed only by the president and secretary of the corporation and attested by the corporate seal. Notice of the proposed amendment ~~shall~~ must be contained in the notice ~~given~~ of ~~any such~~ the annual or special meeting."

Section 16. Section 33-4-313, MCA, is amended to read:

"33-4-313. Annual statement ~~— report — filing~~. ~~(1)~~ The president and secretary of ~~every~~ each insurer, on or before March 1 each year, shall prepare, affirm under oath, affix the corporate seal ~~thereto~~ to, and file with the commissioner, on forms ~~as~~ prescribed and furnished by ~~him~~ the commissioner, an annual statement for the preceding calendar year showing the condition of ~~such~~ the insurer as of December 31 of ~~such~~ the preceding year and exhibiting the following facts:

~~(a)~~(1) the names of the president and secretary;

~~(b)~~(2) the date of the annual meeting;

~~(c)~~(3) the amount of insurance in force;

~~(d)~~(4) the number of members;

~~(e)~~(5) the number of assessments made during the year;

~~(f)~~(6) the amount paid in losses during the year;

~~(g)~~(7) the amount of the losses claimed and not paid, with the reason for nonpayment;

~~(h)~~(8) the number of members withdrawn, suspended, and expelled during the year;

~~(i)~~(9) the number of new members admitted during the year;

~~(j)~~(10) the expenses during the year;

~~(k)~~(11) the amount of money on hand;

~~(l)~~(12) the amount and character of the insurer's assets;

~~(m)~~(13) the amount of the insurer's liabilities, including any reserves required to be established under this chapter; and

~~(n)~~(14) ~~such~~ other information concerning the insurer's affairs ~~as~~ that the commissioner may reasonably require.

~~(2) A report of an insurer's expenditures for educational purposes, if any, for the preceding year must be filed with the commissioner at the same time and in conjunction with the annual report of such insurer, as required under 33-4-404.~~"

Section 17. Section 33-4-314, MCA, is amended to read:

"**33-4-314. Annual statement -- exclusive report -- penalty for failure to file.** (1) ~~No~~ A report, statement, or return of any nature ~~shall~~ may not be required of any farm mutual insurer other than those required by 33-4-313.

(2) The commissioner may:

(a) suspend or revoke the certificate of authority of any insurer failing to file its annual statement as required; or

(b) impose a fine of up to $100 a day for each day that an insurer is late in filing its annual statement, with the aggregate penalty not to exceed $1,000."

Section 18. Section 33-5-402, MCA, is amended to read:

"**33-5-402. Contributions to insurer.** The attorney or other parties may advance to a domestic reciprocal insurer upon reasonable terms ~~such~~ funds ~~as~~ that it may require from time to time in its operations. Sums ~~so~~ advanced ~~shall~~ may not be treated as a liability of the insurer. ~~and, except~~ Except upon

liquidation of the insurer, ~~shall not be withdrawn or repaid except out of the insurer's realized earned surplus in excess of its minimum required surplus~~ during any calendar year, the total of withdrawals and repayments of the advanced sums may not exceed the lesser of the insured's realized earned surplus or 10% of the sums advanced as of the previous December 31. ~~No such~~ A withdrawal or repayment ~~shall~~ may not be made without the advance approval of the commissioner. This section does not apply to bank loans or to loans for which security is given."

Section 19. 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~~ 33-10-201(4) through (6) ~~of 33-10-201~~.

(5) "Impaired insurer" means:

(a) an insurer ~~which after July 1, 1974,~~ that 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 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~~ 33-10-201 and 33-10-224 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) (a) "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.

(b) ~~"Premiums" do~~ The term does not include premiums and considerations on contracts between insurers and reinsurers.

(c) As used in 33-10-227, ~~"premiums"~~ 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 that 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 20. Section 33-15-1106, MCA, is amended to read:

"**33-15-1106. Renewal with altered terms.** (1) If an insurer offers or purports to renew a policy but on less favorable terms, at a higher rate, or at a higher rating plan, the new terms, rate, or rating plan take effect on the policy renewal date only if the insurer has mailed or delivered notice of the new terms, rate, or rating plan to the insured at least 30 days before the expiration date. ~~If the insured has not been so notified, he may cancel the renewal policy within 30 days after receiving the notice. The insurer shall continue coverage for a period of not less than 30 days after mailing or delivery of the notice. If the insured terminates the policy within the 30-day period, the insurer shall calculate the earned premium pro rata based upon the prior policy's rate. The new rate is effective only after the required 30-day notification period has been met. If the insured does not terminate the policy, the premium increase and other changes are effective the day following the prior policy's expiration or anniversary date.~~

(2) This section does not apply if the increase in the rate or the rating plan, or both, results from a classification change based on the altered nature or extent of the risk insured against."

Section 21. Section 33-16-1027, MCA, is amended to read:

"**33-16-1027. Rate filing review.** (1) The commissioner shall review each insurance filing to ensure compliance with the following guidelines:

(a) The effective date of each workers' compensation insurer or advisory organization filing must be the date specified in the filing. The effective date of the filing may not be earlier than 30 days after the date on which the filing is received by the commissioner or the date of receipt of the information furnished in support of the filing, if the supporting information is required by the commissioner.

(b) Upon written application of the insurer or advisory organization, the commissioner may authorize a filing that becomes effective before the expiration of the period described in subsection (1)(a).

(c) A filing is considered to have met the requirements of this part unless disapproved by the commissioner within the period described in subsection (1)(a) or any extension of the period.

(2) Whenever a filing is not accompanied by the information required under this section, the commissioner shall inform the filer of the deficiency within ~~10~~ 30 days of the initial filing. The filing is considered made when the required information is furnished or when the filer certifies to the commissioner that the additional information requested by the commissioner is not maintained or cannot be provided."

Section 22. 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;

(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 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 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~~.~~; or

(xii) a person appointed as a managing general agent in this state whose activities are limited

exclusively to those described in 33-2-1501(10) and Title 33, chapter 2, part 16.

(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 the person or the person's spouse, employer, or 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 chapter, the term "managing general agent" 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 23. Section 33-17-212, MCA, is amended to read:

"**33-17-212. Examination required -- exceptions -- fees.** (1) Except as provided in subsection (7), an individual applying for a license shall pass a written examination. The examination must test the knowledge of the individual concerning each kind of insurance listed in subsection (6) for which application is made, the duties and responsibilities of an insurance producer, and the insurance laws and rules of this state. The examination must be developed and conducted under rules adopted by the commissioner.

(2) The commissioner may conduct the examination or make arrangements, including contracting with an outside testing service, for administering the examination and collecting the fees required by 33-2-708. The commissioner may arrange for the testing service to recover the cost of the examination from the applicant.

(3) Each individual applying for an examination shall remit the fees required by 33-2-708.

(4) An individual who fails to appear for the examination as scheduled or fails to pass the examination may reapply for an examination and shall remit all required fees and forms before being rescheduled for another examination.

(5) If the applicant is a partnership or corporation, each individual who is to be named in the license as having authority to act for the applicant in its insurance transactions under the license shall take the examination.

(6) Examination of an applicant for a license must cover all of the kinds of insurance for which the applicant has applied to be licensed, as constituted by any one or more of the following classifications:

(a) life insurance;

(b) disability insurance;

(c) property insurance. For the purposes of this provision, property insurance includes marine insurance.

(d) casualty insurance;

(e) surety insurance;

(f) credit life and disability insurance;

(g) title insurance.

(7) This section does not apply to and an examination is not required of:

(a) an individual lawfully licensed as an insurance producer as to the kind or kinds of insurance to be transacted as of or immediately prior to January 1, 1961, and ~~thereafter continuing~~ who continues to be licensed;

(b) an applicant for a license covering the same kind or kinds of insurance as to which the applicant was licensed in this state, other than under a temporary license, within the 12 months immediately preceding the date of application unless the commissioner has suspended, revoked, or refused to continue the previous license, except that this subsection (7)(b) does not apply to a title insurance producer, as defined in 33-25-105;

(c) an applicant for a license as a nonresident insurance producer;

(d) an applicant for a license to sell all-risk federal crop insurance if the applicant provides certification from an appropriate governmental agency to the commissioner that ~~he~~ the applicant is qualified to sell the insurance;

(e) transportation ticket agents of common carriers applying for a license to solicit and sell only:

(i) accident insurance ticket policies; or

(ii) insurance of personal effects while being carried as baggage on a common carrier, as incidental to their duties as transportation ticket agents;

(f) an association applying for a license under 33-17-211;

(g) a mechanical breakdown insurance producer~~.~~;

(h) a service contract insurance producer; or

~~(h)~~(i) an individual who, within 60 days of cancellation of a license issued by the state of the individual's residence, files with the commissioner a current letter of clearance certifying that the individual has passed an examination and held an insurance license in good standing in the individual's state of licensure, except that the individual shall take an examination pertaining to this state's law and each kind of insurance for which the individual has applied for a license and ~~which~~ that is not covered under the license held in the other state."

Section 24. Section 33-17-301, MCA, is amended to read:

"**33-17-301. Adjuster license -- qualifications -- catastrophe adjustments -- public adjuster.** (1) A person may not ~~in this state~~ act as or hold ~~himself~~ the person out to be an adjuster in this state unless licensed as an adjuster under this chapter. A person shall apply for an adjuster license to the commissioner according to forms that the commissioner prescribes and furnishes. The commissioner shall issue the adjuster license to individuals qualified to be licensed as an adjuster upon payment of the license fee provided in 33-2-708.

(2) To be licensed as an adjuster, the applicant:

(a) must be an individual 18 years of age or more;

(b) must be a resident of Montana or resident of another state that will permit residents of Montana regularly to act as adjusters in the other state;

(c) must be a full-time salaried employee of a licensed adjuster or a graduate of a recognized law school or have had experience or special education or training as to the handling of loss claims under insurance contracts of sufficient duration and extent reasonably to make ~~him~~ the applicant competent to fulfill the responsibilities of an adjuster;

(d) must be trustworthy and of good character and reputation; and

(e) ~~shall~~ must have and shall maintain in this state an office accessible to the public and shall keep in the office for not less than 5 years the usual and customary records pertaining to transactions under the license. This provision does not prohibit maintenance of the office in the home of the licensee.

(3) A partnership or corporation, whether or not organized under the laws of this state, may be licensed as an adjuster if each individual who is to exercise the adjuster license powers is separately licensed or is named in the partnership or corporation adjuster license and is qualified for an individual adjuster license. An additional full license fee must be paid for each individual in excess of one named in the partnership or corporation adjuster license to exercise its powers.

(4) An adjuster license or qualifications are not required for an adjuster who is sent into this state by and on behalf of an insurer or adjusting partnership or corporation for the purpose of investigating or making adjustments of a particular loss under an insurance policy or for the adjustment of a series of losses resulting from a catastrophe common to all losses.

(5) An adjuster license continues in force until expired, suspended, revoked, or terminated. The license is subject to annual payment to the commissioner of the renewal fee required by 33-2-708, accompanied by a written request for renewal.

(6) The commissioner may adopt rules providing for the examination, licensure, bonding, and regulation of public adjusters."

Section 25. Section 33-17-1203, MCA, is amended to read:

"**33-17-1203. Continuing education -- basic requirements -- exceptions.** (1) Unless exempt under subsection (4):

(a) a person licensed to act as an insurance producer for property, casualty, surety, or title insurance or as a consultant for general insurance shall, during each calendar year, complete at least 10 credit hours of approved continuing education;

(b) a person licensed to act as an insurance producer for life or disability insurance or as a consultant for life insurance shall, during each calendar year, complete at least 10 credit hours of approved continuing education;

(c) a person holding multiple licenses shall, during each calendar year, complete at least 15 credit hours of approved continuing education;

(d) a person licensed to act as an insurance producer only for credit life and disability insurance shall, during each calendar year, complete 5 credit hours of approved continuing education in the areas of insurance law, ethics, or credit life and disability insurance;

(e) a person licensed as an insurance producer or consultant shall, during each biennium, complete at least 1 credit hour of approved continuing education on changes in Montana insurance statutes and administrative rules.

(2) If a person licensed as an insurance producer or consultant completes more credit hours of approved continuing education in a year than the minimum required in subsection (1), the excess credit hours may be carried forward and applied to the continuing education requirements of the next year.

(3) The commissioner may, for good cause ~~shown~~, grant an extension of time, not to exceed 1 year, during which the requirements imposed by subsection (1) may be completed.

(4) The minimum continuing education requirements do not apply to:

(a) a person licensed to sell any kind of insurance for which an examination is not required under 33-17-212(7)(d) through ~~(7)(g)~~ (7)(h);

(b) a person holding a temporary license issued under 33-17-216;

(c) a nonresident licensee who must meet continuing education requirements in the licensee's state of residence if that state ~~accords~~ grants substantially similar privileges to and has similar requirements ~~of~~ for residents of this state;

(d) a newly licensed insurance producer or consultant during the calendar year in which the licensee first received a license; or

(e) an insurance producer or consultant otherwise exempted by the commissioner."

Section 26. Section 33-18-210, MCA, is amended to read:

"**33-18-210. Unfair discrimination and rebates prohibited -- property, casualty, and surety insurances.** (1) A title, property, casualty, or surety insurer or an employee, representative, or insurance producer of an insurer may not, as an inducement to purchase insurance or after insurance has been effected, pay, allow, ~~or~~ give, or offer to pay, allow, or give, directly or indirectly, a:

(a) rebate, discount, abatement, credit, or reduction of the premium named in the insurance policy;

(b) special favor or advantage in the dividends or other benefits to accrue on the policy; or

(c) valuable consideration or inducement not specified in the policy, except to the extent provided for in an applicable filing with the commissioner as provided by law.

(2) An insured named in a policy or an employee of the insured may not knowingly receive or accept, directly or indirectly, a:

(a) rebate, discount, abatement, credit, or reduction of premium;

(b) special favor or advantage; or

(c) valuable consideration or inducement.

(3) An insurer may not make or permit unfair discrimination in the premium or rates charged for insurance, in the dividends or other benefits payable on insurance, or in any other of the terms and conditions of the insurance either between insureds or property having like insuring or risk characteristics or between insureds because of race, color, creed, religion, or national origin.

(4) This section may not be construed as prohibiting the payment of commissions or other compensation to duly licensed insurance producers or as prohibiting an insurer from allowing or returning lawful dividends, savings, or unabsorbed premium deposits to its participating policyholders, members, or subscribers.

(5) An insurer may not make or permit unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, canceling, or limiting the amount of insurance coverage on a property or casualty risk because of the geographic location of the risk, unless:

(a) the refusal, cancellation, or limitation is for a business purpose that is not a mere pretext for unfair discrimination; or

(b) the refusal, cancellation, or limitation is required by law or regulatory mandate.

(6) An insurer may not make or permit unfair discrimination between individuals or risks of the

same class and of essentially the same hazards by refusing to issue, refusing to renew, canceling, or limiting the amount of insurance coverage on a residential property risk or on the personal property contained in the residential property, because of the age of the residential property, unless:

(a) the refusal, cancellation, or limitation is for a business purpose that is not a mere pretext for unfair discrimination; or

(b) the refusal, cancellation, or limitation is required by law or regulatory mandate.

(7) An insurer may not refuse to insure, refuse to continue to insure, or limit the amount of coverage available to an individual because of the sex or marital status of the individual. However, an insurer may take marital status into account for the purpose of defining persons eligible for dependents' benefits.

(8) An insurer may not terminate or modify coverage or refuse to issue or refuse to renew a property or casualty policy or contract of insurance solely because the applicant or insured or any employee of either is mentally or physically impaired. However, this subsection does not apply to accident and health insurance sold by a casualty insurer, and this subsection may not be interpreted to modify any other provision of law relating to the termination, modification, issuance, or renewal of any insurance policy or contract.

(9) An insurer may not refuse to insure, ~~refuse to continue to insure,~~ charge higher rates, or limit the amount of coverage available to an individual based solely on adverse information contained in a driving record that is 3 years old or older. However, an insurer may provide discounts to an insured based on favorable aspects of an insured's claims history that is 3 years old or older.

(10) An insurer may not charge points on, ~~refuse to issue,~~ refuse to renew, remove an existing discount on, or surcharge a private passenger motor vehicle policy because of a claim submitted under the insured's policy if the insured was not at fault.

(11) (a) For the purposes of this subsection (11), "credit history" means that portion of a credit report or background report that addresses the applicant's or insured's debt payment history or lack of history but does not include public information including convictions, lawsuits, bankruptcies, or similar public information.

(b) An insurer writing automobile or homeowner insurance may not refuse to insure, refuse to continue to insure, charge higher rates, or limit the scope or amount of coverage or benefits available to an individual based solely on the insurer's knowledge of the individual's credit history unless:

(i) the insurer possesses substantial documentation that credit history is significantly correlated with the types of risks insured or to be insured;

(ii) the insurer sends written communication to the individual disclosing that the insurance coverage was declined, not renewed, or limited in scope or amount of coverage or benefits because of credit information relating to the applicant or the insured; and

(iii) upon subsequent request of the individual, mailed within 10 days of receipt of the denial, nonrenewal, or limitation, the insurer provides the individual with a copy of the credit report at issue or the name and address of a third party from whom the individual may obtain a copy of the credit report, within 10 days of receipt of the request.

(c) The provisions of this subsection (11) are not intended to conflict with any disclosure provisions of state law or the federal Truth in Lending Act applicable to lending institutions, credit bureaus, or other credit service organizations that maintain or distribute credit histories on insurance applicants or policyholders."

~~**Section 27. Section 33-18-301, MCA, is amended to read:**~~

~~**"33-18-301. Prohibited relations with mortuaries.** (1) A life insurer and its officers, employees, or representatives may not own, manage, supervise, operate, or maintain any mortuary, funeral, or undertaking establishment in Montana.~~

~~(2) A life insurer may not contract or agree with any funeral director, mortuary, or undertaker that the funeral director, undertaker, or mortuary shall conduct the funeral or be named beneficiary of any person insured by 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; and~~

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

~~(d)(4) any~~ 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)~~ (6).

~~(5) An insured may designate a funeral director, mortuary, or undertaker as a specific beneficiary only when the cash value of the policy adversely affects the insured's financial condition for the purpose of determining the availability of medicaid benefits.~~

~~(4)~~(6) ~~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 both.~~"

Section 27. Section 33-20-101, MCA, is amended to read:

"**33-20-101. Scope.** (1) Except as provided in subsection (2), parts 1 through 5 of this chapter apply only to contracts of life insurance and annuities, other than reinsurance, group life insurance, and group annuities.

(2) Sections 33-20-114 and 33-20-131 also apply to group life insurance and group annuities."

Section 28. Section 33-22-107, MCA, is amended to read:

"**33-22-107. Premium increase restriction -- exception.** (1) An insurer or a health service corporation that issues a policy, certificate, or membership contract covering a resident of this state may not increase a premium in an individual's or an ~~individual group's~~ individual's group disability insurance policy more frequently than once during a 12-month period unless failure to increase the premium more frequently than once during the 12-month period would:

(a) place the insurer in violation of the laws of this state; or

(b) cause the financial impairment of the insurer to the extent that further transaction of insurance by the insurer injures or is hazardous to its policyholders or to the public.

(2) Subsection (1) does not apply to a premium increase necessitated by a state or federal law, court decision, or rule adopted by an agency of competent jurisdiction of the state or federal government."

Section 29. 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 or the person's dependents or family members covered under the policy ceases because of termination of the person's employment or of the person's membership in the class or classes eligible for coverage under the policy or as a result of a

person's employer discontinuing the employer's business or as a result of a person's 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 the person is not insured under another major medical disability insurance policy or plan, the person is entitled to have issued to the person by the insurer, without evidence of insurability, group coverage or an individual policy 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 the person or 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. In addition, the insurer shall make available a conversion policy as required by subsection (4).

(3) The premium on the individual policy or group policy must be at no more than 200% of the insurer's then customary rate applicable to the coverage of the individual or group policy. The customary rate is that rate that is normally issued for medically underwritten policies without discount for healthy lifestyles.

(4) The insurer shall also make available ~~an individual~~ a conversion policy, certificate, or membership contract that provides at least the level of benefits provided by the insurer's lowest cost basic health benefit plan, as defined in 33-22-1803. If the insurer is not a small employer carrier under part 18, the insurer shall make available ~~an individual~~ a conversion policy, certificate, or membership contract that provides equivalent benefits to a basic health benefit plan. The conversion rate may not exceed 150% of the highest rate charged for that plan."

Section 30. Section 33-22-903, MCA, is amended to read:

"33-22-903. Definitions. As used in this part, the following definitions apply:

(1) "Applicant" means:

(a) in the case of an individual medicare supplement policy, the person who seeks to contract for insurance benefits; and

(b) in the case of a group medicare supplement policy, the proposed certificate holder.

(2) "Certificate" means a certificate delivered or issued for delivery in this state under a group

medicare supplement policy.

(3) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(4) "Entity" means an insurer as defined in 33-1-201, a health service corporation as defined in 33-30-101, and a health maintenance organization as defined in 33-31-102.

(5) "Health care expenses":

(a) means expenses of a health maintenance organization associated with the delivery of health care services that are analogous to incurred losses of an insurer;

(b) does not include home office and overhead costs, advertising costs, commissions and other acquisition costs, taxes, capital costs, administrative costs, or claims processing costs.

(6) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any entity delivering or issuing for delivery in this state medicare supplement policies or certificates.

(7) "Medicare" means Health Insurance for the Aged, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

(8) "Medicare supplement policy" means a group or individual policy of disability insurance or a subscriber contract of a health service corporation, other than a policy issued pursuant to a contract under ~~42 U.S.C. 1395l or 1395mm~~ 42 U.S.C. 1395ss(g)(1), or a policy issued under a demonstration project authorized pursuant to amendments to the federal Social Security Act, that is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare. The term does not include:

(a) a policy or contract of one or more employers or labor organizations or of the trustees of a fund established by one or more employers or labor organizations, or a combination of employers, organizations, and trustees, for employees or former employees, or a combination of current and former employees, or for members or former members, or a combination of current and former members, of the labor organizations; or

(b) individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when the group or individual policy or contract includes provisions that are inconsistent with the requirements of this part or policies issued to employees or members as additions to franchise plans in existence on April 8, 1981.

(9) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer."

Section 31. Section 33-22-907, MCA, is amended to read:

"**33-22-907. Disclosure standards -- informational brochure -- rules.** (1) In order to provide for full and fair disclosure in the sale of medicare supplement policies and certificates, a medicare supplement policy may not be delivered or issued for delivery in this state and a certificate may not be delivered pursuant to a group medicare supplement policy delivered or issued for delivery in this state unless an outline of coverage is delivered to the applicant at the time that application is made. The outline of coverage must be filed with the commissioner as required by 33-1-501. The filing must be made at least 60 days in advance of the date that the outline of coverage is delivered to any resident of this state.

(2) (a) The commissioner shall prescribe the format and content of the outline of coverage required by subsection (1).

(b) For purposes of this section, "format" means style, arrangements, and overall appearance, including such items as the size, color, and prominence of type and the arrangement of text and captions.

(c) The outline of coverage must include:

(i) a description of the principal benefits and coverage provided in the policy or certificate;

(ii) a statement of the exceptions, reductions, and limitations contained in the policy or certificate;

(iii) a statement of the renewal provisions, including any reservation by the issuer of a right to change premiums and disclosure of the existence of any automatic renewal premium increases based on the policyholder's or certificate holder's age;

(iv) a statement that the outline of coverage is a summary of the policy or certificate issued or applied for and that the policy or certificate should be consulted to determine governing contractual provisions.

(3) The commissioner may prescribe by rule a standard form and the contents of an informational brochure for persons eligible for medicare, which is intended to improve the buyer's ability to select the most appropriate coverage and to improve the buyer's understanding of medicare. Except in the case of direct response insurance policies, the commissioner may require by rule that the information brochure be provided to any prospective insureds eligible for medicare at the same time that the outline of coverage is delivered. With respect to direct response insurance policies, the commissioner may require by rule that the

prescribed brochure be provided upon request, but not later than the time of policy delivery, to any prospective insureds eligible for medicare.

(4) The commissioner may adopt reasonable rules for captions or notice requirements, determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not medicare supplement coverages, for all accident and sickness insurance policies sold to persons eligible for medicare, other than:

(a) medicare supplement policies or certificates; or

(b) disability income policies~~;~~

~~(c) basic, catastrophic, or major medical expense policies;~~

~~(d) single premium, nonrenewable policies; or~~

~~(e) other policies excepted in 33-22-903(8)~~.

(5) The commissioner may further adopt reasonable rules to govern the full and fair disclosure of the information in connection with the replacement of accident and sickness policies or certificates by persons eligible for medicare.

(6) As soon as practicable, but no later than 30 days before the annual effective date of a medicare benefit change, every entity providing medicare supplement insurance or benefits to a resident of this state shall notify its policyholders and certificate holders, in a format that the commissioner prescribes by rule, of the changes that it has made to the medicare supplement policy or certificate."

Section 32. Section 33-22-910, MCA, is amended to read:

"**33-22-910. Filing requirements for advertising.** Every issuer of medicare supplement policies or certificates in this state shall provide to the commissioner for the commissioner's ~~review or~~ approval a copy of any medicare supplement advertising intended for use in this state, whether through written, radio, or television medium."

Section 33. 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 carriers of disability insurance, including excess of loss and stop loss disability insurance.

(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 health benefit plan, except a uniform health benefit plan, developed by a small employer carrier, that has a lower benefit value than the small employer carrier's standard benefit plan and that provides the benefits required by 33-22-1827.

(6) "Benefit equivalency" means a method developed by the small employer carrier for comparing the types of health care services and articles covered under a health benefit plan with the types of health care services required to be covered under a uniform, basic, or standard health benefit plan.

(7) "Benefit value" means an actuarially based method developed by the small employer carrier for comparing the value of determinable contingencies covered under a health benefit plan with the value of determinable contingencies required under a uniform, basic, or standard health benefit plan.

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

(9) "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, and a health maintenance organization. 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.

(10) "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.

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

(12) "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 as a dependent in the health benefit plan covering the employee.

(13) "Eligible employee" means an employee who works on a full-time basis with a normal workweek of 30 hours or more, except that at the sole discretion of the employer, the term may include an employee who works on a full-time basis with a normal workweek of between 20 and 40 hours as long as this eligibility criteria is applied uniformly among all of the employer's employees. 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.

(14) "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.

(15) "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 or any other limited benefit plan;

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

(c) automobile medical payment insurance.

(16) "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.

(17) "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:

(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;

(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.

(18) "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.

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

(20) "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.

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

(22) "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 minimum 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 minimum basic health benefit plan, provided that the policy has been in effect for a period of at least 1 year.

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

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

(25) "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.

(26) "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 small employer member of its association or any employee of

its small employer members who applies for coverage as part of a group.

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

(28) "Standard health benefit plan" means a health benefit plan that is developed by a small employer carrier and that contains the provisions required pursuant to 33-22-1828."

Section 34. 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 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 the premiums necessary to recover one-half of the expenses for the

calendar year. For purposes of this section, expenses include administrative expenses, one-half of the program net loss for the previous calendar year, and the actuarially anticipated claims to be incurred, 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 shall annually review the methodology established under subsection (6)(a), including the system of classification and any rating factors, to ensure that it is actuarially sound and 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, and the actuarially anticipated losses for the calendar year. The sum of one-half of the program net loss for the previous calendar year plus the anticipated net loss for the calendar year must equal the total assessment amount. If the program net loss for the previous calendar year is zero or less, the total assessment amount must equal the actuarially anticipated losses for the calendar year.

(b) (i) Each assessable carrier shall share in the program in an amount determined by multiplying the total assessment amount by a fraction, the numerator of which is the number of individuals in this state covered under disability insurance by the assessable carrier and the denominator of which is the number of all individuals in this state covered under disability insurance by all assessable carriers.

(ii) The board shall make a reasonable effort to ensure that each insured individual is counted only once for the purpose of assessment. The board shall require each assessable carrier that provides excess

of loss or stop loss insurance to include in its count of insured individuals all individuals whose coverage is reinsured in whole or in part, including coverage under excess of loss or stop loss insurance. The board shall allow an assessable carrier who is an excess of loss or stop loss insurer to exclude from its count of insured individuals those who have been counted by a primary disability insurer or by a primary reinsurer.

(iii) ~~The board shall base each assessable carrier's assessment on reports filed with the commissioner as required by 33-22-1820.~~ The board may use any reasonable method of estimating the number of individuals insured by an assessable carrier if the specific number is unknown.

(c) The board shall make an annual determination in accordance with this section of each assessable carrier's liability for its share of the contribution to the program and, except as otherwise provided by this section, make an annual assessment against each assessable carrier to the extent of that liability. Payment of an 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.

(d) The board may establish and maintain program reserves not to exceed five times the actuarially anticipated losses for the calendar year.

(e) If the sum of the reinsurance premiums and assessments in any calendar year exceeds the sum of the administrative expenses and incurred claims for that year, the board may proportionately credit the excess to assessable carriers or it may place the excess in program reserves, subject to the limits in subsection (8)(d).

(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 35. Section 33-22-1820, MCA, is amended to read:

"**33-22-1820. Periodic market evaluation -- report.** The ~~board shall~~ commissioner may study and report at least every 3 years to the ~~commissioner~~ governor or other interested persons on the effectiveness of this part. The report must analyze the effectiveness of this part in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the small employer health insurance markets. The report must address whether carriers and producers are fairly and actively marketing or issuing health benefit plans to small employers in fulfillment of the purposes of this part. The report may contain recommendations for market conduct or other regulatory standards or action."

Section 36. Section 33-22-1828, MCA, is amended to read:

"**33-22-1828. Benefits required in standard benefit plan.** (1) The minimum benefits must be equal to at least 75% of the covered expenses in excess of an annual deductible that does not exceed $500 per person or $1,000 per family. The coverage must include a limitation of $2,000 per person or $4,000 per family on the total annual out-of-pocket expenses for services covered. The coverage may be subject to a maximum lifetime benefit, but a maximum, if any, may not be less than $1 million.

(2) The commissioner may not require coverage in a standard health benefit plan for any benefit

unless other provisions of Title 33, chapter 22, 30, or 31, specifically require coverage for the benefit. A small employer carrier may offer coverage for additional services and articles.

(3) A standard health benefit plan provided by a health maintenance organization or a basic health benefit plan with a restricted network provision must provide a comparable level of benefits to those required by subsection (1), as determined by the ~~benefit equivalency and~~ benefit value."

Section 37. 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 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: 33-3-308; 33-3-701 through 33-3-704; 33-17-101; 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 33-3-701 through 33-3-704~~.

(2) A law of this state other than the provisions of this chapter applicable to health service corporations must be construed in accordance with the fundamental nature of a health service corporation, and in the event of a conflict the provisions of this chapter prevail."

Section 38. Section 33-30-107, MCA, is amended to read:

"**33-30-107. Annual statement.** (1) On or before March 1 of each year, each health service corporation shall file an annual statement for the preceding year on 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.

(4) The commissioner may, after notice and hearing, suspend or revoke a health maintenance organization's license or impose a fine not to exceed $100 a day and not to exceed $1,000 upon a health maintenance organization that fails to file an annual statement as required by this part."

Section 39. 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 the prohibition of pecuniary interest under 33-3-308 or the material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance organization must be considered an insurer for the purposes of 33-3-308 and 33-3-701 through 33-3-704."

Section 40. Section 33-31-211, MCA, is amended to read:

"**33-31-211. Annual statement -- revocation for failure to file -- penalty for false swearing.** (1) Unless it is operated by an insurer or a health service corporation as a plan, each authorized health maintenance organization 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. The

statement must be in the general form and content required by the commissioner. The statement must be verified by the oath of at least two principal officers of the health maintenance organization. The commissioner may ~~in his discretion~~ waive any verification under oath.

(2) At the time of filing its annual statement, the health maintenance organization shall pay the commissioner the fee for filing its statement as prescribed in 33-31-212. The commissioner may refuse to accept the fee for continuance of the insurer's certificate of authority, as provided in 33-31-212, may impose a penalty of $100, or may ~~in his discretion~~ suspend or revoke the certificate of authority of a health maintenance organization that fails to file an annual statement when due. Each day that the insurer fails to file its annual statement constitutes a separate violation. The total penalty may not exceed $1,000.

(3) The commissioner may, after notice and hearing, impose a fine not to exceed $5,000 ~~per~~ for each violation upon a director, officer, partner, member, insurance producer, or employee of a health maintenance organization who knowingly subscribes to or concurs in making or publishing an annual statement required by law that contains a material statement ~~which~~ that is false.

(4) The commissioner may require ~~such~~ reports ~~as he~~ that the commissioner considers reasonably necessary and appropriate to enable ~~him~~ the commissioner to carry out ~~his~~ the commissioner's duties under this chapter, including but not limited to a statement of operations, transactions, and affairs of a health maintenance organization operated by an insurer or a health service corporation as a plan."

NEW SECTION. **Section 41. Uniform claim forms and procedures.** (1) The commissioner of insurance, after consultation with the health care advisory council, may adopt by rule uniform health insurance claim forms and uniform standards and procedures for the use of the forms and processing of claims, including the submission of claims by means of an electronic claims processing system.

(2) The commissioner may contract with a private or public entity to administer and operate an electronic claims processing system. If the commissioner elects to contract for administration and operation of the system, the commissioner shall award a contract according to Title 18, chapter 4.

NEW SECTION. **Section 42. Statute of limitations.** The period prescribed for the commencement of a civil or administrative action by the commissioner for alleged violation of Title 33 is within 2 years of the commissioner's discovery of the facts constituting the alleged violation.

NEW SECTION. **Section 43. Filing or making false statements.** (1) A person may not purposely or knowingly make or cause to be made, in any document filed with the commissioner or in any proceeding before the commissioner, any statement that is, at the time and in the light of the circumstances under which it is made, false or misleading in any material respect.

(2) A person found to have willfully violated subsection (1) is subject to a fine of up to $5,000 and, if applicable, may be subject to the criminal laws of this state.

NEW SECTION. **Section 44. Credit life and disability applications.** (1) The insurance producer who effects the sale of a policy or certificate of credit life and disability insurance shall sign the application.

(2) An insurance company may not accept an application for credit life and disability insurance unless the application is signed by the insurance producer who effected the sale.

(3) This section does not apply to policies or certificates subject to the provisions of 33-21-204.

NEW SECTION. **Section 45. Service contract insurance.** (1) Service contract insurance is a contract or agreement for a separately stated consideration or for a specific duration to:

(a) perform the repair, replacement, or maintenance of property; or

(b) indemnify for repair, replacement, or maintenance of property.

(2) Service contract insurance does not include contracts or agreements that:

(a) are indemnified only by the seller or manufacturer; and

(b) insure only the inherent quality of the product.

NEW SECTION. **Section 46. Loss and loss expense reserves for property and casualty insurance.** (1) (a) In determining the financial condition of a property and casualty insurer for the purpose of applying the provisions of this chapter and in any financial statement or report of an insurer, loss reserves and loss expense reserves at least equal to the amounts required under the provisions of this section must be included in the insurer's liabilities. The date from which the determination, statement, or report is made is, for the purpose of this part, the date of determination.

(b) Accepted actuarial standards as adopted by the actuarial standards board must be taken into consideration for the purpose of determining the loss reserves and loss expense reserves.

(2) Except as provided in subsections (3) and (4), the reserves for all outstanding losses and loss

expenses must include the following:

(a) the aggregate estimated amounts due or to become due on account of all known losses, claims, and loss expenses incurred but not paid, including the estimated liability on any notice received by the insurer of the occurrence of any event that may result in a loss; and

(b) the aggregate amounts of liability for all losses and loss expenses incurred for which notice has not been received, estimated in accordance with the insurer's prior experience, if any, or otherwise in accordance with Montana industry ~~data~~ EXPERIENCE, OR COUNTRYWIDE INDUSTRY EXPERIENCE IF THIS STATE'S EXPERIENCE IS NOT CREDIBLE, FOR SIMILAR CONTRACTS OF INSURANCE. The estimated liabilities for losses under all bonds, policies, or contracts of fidelity insurance may not be less than 10% of the net premiums in force, and the estimated liabilities for all of those losses under all the insurer's surety contracts may not be less than 5% of the net premiums in force.

(3) Except as provided in subsection (4), tabular reserves for outstanding losses under policies of workers' compensation insurance may be actuarially calculated for both indemnity and medical payments. The loss adjustment expenses are not eligible for discounting. Tabular reserves are those reserves that are:

(a) calculated using discounts determined with reference to actuarial tables, which incorporate mortality, interest, not to exceed 4%, remarriage, and other contingencies applied to a reasonably determinable payment stream associated with lifetime benefit cases; or

(b) annuities certain, such as those arising from structured settlements.

(4) Whenever, in the judgment of the commissioner, the loss and loss expense reserves of any property and casualty insurer doing business in this state, calculated in accordance with the provisions of this section, are inadequate or excessive, the commissioner may prescribe any other method that will produce adequate and reasonable reserves.

(5) The excess, if any, of statutory reserves over statement reserves must be calculated in accordance with the annual statement instructions adopted by the national association of insurance commissioners.

NEW SECTION. **Section 47. Repealer.** Sections 33-2-515, 33-2-536, 33-2-721, 33-2-722, 33-2-723, 33-4-404, 33-4-409, 33-22-1201, 33-22-1202, 33-22-1203, 33-22-1204, and 33-22-1205, MCA, are repealed.

NEW SECTION. **Section 48. Codification instruction.** (1) [Section ~~42~~ 41] is intended to be codified as an integral part of Title 50, chapter 4, part 5, and the provisions of Title 50, chapter 4, part 5, apply to [section ~~42~~ 41].

(2) [Sections ~~43 and 44~~ 42 AND 43] are intended to be codified as an integral part of Title 33, chapter 1, part 3, and the provisions of Title 33, chapter 1, part 3, apply to [sections ~~43 and 44~~ 42 AND 43].

(3) [Section ~~45~~ 44] is intended to be codified as an integral part of Title 33, chapter 21, part 1, and the provisions of Title 33, chapter 21, part 1, apply to [section ~~45~~ 44].

(4) [Section ~~46~~ 45] is intended to be codified as an integral part of Title 33, chapter 1, part 2, and the provisions of Title 33, chapter 1, part 2, apply to [section ~~46~~ 45].

(5) [Section ~~47~~ 46] 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 ~~47~~ 46].

NEW SECTION. **Section 49. 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-

HOUSE BILL NO. 131

INTRODUCED BY SIMON

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING STATE INSURANCE LAWS; PROVIDING FOR UNIFORM HEALTH INSURANCE CLAIM FORMS; PROVIDING A STATUTE OF LIMITATIONS FOR ACTIONS BROUGHT BY THE COMMISSIONER OF INSURANCE; PROVIDING PENALTIES FOR MISREPRESENTATIONS MADE TO THE COMMISSIONER; REQUIRING THAT CREDIT LIFE AND DISABILITY INSURANCE APPLICATIONS BE SIGNED BY THE INSURANCE PRODUCER EFFECTING THE SALE; DEFINING "SERVICE CONTRACT INSURANCE"; AMENDING SECTIONS 18-8-103, 33-2-307, 33-2-317, 33-2-514, 33-2-517, 33-2-537, 33-2-704, 33-2-806, 33-2-1359, 33-2-1902, 33-3-303, 33-3-307, 33-4-202, 33-4-203, 33-4-204, 33-4-313, 33-4-314, 33-5-402, 33-10-202, 33-15-1106, 33-16-1027, 33-17-102, 33-17-212, 33-17-301, 33-17-1203, 33-18-210, ~~33-18-301,~~ 33-20-101, 33-22-107, 33-22-508, 33-22-903, 33-22-907, 33-22-910, 33-22-1803, 33-22-1819, 33-22-1820, 33-22-1828, 33-30-102, 33-30-107, 33-31-111, AND 33-31-211, MCA; AND REPEALING SECTIONS 33-2-515, 33-2-536, 33-2-721, 33-2-722, 33-2-723, 33-4-404, 33-4-409, 33-22-1201, 33-22-1202, 33-22-1203, 33-22-1204, AND 33-22-1205, MCA."

THERE ARE NO CHANGES IN THIS BILL AND IT WILL NOT BE REPRINTED. PLEASE REFER TO SECOND READING COPY (YELLOW) FOR COMPLETE TEXT.

APPROVED BY COM ON
BUSINESS & INDUSTRY

HOUSE BILL NO. 131

INTRODUCED BY SIMON

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING STATE INSURANCE LAWS; PROVIDING FOR UNIFORM HEALTH INSURANCE CLAIM FORMS; ~~PROVIDING A STATUTE OF LIMITATIONS FOR ACTIONS BROUGHT BY THE COMMISSIONER OF INSURANCE;~~ PROVIDING PENALTIES FOR MISREPRESENTATIONS MADE TO THE COMMISSIONER; ~~REQUIRING THAT CREDIT LIFE AND DISABILITY INSURANCE APPLICATIONS BE SIGNED BY THE INSURANCE PRODUCER EFFECTING THE SALE;~~ DEFINING "SERVICE CONTRACT INSURANCE"; AMENDING SECTIONS 18-8-103, 33-1-1205, 33-2-307, 33-2-317, 33-2-514, 33-2-517, 33-2-537, 33-2-704, 33-2-806, 33-2-1359, 33-2-1902, 33-3-303, 33-3-307, 33-4-202, 33-4-203, 33-4-204, 33-4-313, 33-4-314, 33-5-402, 33-10-202, 33-15-1105, 33-15-1106, 33-16-1027, 33-17-102, 33-17-212, 33-17-301, 33-17-1203, 33-18-210, ~~33-18-301,~~ 33-20-101, 33-22-107, 33-22-508, 33-22-903, 33-22-907, 33-22-910, 33-22-1803, 33-22-1819, 33-22-1820, 33-22-1828, 33-30-102, 33-30-107, 33-31-111, AND 33-31-211, MCA; AND REPEALING SECTIONS 33-2-515, 33-2-536, 33-2-721, 33-2-722, 33-2-723, 33-4-404, 33-4-409, 33-22-1201, 33-22-1202, 33-22-1203, 33-22-1204, AND 33-22-1205, MCA."

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

Section 1. Section 18-8-103, MCA, is amended to read:

"18-8-103. Exemptions. This part does not apply to employment of:

(1) registered professional engineers, surveyors, real estate appraisers, or registered architects;

(2) physicians, dentists, or other medical, dental, or health care providers;

(3) expert witnesses hired for use in litigation, hearings officers hired in rulemaking and contested case proceedings under the Montana Administrative Procedure Act, or attorneys as specified by executive order of the governor;

(4) consulting actuaries to the public retirement boards, ~~or~~ the state compensation insurance fund, or the commissioner of insurance;

(5) private consultants employed by the student associations of the university system with money

raised from student activity fees designated for use by those student associations; or

(6) private consultants employed by the Montana state lottery."

SECTION 2. SECTION 33-1-1205, MCA, IS AMENDED TO READ:

"**33-1-1205. Duties of authorized insurers, adjusters, administrators, consultants, and producers.** (1) Each insurer, independent adjuster, independent administrator, independent consultant, and independent producer shall cooperate fully with the commissioner with respect to the provisions of this part.

(2) An insurer, an officer, or an employee~~, or producer~~ of the insurer, an independent adjuster, an independent administrator, an independent consultant, or an independent producer who has reason to believe that an insurance fraud has been or is being committed shall provide notice of the alleged insurance fraud to the commissioner within 60 days. A producer of an insurer who has reason to believe that an insurance fraud has been or is being committed shall provide notice within 60 days of discovery of the alleged insurance fraud to the insurer who shall within 30 days of receiving notice from the producer report it to the commissioner.

(3) Notice to the commissioner by an insurer who has reason to believe that an insurance fraud has been committed in connection with an insurance claim, application, or policy tolls any applicable time period, for the commissioner, in any applicable insurance statute, related insurance regulation, or applicable sections of the criminal code and tolls any time period arising under 33-18-232 or 33-18-242 regarding unfair claims settlement practices."

Section 3. 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) $7 million. An insurer possessing less than ~~$6~~ $7 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 ~~$6~~ $7 million.

(ii) in the case of Lloyd's or another similar group including incorporated and unincorporated alien 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~~ not 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 4. Section 33-2-317, MCA, is amended to read:

"**33-2-317. Exemptions.** The Surplus Lines Insurance Law does not apply to reinsurance or to the following kinds of insurance when placed by a licensed insurance producer of this state:

(1) wet marine ~~and transportation insurances~~ insurance;

(2) insurance on subjects located, residing, or to be performed wholly outside of this state or on vehicles or aircraft owned and principally garaged outside this state;

(3) insurance on property or operations of railroads engaged in interstate commerce; and

(4) insurance of aircraft owned or operated by manufacturers of aircraft or aircraft operated in scheduled interstate flight or cargo of the aircraft or against liability, other than workers' compensation and employers' liability, arising out of the ownership, maintenance, or use of the aircraft."

Section 5. Section 33-2-514, MCA, is amended to read:

"**33-2-514. Reserve for disability insurance.** (1) For all disability insurance policies, the insurer shall maintain an active life reserve ~~which shall place~~ that places a sound value on its liabilities under ~~such~~ the policies and that may not be ~~not~~ less than ~~the reserve according to appropriate standards set forth in regulations issued by the commissioner and, in no event, less in the aggregate than~~ the pro rata gross unearned premiums for ~~such~~ the policies.

(2) The commissioner may promulgate rules to define additional standards for reserve requirements."

Section 6. Section 33-2-517, MCA, is amended to read:

"**33-2-517. Title insurance reserves.** (1) In addition to an adequate reserve as to outstanding losses as required under 33-2-511, a title insurer shall maintain a guaranty fund or unearned premium reserve of not less than an amount computed as follows:

(a) Ten percent of the total amount of the risk premiums written in the calendar year for title insurance contracts ~~shall~~ must be assigned originally to the reserve.

(b) During each of the 20 years next following the year in which the title insurance contract was issued, the reserve applicable to the contract ~~shall~~ must be reduced by 5% of the original amount of ~~such~~ the reserve.

(2) The reserve sums ~~herein~~ required ~~to be reserved~~ by subsection (1) for unearned premiums on contracts of title insurance ~~shall~~ must at all times and for all purposes be considered and constitute unearned portions of the original premiums and ~~shall~~ must be held in trust for the benefit of policyholders.

(3) The reduction of the unearned premium reserve required by subsection (1)(b) ~~of this section~~

~~shall~~ must be made for all title insurance contracts issued after December 31, 1958, with respect to which 10% of the risk premiums have been assigned to the reserve pursuant to subsection (1)(a) ~~of this section~~. ~~In the event that any title insurer has not in accordance with subsection (1)(b) of this section reduced the amount of its unearned premium reserve by 5% of the amount originally assigned to the reserve pursuant to subsection (1)(a) of this section for years ending after December 31, 1958, and before January 1, 1977, the insurer shall effect such reduction for such prior years during its accounting year which includes December 31, 1976.~~ If the insurer has not reduced the amount of its unearned premium reserves pursuant to subsection (1)(b) for a previous year or years, the insurer shall make the reduction for the prior year or years in its next accounting year."

Section 7. Section 33-2-537, MCA, is amended to read:

"**33-2-537. 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~~ may promulgate a rule containing the minimum standards applicable to the valuation of disability plans."

Section 8. Section 33-2-704, MCA, is amended to read:

"**33-2-704. Insured lives reporting requirement.** On or before ~~February 15~~ March 1 of each year, each insurer providing disability insurance shall, on a form prescribed by the commissioner, report the number of Montana residents insured on February 1 under any policy of individual or group disability insurance, including excess of loss or stop loss insurance policies covering disability insurance."

Section 9. 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 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 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 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~~ 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:~~ in 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, in securities, in both cash and securities, or in investments provided for ~~under~~ in 33-2-531.

(5) Except with the commissioner's consent, an insurer 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) Except with the commissioner's consent, an ~~An~~ insurer may not invest and have invested at any one time in aggregate amount more than 15% of its assets in all stocks ~~under~~ provided for in 33-2-820 and 33-2-821. Determination of the amount that an insurer has invested in common stocks for the purposes of this provision must be based on the cost of the stocks to the insurer. This provision does not apply ~~as~~ to stock of a controlled or subsidiary insurance corporation or other corporations ~~under~~ provided for in 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~~ in 33-2-824. Money market funds, as defined by

the commissioner by rule, are exempt from the 5% limitation of this subsection.

(8) Except with the commissioner's consent, an insurer 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~~ of investments in ~~the category of~~ real estate ~~shall~~ must be as provided in 33-2-832. Other specific limits apply as stated in the sections dealing with other respective kinds of investments."

Section 10. Section 33-2-1359, MCA, is amended to read:

"**33-2-1359. Setoffs ~~and counterclaims~~.** (1) Mutual debts or mutual credits between the insurer and another person in connection with any action or proceeding under this part ~~shall~~ must be set off and the balance only ~~shall be~~ allowed or paid, except as provided in ~~subsection (2) and~~ 33-2-1362 and subsection (2) of this section.

(2) ~~No~~ A setoff ~~or counterclaim~~ may not be allowed in favor of any person when:

(a) the obligation of the insurer to the person would not at the date of the filing of a petition for liquidation entitle the person to share as a claimant in the assets of the insurer;

(b) the obligation of the insurer to the person was purchased by or transferred to the person with a view to its being used as a setoff; or

(c) the obligation of the person is to pay an assessment levied against the members or subscribers of the insurer or is to pay a balance upon a subscription to the capital stock of the insurer or is in any other way in the nature of a capital contribution.~~; or~~

~~(d) the obligation of the person is to pay premiums, whether earned or unearned, to the insurer.~~"

Section 11. Section 33-2-1902, MCA, is amended to read:

"**33-2-1902. Definitions.** As used in this part, the following definitions apply:

(1) "Adjusted RBC report" means an RBC report that has been adjusted by the commissioner in accordance with 33-2-1903(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; or

(c) any insurer engaged solely in the business of reinsurance of life or disability contracts.

(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 :

(i) 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;

(ii) any insurance company engaged solely in the business of reinsurance of property and casualty contracts; or

(iii) any insurance company engaged in the business of surety and marine insurance.

(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

33-2-1904(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 33-2-1903.

(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."

Section 12. Section 33-3-303, MCA, is amended to read:

"33-3-303. Meetings of stockholders or members. (1) Meetings of stockholders or members of a domestic insurer ~~shall~~ must be held in the city or town of its principal office or place of business in this state.

(2) ~~No~~ A meeting of stockholders or members ~~shall~~ may not amend the insurer's articles of incorporation unless the proposal ~~so~~ to amend was included in the notice of the meeting.

(3) Except with the commissioner's consent, each ~~Each~~ insurer shall, during the first 6 months of each calendar year, hold the annual meeting of its stockholders or members to fill vacancies existing or occurring in the board of directors, must receive and shall consider reports of the insurer's officers as to its affairs, and shall transact ~~such~~ other business ~~as may~~ properly ~~be~~ brought before it. Not less than 20 days' notice ~~shall~~ must be given of ~~such~~ the meeting in the manner provided in the bylaws, except ~~where~~ when notice of the annual meeting of a mutual insurer is contained in its policies.

(4) Special meetings of the stockholders or members may be called at any time for any purpose by the board of directors upon not less than 10 days' notice, with notice given as provided in the bylaws. The notice ~~shall~~ must state the purpose of the meeting, and ~~no~~ business for which notice was not given may not ~~shall~~ be transacted at the meeting ~~of which notice was not so given~~.

(5) If more than 15 months are allowed to elapse without an annual stockholders' or members' meeting being held, any stockholder or member may call ~~such a~~ for an annual meeting to be held. At any time, upon written request of any director or of any stockholders or members holding in the aggregate one-fifth of the voting power of all stockholders or members, it ~~shall be~~ is the duty of the secretary to call a special meeting of stockholders or members to be held at ~~such~~ the time ~~as~~ that the secretary may fix, not less than 10 or more than 30 days after the receipt of the request. If the secretary fails to issue ~~such~~ a call, the director, stockholders, or members making the request may do so.

(6) A stockholders' or members' meeting duly held ~~can~~ may be organized for the transaction of business whenever a quorum is present. Except as otherwise provided by law or the articles of incorporation:

(a) the presence, in person or by proxy, of the holders of a majority of the voting power of all stockholders or of all members ~~shall constitute~~ constitutes a quorum;

(b) the stockholders or members present at a duly organized meeting ~~can~~ may continue to do business until adjournment, notwithstanding the withdrawal of enough stockholders or members to leave less than a quorum;

(c) if any necessary officer fails to attend ~~such~~ a meeting, any stockholder or member present may be elected to act temporarily in lieu of ~~any such~~ the absent officer;

(d) if a meeting cannot be ~~organized~~ held because a quorum ~~has not attended~~ is not present, those present may adjourn the meeting to ~~such~~ a time ~~as~~ that they ~~may~~ determine, but in the case of any meeting called for the election of any director, the adjournment must be to the next day and those who attend the second ~~of such adjourned meetings~~ meeting, although less than a quorum as fixed in this section or in the articles of incorporation, ~~shall nevertheless~~ constitute a quorum for the purpose of electing any director; and

(e) an annual or special meeting of stockholders or members may be adjourned to another date without new notice being given."

Section 13. Section 33-3-307, MCA, is amended to read:

"**33-3-307. Bond of officers.** (1) The president, secretary, and treasurer of ~~every~~ each mutual insurer or stock insurer shall each file with the commissioner and ~~thereafter~~ maintain in force so long as ~~he~~ that individual is ~~such~~ an officer a fidelity bond in ~~the sum of $10,000~~ an amount set by the commissioner by rule and issued by an authorized corporate surety in favor of the insurer. The commissioner shall consider the insurer's exposure, total assets, and total income in determining the bond amount. In lieu of individual bonds, ~~all such~~ officers may be covered under a blanket bond for the same respective amounts, ~~and which~~ The blanket bond ~~shall likewise~~ must be filed with the commissioner.

(2) The premium for the bond ~~shall~~ must be payable by the insurer.

(3) ~~No such~~ A bond ~~shall~~ is not ~~be~~ subject to cancellation except upon written notice to both the insurer and the commissioner, delivered not less than 30 days in advance of the effective date of ~~such~~ the

cancellation.

(4) The insurer shall provide for the bonding by authorized corporate surety of all other officers in any way responsible for the handling of the funds of the insurer.

(5) This section ~~shall~~ may not be ~~deemed~~ considered to limit the amount of bonded protection ~~which~~ that the insurer may carry as to any officer."

Section 14. 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 the corporation 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) four copies of proposed articles of incorporation executed ~~in 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~~ The signatures of the incorporators must be notarized.

(2) The articles of incorporation 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 must contain the words "farm mutual" or "rural mutual" together with the name of the county in which its principal place of business is to be located. The name 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 must be located in this state;

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

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

(f) the duration of ~~its~~ the corporation's existence, which may be perpetual;

(g) the number of its directors, which may not be less than 5 or more than 11, 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~~ at which time successors are elected and qualified;

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

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

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

Section 15. Section 33-4-203, MCA, is amended to read:

"**33-4-203. Approval of articles -- commencement of corporate existence.** (1) If the 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 commissioner shall make a certificate of the facts.

(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 commissioner, the commissioner shall endorse the ~~commissioner's~~ approval upon each set of the articles and forward ~~three~~ four 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 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 16. Section 33-4-204, MCA, is amended to read:

"**33-4-204. Amendment of articles.** A farm mutual insurer may, by a vote of two-thirds of its members present at any annual meeting or at any special meeting ~~of members~~ called for that purpose,

amend its articles of incorporation to extend its corporate duration or ~~in~~ any other particular within the scope of this chapter by causing amended articles to be filed in the same form and manner as required for original articles of incorporation. The commissioner shall review the amended articles for compliance with this title. The amended articles of incorporation ~~shall~~ may be signed only by the president and secretary of the corporation and attested by the corporate seal. Notice of the proposed amendment ~~shall~~ must be contained in the notice ~~given~~ of ~~any such~~ the annual or special meeting."

Section 17. Section 33-4-313, MCA, is amended to read:

"**33-4-313. Annual statement ~~--report--filing~~.** ~~(1)~~ The president and secretary of ~~every~~ each insurer, on or before March 1 each year, shall prepare, affirm under oath, affix the corporate seal ~~thereto~~ to, and file with the commissioner, on forms ~~as~~ prescribed and furnished by ~~him~~ the commissioner, an annual statement for the preceding calendar year showing the condition of ~~such~~ the insurer as of December 31 of ~~such~~ the preceding year and exhibiting the following facts:

~~(a)~~(1) the names of the president and secretary;

~~(b)~~(2) the date of the annual meeting;

~~(c)~~(3) the amount of insurance in force;

~~(d)~~(4) the number of members;

~~(e)~~(5) the number of assessments made during the year;

~~(f)~~(6) the amount paid in losses during the year;

~~(g)~~(7) the amount of the losses claimed and not paid, with the reason for nonpayment;

~~(h)~~(8) the number of members withdrawn, suspended, and expelled during the year;

~~(i)~~(9) the number of new members admitted during the year;

~~(j)~~(10) the expenses during the year;

~~(k)~~(11) the amount of money on hand;

~~(l)~~(12) the amount and character of the insurer's assets;

~~(m)~~(13) the amount of the insurer's liabilities, including any reserves required to be established under this chapter; and

~~(n)~~(14) ~~such~~ other information concerning the insurer's affairs ~~as~~ that the commissioner may reasonably require.

~~(2) A report of an insurer's expenditures for educational purposes, if any, for the preceding year~~

~~must be filed with the commissioner at the same time and in conjunction with the annual report of such insurer, as required under 33-4-404.~~"

Section 18. Section 33-4-314, MCA, is amended to read:

"**33-4-314. Annual statement -- exclusive report -- penalty for failure to file.** (1) ~~No~~ A report, statement, or return of any nature ~~shall~~ may not be required of any farm mutual insurer other than those required by 33-4-313.

(2) The commissioner may:

(a) suspend or revoke the certificate of authority of any insurer failing to file its annual statement as required; or

(b) impose a fine of up to $100 a day for each day that an insurer is late in filing its annual statement, with the aggregate penalty not to exceed $1,000."

Section 19. Section 33-5-402, MCA, is amended to read:

"**33-5-402. Contributions to insurer.** The attorney or other parties may advance to a domestic reciprocal insurer upon reasonable terms ~~such~~ funds ~~as~~ that it may require from time to time in its operations. Sums ~~so~~ advanced ~~shall~~ may not be treated as a liability of the insurer, ~~and, except~~ Except upon liquidation of the insurer, ~~shall not be withdrawn or repaid except out of the insurer's realized earned surplus in excess of its minimum required surplus~~ during any calendar year, the total of withdrawals and repayments of the advanced sums may not exceed the lesser of the insured's realized earned surplus or 10% of the sums advanced as of the previous December 31. ~~No such~~ A withdrawal or repayment ~~shall~~ may not be made without the advance approval of the commissioner. This section does not apply to bank loans or to loans for which security is given."

Section 20. 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~~ 33-10-201(4) through (6) ~~of 33-10-201~~.

(5) "Impaired insurer" means:

(a) an insurer ~~which after July 1, 1974,~~ that 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 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~~ 33-10-201 and 33-10-224 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) (a) "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.

(b) ~~"Premiums" do~~ The term does not include premiums and considerations on contracts between insurers and reinsurers.

(c) As used in 33-10-227, ~~"premiums"~~ 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 that 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 21. SECTION 33-15-1105, MCA, IS AMENDED TO READ:

"**33-15-1105. Nonrenewal -- renewal premium.** (1) (a) An insured has a right to reasonable notice of nonrenewal. Unless otherwise provided by statute or unless a longer term is provided in the policy, at least 30 days prior to the expiration date provided in the policy, an insurer who does not intend to renew a policy beyond the agreed expiration date shall mail or deliver to the insured a notice of such intention. The insurer shall also mail or deliver a copy to the insured's insurance producer.

(b) Notification or nonrenewal to the insured's insurance producer via electronic transfer of data or by electronic data retrieval device meets the requirement of a mailed or delivered copy.

(2) An insurer shall give notice of premium due not more than 60 days or less than 10 days before the due date of a renewal premium. The notice must clearly state the effect of nonpayment of the premium on or before the due date.

(3) Subsections (1) and (2) do not apply if:

(a) the insured has obtained insurance elsewhere, has accepted replacement coverage, or has requested or agreed to nonrenewal; or

(b) the policy is expressly designated as nonrenewable."

Section 22. Section 33-15-1106, MCA, is amended to read:

"**33-15-1106. Renewal with altered terms.** (1) If an insurer offers or purports to renew a policy but on less favorable terms, at a higher rate, or at a higher rating plan, the new terms, rate, or rating plan take effect on the policy renewal date only if the insurer has mailed or delivered notice of the new terms, rate, or rating plan to the insured at least 30 days before the expiration date. ~~If the insured has not been so notified, he may cancel the renewal policy within 30 days after receiving the notice. The insurer shall continue coverage for a period of not less than 30 days after mailing or delivery of the notice. If the insured terminates the policy within the 30-day period, the insurer shall calculate the earned premium pro rata based upon the prior policy's rate. The new rate is effective only after the required 30-day notification period has been met. If the insured does not terminate the policy, the premium increase and other changes are effective the day following the prior policy's expiration or anniversary date.~~

(2) This section does not apply if the increase in the rate or the rating plan, or both, results from a classification change based on the altered nature or extent of the risk insured against."

Section 23. Section 33-16-1027, MCA, is amended to read:

"**33-16-1027. Rate filing review.** (1) The commissioner shall review each insurance filing to ensure compliance with the following guidelines:

(a) The effective date of each workers' compensation insurer or advisory organization filing must be the date specified in the filing. The effective date of the filing may not be earlier than 30 days after the date on which the filing is received by the commissioner or the date of receipt of the information furnished in support of the filing, if the supporting information is required by the commissioner.

(b) Upon written application of the insurer or advisory organization, the commissioner may authorize a filing that becomes effective before the expiration of the period described in subsection (1)(a).

(c) A filing is considered to have met the requirements of this part unless disapproved by the commissioner within the period described in subsection (1)(a) or any extension of the period.

(2) Whenever a filing is not accompanied by the information required under this section, the commissioner shall inform the filer of the deficiency within ~~10~~ 30 days of the initial filing. The filing is considered made when the required information is furnished or when the filer certifies to the commissioner that the additional information requested by the commissioner is not maintained or cannot be provided."

Section 24. 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;

(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 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 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.; or

(xii) a person appointed as a managing general agent in this state whose activities are limited exclusively to those described in 33-2-1501(10) and Title 33, chapter 2, part 16.

(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 the person or the person's spouse, employer, or 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 chapter, the term "managing general agent" 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 25. Section 33-17-212, MCA, is amended to read:

"**33-17-212. Examination required -- exceptions -- fees.** (1) Except as provided in subsection (7), an individual applying for a license shall pass a written examination. The examination must test the knowledge of the individual concerning each kind of insurance listed in subsection (6) for which application is made, the duties and responsibilities of an insurance producer, and the insurance laws and rules of this state. The examination must be developed and conducted under rules adopted by the commissioner.

(2) The commissioner may conduct the examination or make arrangements, including contracting with an outside testing service, for administering the examination and collecting the fees required by 33-2-708. The commissioner may arrange for the testing service to recover the cost of the examination from the applicant.

(3) Each individual applying for an examination shall remit the fees required by 33-2-708.

(4) An individual who fails to appear for the examination as scheduled or fails to pass the examination may reapply for an examination and shall remit all required fees and forms before being rescheduled for another examination.

(5) If the applicant is a partnership or corporation, each individual who is to be named in the license as having authority to act for the applicant in its insurance transactions under the license shall take the examination.

(6) Examination of an applicant for a license must cover all of the kinds of insurance for which the applicant has applied to be licensed, as constituted by any one or more of the following classifications:

(a) life insurance;

(b) disability insurance;

(c) property insurance. For the purposes of this provision, property insurance includes marine insurance.

(d) casualty insurance;

(e) surety insurance;

(f) credit life and disability insurance;

(g) title insurance.

(7) This section does not apply to and an examination is not required of:

(a) an individual lawfully licensed as an insurance producer as to the kind or kinds of insurance to be transacted as of or immediately prior to January 1, 1961, and ~~thereafter continuing~~ who continues to be licensed;

(b) an applicant for a license covering the same kind or kinds of insurance as to which the applicant was licensed in this state, other than under a temporary license, within the 12 months immediately preceding the date of application unless the commissioner has suspended, revoked, or refused to continue the previous license, except that this subsection (7)(b) does not apply to a title insurance producer, as defined in 33-25-105;

(c) an applicant for a license as a nonresident insurance producer;

(d) an applicant for a license to sell all-risk federal crop insurance if the applicant provides certification from an appropriate governmental agency to the commissioner that ~~he~~ the applicant is qualified to sell the insurance;

(e) transportation ticket agents of common carriers applying for a license to solicit and sell only:

(i) accident insurance ticket policies; or

(ii) insurance of personal effects while being carried as baggage on a common carrier, as incidental to their duties as transportation ticket agents;

(f) an association applying for a license under 33-17-211;

(g) a mechanical breakdown insurance producer~~.~~;

(h) a service contract insurance producer; or

~~(h)~~(i) an individual who, within 60 days of cancellation of a license issued by the state of the individual's residence, files with the commissioner a current letter of clearance certifying that the individual has passed an examination and held an insurance license in good standing in the individual's state of licensure, except that the individual shall take an examination pertaining to this state's law and each kind of insurance for which the individual has applied for a license and ~~which~~ that is not covered under the license held in the other state."

Section 26. Section 33-17-301, MCA, is amended to read:

"**33-17-301. Adjuster license -- qualifications -- catastrophe adjustments -- public adjuster.** (1) A person may not ~~in this state~~ act as or hold ~~himself~~ the person out to be an adjuster in this state unless licensed as an adjuster under this chapter. A person shall apply for an adjuster license to the commissioner

according to forms that the commissioner prescribes and furnishes. The commissioner shall issue the adjuster license to individuals qualified to be licensed as an adjuster upon payment of the license fee provided in 33-2-708.

(2) To be licensed as an adjuster, the applicant:

(a) must be an individual 18 years of age or more;

(b) must be a resident of Montana or resident of another state that will permit residents of Montana regularly to act as adjusters in the other state;

(c) must be a full-time salaried employee of a licensed adjuster or a graduate of a recognized law school or have had experience or special education or training as to the handling of loss claims under insurance contracts of sufficient duration and extent reasonably to make ~~him~~ the applicant competent to fulfill the responsibilities of an adjuster;

(d) must be trustworthy and of good character and reputation; and

(e) ~~shall~~ must have and shall maintain in this state an office accessible to the public and shall keep in the office for not less than 5 years the usual and customary records pertaining to transactions under the license. This provision does not prohibit maintenance of the office in the home of the licensee.

(3) A partnership or corporation, whether or not organized under the laws of this state, may be licensed as an adjuster if each individual who is to exercise the adjuster license powers is separately licensed or is named in the partnership or corporation adjuster license and is qualified for an individual adjuster license. An additional full license fee must be paid for each individual in excess of one named in the partnership or corporation adjuster license to exercise its powers.

(4) An adjuster license or qualifications are not required for an adjuster who is sent into this state by and on behalf of an insurer or adjusting partnership or corporation for the purpose of investigating or making adjustments of a particular loss under an insurance policy or for the adjustment of a series of losses resulting from a catastrophe common to all losses.

(5) An adjuster license continues in force until expired, suspended, revoked, or terminated. The license is subject to annual payment to the commissioner of the renewal fee required by 33-2-708, accompanied by a written request for renewal.

(6) The commissioner may adopt rules providing for the examination, licensure, bonding, and regulation of public adjusters."

Section 27. Section 33-17-1203, MCA, is amended to read:

"**33-17-1203. Continuing education -- basic requirements -- exceptions.** (1) Unless exempt under subsection (4):

(a) a person licensed to act as an insurance producer for property, casualty, surety, or title insurance or as a consultant for general insurance shall, during each calendar year, complete at least 10 credit hours of approved continuing education;

(b) a person licensed to act as an insurance producer for life or disability insurance or as a consultant for life insurance shall, during each calendar year, complete at least 10 credit hours of approved continuing education;

(c) a person holding multiple licenses shall, during each calendar year, complete at least 15 credit hours of approved continuing education;

(d) a person licensed to act as an insurance producer only for credit life and disability insurance shall, during each calendar year, complete 5 credit hours of approved continuing education in the areas of insurance law, ethics, or credit life and disability insurance;

(e) a person licensed as an insurance producer or consultant shall, during each biennium, complete at least 1 credit hour of approved continuing education on changes in Montana insurance statutes and administrative rules.

(2) If a person licensed as an insurance producer or consultant completes more credit hours of approved continuing education in a year than the minimum required in subsection (1), the excess credit hours may be carried forward and applied to the continuing education requirements of the next year.

(3) The commissioner may, for good cause ~~shown~~, grant an extension of time, not to exceed 1 year, during which the requirements imposed by subsection (1) may be completed.

(4) The minimum continuing education requirements do not apply to:

(a) a person licensed to sell any kind of insurance for which an examination is not required under 33-17-212(7)(d) through ~~(7)(g)~~ (7)(h);

(b) a person holding a temporary license issued under 33-17-216;

(c) a nonresident licensee who must meet continuing education requirements in the licensee's state of residence if that state ~~accords~~ grants substantially similar privileges to and has similar requirements ~~of~~ for residents of this state;

(d) a newly licensed insurance producer or consultant during the calendar year in which the

licensee first received a license; or

(e) an insurance producer or consultant otherwise exempted by the commissioner."

Section 28. Section 33-18-210, MCA, is amended to read:

"33-18-210. Unfair discrimination and rebates prohibited -- property, casualty, and surety insurances. (1) A title, property, casualty, or surety insurer or an employee, representative, or insurance producer of an insurer may not, as an inducement to purchase insurance or after insurance has been effected, pay, allow, ~~or~~ give, or offer to pay, allow, or give, directly or indirectly, a:

(a) rebate, discount, abatement, credit, or reduction of the premium named in the insurance policy;

(b) special favor or advantage in the dividends or other benefits to accrue on the policy; or

(c) valuable consideration or inducement not specified in the policy, except to the extent provided for in an applicable filing with the commissioner as provided by law.

(2) An insured named in a policy or an employee of the insured may not knowingly receive or accept, directly or indirectly, a:

(a) rebate, discount, abatement, credit, or reduction of premium;

(b) special favor or advantage; or

(c) valuable consideration or inducement.

(3) An insurer may not make or permit unfair discrimination in the premium or rates charged for insurance, in the dividends or other benefits payable on insurance, or in any other of the terms and conditions of the insurance either between insureds or property having like insuring or risk characteristics or between insureds because of race, color, creed, religion, or national origin.

(4) This section may not be construed as prohibiting the payment of commissions or other compensation to duly licensed insurance producers or as prohibiting an insurer from allowing or returning lawful dividends, savings, or unabsorbed premium deposits to its participating policyholders, members, or subscribers.

(5) An insurer may not make or permit unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, canceling, or limiting the amount of insurance coverage on a property or casualty risk because of the geographic location of the risk, unless:

(a) the refusal, cancellation, or limitation is for a business purpose that is not a mere pretext for

unfair discrimination; or

(b) the refusal, cancellation, or limitation is required by law or regulatory mandate.

(6) An insurer may not make or permit unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, canceling, or limiting the amount of insurance coverage on a residential property risk or on the personal property contained in the residential property, because of the age of the residential property, unless:

(a) the refusal, cancellation, or limitation is for a business purpose that is not a mere pretext for unfair discrimination; or

(b) the refusal, cancellation, or limitation is required by law or regulatory mandate.

(7) An insurer may not refuse to insure, refuse to continue to insure, or limit the amount of coverage available to an individual because of the sex or marital status of the individual. However, an insurer may take marital status into account for the purpose of defining persons eligible for dependents' benefits.

(8) An insurer may not terminate or modify coverage or refuse to issue or refuse to renew a property or casualty policy or contract of insurance solely because the applicant or insured or any employee of either is mentally or physically impaired. However, this subsection does not apply to accident and health insurance sold by a casualty insurer and this subsection may not be interpreted to modify any other provision of law relating to the termination, modification, issuance, or renewal of any insurance policy or contract.

(9) An insurer may not refuse to insure, ~~refuse to continue to insure,~~ charge higher rates, or limit the amount of coverage available to an individual based solely on adverse information contained in a driving record that is 3 years old or older. However, an insurer may provide discounts to an insured based on favorable aspects of an insured's claims history that is 3 years old or older.

(10) An insurer may not charge points on, ~~refuse to issue,~~ REFUSE TO ISSUE, refuse to renew, remove an existing discount on, or surcharge a private passenger motor vehicle policy because of a claim submitted under the insured's policy if the insured was not at fault.

(11) (a) For the purposes of this subsection (11), "credit history" means that portion of a credit report or background report that addresses the applicant's or insured's debt payment history or lack of history but does not include public information including convictions, lawsuits, bankruptcies, or similar public information.

(b) An insurer writing automobile or homeowner insurance may not refuse to insure, refuse to continue to insure, charge higher rates, or limit the scope or amount of coverage or benefits available to an individual based solely on the insurer's knowledge of the individual's credit history unless:

(i) the insurer possesses substantial documentation that credit history is significantly correlated with the types of risks insured or to be insured;

(ii) the insurer sends written communication to the individual disclosing that the insurance coverage was declined, not renewed, or limited in scope or amount of coverage or benefits because of credit information relating to the applicant or the insured; and

(iii) upon subsequent request of the individual, mailed within 10 days of receipt of the denial, nonrenewal, or limitation, the insurer provides the individual with a copy of the credit report at issue or the name and address of a third party from whom the individual may obtain a copy of the credit report, within 10 days of receipt of the request.

(c) The provisions of this subsection (11) are not intended to conflict with any disclosure provisions of state law or the federal Truth in Lending Act applicable to lending institutions, credit bureaus, or other credit service organizations that maintain or distribute credit histories on insurance applicants or policyholders."

~~**Section 27.** Section 33-18-301, MCA, is amended to read:~~

~~**"33-18-301. Prohibited relations with mortuaries.** (1) A life insurer and its officers, employees, or representatives may not own, manage, supervise, operate, or maintain any mortuary, funeral, or undertaking establishment in Montana.~~

~~(2) A life insurer may not contract or agree with any funeral director, mortuary, or undertaker that the funeral director, undertaker, or mortuary shall conduct the funeral or be named beneficiary of any person insured by 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; and~~

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

~~(d)~~(4) ~~any~~ 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)~~ (6).

~~(5) An insured may designate a funeral director, mortuary, or undertaker as a specific beneficiary only when the cash value of the policy adversely affects the insured's financial condition for the purpose of determining the availability of medicaid benefits.~~

~~(4)~~(6) ~~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 both.~~"

Section 29. Section 33-20-101, MCA, is amended to read:

"**33-20-101. Scope.** (1) Except as provided in subsection (2), parts 1 through 5 of this chapter apply only to contracts of life insurance and annuities, other than reinsurance, group life insurance, and group annuities.

(2) Sections 33-20-114 and 33-20-131 also apply to group life insurance and group annuities."

Section 30. Section 33-22-107, MCA, is amended to read:

"**33-22-107. Premium increase restriction -- exception.** (1) An insurer or a health service corporation that issues a policy, certificate, or membership contract covering a resident of this state may not increase a premium in an individual's or an ~~individual group's~~ individual's group disability insurance policy more frequently than once during a 12-month period unless failure to increase the premium more frequently than once during the 12-month period would:

(a) place the insurer in violation of the laws of this state; or

(b) cause the financial impairment of the insurer to the extent that further transaction of insurance by the insurer injures or is hazardous to its policyholders or to the public.

(2) Subsection (1) does not apply to a premium increase necessitated by a state or federal law, court decision, or rule adopted by an agency of competent jurisdiction of the state or federal government."

Section 31. 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 or the person's dependents or family members covered under the policy ceases because of termination of the person's employment or of the person's membership in the class or classes eligible for coverage under the policy or as a result of a person's employer discontinuing the employer's business or as a result of a person's 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 the person is not insured under another major medical disability insurance policy or plan, the person is entitled to have issued to the person by the insurer, without evidence of insurability, group coverage or an individual policy 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 the person or 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. In addition, the insurer shall make available a conversion policy as required by subsection (4).

(3) The premium on the individual policy or group policy must be at no more than 200% of the insurer's then customary rate applicable to the coverage of the individual or group policy. The customary rate is that rate that is normally issued for medically underwritten policies without discount for healthy lifestyles.

(4) The insurer shall also make available ~~an individual~~ a conversion policy, certificate, or membership contract that provides at least the level of benefits provided by the insurer's lowest cost basic health benefit plan, as defined in 33-22-1803. If the insurer is not a small employer carrier under part 18, the insurer shall make available ~~an individual~~ a conversion policy, certificate, or membership contract that provides equivalent benefits to a basic health benefit plan. The conversion rate may not exceed 150% of the highest rate charged for that plan."

Section 32. Section 33-22-903, MCA, is amended to read:

"**33-22-903. Definitions.** As used in this part, the following definitions apply:

(1) "Applicant" means:

(a) in the case of an individual medicare supplement policy, the person who seeks to contract for

insurance benefits; and

(b) in the case of a group medicare supplement policy, the proposed certificate holder.

(2) "Certificate" means a certificate delivered or issued for delivery in this state under a group medicare supplement policy.

(3) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(4) "Entity" means an insurer as defined in 33-1-201, a health service corporation as defined in 33-30-101, and a health maintenance organization as defined in 33-31-102.

(5) "Health care expenses":

(a) means expenses of a health maintenance organization associated with the delivery of health care services that are analogous to incurred losses of an insurer;

(b) does not include home office and overhead costs, advertising costs, commissions and other acquisition costs, taxes, capital costs, administrative costs, or claims processing costs.

(6) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any entity delivering or issuing for delivery in this state medicare supplement policies or certificates.

(7) "Medicare" means Health Insurance for the Aged, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

(8) "Medicare supplement policy" means a group or individual policy of disability insurance or a subscriber contract of a health service corporation, other than a policy issued pursuant to a contract under ~~42 U.S.C. 1395l or 1395mm~~ 42 U.S.C. 1395ss(g)(1), or a policy issued under a demonstration project authorized pursuant to amendments to the federal Social Security Act, that is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare. The term does not include:

(a) a policy or contract of one or more employers or labor organizations or of the trustees of a fund established by one or more employers or labor organizations, or a combination of employers, organizations, and trustees, for employees or former employees, or a combination of current and former employees, or for members or former members, or a combination of current and former members, of the labor organizations; or

(b) individual policies or contracts issued pursuant to a conversion privilege under a policy or

contract of group or individual insurance when the group or individual policy or contract includes provisions that are inconsistent with the requirements of this part or policies issued to employees or members as additions to franchise plans in existence on April 8, 1981.

(9) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer."

Section 33. Section 33-22-907, MCA, is amended to read:

"**33-22-907. Disclosure standards -- informational brochure -- rules.** (1) In order to provide for full and fair disclosure in the sale of medicare supplement policies and certificates, a medicare supplement policy may not be delivered or issued for delivery in this state and a certificate may not be delivered pursuant to a group medicare supplement policy delivered or issued for delivery in this state unless an outline of coverage is delivered to the applicant at the time that application is made. The outline of coverage must be filed with the commissioner as required by 33-1-501. The filing must be made at least 60 days in advance of the date that the outline of coverage is delivered to any resident of this state.

(2) (a) The commissioner shall prescribe the format and content of the outline of coverage required by subsection (1).

(b) For purposes of this section, "format" means style, arrangements, and overall appearance, including such items as the size, color, and prominence of type and the arrangement of text and captions.

(c) The outline of coverage must include:

(i) a description of the principal benefits and coverage provided in the policy or certificate;

(ii) a statement of the exceptions, reductions, and limitations contained in the policy or certificate;

(iii) a statement of the renewal provisions, including any reservation by the issuer of a right to change premiums and disclosure of the existence of any automatic renewal premium increases based on the policyholder's or certificate holder's age;

(iv) a statement that the outline of coverage is a summary of the policy or certificate issued or applied for and that the policy or certificate should be consulted to determine governing contractual provisions.

(3) The commissioner may prescribe by rule a standard form and the contents of an informational brochure for persons eligible for medicare, which is intended to improve the buyer's ability to select the most appropriate coverage and to improve the buyer's understanding of medicare. Except in the case of

direct response insurance policies, the commissioner may require by rule that the information brochure be provided to any prospective insureds eligible for medicare at the same time that the outline of coverage is delivered. With respect to direct response insurance policies, the commissioner may require by rule that the prescribed brochure be provided upon request, but not later than the time of policy delivery, to any prospective insureds eligible for medicare.

(4) The commissioner may adopt reasonable rules for captions or notice requirements, determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not medicare supplement coverages, for all accident and sickness insurance policies sold to persons eligible for medicare, other than:

(a) medicare supplement policies or certificates; or

(b) disability income policies~~;~~

~~(c) basic, catastrophic, or major medical expense policies;~~

~~(d) single premium, nonrenewable policies; or~~

~~(e) other policies excepted in 33-22-903(8)~~.

(5) The commissioner may further adopt reasonable rules to govern the full and fair disclosure of the information in connection with the replacement of accident and sickness policies or certificates by persons eligible for medicare.

(6) As soon as practicable, but no later than 30 days before the annual effective date of a medicare benefit change, every entity providing medicare supplement insurance or benefits to a resident of this state shall notify its policyholders and certificate holders, in a format that the commissioner prescribes by rule, of the changes that it has made to the medicare supplement policy or certificate."

Section 34. Section 33-22-910, MCA, is amended to read:

"**33-22-910. Filing requirements for advertising.** Every issuer of medicare supplement policies or certificates in this state shall provide to the commissioner for the commissioner's ~~review or~~ approval a copy of any medicare supplement advertising intended for use in this state, whether through written, radio, or television medium."

Section 35. 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 carriers of disability insurance, including excess of loss and stop loss disability insurance.

(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 health benefit plan, except a uniform health benefit plan, developed by a small employer carrier, that has a lower benefit value than the small employer carrier's standard benefit plan and that provides the benefits required by 33-22-1827.

(6) "Benefit equivalency" means a method developed by the small employer carrier for comparing the types of health care services and articles covered under a health benefit plan with the types of health care services required to be covered under a uniform, basic, or standard health benefit plan.

(7) "Benefit value" means an actuarially based method developed by the small employer carrier for comparing the value of determinable contingencies covered under a health benefit plan with the value of determinable contingencies required under a uniform, basic, or standard health benefit plan.

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

(9) "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, and a health maintenance organization. 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.

(10) "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.

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

(12) "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 as a dependent in the health benefit plan covering the employee.

(13) "Eligible employee" means an employee who works on a full-time basis with a normal workweek of 30 hours or more, except that at the sole discretion of the employer, the term may include an employee who works on a full-time basis with a normal workweek of between 20 and 40 hours as long as this eligibility criteria is applied uniformly among all of the employer's employees. 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.

(14) "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.

(15) "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 or any other limited benefit plan;

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

(c) automobile medical payment insurance.

(16) "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.

(17) "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:

(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;

(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.

(18) "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.

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

(20) "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.

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

(22) "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 minimum 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 minimum basic health benefit plan, provided that the policy has been in effect for a period of at least 1 year.

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

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

(25) "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.

(26) "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 small employer member of its association or any employee of its small employer members who applies for coverage as part of a group.

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

(28) "Standard health benefit plan" means a health benefit plan that is developed by a small employer carrier and that contains the provisions required pursuant to 33-22-1828."

Section 36. 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 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 the premiums necessary to recover one-half of the expenses for the calendar year. For purposes of this section, expenses include administrative expenses, one-half of the program net loss for the previous calendar year, and the actuarially anticipated claims to be incurred, 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 shall annually review the methodology established under subsection (6)(a), including the system of classification and any rating factors, to ensure that it is actuarially sound and 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, and the actuarially anticipated losses for the calendar year. The sum of one-half of the program net loss for the previous calendar year plus the anticipated net loss for the calendar year must equal the total assessment amount. If the program net loss for the previous calendar year is zero or less, the total assessment amount must equal the actuarially anticipated losses for the calendar year.

(b) (i) Each assessable carrier shall share in the program in an amount determined by multiplying the total assessment amount by a fraction, the numerator of which is the number of individuals in this state covered under disability insurance by the assessable carrier and the denominator of which is the number

of all individuals in this state covered under disability insurance by all assessable carriers.

(ii) The board shall make a reasonable effort to ensure that each insured individual is counted only once for the purpose of assessment. The board shall require each assessable carrier that provides excess of loss or stop loss insurance to include in its count of insured individuals all individuals whose coverage is reinsured in whole or in part, including coverage under excess of loss or stop loss insurance. The board shall allow an assessable carrier who is an excess of loss or stop loss insurer to exclude from its count of insured individuals those who have been counted by a primary disability insurer or by a primary reinsurer.

(iii) ~~The board shall base each assessable carrier's assessment on reports filed with the commissioner as required by 33-22-1820.~~ The board may use any reasonable method of estimating the number of individuals insured by an assessable carrier if the specific number is unknown.

(c) The board shall make an annual determination in accordance with this section of each assessable carrier's liability for its share of the contribution to the program and, except as otherwise provided by this section, make an annual assessment against each assessable carrier to the extent of that liability. Payment of an 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.

(d) The board may establish and maintain program reserves not to exceed five times the actuarially anticipated losses for the calendar year.

(e) If the sum of the reinsurance premiums and assessments in any calendar year exceeds the sum of the administrative expenses and incurred claims for that year, the board may proportionately credit the excess to assessable carriers or it may place the excess in program reserves, subject to the limits in subsection (8)(d).

(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 37. Section 33-22-1820, MCA, is amended to read:

"**33-22-1820. Periodic market evaluation -- report.** The ~~board shall~~ commissioner may study and report at least every 3 years to the ~~commissioner~~ governor or other interested persons on the effectiveness of this part. The report must analyze the effectiveness of this part in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the small employer health insurance markets. The report must address whether carriers and producers are fairly and actively marketing or issuing health benefit plans to small employers in fulfillment of the purposes of this part. The report may contain recommendations for market conduct or other regulatory standards or action."

Section 38. Section 33-22-1828, MCA, is amended to read:

"**33-22-1828. Benefits required in standard benefit plan.** (1) The minimum benefits must be equal to at least 75% of the covered expenses in excess of an annual deductible that does not exceed $500 per person or $1,000 per family. The coverage must include a limitation of $2,000 per person or $4,000 per

family on the total annual out-of-pocket expenses for services covered. The coverage may be subject to a maximum lifetime benefit, but a maximum, if any, may not be less than $1 million.

(2) The commissioner may not require coverage in a standard health benefit plan for any benefit unless other provisions of Title 33, chapter 22, 30, or 31, specifically require coverage for the benefit. A small employer carrier may offer coverage for additional services and articles.

(3) A standard health benefit plan provided by a health maintenance organization or a basic health benefit plan with a restricted network provision must provide a comparable level of benefits to those required by subsection (1), as determined by the ~~benefit equivalency and~~ benefit value."

Section 39. 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 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: 33-3-308; 33-3-701 through 33-3-704; 33-17-101; 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 33-3-701 through 33-3-704~~.

(2) A law of this state other than the provisions of this chapter applicable to health service corporations must be construed in accordance with the fundamental nature of a health service corporation, and in the event of a conflict the provisions of this chapter prevail."

Section 40. Section 33-30-107, MCA, is amended to read:

"**33-30-107. Annual statement.** (1) On or before March 1 of each year, each health service corporation shall file an annual statement for the preceding year on 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.

(4) The commissioner may, after notice and hearing, suspend or revoke a health ~~maintenance~~ SERVICE CORPORATION'S ~~organization's~~ license or impose a fine not to exceed $100 a day and not to exceed $1,000 upon a health ~~maintenance organization~~ SERVICE CORPORATION that fails to file an annual statement as required by this part."

Section 41. 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 the prohibition of pecuniary interest under 33-3-308 or the material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance organization must be considered an insurer for the purposes of 33-3-308 and 33-3-701 through 33-3-704."

Section 42. Section 33-31-211, MCA, is amended to read:

"**33-31-211. Annual statement -- revocation for failure to file -- penalty for false swearing.** (1) Unless it is operated by an insurer or a health service corporation as a plan, each authorized health maintenance organization 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. The statement must be in the general form and content required by the commissioner. The statement must be verified by the oath of at least two principal officers of the health maintenance organization. The commissioner may ~~in his discretion~~ waive any verification under oath.

(2) At the time of filing its annual statement, the health maintenance organization shall pay the commissioner the fee for filing its statement as prescribed in 33-31-212. The commissioner may refuse to accept the fee for continuance of the insurer's certificate of authority, as provided in 33-31-212, may impose a penalty of $100, or may ~~in his discretion~~ suspend or revoke the certificate of authority of a health maintenance organization that fails to file an annual statement when due. Each day that the insurer fails to file its annual statement constitutes a separate violation. The total penalty may not exceed $1,000.

(3) The commissioner may, after notice and hearing, impose a fine not to exceed $5,000 ~~per~~ for each violation upon a director, officer, partner, member, insurance producer, or employee of a health maintenance organization who knowingly subscribes to or concurs in making or publishing an annual statement required by law that contains a material statement ~~which~~ that is false.

(4) The commissioner may require ~~such~~ reports ~~as he~~ that the commissioner considers reasonably necessary and appropriate to enable ~~him~~ the commissioner to carry out ~~his~~ the commissioner's duties under this chapter, including but not limited to a statement of operations, transactions, and affairs of a health maintenance organization operated by an insurer or a health service corporation as a plan."

NEW SECTION. **Section 43. Uniform claim forms and procedures.** ~~(1)~~ The commissioner of insurance, after consultation with the health care advisory council, may adopt by rule uniform health insurance claim forms and uniform standards and procedures for the use of the forms and processing of claims, including the submission of claims by means of an electronic claims processing system.

~~(2) The commissioner may contract with a private or public entity to administer and operate an electronic claims processing system. If the commissioner elects to contract for administration and operation of the system, the commissioner shall award a contract according to Title 18, chapter 4.~~

~~NEW SECTION. **Section 42. Statute of limitations.** The period prescribed for the commencement of a civil or administrative action by the commissioner for alleged violation of Title 33 is within 2 years of the commissioner's discovery of the facts constituting the alleged violation.~~

~~NEW SECTION. **Section 43. Filing or making false statements.** (1) A person may not purposely or knowingly make or cause to be made, in any document filed with the commissioner or in any proceeding before the commissioner, any statement that is, at the time and in the light of the circumstances under which it is made, false or misleading in any material respect.~~

~~(2) A person found to have willfully violated subsection (1) is subject to a fine of up to $5,000 and, if applicable, may be subject to the criminal laws of this state.~~

~~NEW SECTION. **Section 44. Credit life and disability applications.** (1) The insurance producer who effects the sale of a policy or certificate of credit life and disability insurance shall sign the application.~~

~~(2) An insurance company may not accept an application for credit life and disability insurance unless the application is signed by the insurance producer who effected the sale.~~

~~(3) This section does not apply to policies or certificates subject to the provisions of 33-21-204.~~

NEW SECTION. **Section 44. Service contract insurance.** (1) Service contract insurance is a contract or agreement for a separately stated consideration or for a specific duration to:

(a) perform the repair, replacement, or maintenance of property; or

(b) indemnify for repair, replacement, or maintenance of property.

(2) Service contract insurance does not include contracts or agreements that:

(a) are indemnified only by the seller or manufacturer; and

(b) insure only the inherent quality of the product.

NEW SECTION. **Section 45. Loss and loss expense reserves for property and casualty insurance.** (1) (a) In determining the financial condition of a property and casualty insurer for the purpose of applying the provisions of this chapter and in any financial statement or report of an insurer, loss reserves and loss expense reserves at least equal to the amounts required under the provisions of this section must be included in the insurer's liabilities. The date from which the determination, statement, or report is made

is, for the purpose of this part, the date of determination.

(b) Accepted actuarial standards as adopted by the actuarial standards board must be taken into consideration for the purpose of determining the loss reserves and loss expense reserves.

(2) Except as provided in subsections (3) and (4), the reserves for all outstanding losses and loss expenses must include the following:

(a) the aggregate estimated amounts due or to become due on account of all known losses, claims, and loss expenses incurred but not paid, including the estimated liability on any notice received by the insurer of the occurrence of any event that may result in a loss; and

(b) the aggregate amounts of liability for all losses and loss expenses incurred for which notice has not been received, estimated in accordance with the insurer's prior experience, if any, or otherwise in accordance with Montana industry ~~data~~ EXPERIENCE, OR COUNTRYWIDE INDUSTRY EXPERIENCE IF THIS STATE'S EXPERIENCE IS NOT CREDIBLE, FOR SIMILAR CONTRACTS OF INSURANCE. The estimated liabilities for losses under all bonds, policies, or contracts of fidelity insurance may not be less than 10% of the net premiums in force, and the estimated liabilities for all of those losses under all the insurer's surety contracts may not be less than 5% of the net premiums in force.

(3) Except as provided in subsection (4), tabular reserves for outstanding losses under policies of workers' compensation insurance may be actuarially calculated for both indemnity and medical payments. The loss adjustment expenses are not eligible for discounting. Tabular reserves are those reserves that are:

(a) calculated using discounts determined with reference to actuarial tables, which incorporate mortality, interest, not to exceed 4%, remarriage, and other contingencies applied to a reasonably determinable payment stream associated with lifetime benefit cases; or

(b) annuities certain, such as those arising from structured settlements.

(4) Whenever, in the judgment of the commissioner, the loss and loss expense reserves of any property and casualty insurer doing business in this state, calculated in accordance with the provisions of this section, are inadequate or excessive, the commissioner may prescribe any other method that will produce adequate and reasonable reserves.

(5) The excess, if any, of statutory reserves over statement reserves must be calculated in accordance with the annual statement instructions adopted by the national association of insurance commissioners.

NEW SECTION. **Section 46. Repealer.** Sections 33-2-515, 33-2-536, 33-2-721, 33-2-722, 33-2-723, 33-4-404, 33-4-409, 33-22-1201, 33-22-1202, 33-22-1203, 33-22-1204, and 33-22-1205, MCA, are repealed.

NEW SECTION. **Section 47. Codification instruction.** (1) [Section ~~42~~ ~~41~~ 43] is intended to be codified as an integral part of Title 50, chapter 4, part 5, and the provisions of Title 50, chapter 4, part 5, apply to [section ~~42~~ ~~41~~ 43].

~~(2) [Sections 43 and 44 42 AND 43] are intended to be codified as an integral part of Title 33, chapter 1, part 3, and the provisions of Title 33, chapter 1, part 3, apply to [sections 43 and 44 42 AND 43].~~

~~(3) [Section 45 44] is intended to be codified as an integral part of Title 33, chapter 21, part 1, and the provisions of Title 33, chapter 21, part 1, apply to [section 45 44].~~

~~(4)~~(2) [Section ~~46~~ ~~45~~ 44] is intended to be codified as an integral part of Title 33, chapter 1, part 2, and the provisions of Title 33, chapter 1, part 2, apply to [section ~~46~~ ~~45~~ 44].

~~(5)~~(3) [Section ~~47~~ ~~46~~ 45] 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 ~~47~~ ~~46~~ 45].

NEW SECTION. **Section 48. 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-

HOUSE BILL NO. 131

INTRODUCED BY SIMON

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING STATE INSURANCE LAWS; PROVIDING FOR UNIFORM HEALTH INSURANCE CLAIM FORMS; ~~PROVIDING A STATUTE OF LIMITATIONS FOR ACTIONS BROUGHT BY THE COMMISSIONER OF INSURANCE;~~ PROVIDING PENALTIES FOR MISREPRESENTATIONS MADE TO THE COMMISSIONER; ~~REQUIRING THAT CREDIT LIFE AND DISABILITY INSURANCE APPLICATIONS BE SIGNED BY THE INSURANCE PRODUCER EFFECTING THE SALE; DEFINING "SERVICE CONTRACT INSURANCE";~~ AMENDING SECTIONS 18-8-103, 33-1-1205, 33-2-307, 33-2-317, 33-2-514, 33-2-517, 33-2-537, 33-2-704, 33-2-806, 33-2-1359, 33-2-1902, 33-3-303, 33-3-307, 33-4-202, 33-4-203, 33-4-204, 33-4-313, 33-4-314, 33-5-402, 33-10-202, 33-15-1105, 33-15-1106, 33-16-1027, 33-17-102, 33-17-212, 33-17-301, 33-17-1203, 33-18-210, ~~33-18-301,~~ 33-20-101, 33-22-107, 33-22-508, 33-22-903, 33-22-907, 33-22-910, 33-22-1803, 33-22-1819, 33-22-1820, 33-22-1828, 33-30-102, 33-30-107, 33-31-111, AND 33-31-211, MCA; AND REPEALING SECTIONS 33-2-515, 33-2-536, 33-2-721, 33-2-722, 33-2-723, 33-4-404, 33-4-409, 33-22-1201, 33-22-1202, 33-22-1203, 33-22-1204, AND 33-22-1205, MCA."

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

Section 1. Section 18-8-103, MCA, is amended to read:

"**18-8-103. Exemptions.** This part does not apply to employment of:

(1) registered professional engineers, surveyors, real estate appraisers, or registered architects;

(2) physicians, dentists, or other medical, dental, or health care providers;

(3) expert witnesses hired for use in litigation, hearings officers hired in rulemaking and contested case proceedings under the Montana Administrative Procedure Act, or attorneys as specified by executive order of the governor;

(4) consulting actuaries to the public retirement boards, ~~or~~ the state compensation insurance fund, or the commissioner of insurance;

(5) private consultants employed by the student associations of the university system with money

raised from student activity fees designated for use by those student associations; or

(6) private consultants employed by the Montana state lottery."

SECTION 2. SECTION 33-1-1205, MCA, IS AMENDED TO READ:

"**33-1-1205. Duties of authorized insurers, adjusters, administrators, consultants, and producers.** (1) Each insurer, independent adjuster, independent administrator, independent consultant, and independent producer shall cooperate fully with the commissioner with respect to the provisions of this part.

(2) An insurer, an officer, or an employee~~, or producer~~ of the insurer, an independent adjuster, an independent administrator, an independent consultant, or an independent producer who has reason to believe that an insurance fraud has been or is being committed shall provide notice of the alleged insurance fraud to the commissioner within 60 days. A producer of an insurer who has reason to believe that an insurance fraud has been or is being committed shall provide notice within 60 days of discovery of the alleged insurance fraud to the insurer who shall within 30 days of receiving notice from the producer report it to the commissioner.

(3) Notice to the commissioner by an insurer who has reason to believe that an insurance fraud has been committed in connection with an insurance claim, application, or policy tolls any applicable time period, for the commissioner, in any applicable insurance statute, related insurance regulation, or applicable sections of the criminal code and tolls any time period arising under 33-18-232 or 33-18-242 regarding unfair claims settlement practices."

Section 3. 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) $7 million. An insurer possessing less than ~~$6~~ $7 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 ~~$6~~ $7 million.

(ii) in the case of Lloyd's or another similar group including incorporated and unincorporated alien 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~~ not 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 4. Section 33-2-317, MCA, is amended to read:

"**33-2-317. Exemptions.** The Surplus Lines Insurance Law does not apply to reinsurance or to the following kinds of insurance when placed by a licensed insurance producer of this state:

(1) wet marine ~~and transportation insurances~~ insurance;

(2) insurance on subjects located, residing, or to be performed wholly outside of this state or on vehicles or aircraft owned and principally garaged outside this state;

(3) insurance on property or operations of railroads engaged in interstate commerce; and

(4) insurance of aircraft owned or operated by manufacturers of aircraft or aircraft operated in scheduled interstate flight or cargo of the aircraft or against liability, other than workers' compensation and employers' liability, arising out of the ownership, maintenance, or use of the aircraft."

Section 5. Section 33-2-514, MCA, is amended to read:

"**33-2-514. Reserve for disability insurance.** (1) For all disability insurance policies, the insurer shall maintain an active life reserve ~~which shall place~~ that places a sound value on its liabilities under ~~such~~ the policies and that may not be ~~not~~ less than ~~the reserve according to appropriate standards set forth in regulations issued by the commissioner and, in no event, less in the aggregate than~~ the pro rata gross unearned premiums for ~~such~~ the policies.

(2) The commissioner may promulgate rules to define additional standards for reserve requirements."

Section 6. Section 33-2-517, MCA, is amended to read:

"**33-2-517. Title insurance reserves.** (1) In addition to an adequate reserve as to outstanding losses as required under 33-2-511, a title insurer shall maintain a guaranty fund or unearned premium reserve of not less than an amount computed as follows:

(a) Ten percent of the total amount of the risk premiums written in the calendar year for title insurance contracts ~~shall~~ must be assigned originally to the reserve.

(b) During each of the 20 years next following the year in which the title insurance contract was issued, the reserve applicable to the contract ~~shall~~ must be reduced by 5% of the original amount of ~~such~~ the reserve.

(2) The reserve sums ~~herein~~ required ~~to be reserved~~ by subsection (1) for unearned premiums on contracts of title insurance ~~shall~~ must at all times and for all purposes be considered and constitute unearned portions of the original premiums and ~~shall~~ must be held in trust for the benefit of policyholders.

(3) The reduction of the unearned premium reserve required by subsection (1)(b) ~~of this section~~

~~shall~~ must be made for all title insurance contracts issued after December 31, 1958, with respect to which 10% of the risk premiums have been assigned to the reserve pursuant to subsection (1)(a) ~~of this section~~. ~~In the event that any title insurer has not in accordance with subsection (1)(b) of this section reduced the amount of its unearned premium reserve by 5% of the amount originally assigned to the reserve pursuant to subsection (1)(a) of this section for years ending after December 31, 1958, and before January 1, 1977, the insurer shall effect such reduction for such prior years during its accounting year which includes December 31, 1976.~~ If the insurer has not reduced the amount of its unearned premium reserves pursuant to subsection (1)(b) for a previous year or years, the insurer shall make the reduction for the prior year or years in its next accounting year."

Section 7. Section 33-2-537, MCA, is amended to read:

"**33-2-537. 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~~ may promulgate a rule containing the minimum standards applicable to the valuation of disability plans."

Section 8. Section 33-2-704, MCA, is amended to read:

"**33-2-704. Insured lives reporting requirement.** On or before ~~February 15~~ March 1 of each year, each insurer providing disability insurance shall, on a form prescribed by the commissioner, report the number of Montana residents insured on February 1 under any policy of individual or group disability insurance, including excess of loss or stop loss insurance policies covering disability insurance."

Section 9. 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 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 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 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~~ 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:~~ in 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, in securities, in both cash and securities, or in investments provided for ~~under~~ in 33-2-531.

(5) Except with the commissioner's consent, an insurer 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) Except with the commissioner's consent, an ~~An~~ insurer may not invest and have invested at any one time in aggregate amount more than 15% of its assets in all stocks ~~under~~ provided for in 33-2-820 and 33-2-821. Determination of the amount that an insurer has invested in common stocks for the purposes of this provision must be based on the cost of the stocks to the insurer. This provision does not apply ~~as~~ to stock of a controlled or subsidiary insurance corporation or other corporations ~~under~~ provided for in 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~~ in 33-2-824. Money market funds, as defined by

the commissioner by rule, are exempt from the 5% limitation of this subsection.

(8) Except with the commissioner's consent, an insurer 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~~ of investments in ~~the category of~~ real estate ~~shall~~ must be as provided in 33-2-832. Other specific limits apply as stated in the sections dealing with other respective kinds of investments."

Section 10. Section 33-2-1359, MCA, is amended to read:

"**33-2-1359. Setoffs ~~and counterclaims~~.** (1) Mutual debts or mutual credits between the insurer and another person in connection with any action or proceeding under this part ~~shall~~ must be set off and the balance only ~~shall be~~ allowed or paid, except as provided in ~~subsection (2) and~~ 33-2-1362 and subsection (2) of this section.

(2) ~~No~~ A setoff ~~or counterclaim~~ may not be allowed in favor of any person when:

(a) the obligation of the insurer to the person would not at the date of the filing of a petition for liquidation entitle the person to share as a claimant in the assets of the insurer;

(b) the obligation of the insurer to the person was purchased by or transferred to the person with a view to its being used as a setoff; or

(c) the obligation of the person is to pay an assessment levied against the members or subscribers of the insurer or is to pay a balance upon a subscription to the capital stock of the insurer or is in any other way in the nature of a capital contribution.~~; or~~

~~(d) the obligation of the person is to pay premiums, whether earned or unearned, to the insurer.~~"

Section 11. Section 33-2-1902, MCA, is amended to read:

"**33-2-1902. Definitions.** As used in this part, the following definitions apply:

(1) "Adjusted RBC report" means an RBC report that has been adjusted by the commissioner in accordance with 33-2-1903(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; or

(c) any insurer engaged solely in the business of reinsurance of life or disability contracts.

(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 :

(i) 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;

(ii) any insurance company engaged solely in the business of reinsurance of property and casualty contracts; or

(iii) any insurance company engaged in the business of surety and marine insurance.

(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

33-2-1904(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 33-2-1903.

(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."

Section 12. Section 33-3-303, MCA, is amended to read:

"**33-3-303. Meetings of stockholders or members.** (1) Meetings of stockholders or members of a domestic insurer ~~shall~~ must be held in the city or town of its principal office or place of business in this state.

(2) ~~No~~ A meeting of stockholders or members ~~shall~~ may not amend the insurer's articles of incorporation unless the proposal ~~so~~ to amend was included in the notice of the meeting.

(3) Except with the commissioner's consent, each ~~Each~~ insurer shall, during the first 6 months of each calendar year, hold the annual meeting of its stockholders or members to fill vacancies existing or occurring in the board of directors, must receive and shall consider reports of the insurer's officers as to its affairs, and shall transact ~~such~~ other business ~~as may~~ properly ~~be~~ brought before it. Not less than 20 days' notice ~~shall~~ must be given of ~~such~~ the meeting in the manner provided in the bylaws, except ~~where~~ when notice of the annual meeting of a mutual insurer is contained in its policies.

(4) Special meetings of the stockholders or members may be called at any time for any purpose by the board of directors upon not less than 10 days' notice, with notice given as provided in the bylaws. The notice ~~shall~~ must state the purpose of the meeting, and ~~no~~ business for which notice was not given may not ~~shall~~ be transacted at the meeting ~~of which notice was not so given~~.

(5) If more than 15 months are allowed to elapse without an annual stockholders' or members' meeting being held, any stockholder or member may call ~~such a~~ for an annual meeting to be held. At any time, upon written request of any director or of any stockholders or members holding in the aggregate one-fifth of the voting power of all stockholders or members, it ~~shall be~~ is the duty of the secretary to call a special meeting of stockholders or members to be held at ~~such~~ the time ~~as~~ that the secretary may fix, not less than 10 or more than 30 days after the receipt of the request. If the secretary fails to issue ~~such~~ a call, the director, stockholders, or members making the request may do so.

(6) A stockholders' or members' meeting duly held ~~can~~ may be organized for the transaction of business whenever a quorum is present. Except as otherwise provided by law or the articles of incorporation:

(a) the presence, in person or by proxy, of the holders of a majority of the voting power of all stockholders or of all members ~~shall constitute~~ constitutes a quorum;

(b) the stockholders or members present at a duly organized meeting ~~can~~ may continue to do business until adjournment, notwithstanding the withdrawal of enough stockholders or members to leave less than a quorum;

(c) if any necessary officer fails to attend ~~such~~ a meeting, any stockholder or member present may be elected to act temporarily in lieu of ~~any such~~ the absent officer;

(d) if a meeting cannot be ~~organized~~ held because a quorum ~~has not attended~~ is not present, those present may adjourn the meeting to ~~such~~ a time ~~as~~ that they ~~may~~ determine, but in the case of any meeting called for the election of any director, the adjournment must be to the next day and those who attend the second ~~of such adjourned meetings~~ meeting, although less than a quorum as fixed in this section or in the articles of incorporation, ~~shall nevertheless~~ constitute a quorum for the purpose of electing any director; and

(e) an annual or special meeting of stockholders or members may be adjourned to another date without new notice being given."

Section 13. Section 33-3-307, MCA, is amended to read:

"**33-3-307. Bond of officers.** (1) The president, secretary, and treasurer of ~~every~~ each mutual insurer or stock insurer shall each file with the commissioner and ~~thereafter~~ maintain in force so long as ~~he~~ that individual is ~~such~~ an officer a fidelity bond in ~~the sum of $10,000~~ an amount set by the commissioner by rule and issued by an authorized corporate surety in favor of the insurer. The commissioner shall consider the insurer's exposure, total assets, and total income in determining the bond amount. In lieu of individual bonds, ~~all such~~ officers may be covered under a blanket bond for the same respective amounts, ~~and which~~ The blanket bond ~~shall likewise~~ must be filed with the commissioner.

(2) The premium for the bond ~~shall~~ must be payable by the insurer.

(3) ~~No such~~ A bond ~~shall~~ is not ~~be~~ subject to cancellation except upon written notice to both the insurer and the commissioner, delivered not less than 30 days in advance of the effective date of ~~such~~ the

cancellation.

(4) The insurer shall provide for the bonding by authorized corporate surety of all other officers in any way responsible for the handling of the funds of the insurer.

(5) This section ~~shall~~ may not be ~~deemed~~ considered to limit the amount of bonded protection ~~which~~ that the insurer may carry as to any officer."

Section 14. 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 the corporation 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) four copies of proposed articles of incorporation executed ~~in 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~~ The signatures of the incorporators must be notarized.

(2) The articles of incorporation 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 must contain the words "farm mutual" or "rural mutual" together with the name of the county in which its principal place of business is to be located. The name 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 must be located in this state;

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

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

(f) the duration of ~~its~~ the corporation's existence, which may be perpetual;

(g) the number of its directors, which may not be less than 5 or more than 11, 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~~ at which time successors are elected and qualified;

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

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

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

Section 15. Section 33-4-203, MCA, is amended to read:

"**33-4-203. Approval of articles -- commencement of corporate existence.** (1) If the 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 commissioner shall make a certificate of the facts.

(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 commissioner, the commissioner shall endorse the ~~commissioner's~~ approval upon each set of the articles and forward ~~three~~ four 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 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 16. Section 33-4-204, MCA, is amended to read:

"**33-4-204. Amendment of articles.** A farm mutual insurer may, by a vote of two-thirds of its members present at any annual meeting or at any special meeting ~~of members~~ called for that purpose

amend its articles of incorporation to extend its corporate duration or ~~in~~ any other particular within the scope of this chapter by causing amended articles to be filed in the same form and manner as required for original articles of incorporation. The commissioner shall review the amended articles for compliance with this title. The amended articles of incorporation ~~shall~~ may be signed only by the president and secretary of the corporation and attested by the corporate seal. Notice of the proposed amendment ~~shall~~ must be contained in the notice ~~given~~ of ~~any such~~ the annual or special meeting."

Section 17. Section 33-4-313, MCA, is amended to read:

"**33-4-313. Annual statement ~~— report — filing~~.** ~~(1)~~ The president and secretary of ~~every~~ each insurer, on or before March 1 each year, shall prepare, affirm under oath, affix the corporate seal ~~thereto~~ to, and file with the commissioner, on forms ~~as~~ prescribed and furnished by ~~him~~ the commissioner, an annual statement for the preceding calendar year showing the condition of ~~such~~ the insurer as of December 31 of ~~such~~ the preceding year and exhibiting the following facts:

~~(a)~~(1) the names of the president and secretary;

~~(b)~~(2) the date of the annual meeting;

~~(c)~~(3) the amount of insurance in force;

~~(d)~~(4) the number of members;

~~(e)~~(5) the number of assessments made during the year;

~~(f)~~(6) the amount paid in losses during the year;

~~(g)~~(7) the amount of the losses claimed and not paid, with the reason for nonpayment;

~~(h)~~(8) the number of members withdrawn, suspended, and expelled during the year;

~~(i)~~(9) the number of new members admitted during the year;

~~(j)~~(10) the expenses during the year;

~~(k)~~(11) the amount of money on hand;

~~(l)~~(12) the amount and character of the insurer's assets;

~~(m)~~(13) the amount of the insurer's liabilities, including any reserves required to be established under this chapter; and

~~(n)~~(14) ~~such~~ other information concerning the insurer's affairs ~~as~~ that the commissioner may reasonably require.

~~(2) A report of an insurer's expenditures for educational purposes, if any, for the preceding year~~

~~must be filed with the commissioner at the same time and in conjunction with the annual report of such insurer, as required under 33-4-404.~~"

Section 18. Section 33-4-314, MCA, is amended to read:

"**33-4-314. Annual statement -- exclusive report -- penalty for failure to file.** (1) ~~No~~ A report, statement, or return of any nature ~~shall~~ may not be required of any farm mutual insurer other than those required by 33-4-313.

(2) The commissioner may:

(a) suspend or revoke the certificate of authority of any insurer failing to file its annual statement as required; or

(b) impose a fine of up to $100 a day for each day that an insurer is late in filing its annual statement, with the aggregate penalty not to exceed $1,000."

Section 19. Section 33-5-402, MCA, is amended to read:

"**33-5-402. Contributions to insurer.** The attorney or other parties may advance to a domestic reciprocal insurer upon reasonable terms ~~such~~ funds ~~as~~ that it may require from time to time in its operations. Sums ~~so~~ advanced ~~shall~~ may not be treated as a liability of the insurer, ~~and, except~~ Except upon liquidation of the insurer, ~~shall not be withdrawn or repaid except out of the insurer's realized earned surplus in excess of its minimum required surplus~~ during any calendar year, the total of withdrawals and repayments of the advanced sums may not exceed the lesser of the insured's realized earned surplus or 10% of the sums advanced as of the previous December 31. ~~No such~~ A withdrawal or repayment ~~shall~~ may not be made without the advance approval of the commissioner. This section does not apply to bank loans or to loans for which security is given."

Section 20. 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~~ 33-10-201(4) through (6) ~~of 33-10-201~~.

(5) "Impaired insurer" means:

(a) an insurer ~~which after July 1, 1974,~~ that 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 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~~ 33-10-201 and 33-10-224 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) (a) "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.

(b) ~~"Premiums" do~~ The term does not include premiums and considerations on contracts between insurers and reinsurers.

(c) As used in 33-10-227, ~~"premiums"~~ 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 that 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 21. SECTION 33-15-1105, MCA, IS AMENDED TO READ:

"**33-15-1105. Nonrenewal -- renewal premium.** (1) (a) An insured has a right to reasonable notice of nonrenewal. Unless otherwise provided by statute or unless a longer term is provided in the policy, at least 30 days prior to the expiration date provided in the policy, an insurer who does not intend to renew a policy beyond the agreed expiration date shall mail or deliver to the insured a notice of such intention. The insurer shall also mail or deliver a copy to the insured's insurance producer.

(b) Notification or nonrenewal to the insured's insurance producer via electronic transfer of data or by electronic data retrieval device meets the requirement of a mailed or delivered copy.

(2) An insurer shall give notice of premium due not more than 60 days or less than 10 days before the due date of a renewal premium. The notice must clearly state the effect of nonpayment of the premium on or before the due date.

(3) Subsections (1) and (2) do not apply if:

(a) the insured has obtained insurance elsewhere, has accepted replacement coverage, or has requested or agreed to nonrenewal; or

(b) the policy is expressly designated as nonrenewable."

Section 22. Section 33-15-1106, MCA, is amended to read:

"**33-15-1106. Renewal with altered terms.** (1) If an insurer offers or purports to renew a policy but on less favorable terms, at a higher rate, or at a higher rating plan, the new terms, rate, or rating plan take effect on the policy renewal date only if the insurer has mailed or delivered notice of the new terms, rate, or rating plan to the insured at least 30 days before the expiration date. ~~If the insured has not been so notified, he may cancel the renewal policy within 30 days after receiving the notice. The insurer shall continue coverage for a period of not less than 30 days after mailing or delivery of the notice. If the insured terminates the policy within the 30-day period, the insurer shall calculate the earned premium pro rata based upon the prior policy's rate. The new rate is effective only after the required 30-day notification period has been met. If the insured does not terminate the policy, the premium increase and other changes are effective the day following the prior policy's expiration or anniversary date.~~

(2) This section does not apply if the increase in the rate or the rating plan, or both, results from a classification change based on the altered nature or extent of the risk insured against."

Section 23. Section 33-16-1027, MCA, is amended to read:

"**33-16-1027. Rate filing review.** (1) The commissioner shall review each insurance filing to ensure compliance with the following guidelines:

(a) The effective date of each workers' compensation insurer or advisory organization filing must be the date specified in the filing. The effective date of the filing may not be earlier than 30 days after the date on which the filing is received by the commissioner or the date of receipt of the information furnished in support of the filing, if the supporting information is required by the commissioner.

(b) Upon written application of the insurer or advisory organization, the commissioner may authorize a filing that becomes effective before the expiration of the period described in subsection (1)(a).

(c) A filing is considered to have met the requirements of this part unless disapproved by the commissioner within the period described in subsection (1)(a) or any extension of the period.

(2) Whenever a filing is not accompanied by the information required under this section, the commissioner shall inform the filer of the deficiency within ~~10~~ 30 days of the initial filing. The filing is considered made when the required information is furnished or when the filer certifies to the commissioner that the additional information requested by the commissioner is not maintained or cannot be provided."

Section 24. 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;

(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 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 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~~.~~; or

(xii) a person appointed as a managing general agent in this state whose activities are limited exclusively to those described in 33-2-1501(10) and Title 33, chapter 2, part 16.

(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 the person or the person's spouse, employer, or 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 chapter, the term "managing general agent" 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 25. Section 33-17-212, MCA, is amended to read:

"**33-17-212. Examination required -- exceptions -- fees.** (1) Except as provided in subsection (7), an individual applying for a license shall pass a written examination. The examination must test the knowledge of the individual concerning each kind of insurance listed in subsection (6) for which application is made, the duties and responsibilities of an insurance producer, and the insurance laws and rules of this state. The examination must be developed and conducted under rules adopted by the commissioner.

(2) The commissioner may conduct the examination or make arrangements, including contracting with an outside testing service, for administering the examination and collecting the fees required by 33-2-708. The commissioner may arrange for the testing service to recover the cost of the examination from the applicant.

(3) Each individual applying for an examination shall remit the fees required by 33-2-708.

(4) An individual who fails to appear for the examination as scheduled or fails to pass the examination may reapply for an examination and shall remit all required fees and forms before being rescheduled for another examination.

(5) If the applicant is a partnership or corporation, each individual who is to be named in the license as having authority to act for the applicant in its insurance transactions under the license shall take the examination.

(6) Examination of an applicant for a license must cover all of the kinds of insurance for which the applicant has applied to be licensed, as constituted by any one or more of the following classifications:

(a) life insurance;

(b) disability insurance;

(c) property insurance. For the purposes of this provision, property insurance includes marine insurance.

(d) casualty insurance;

(e) surety insurance;

(f) credit life and disability insurance;

(g) title insurance.

(7) This section does not apply to and an examination is not required of:

(a) an individual lawfully licensed as an insurance producer as to the kind or kinds of insurance to be transacted as of or immediately prior to January 1, 1961, and ~~thereafter continuing~~ who continues to be licensed;

(b) an applicant for a license covering the same kind or kinds of insurance as to which the applicant was licensed in this state, other than under a temporary license, within the 12 months immediately preceding the date of application unless the commissioner has suspended, revoked, or refused to continue the previous license, except that this subsection (7)(b) does not apply to a title insurance producer, as defined in 33-25-105;

(c) an applicant for a license as a nonresident insurance producer;

(d) an applicant for a license to sell all-risk federal crop insurance if the applicant provides certification from an appropriate governmental agency to the commissioner that ~~he~~ the applicant is qualified to sell the insurance;

(e) transportation ticket agents of common carriers applying for a license to solicit and sell only:

(i) accident insurance ticket policies; or

(ii) insurance of personal effects while being carried as baggage on a common carrier, as incidental to their duties as transportation ticket agents;

(f) an association applying for a license under 33-17-211;

(g) a mechanical breakdown insurance producer~~.~~;

(h) a service contract insurance producer; or

~~(h)~~(i) an individual who, within 60 days of cancellation of a license issued by the state of the individual's residence, files with the commissioner a current letter of clearance certifying that the individual has passed an examination and held an insurance license in good standing in the individual's state of licensure, except that the individual shall take an examination pertaining to this state's law and each kind of insurance for which the individual has applied for a license and ~~which~~ that is not covered under the license held in the other state."

Section 26. Section 33-17-301, MCA, is amended to read:

"**33-17-301. Adjuster license -- qualifications -- catastrophe adjustments -- public adjuster.** (1) A person may not ~~in this state~~ act as or hold ~~himself~~ the person out to be an adjuster in this state unless licensed as an adjuster under this chapter. A person shall apply for an adjuster license to the commissioner

according to forms that the commissioner prescribes and furnishes. The commissioner shall issue the adjuster license to individuals qualified to be licensed as an adjuster upon payment of the license fee provided in 33-2-708.

(2) To be licensed as an adjuster, the applicant:

(a) must be an individual 18 years of age or more:

(b) must be a resident of Montana or resident of another state that will permit residents of Montana regularly to act as adjusters in the other state;

(c) must be a full-time salaried employee of a licensed adjuster or a graduate of a recognized law school or have had experience or special education or training as to the handling of loss claims under insurance contracts of sufficient duration and extent reasonably to make ~~him~~ the applicant competent to fulfill the responsibilities of an adjuster;

(d) must be trustworthy and of good character and reputation; and

(e) ~~shall~~ must have and shall maintain in this state an office accessible to the public and shall keep in the office for not less than 5 years the usual and customary records pertaining to transactions under the license. This provision does not prohibit maintenance of the office in the home of the licensee.

(3) A partnership or corporation, whether or not organized under the laws of this state, may be licensed as an adjuster if each individual who is to exercise the adjuster license powers is separately licensed or is named in the partnership or corporation adjuster license and is qualified for an individual adjuster license. An additional full license fee must be paid for each individual in excess of one named in the partnership or corporation adjuster license to exercise its powers.

(4) An adjuster license or qualifications are not required for an adjuster who is sent into this state by and on behalf of an insurer or adjusting partnership or corporation for the purpose of investigating or making adjustments of a particular loss under an insurance policy or for the adjustment of a series of losses resulting from a catastrophe common to all losses.

(5) An adjuster license continues in force until expired, suspended, revoked, or terminated. The license is subject to annual payment to the commissioner of the renewal fee required by 33-2-708, accompanied by a written request for renewal.

(6) The commissioner may adopt rules providing for the examination, licensure, bonding, and regulation of public adjusters."

Section 27. Section 33-17-1203, MCA, is amended to read:

"**33-17-1203. Continuing education -- basic requirements -- exceptions.** (1) Unless exempt under subsection (4):

(a) a person licensed to act as an insurance producer for property, casualty, surety, or title insurance or as a consultant for general insurance shall, during each calendar year, complete at least 10 credit hours of approved continuing education;

(b) a person licensed to act as an insurance producer for life or disability insurance or as a consultant for life insurance shall, during each calendar year, complete at least 10 credit hours of approved continuing education;

(c) a person holding multiple licenses shall, during each calendar year, complete at least 15 credit hours of approved continuing education;

(d) a person licensed to act as an insurance producer only for credit life and disability insurance shall, during each calendar year, complete 5 credit hours of approved continuing education in the areas of insurance law, ethics, or credit life and disability insurance;

(e) a person licensed as an insurance producer or consultant shall, during each biennium, complete at least 1 credit hour of approved continuing education on changes in Montana insurance statutes and administrative rules.

(2) If a person licensed as an insurance producer or consultant completes more credit hours of approved continuing education in a year than the minimum required in subsection (1), the excess credit hours may be carried forward and applied to the continuing education requirements of the next year.

(3) The commissioner may, for good cause ~~shown~~, grant an extension of time, not to exceed 1 year, during which the requirements imposed by subsection (1) may be completed.

(4) The minimum continuing education requirements do not apply to:

(a) a person licensed to sell any kind of insurance for which an examination is not required under 33-17-212(7)(d) through ~~(7)(g)~~ (7)(h);

(b) a person holding a temporary license issued under 33-17-216;

(c) a nonresident licensee who must meet continuing education requirements in the licensee's state of residence if that state ~~accords~~ grants substantially similar privileges to and has similar requirements ~~of~~ for residents of this state;

(d) a newly licensed insurance producer or consultant during the calendar year in which the

licensee first received a license; or

(e) an insurance producer or consultant otherwise exempted by the commissioner."

Section 28. Section 33-18-210, MCA, is amended to read:

"**33-18-210. Unfair discrimination and rebates prohibited -- property, casualty, and surety insurances.** (1) A title, property, casualty, or surety insurer or an employee, representative, or insurance producer of an insurer may not, as an inducement to purchase insurance or after insurance has been effected, pay, allow, ~~or~~ give, or offer to pay, allow, or give, directly or indirectly, a:

(a) rebate, discount, abatement, credit, or reduction of the premium named in the insurance policy;

(b) special favor or advantage in the dividends or other benefits to accrue on the policy; or

(c) valuable consideration or inducement not specified in the policy, except to the extent provided for in an applicable filing with the commissioner as provided by law.

(2) An insured named in a policy or an employee of the insured may not knowingly receive or accept, directly or indirectly, a:

(a) rebate, discount, abatement, credit, or reduction of premium;

(b) special favor or advantage; or

(c) valuable consideration or inducement.

(3) An insurer may not make or permit unfair discrimination in the premium or rates charged for insurance, in the dividends or other benefits payable on insurance, or in any other of the terms and conditions of the insurance either between insureds or property having like insuring or risk characteristics or between insureds because of race, color, creed, religion, or national origin.

(4) This section may not be construed as prohibiting the payment of commissions or other compensation to duly licensed insurance producers or as prohibiting an insurer from allowing or returning lawful dividends, savings, or unabsorbed premium deposits to its participating policyholders, members, or subscribers.

(5) An insurer may not make or permit unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, canceling, or limiting the amount of insurance coverage on a property or casualty risk because of the geographic location of the risk, unless:

(a) the refusal, cancellation, or limitation is for a business purpose that is not a mere pretext for

unfair discrimination; or

(b) the refusal, cancellation, or limitation is required by law or regulatory mandate.

(6) An insurer may not make or permit unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, canceling, or limiting the amount of insurance coverage on a residential property risk or on the personal property contained in the residential property, because of the age of the residential property, unless:

(a) the refusal, cancellation, or limitation is for a business purpose that is not a mere pretext for unfair discrimination; or

(b) the refusal, cancellation, or limitation is required by law or regulatory mandate.

(7) An insurer may not refuse to insure, refuse to continue to insure, or limit the amount of coverage available to an individual because of the sex or marital status of the individual. However, an insurer may take marital status into account for the purpose of defining persons eligible for dependents' benefits.

(8) An insurer may not terminate or modify coverage or refuse to issue or refuse to renew a property or casualty policy or contract of insurance solely because the applicant or insured or any employee of either is mentally or physically impaired. However, this subsection does not apply to accident and health insurance sold by a casualty insurer, and this subsection may not be interpreted to modify any other provision of law relating to the termination, modification, issuance, or renewal of any insurance policy or contract.

(9) An insurer may not refuse to insure, ~~refuse to continue to insure,~~ charge higher rates, or limit the amount of coverage available to an individual based solely on adverse information contained in a driving record that is 3 years old or older. However, an insurer may provide discounts to an insured based on favorable aspects of an insured's claims history that is 3 years old or older.

(10) An insurer may not charge points on, ~~refuse to issue,~~ REFUSE TO ISSUE, refuse to renew, remove an existing discount on, or surcharge a private passenger motor vehicle policy because of a claim submitted under the insured's policy if the insured was not at fault.

(11) (a) For the purposes of this subsection (11), "credit history" means that portion of a credit report or background report that addresses the applicant's or insured's debt payment history or lack of history but does not include public information including convictions, lawsuits, bankruptcies, or similar public information.

(b) An insurer writing automobile or homeowner insurance may not refuse to insure, refuse to continue to insure, charge higher rates, or limit the scope or amount of coverage or benefits available to an individual based solely on the insurer's knowledge of the individual's credit history unless:

(i) the insurer possesses substantial documentation that credit history is significantly correlated with the types of risks insured or to be insured;

(ii) the insurer sends written communication to the individual disclosing that the insurance coverage was declined, not renewed, or limited in scope or amount of coverage or benefits because of credit information relating to the applicant or the insured; and

(iii) upon subsequent request of the individual, mailed within 10 days of receipt of the denial, nonrenewal, or limitation, the insurer provides the individual with a copy of the credit report at issue or the name and address of a third party from whom the individual may obtain a copy of the credit report, within 10 days of receipt of the request.

(c) The provisions of this subsection (11) are not intended to conflict with any disclosure provisions of state law or the federal Truth in Lending Act applicable to lending institutions, credit bureaus, or other credit service organizations that maintain or distribute credit histories on insurance applicants or policyholders."

~~**Section 27.** Section 33-18-301, MCA, is amended to read:~~

~~"**33-18-301. Prohibited relations with mortuaries.** (1) A life insurer and its officers, employees, or representatives may not own, manage, supervise, operate, or maintain any mortuary, funeral, or undertaking establishment in Montana.~~

~~(2) A life insurer may not contract or agree with any funeral director, mortuary, or undertaker that the funeral director, undertaker, or mortuary shall conduct the funeral or be named beneficiary of any person insured by 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; and~~

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

~~(d)(4) any 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) (6).~~

~~(5) An insured may designate a funeral director, mortuary, or undertaker as a specific beneficiary only when the cash value of the policy adversely affects the insured's financial condition for the purpose of determining the availability of medicaid benefits.~~

~~(4)(6) 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 both."~~

Section 29. Section 33-20-101, MCA, is amended to read:

"**33-20-101. Scope.** (1) Except as provided in subsection (2), parts 1 through 5 of this chapter apply only to contracts of life insurance and annuities, other than reinsurance, group life insurance, and group annuities.

(2) Sections 33-20-114 and 33-20-131 also apply to group life insurance and group annuities."

Section 30. Section 33-22-107, MCA, is amended to read:

"**33-22-107. Premium increase restriction -- exception.** (1) An insurer or a health service corporation that issues a policy, certificate, or membership contract covering a resident of this state may not increase a premium in an individual's or an ~~individual group's~~ individual's group disability insurance policy more frequently than once during a 12-month period unless failure to increase the premium more frequently than once during the 12-month period would:

(a) place the insurer in violation of the laws of this state; or

(b) cause the financial impairment of the insurer to the extent that further transaction of insurance by the insurer injures or is hazardous to its policyholders or to the public.

(2) Subsection (1) does not apply to a premium increase necessitated by a state or federal law, court decision, or rule adopted by an agency of competent jurisdiction of the state or federal government."

Section 31. 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 or the person's dependents or family members covered under the policy ceases because of termination of the person's employment or of the person's membership in the class or classes eligible for coverage under the policy or as a result of a person's employer discontinuing the employer's business or as a result of a person's 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 the person is not insured under another major medical disability insurance policy or plan, the person is entitled to have issued to the person by the insurer, without evidence of insurability, group coverage or an individual policy 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 the person or 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. In addition, the insurer shall make available a conversion policy as required by subsection (4).

(3) The premium on the individual policy or group policy must be at no more than 200% of the insurer's then customary rate applicable to the coverage of the individual or group policy. The customary rate is that rate that is normally issued for medically underwritten policies without discount for healthy lifestyles.

(4) The insurer shall also make available ~~an individual~~ a conversion policy, certificate, or membership contract that provides at least the level of benefits provided by the insurer's lowest cost basic health benefit plan, as defined in 33-22-1803. If the insurer is not a small employer carrier under part 18, the insurer shall make available ~~an individual~~ a conversion policy, certificate, or membership contract that provides equivalent benefits to a basic health benefit plan. The conversion rate may not exceed 150% of the highest rate charged for that plan."

Section 32. Section 33-22-903, MCA, is amended to read:

"**33-22-903. Definitions.** As used in this part, the following definitions apply:

(1) "Applicant" means:

(a) in the case of an individual medicare supplement policy, the person who seeks to contract for

insurance benefits; and

(b) in the case of a group medicare supplement policy, the proposed certificate holder.

(2) "Certificate" means a certificate delivered or issued for delivery in this state under a group medicare supplement policy.

(3) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(4) "Entity" means an insurer as defined in 33-1-201, a health service corporation as defined in 33-30-101, and a health maintenance organization as defined in 33-31-102.

(5) "Health care expenses":

(a) means expenses of a health maintenance organization associated with the delivery of health care services that are analogous to incurred losses of an insurer;

(b) does not include home office and overhead costs, advertising costs, commissions and other acquisition costs, taxes, capital costs, administrative costs, or claims processing costs.

(6) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any entity delivering or issuing for delivery in this state medicare supplement policies or certificates.

(7) "Medicare" means Health Insurance for the Aged, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

(8) "Medicare supplement policy" means a group or individual policy of disability insurance or a subscriber contract of a health service corporation, other than a policy issued pursuant to a contract under ~~42 U.S.C. 1395l or 1395mm~~ 42 U.S.C. 1395ss(g)(1), or a policy issued under a demonstration project authorized pursuant to amendments to the federal Social Security Act, that is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare. The term does not include:

(a) a policy or contract of one or more employers or labor organizations or of the trustees of a fund established by one or more employers or labor organizations, or a combination of employers, organizations, and trustees, for employees or former employees, or a combination of current and former employees, or for members or former members, or a combination of current and former members, of the labor organizations; or

(b) individual policies or contracts issued pursuant to a conversion privilege under a policy or

contract of group or individual insurance when the group or individual policy or contract includes provisions that are inconsistent with the requirements of this part or policies issued to employees or members as additions to franchise plans in existence on April 8, 1981.

(9) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer."

Section 33. Section 33-22-907, MCA, is amended to read:

"**33-22-907. Disclosure standards -- informational brochure -- rules.** (1) In order to provide for full and fair disclosure in the sale of medicare supplement policies and certificates, a medicare supplement policy may not be delivered or issued for delivery in this state and a certificate may not be delivered pursuant to a group medicare supplement policy delivered or issued for delivery in this state unless an outline of coverage is delivered to the applicant at the time that application is made. The outline of coverage must be filed with the commissioner as required by 33-1-501. The filing must be made at least 60 days in advance of the date that the outline of coverage is delivered to any resident of this state.

(2) (a) The commissioner shall prescribe the format and content of the outline of coverage required by subsection (1).

(b) For purposes of this section, "format" means style, arrangements, and overall appearance, including such items as the size, color, and prominence of type and the arrangement of text and captions.

(c) The outline of coverage must include:

(i) a description of the principal benefits and coverage provided in the policy or certificate;

(ii) a statement of the exceptions, reductions, and limitations contained in the policy or certificate;

(iii) a statement of the renewal provisions, including any reservation by the issuer of a right to change premiums and disclosure of the existence of any automatic renewal premium increases based on the policyholder's or certificate holder's age;

(iv) a statement that the outline of coverage is a summary of the policy or certificate issued or applied for and that the policy or certificate should be consulted to determine governing contractual provisions.

(3) The commissioner may prescribe by rule a standard form and the contents of an informational brochure for persons eligible for medicare, which is intended to improve the buyer's ability to select the most appropriate coverage and to improve the buyer's understanding of medicare. Except in the case of

direct response insurance policies, the commissioner may require by rule that the information brochure be provided to any prospective insureds eligible for medicare at the same time that the outline of coverage is delivered. With respect to direct response insurance policies, the commissioner may require by rule that the prescribed brochure be provided upon request, but not later than the time of policy delivery, to any prospective insureds eligible for medicare.

(4) The commissioner may adopt reasonable rules for captions or notice requirements, determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not medicare supplement coverages, for all accident and sickness insurance policies sold to persons eligible for medicare, other than:

(a) medicare supplement policies or certificates; or

(b) disability income policies;

~~(c) basic, catastrophic, or major medical expense policies;~~

~~(d) single premium, nonrenewable policies; or~~

~~(e) other policies excepted in 33-22-903(8)~~.

(5) The commissioner may further adopt reasonable rules to govern the full and fair disclosure of the information in connection with the replacement of accident and sickness policies or certificates by persons eligible for medicare.

(6) As soon as practicable, but no later than 30 days before the annual effective date of a medicare benefit change, every entity providing medicare supplement insurance or benefits to a resident of this state shall notify its policyholders and certificate holders, in a format that the commissioner prescribes by rule, of the changes that it has made to the medicare supplement policy or certificate."

Section 34. Section 33-22-910, MCA, is amended to read:

"**33-22-910. Filing requirements for advertising.** Every issuer of medicare supplement policies or certificates in this state shall provide to the commissioner for the commissioner's ~~review or~~ approval a copy of any medicare supplement advertising intended for use in this state, whether through written, radio, or television medium."

Section 35. 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 carriers of disability insurance, including excess of loss and stop loss disability insurance.

(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 health benefit plan, except a uniform health benefit plan, developed by a small employer carrier, that has a lower benefit value than the small employer carrier's standard benefit plan and that provides the benefits required by 33-22-1827.

(6) "Benefit equivalency" means a method developed by the small employer carrier for comparing the types of health care services and articles covered under a health benefit plan with the types of health care services required to be covered under a uniform, basic, or standard health benefit plan.

(7) "Benefit value" means an actuarially based method developed by the small employer carrier for comparing the value of determinable contingencies covered under a health benefit plan with the value of determinable contingencies required under a uniform, basic, or standard health benefit plan.

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

(9) "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, and a health maintenance organization. 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.

(10) "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.

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

(12) "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 as a dependent in the health benefit plan covering the employee.

(13) "Eligible employee" means an employee who works on a full-time basis with a normal workweek of 30 hours or more, except that at the sole discretion of the employer, the term may include an employee who works on a full-time basis with a normal workweek of between 20 and 40 hours as long as this eligibility criteria is applied uniformly among all of the employer's employees. 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.

(14) "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.

(15) "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 or any other limited benefit plan;

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

(c) automobile medical payment insurance.

(16) "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.

(17) "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:

(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;

(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.

(18) "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.

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

(20) "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.

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

(22) "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 minimum 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 minimum basic health benefit plan, provided that the policy has been in effect for a period of at least 1 year.

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

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

(25) "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.

(26) "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 small employer member of its association or any employee of its small employer members who applies for coverage as part of a group.

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

(28) "Standard health benefit plan" means a health benefit plan that is developed by a small employer carrier and that contains the provisions required pursuant to 33-22-1828."

Section 36. 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 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 the premiums necessary to recover one-half of the expenses for the calendar year. For purposes of this section, expenses include administrative expenses, one-half of the program net loss for the previous calendar year, and the actuarially anticipated claims to be incurred, 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 shall annually review the methodology established under subsection (6)(a), including the system of classification and any rating factors, to ensure that it is actuarially sound and 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, and the actuarially anticipated losses for the calendar year. The sum of one-half of the program net loss for the previous calendar year plus the anticipated net loss for the calendar year must equal the total assessment amount. If the program net loss for the previous calendar year is zero or less, the total assessment amount must equal the actuarially anticipated losses for the calendar year.

(b) (i) Each assessable carrier shall share in the program in an amount determined by multiplying the total assessment amount by a fraction, the numerator of which is the number of individuals in this state covered under disability insurance by the assessable carrier and the denominator of which is the number

of all individuals in this state covered under disability insurance by all assessable carriers.

(ii) The board shall make a reasonable effort to ensure that each insured individual is counted only once for the purpose of assessment. The board shall require each assessable carrier that provides excess of loss or stop loss insurance to include in its count of insured individuals all individuals whose coverage is reinsured in whole or in part, including coverage under excess of loss or stop loss insurance. The board shall allow an assessable carrier who is an excess of loss or stop loss insurer to exclude from its count of insured individuals those who have been counted by a primary disability insurer or by a primary reinsurer.

(iii) ~~The board shall base each assessable carrier's assessment on reports filed with the commissioner as required by 33-22-1820.~~ The board may use any reasonable method of estimating the number of individuals insured by an assessable carrier if the specific number is unknown.

(c) The board shall make an annual determination in accordance with this section of each assessable carrier's liability for its share of the contribution to the program and, except as otherwise provided by this section, make an annual assessment against each assessable carrier to the extent of that liability. Payment of an 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.

(d) The board may establish and maintain program reserves not to exceed five times the actuarially anticipated losses for the calendar year.

(e) If the sum of the reinsurance premiums and assessments in any calendar year exceeds the sum of the administrative expenses and incurred claims for that year, the board may proportionately credit the excess to assessable carriers or it may place the excess in program reserves, subject to the limits in subsection (8)(d).

(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 37. Section 33-22-1820, MCA, is amended to read:

"**33-22-1820. Periodic market evaluation -- report.** The ~~board shall~~ commissioner may study and report at least every 3 years to the ~~commissioner~~ governor or other interested persons on the effectiveness of this part. The report must analyze the effectiveness of this part in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the small employer health insurance markets. The report must address whether carriers and producers are fairly and actively marketing or issuing health benefit plans to small employers in fulfillment of the purposes of this part. The report may contain recommendations for market conduct or other regulatory standards or action."

Section 38. Section 33-22-1828, MCA, is amended to read:

"**33-22-1828. Benefits required in standard benefit plan.** (1) The minimum benefits must be equal to at least 75% of the covered expenses in excess of an annual deductible that does not exceed $500 per person or $1,000 per family. The coverage must include a limitation of $2,000 per person or $4,000 per

family on the total annual out-of-pocket expenses for services covered. The coverage may be subject to a maximum lifetime benefit, but a maximum, if any, may not be less than $1 million.

(2) The commissioner may not require coverage in a standard health benefit plan for any benefit unless other provisions of Title 33, chapter 22, 30, or 31, specifically require coverage for the benefit. A small employer carrier may offer coverage for additional services and articles.

(3) A standard health benefit plan provided by a health maintenance organization or a basic health benefit plan with a restricted network provision must provide a comparable level of benefits to those required by subsection (1), as determined by the ~~benefit equivalency and~~ benefit value."

Section 39. 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 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: 33-3-308; 33-3-701 through 33-3-704; 33-17-101; 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 33-3-701 through 33-3-704~~.

(2) A law of this state other than the provisions of this chapter applicable to health service corporations must be construed in accordance with the fundamental nature of a health service corporation, and in the event of a conflict the provisions of this chapter prevail."

Section 40. Section 33-30-107, MCA, is amended to read:

"**33-30-107. Annual statement.** (1) On or before March 1 of each year, each health service corporation shall file an annual statement for the preceding year on 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.

(4) The commissioner may, after notice and hearing, suspend or revoke a health ~~maintenance~~ SERVICE CORPORATION'S ~~organization's~~ license or impose a fine not to exceed $100 a day and not to exceed $1,000 upon a health ~~maintenance organization~~ SERVICE CORPORATION that fails to file an annual statement as required by this part."

Section 41. 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 the prohibition of pecuniary interest under 33-3-308 or the material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance organization must be considered an insurer for the purposes of 33-3-308 and 33-3-701 through 33-3-704."

Section 42. Section 33-31-211, MCA, is amended to read:

"33-31-211. **Annual statement -- revocation for failure to file -- penalty for false swearing.** (1) Unless it is operated by an insurer or a health service corporation as a plan, each authorized health maintenance organization 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. The statement must be in the general form and content required by the commissioner. The statement must be verified by the oath of at least two principal officers of the health maintenance organization. The commissioner may ~~in his discretion~~ waive any verification under oath.

(2) At the time of filing its annual statement, the health maintenance organization shall pay the commissioner the fee for filing its statement as prescribed in 33-31-212. The commissioner may refuse to accept the fee for continuance of the insurer's certificate of authority, as provided in 33-31-212, may impose a penalty of $100, or may ~~in his discretion~~ suspend or revoke the certificate of authority of a health maintenance organization that fails to file an annual statement when due. Each day that the insurer fails to file its annual statement constitutes a separate violation. The total penalty may not exceed $1,000.

(3) The commissioner may, after notice and hearing, impose a fine not to exceed $5,000 ~~per~~ for each violation upon a director, officer, partner, member, insurance producer, or employee of a health maintenance organization who knowingly subscribes to or concurs in making or publishing an annual statement required by law that contains a material statement ~~which~~ that is false.

(4) The commissioner may require ~~such~~ reports ~~as he~~ that the commissioner considers reasonably necessary and appropriate to enable ~~him~~ the commissioner to carry out ~~his~~ the commissioner's duties under this chapter, including but not limited to a statement of operations, transactions, and affairs of a health maintenance organization operated by an insurer or a health service corporation as a plan."

NEW SECTION. **Section 43. Uniform claim forms and procedures.** ~~(1)~~ The commissioner of insurance, after consultation with the health care advisory council, may adopt by rule uniform health insurance claim forms and uniform standards and procedures for the use of the forms and processing of claims, including the submission of claims by means of an electronic claims processing system.

~~(2) The commissioner may contract with a private or public entity to administer and operate an electronic claims processing system. If the commissioner elects to contract for administration and operation of the system, the commissioner shall award a contract according to Title 18, chapter 4.~~

~~NEW SECTION. **Section 42. Statute of limitations.** The period prescribed for the commencement of a civil or administrative action by the commissioner for alleged violation of Title 33 is within 2 years of the commissioner's discovery of the facts constituting the alleged violation.~~

~~NEW SECTION. **Section 43. Filing or making false statements.** (1) A person may not purposely or knowingly make or cause to be made, in any document filed with the commissioner or in any proceeding before the commissioner, any statement that is, at the time and in the light of the circumstances under which it is made, false or misleading in any material respect.~~

~~(2) A person found to have willfully violated subsection (1) is subject to a fine of up to $5,000 and, if applicable, may be subject to the criminal laws of this state.~~

~~NEW SECTION. **Section 44. Credit life and disability applications.** (1) The insurance producer who effects the sale of a policy or certificate of credit life and disability insurance shall sign the application.~~

~~(2) An insurance company may not accept an application for credit life and disability insurance unless the application is signed by the insurance producer who effected the sale.~~

~~(3) This section does not apply to policies or certificates subject to the provisions of 33-21-204.~~

~~NEW SECTION. **Section 44. Service contract insurance.** (1) Service contract insurance is a contract or agreement for a separately stated consideration or for a specific duration to:~~

~~(a) perform the repair, replacement, or maintenance of property; or~~

~~(b) indemnify for repair, replacement, or maintenance of property.~~

~~(2) Service contract insurance does not include contracts or agreements that:~~

~~(a) are indemnified only by the seller or manufacturer; and~~

~~(b) insure only the inherent quality of the product.~~

NEW SECTION. **Section 44. Loss and loss expense reserves for property and casualty insurance.** (1) (a) In determining the financial condition of a property and casualty insurer for the purpose of applying the provisions of this chapter and in any financial statement or report of an insurer, loss reserves and loss expense reserves at least equal to the amounts required under the provisions of this section must be included in the insurer's liabilities. The date from which the determination, statement, or report is made

is, for the purpose of this part, the date of determination.

(b) Accepted actuarial standards as adopted by the actuarial standards board must be taken into consideration for the purpose of determining the loss reserves and loss expense reserves.

(2) Except as provided in subsections (3) and (4), the reserves for all outstanding losses and loss expenses must include the following:

(a) the aggregate estimated amounts due or to become due on account of all known losses, claims, and loss expenses incurred but not paid, including the estimated liability on any notice received by the insurer of the occurrence of any event that may result in a loss; and

(b) the aggregate amounts of liability for all losses and loss expenses incurred for which notice has not been received, estimated in accordance with the insurer's prior experience, if any, or otherwise in accordance with Montana industry ~~data~~ EXPERIENCE, OR COUNTRYWIDE INDUSTRY EXPERIENCE IF THIS STATE'S EXPERIENCE IS NOT CREDIBLE, FOR SIMILAR CONTRACTS OF INSURANCE. The estimated liabilities for losses under all bonds, policies, or contracts of fidelity insurance may not be less than 10% of the net premiums in force, and the estimated liabilities for all of those losses under all the insurer's surety contracts may not be less than 5% of the net premiums in force.

(3) Except as provided in subsection (4), tabular reserves for outstanding losses under policies of workers' compensation insurance may be actuarially calculated for both indemnity and medical payments. The loss adjustment expenses are not eligible for discounting. Tabular reserves are those reserves that are:

(a) calculated using discounts determined with reference to actuarial tables, which incorporate mortality, interest, not to exceed 4%, remarriage, and other contingencies applied to a reasonably determinable payment stream associated with lifetime benefit cases; or

(b) annuities certain, such as those arising from structured settlements.

(4) Whenever, in the judgment of the commissioner, the loss and loss expense reserves of any property and casualty insurer doing business in this state, calculated in accordance with the provisions of this section, are inadequate or excessive, the commissioner may prescribe any other method that will produce adequate and reasonable reserves.

(5) The excess, if any, of statutory reserves over statement reserves must be calculated in accordance with the annual statement instructions adopted by the national association of insurance commissioners.

NEW SECTION. **Section 45. Repealer.** Sections 33-2-515, 33-2-536, 33-2-721, 33-2-722, 33-2-723, 33-4-404, 33-4-409, 33-22-1201, 33-22-1202, 33-22-1203, 33-22-1204, and 33-22-1205, MCA, are repealed.

NEW SECTION. **Section 46. Codification instruction.** (1) [Section ~~42~~ ~~41~~ 43] is intended to be codified as an integral part of Title 50, chapter 4, part 5, and the provisions of Title 50, chapter 4, part 5, apply to [section ~~42~~ ~~41~~ 43].

~~(2) [Sections 43 and 44 42 AND 43] are intended to be codified as an integral part of Title 33, chapter 1, part 3, and the provisions of Title 33, chapter 1, part 3, apply to [sections 43 and 44 42 AND 43].~~

~~(3) [Section 45 44] is intended to be codified as an integral part of Title 33, chapter 21, part 1, and the provisions of Title 33, chapter 21, part 1, apply to [section 45 44].~~

~~(4)~~(2) ~~[Section 46 45 44] is intended to be codified as an integral part of Title 33, chapter 1, part 2, and the provisions of Title 33, chapter 1, part 2, apply to [section 46 45 44].~~

~~(5)~~(3)(2) [Section ~~47~~ ~~46~~ ~~45~~ 44] 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 ~~47~~ ~~46~~ ~~45~~ 44].

NEW SECTION. **Section 47. 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-

FREE CONFERENCE COMMITTEE

on House Bill 131
Report No. 1, April 11, 1997

Mr. Speaker and Mr. President:

We, your Free Conference Committee met and considered **House Bill 131** (reference copy -- salmon) and recommend that **House Bill 131** be amended as follows:

1. Title, line 13.
Strike: "33-18-210,"

2. Title, line 17.
Strike: "AND"
Following: "MCA"
Insert: "; AND PROVIDING EFFECTIVE DATES"

3. Page 2, line 12.
Strike: "provide notice"
Insert: "report the alleged fraud to the insurer"

4. Page 2, lines 13 and 14.
Strike: "to" on line 13 through "commissioner" on line 14

5. Page 2, line 14.
Following: "."
Insert: "The insurer shall review the report. If the insurer determines that there is reasonable likelihood that fraud has occurred, the insurer shall forward the report to the commissioner within 30 days of receipt of the report."

6. Page 7, lines 9 and 10.
Strike: "given" on line 9 through "dividends" on line 10

7. Page 25, line 4, through page 27, line 16.
Strike: section 28 in its entirety
Renumber: subsequent sections

8. Page 48, following line 21.
Insert: "

4-11-97

ADOPT

AC HB 131-1

REJECT

771046CC.Hgd

Vote: 6-0

HB 131

NEW SECTION. **Section 47. Effective dates.** (1) Except as provided in subsection (2), [this act] is effective October 1, 1997.

(2) [Section 9] and this section are effective on passage and approval."

And this FREE Conference Committee report be adopted.

For the House:

Representative Barnett, Chair

Representative Trexler

Representative Squires

For the Senate:

Senator Benedict, Chair

Senator Crismore

Senator McCarthy

HOUSE BILL NO. 131

INTRODUCED BY SIMON

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING STATE INSURANCE LAWS; PROVIDING FOR UNIFORM HEALTH INSURANCE CLAIM FORMS; ~~PROVIDING A STATUTE OF LIMITATIONS FOR ACTIONS BROUGHT BY THE COMMISSIONER OF INSURANCE;~~ PROVIDING PENALTIES FOR MISREPRESENTATIONS MADE TO THE COMMISSIONER; ~~REQUIRING THAT CREDIT LIFE AND DISABILITY INSURANCE APPLICATIONS BE SIGNED BY THE INSURANCE PRODUCER EFFECTING THE SALE; DEFINING "SERVICE CONTRACT INSURANCE";~~ AMENDING SECTIONS 18-8-103, 33-1-1205, 33-2-307, 33-2-317, 33-2-514, 33-2-517, 33-2-537, 33-2-704, 33-2-806, 33-2-1359, 33-2-1902, 33-3-303, 33-3-307, 33-4-202, 33-4-203, 33-4-204, 33-4-313, 33-4-314, 33-5-402, 33-10-202, 33-15-1105, 33-15-1106, 33-16-1027, 33-17-102, 33-17-212, 33-17-301, 33-17-1203, ~~33-18-210, 33-18-301,~~ 33-20-101, 33-22-107, 33-22-508, 33-22-903, 33-22-907, 33-22-910, 33-22-1803, 33-22-1819, 33-22-1820, 33-22-1828, 33-30-102, 33-30-107, 33-31-111, AND 33-31-211, MCA; ~~AND~~ REPEALING SECTIONS 33-2-515, 33-2-536, 33-2-721, 33-2-722, 33-2-723, 33-4-404, 33-4-409, 33-22-1201, 33-22-1202, 33-22-1203, 33-22-1204, AND 33-22-1205, MCA; AND PROVIDING EFFECTIVE DATES."

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

Section 1. Section 18-8-103, MCA, is amended to read:

"**18-8-103. Exemptions.** This part does not apply to employment of:

(1) registered professional engineers, surveyors, real estate appraisers, or registered architects;

(2) physicians, dentists, or other medical, dental, or health care providers;

(3) expert witnesses hired for use in litigation, hearings officers hired in rulemaking and contested case proceedings under the Montana Administrative Procedure Act, or attorneys as specified by executive order of the governor;

(4) consulting actuaries to the public retirement boards, ~~or~~ the state compensation insurance fund, or the commissioner of insurance;

(5) private consultants employed by the student associations of the university system with money

REFERENCE BILL: INCLUDES FREE CONFERENCE COMMITTEE REPORT DATED 4-11-97

raised from student activity fees designated for use by those student associations; or

(6) private consultants employed by the Montana state lottery."

SECTION 2. SECTION 33-1-1205, MCA, IS AMENDED TO READ:

"**33-1-1205. Duties of authorized insurers, adjusters, administrators, consultants, and producers.** (1) Each insurer, independent adjuster, independent administrator, independent consultant, and independent producer shall cooperate fully with the commissioner with respect to the provisions of this part.

(2) An insurer, an officer, or an employee~~, or producer~~ of the insurer, an independent adjuster, an independent administrator, an independent consultant, or an independent producer who has reason to believe that an insurance fraud has been or is being committed shall provide notice of the alleged insurance fraud to the commissioner within 60 days. A producer of an insurer who has reason to believe that an insurance fraud has been or is being committed shall ~~provide notice~~ REPORT THE ALLEGED FRAUD TO THE INSURER within 60 days of discovery of the alleged insurance fraud ~~to the insurer who shall within 30 days of receiving notice from the producer report it to the commissioner~~. THE INSURER SHALL REVIEW THE REPORT. IF THE INSURER DETERMINES THAT THERE IS REASONABLE LIKELIHOOD THAT FRAUD HAS OCCURRED, THE INSURER SHALL FORWARD THE REPORT TO THE COMMISSIONER WITHIN 30 DAYS OF RECEIPT OF THE REPORT.

(3) Notice to the commissioner by an insurer who has reason to believe that an insurance fraud has been committed in connection with an insurance claim, application, or policy tolls any applicable time period, for the commissioner, in any applicable insurance statute, related insurance regulation, or applicable sections of the criminal code and tolls any time period arising under 33-18-232 or 33-18-242 regarding unfair claims settlement practices."

Section 3. 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) $7 million. An insurer possessing less than ~~$6~~ $7 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 ~~$6~~ $7 million.

(ii) in the case of Lloyd's or another similar group including incorporated and unincorporated alien 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~~ not 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 4. Section 33-2-317, MCA, is amended to read:

"**33-2-317. Exemptions.** The Surplus Lines Insurance Law does not apply to reinsurance or to the following kinds of insurance when placed by a licensed insurance producer of this state:

(1) wet marine ~~and transportation insurances~~ insurance;

(2) insurance on subjects located, residing, or to be performed wholly outside of this state or on vehicles or aircraft owned and principally garaged outside this state;

(3) insurance on property or operations of railroads engaged in interstate commerce; and

(4) insurance of aircraft owned or operated by manufacturers of aircraft or aircraft operated in scheduled interstate flight or cargo of the aircraft or against liability, other than workers' compensation and employers' liability, arising out of the ownership, maintenance, or use of the aircraft."

Section 5. Section 33-2-514, MCA, is amended to read:

"**33-2-514. Reserve for disability insurance.** (1) For all disability insurance policies, the insurer shall maintain an active life reserve ~~which shall place~~ that places a sound value on its liabilities under ~~such~~ the policies and that may not be ~~not~~ less than ~~the reserve according to appropriate standards set forth in regulations issued by the commissioner and, in no event, less in the aggregate than~~ the pro rata gross unearned premiums for ~~such~~ the policies.

(2) The commissioner may promulgate rules to define additional standards for reserve requirements."

Section 6. Section 33-2-517, MCA, is amended to read:

"**33-2-517. Title insurance reserves.** (1) In addition to an adequate reserve as to outstanding losses as required under 33-2-511, a title insurer shall maintain a guaranty fund or unearned premium reserve of not less than an amount computed as follows:

(a) Ten percent of the total amount of the risk premiums written in the calendar year for title insurance contracts ~~shall~~ must be assigned originally to the reserve.

(b) During each of the 20 years next following the year in which the title insurance contract was issued, the reserve applicable to the contract ~~shall~~ must be reduced by 5% of the original amount of ~~such~~ the reserve.

(2) The reserve sums ~~herein~~ required ~~to be reserved~~ by subsection (1) for unearned premiums on

contracts of title insurance ~~shall~~ must at all times and for all purposes be considered and constitute unearned portions of the original premiums and ~~shall~~ must be held in trust for the benefit of policyholders.

(3) The reduction of the unearned premium reserve required by subsection (1)(b) ~~of this section~~ ~~shall~~ must be made for all title insurance contracts issued after December 31, 1958, with respect to which 10% of the risk premiums have been assigned to the reserve pursuant to subsection (1)(a) ~~of this section~~. ~~In the event that any title insurer has not in accordance with subsection (1)(b) of this section reduced the amount of its unearned premium reserve by 5% of the amount originally assigned to the reserve pursuant to subsection (1)(a) of this section for years ending after December 31, 1958, and before January 1, 1977, the insurer shall effect such reduction for such prior years during its accounting year which includes December 31, 1976.~~ If the insurer has not reduced the amount of its unearned premium reserves pursuant to subsection (1)(b) for a previous year or years, the insurer shall make the reduction for the prior year or years in its next accounting year."

Section 7. Section 33-2-537, MCA, is amended to read:

"**33-2-537. 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~~ may promulgate a rule containing the minimum standards applicable to the valuation of disability plans."

Section 8. Section 33-2-704, MCA, is amended to read:

"**33-2-704. Insured lives reporting requirement.** On or before ~~February 15~~ March 1 of each year, each insurer providing disability insurance shall, on a form prescribed by the commissioner, report the number of Montana residents insured on February 1 under any policy of individual or group disability

insurance, including excess of loss or stop loss insurance policies covering disability insurance."

Section 9. 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 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 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 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~~ 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:~~ in 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, in securities, in both cash and securities, or in investments provided for ~~under~~ in 33-2-531.

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

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~~ in 33-2-824. Money market funds, as defined by the commissioner by rule, are exempt from the 5% limitation of this subsection.

(8) Except with the commissioner's consent, an insurer 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~~ of investments in ~~the category of~~ real estate ~~shall~~ must be as provided in 33-2-832. Other specific limits apply as stated in the sections dealing with other respective kinds of investments."

Section 10. Section 33-2-1359, MCA, is amended to read:

"**33-2-1359. Setoffs ~~and counterclaims~~.** (1) Mutual debts or mutual credits between the insurer and another person in connection with any action or proceeding under this part ~~shall~~ must be set off and the balance only ~~shall be~~ allowed or paid, except as provided in ~~subsection (2) and~~ 33-2-1362 and subsection (2) of this section.

(2) ~~No~~ A setoff ~~or counterclaim~~ may not be allowed in favor of any person when:

(a) the obligation of the insurer to the person would not at the date of the filing of a petition for liquidation entitle the person to share as a claimant in the assets of the insurer;

(b) the obligation of the insurer to the person was purchased by or transferred to the person with a view to its being used as a setoff; or

(c) the obligation of the person is to pay an assessment levied against the members or subscribers of the insurer or is to pay a balance upon a subscription to the capital stock of the insurer or is in any other way in the nature of a capital contribution.~~; or~~

~~(d) the obligation of the person is to pay premiums, whether earned or unearned, to the insurer.~~"

Section 11. Section 33-2-1902, MCA, is amended to read:

"**33-2-1902. Definitions.** As used in this part, the following definitions apply:

(1) "Adjusted RBC report" means an RBC report that has been adjusted by the commissioner in accordance with 33-2-1903(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; or

(c) any insurer engaged solely in the business of reinsurance of life or disability contracts.

(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 :

(i) 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;

(ii) any insurance company engaged solely in the business of reinsurance of property and casualty contracts; or

(iii) any insurance company engaged in the business of surety and marine insurance.

(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 33-2-1904(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 33-2-1903.

(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."

Section 12. Section 33-3-303, MCA, is amended to read:

"**33-3-303. Meetings of stockholders or members.** (1) Meetings of stockholders or members of a domestic insurer ~~shall~~ must be held in the city or town of its principal office or place of business in this state.

(2) ~~No~~ A meeting of stockholders or members ~~shall~~ may not amend the insurer's articles of incorporation unless the proposal ~~so~~ to amend was included in the notice of the meeting.

(3) Except with the commissioner's consent, each ~~Each~~ insurer shall, during the first 6 months of each calendar year, hold the annual meeting of its stockholders or members to fill vacancies existing or occurring in the board of directors, must receive and shall consider reports of the insurer's officers as to its affairs, and shall transact ~~such~~ other business ~~as may~~ properly ~~be~~ brought before it. Not less than 20 days' notice ~~shall~~ must be given of ~~such~~ the meeting in the manner provided in the bylaws, except ~~where~~ when notice of the annual meeting of a mutual insurer is contained in its policies.

(4) Special meetings of the stockholders or members may be called at any time for any purpose by the board of directors upon not less than 10 days' notice, with notice given as provided in the bylaws. The notice ~~shall~~ must state the purpose of the meeting, and ~~no~~ business for which notice was not given may not ~~shall~~ be transacted at the meeting ~~of which notice was not so given~~.

(5) If more than 15 months are allowed to elapse without an annual stockholders' or members' meeting being held, any stockholder or member may call ~~such a~~ for an annual meeting to be held. At any time, upon written request of any director or of any stockholders or members holding in the aggregate one-fifth of the voting power of all stockholders or members, it ~~shall be~~ is the duty of the secretary to call

a special meeting of stockholders or members to be held at ~~such~~ the time ~~as~~ that the secretary may fix, not less than 10 or more than 30 days after the receipt of the request. If the secretary fails to issue ~~such~~ a call, the director, stockholders, or members making the request may do so.

(6) A stockholders' or members' meeting duly held ~~can~~ may be organized for the transaction of business whenever a quorum is present. Except as otherwise provided by law or the articles of incorporation:

(a) the presence, in person or by proxy, of the holders of a majority of the voting power of all stockholders or of all members ~~shall constitute~~ constitutes a quorum;

(b) the stockholders or members present at a duly organized meeting ~~can~~ may continue to do business until adjournment, notwithstanding the withdrawal of enough stockholders or members to leave less than a quorum;

(c) if any necessary officer fails to attend ~~such~~ a meeting, any stockholder or member present may be elected to act temporarily in lieu of ~~any such~~ the absent officer;

(d) if a meeting cannot be ~~organized~~ held because a quorum ~~has not attended~~ is not present, those present may adjourn the meeting to ~~such~~ a time ~~as~~ that they ~~may~~ determine, but in the case of any meeting called for the election of any director, the adjournment must be to the next day and those who attend the second ~~of such adjourned meetings~~ meeting, although less than a quorum as fixed in this section or in the articles of incorporation, ~~shall nevertheless~~ constitute a quorum for the purpose of electing any director; and

(e) an annual or special meeting of stockholders or members may be adjourned to another date without new notice being given."

Section 13. Section 33-3-307, MCA, is amended to read:

"**33-3-307. Bond of officers.** (1) The president, secretary, and treasurer of ~~every~~ each mutual insurer or stock insurer shall each file with the commissioner and ~~thereafter~~ maintain in force so long as ~~he~~ that individual is ~~such~~ an officer a fidelity bond in ~~the sum of $10,000~~ an amount set by the commissioner by rule and issued by an authorized corporate surety in favor of the insurer. The commissioner shall consider the insurer's exposure, total assets, and total income in determining the bond amount. In lieu of individual bonds, ~~all such~~ officers may be covered under a blanket bond for the same respective amounts~~,~~ ~~and which~~ The blanket bond ~~shall likewise~~ must be filed with the commissioner.

(2) The premium for the bond ~~shall~~ must be payable by the insurer.

(3) ~~No such~~ A bond ~~shall~~ is not ~~be~~ subject to cancellation except upon written notice to both the insurer and the commissioner, delivered not less than 30 days in advance of the effective date of ~~such~~ the cancellation.

(4) The insurer shall provide for the bonding by authorized corporate surety of all other officers in any way responsible for the handling of the funds of the insurer.

(5) This section ~~shall~~ may not be ~~deemed~~ considered to limit the amount of bonded protection ~~which~~ that the insurer may carry as to any officer."

Section 14. 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 the corporation 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) four copies of proposed articles of incorporation executed ~~in 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~~ The signatures of the incorporators must be notarized.

(2) The articles of incorporation 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 must contain the words "farm mutual" or "rural mutual" together with the name of the county in which its principal place of business is to be located. The name 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 must be located in this state;

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

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

(f) the duration of ~~its~~ the corporation's existence, which may be perpetual;

(g) the number of its directors, which may not be less than 5 or more than 11, 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~~ at which time successors are elected and qualified;

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

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

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

Section 15. Section 33-4-203, MCA, is amended to read:

"**33-4-203. Approval of articles -- commencement of corporate existence.** (1) If the 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 commissioner shall make a certificate of the facts.

(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 commissioner, the commissioner shall endorse the ~~commissioner's~~ approval upon each set of the articles and forward ~~three~~ four 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 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 16. Section 33-4-204, MCA, is amended to read:

"**33-4-204. Amendment of articles.** A farm mutual insurer may, by a vote of two-thirds of its members present at any annual meeting or at any special meeting ~~of members~~ called for that purpose, amend its articles of incorporation to extend its corporate duration or ~~in~~ any other particular within the scope of this chapter by causing amended articles to be filed in the same form and manner as required for original articles of incorporation. The commissioner shall review the amended articles for compliance with this title. The amended articles of incorporation ~~shall~~ may be signed only by the president and secretary of the corporation and attested by the corporate seal. Notice of the proposed amendment ~~shall~~ must be contained in the notice ~~given~~ of ~~any such~~ the annual or special meeting."

Section 17. Section 33-4-313, MCA, is amended to read:

"**33-4-313. Annual statement ~~-- report -- filing~~.** ~~(1)~~ The president and secretary of ~~every~~ each insurer, on or before March 1 each year, shall prepare, affirm under oath, affix the corporate seal ~~thereto~~ to, and file with the commissioner, on forms ~~as~~ prescribed and furnished by ~~him~~ the commissioner, an annual statement for the preceding calendar year showing the condition of ~~such~~ the insurer as of December 31 of ~~such~~ the preceding year and exhibiting the following facts:

~~(a)~~(1) the names of the president and secretary;

~~(b)~~(2) the date of the annual meeting;

~~(c)~~(3) the amount of insurance in force;

~~(d)~~(4) the number of members;

~~(e)~~(5) the number of assessments made during the year;

~~(f)~~(6) the amount paid in losses during the year;

~~(g)~~(7) the amount of the losses claimed and not paid, with the reason for nonpayment;

~~(h)~~(8) the number of members withdrawn, suspended, and expelled during the year;

~~(i)~~(9) the number of new members admitted during the year;

~~(j)~~(10) the expenses during the year;

~~(k)~~(11) the amount of money on hand;

~~(l)~~(12) the amount and character of the insurer's assets;

~~(m)~~(13) the amount of the insurer's liabilities, including any reserves required to be established under this chapter; and

~~(n)~~(14) ~~such~~ other information concerning the insurer's affairs ~~as~~ that the commissioner may reasonably require.

~~(2) A report of an insurer's expenditures for educational purposes, if any, for the preceding year must be filed with the commissioner at the same time and in conjunction with the annual report of such insurer, as required under 33-4-404.~~"

Section 18. Section 33-4-314, MCA, is amended to read:

"**33-4-314. Annual statement -- exclusive report -- penalty for failure to file.** (1) ~~No~~ A report, statement, or return of any nature ~~shall~~ may not be required of any farm mutual insurer other than those required by 33-4-313.

(2) The commissioner may:

(a) suspend or revoke the certificate of authority of any insurer failing to file its annual statement as required; or

(b) impose a fine of up to $100 a day for each day that an insurer is late in filing its annual statement, with the aggregate penalty not to exceed $1,000."

Section 19. Section 33-5-402, MCA, is amended to read:

"**33-5-402. Contributions to insurer.** The attorney or other parties may advance to a domestic reciprocal insurer upon reasonable terms ~~such~~ funds ~~as~~ that it may require from time to time in its operations. Sums ~~so~~ advanced ~~shall~~ may not be treated as a liability of the insurer, ~~and, except~~ Except upon liquidation of the insurer, ~~shall not be withdrawn or repaid except out of the insurer's realized earned surplus in excess of its minimum required surplus~~ during any calendar year, the total of withdrawals and repayments of the advanced sums may not exceed the lesser of the insured's realized earned surplus or 10% of the sums advanced as of the previous December 31. ~~No such~~ A withdrawal or repayment ~~shall~~ may not be made without the advance approval of the commissioner. This section does not apply to bank loans or to loans for which security is given."

Section 20. 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~~ 33-10-201(4) through (6) ~~of 33-10-201~~.

(5) "Impaired insurer" means:

(a) an insurer ~~which after July 1, 1974,~~ that 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 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~~ 33-10-201 and 33-10-224 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) (a) "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.

(b) ~~"Premiums" do~~ The term does not include premiums and considerations on contracts between insurers and reinsurers.

(c) As used in 33-10-227, ~~"premiums"~~ 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 that 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 21. SECTION 33-15-1105, MCA, IS AMENDED TO READ:

"**33-15-1105. Nonrenewal -- renewal premium.** (1) (a) An insured has a right to reasonable notice of nonrenewal. Unless otherwise provided by statute or unless a longer term is provided in the policy, at least 30 days prior to the expiration date provided in the policy, an insurer who does not intend to renew a policy beyond the agreed expiration date shall mail or deliver to the insured a notice of such intention. The insurer shall also mail or deliver a copy to the insured's insurance producer.

(b) Notification or nonrenewal to the insured's insurance producer via electronic transfer of data or by electronic data retrieval device meets the requirement of a mailed or delivered copy.

(2) An insurer shall give notice of premium due not more than 60 days or less than 10 days before the due date of a renewal premium. The notice must clearly state the effect of nonpayment of the premium on or before the due date.

(3) Subsections (1) and (2) do not apply if:

(a) the insured has obtained insurance elsewhere, has accepted replacement coverage, or has requested or agreed to nonrenewal; or

(b) the policy is expressly designated as nonrenewable."

Section 22. Section 33-15-1106, MCA, is amended to read:

"**33-15-1106. Renewal with altered terms.** (1) If an insurer offers or purports to renew a policy but on less favorable terms, at a higher rate, or at a higher rating plan, the new terms, rate, or rating plan take effect on the policy renewal date only if the insurer has mailed or delivered notice of the new terms, rate, or rating plan to the insured at least 30 days before the expiration date. ~~If the insured has not been so notified, he may cancel the renewal policy within 30 days after receiving the notice. The insurer shall continue coverage for a period of not less than 30 days after mailing or delivery of the notice. If the insured terminates the policy within the 30-day period, the insurer shall calculate the earned premium pro rata~~

~~based upon the prior policy's rate. The new rate is effective only after the required 30-day notification period has been met. If the insured does not terminate the policy, the premium increase and other changes are effective the day following the prior policy's expiration or anniversary date.~~

(2) This section does not apply if the increase in the rate or the rating plan, or both, results from a classification change based on the altered nature or extent of the risk insured against."

Section 23. Section 33-16-1027, MCA, is amended to read:

"**33-16-1027. Rate filing review.** (1) The commissioner shall review each insurance filing to ensure compliance with the following guidelines:

(a) The effective date of each workers' compensation insurer or advisory organization filing must be the date specified in the filing. The effective date of the filing may not be earlier than 30 days after the date on which the filing is received by the commissioner or the date of receipt of the information furnished in support of the filing, if the supporting information is required by the commissioner.

(b) Upon written application of the insurer or advisory organization, the commissioner may authorize a filing that becomes effective before the expiration of the period described in subsection (1)(a).

(c) A filing is considered to have met the requirements of this part unless disapproved by the commissioner within the period described in subsection (1)(a) or any extension of the period.

(2) Whenever a filing is not accompanied by the information required under this section, the commissioner shall inform the filer of the deficiency within ~~10~~ 30 days of the initial filing. The filing is considered made when the required information is furnished or when the filer certifies to the commissioner that the additional information requested by the commissioner is not maintained or cannot be provided."

Section 24. 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;

(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 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 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~~,~~; or

(xii) a person appointed as a managing general agent in this state whose activities are limited exclusively to those described in 33-2-1501(10) and Title 33, chapter 2, part 16.

(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 the person or the person's spouse, employer, or 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 chapter, the term "managing general agent" 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 25. Section 33-17-212, MCA, is amended to read:

"**33-17-212. Examination required -- exceptions -- fees.** (1) Except as provided in subsection (7), an individual applying for a license shall pass a written examination. The examination must test the knowledge of the individual concerning each kind of insurance listed in subsection (6) for which application is made, the duties and responsibilities of an insurance producer, and the insurance laws and rules of this state. The examination must be developed and conducted under rules adopted by the commissioner.

(2) The commissioner may conduct the examination or make arrangements, including contracting with an outside testing service, for administering the examination and collecting the fees required by 33-2-708. The commissioner may arrange for the testing service to recover the cost of the examination from the applicant.

(3) Each individual applying for an examination shall remit the fees required by 33-2-708.

(4) An individual who fails to appear for the examination as scheduled or fails to pass the examination may reapply for an examination and shall remit all required fees and forms before being rescheduled for another examination.

(5) If the applicant is a partnership or corporation, each individual who is to be named in the license as having authority to act for the applicant in its insurance transactions under the license shall take the examination.

(6) Examination of an applicant for a license must cover all of the kinds of insurance for which the applicant has applied to be licensed, as constituted by any one or more of the following classifications:

(a) life insurance;

(b) disability insurance;

(c) property insurance. For the purposes of this provision, property insurance includes marine insurance.

(d) casualty insurance;

(e) surety insurance;

(f) credit life and disability insurance;

(g) title insurance.

(7) This section does not apply to and an examination is not required of:

(a) an individual lawfully licensed as an insurance producer as to the kind or kinds of insurance to be transacted as of or immediately prior to January 1, 1961, and ~~thereafter continuing~~ who continues to be licensed;

(b) an applicant for a license covering the same kind or kinds of insurance as to which the applicant was licensed in this state, other than under a temporary license, within the 12 months immediately preceding the date of application unless the commissioner has suspended, revoked, or refused to continue the previous license, except that this subsection (7)(b) does not apply to a title insurance producer, as defined in 33-25-105;

(c) an applicant for a license as a nonresident insurance producer;

(d) an applicant for a license to sell all-risk federal crop insurance if the applicant provides certification from an appropriate governmental agency to the commissioner that ~~he~~ the applicant is qualified to sell the insurance;

(e) transportation ticket agents of common carriers applying for a license to solicit and sell only:

(i) accident insurance ticket policies; or

(ii) insurance of personal effects while being carried as baggage on a common carrier, as incidental to their duties as transportation ticket agents;

(f) an association applying for a license under 33-17-211;

(g) a mechanical breakdown insurance producer~~.~~;

(h) a service contract insurance producer; or

~~(h)~~(i) an individual who, within 60 days of cancellation of a license issued by the state of the individual's residence, files with the commissioner a current letter of clearance certifying that the individual has passed an examination and held an insurance license in good standing in the individual's state of licensure, except that the individual shall take an examination pertaining to this state's law and each kind of insurance for which the individual has applied for a license and ~~which~~ that is not covered under the license held in the other state."

Section 26. Section 33-17-301, MCA, is amended to read:

"**33-17-301. Adjuster license -- qualifications -- catastrophe adjustments -- public adjuster.** (1) A person may not ~~in this state~~ act as or hold ~~himself~~ the person out to be an adjuster in this state unless licensed as an adjuster under this chapter. A person shall apply for an adjuster license to the commissioner according to forms that the commissioner prescribes and furnishes. The commissioner shall issue the adjuster license to individuals qualified to be licensed as an adjuster upon payment of the license fee provided in 33-2-708.

(2) To be licensed as an adjuster, the applicant:

(a) must be an individual 18 years of age or more;

(b) must be a resident of Montana or resident of another state that will permit residents of Montana regularly to act as adjusters in the other state;

(c) must be a full-time salaried employee of a licensed adjuster or a graduate of a recognized law school or have had experience or special education or training as to the handling of loss claims under insurance contracts of sufficient duration and extent reasonably to make ~~him~~ the applicant competent to fulfill the responsibilities of an adjuster;

(d) must be trustworthy and of good character and reputation; and

(e) ~~shall~~ must have and shall maintain in this state an office accessible to the public and shall keep in the office for not less than 5 years the usual and customary records pertaining to transactions under the license. This provision does not prohibit maintenance of the office in the home of the licensee.

(3) A partnership or corporation, whether or not organized under the laws of this state, may be licensed as an adjuster if each individual who is to exercise the adjuster license powers is separately licensed or is named in the partnership or corporation adjuster license and is qualified for an individual adjuster license. An additional full license fee must be paid for each individual in excess of one named in the partnership or corporation adjuster license to exercise its powers.

(4) An adjuster license or qualifications are not required for an adjuster who is sent into this state by and on behalf of an insurer or adjusting partnership or corporation for the purpose of investigating or making adjustments of a particular loss under an insurance policy or for the adjustment of a series of losses resulting from a catastrophe common to all losses.

(5) An adjuster license continues in force until expired, suspended, revoked, or terminated. The license is subject to annual payment to the commissioner of the renewal fee required by 33-2-708, accompanied by a written request for renewal.

(6) The commissioner may adopt rules providing for the examination, licensure, bonding, and regulation of public adjusters."

Section 27. Section 33-17-1203, MCA, is amended to read:

"**33-17-1203. Continuing education -- basic requirements -- exceptions.** (1) Unless exempt under subsection (4):

(a) a person licensed to act as an insurance producer for property, casualty, surety, or title insurance or as a consultant for general insurance shall, during each calendar year, complete at least 10 credit hours of approved continuing education;

(b) a person licensed to act as an insurance producer for life or disability insurance or as a consultant for life insurance shall, during each calendar year, complete at least 10 credit hours of approved continuing education;

(c) a person holding multiple licenses shall, during each calendar year, complete at least 15 credit hours of approved continuing education;

(d) a person licensed to act as an insurance producer only for credit life and disability insurance shall, during each calendar year, complete 5 credit hours of approved continuing education in the areas of insurance law, ethics, or credit life and disability insurance;

(e) a person licensed as an insurance producer or consultant shall, during each biennium, complete at least 1 credit hour of approved continuing education on changes in Montana insurance statutes and administrative rules.

(2) If a person licensed as an insurance producer or consultant completes more credit hours of approved continuing education in a year than the minimum required in subsection (1), the excess credit hours may be carried forward and applied to the continuing education requirements of the next year.

(3) The commissioner may, for good cause ~~shown~~, grant an extension of time, not to exceed 1 year, during which the requirements imposed by subsection (1) may be completed.

(4) The minimum continuing education requirements do not apply to:

(a) a person licensed to sell any kind of insurance for which an examination is not required under 33-17-212(7)(d) through ~~(7)(g)~~ (7)(h);

(b) a person holding a temporary license issued under 33-17-216;

(c) a nonresident licensee who must meet continuing education requirements in the licensee's state

of residence if that state ~~accords~~ grants substantially similar privileges to and has similar requirements ~~of~~ for residents of this state;

(d) a newly licensed insurance producer or consultant during the calendar year in which the licensee first received a license; or

(e) an insurance producer or consultant otherwise exempted by the commissioner."

~~**Section 28.** Section 33-18-210, MCA, is amended to read:~~

~~"**33-18-210. Unfair discrimination and rebates prohibited -- property, casualty, and surety insurances.** (1) A title, property, casualty, or surety insurer or an employee, representative, or insurance producer of an insurer may not, as an inducement to purchase insurance or after insurance has been effected, pay, allow, or give, or offer to pay, allow, or give, directly or indirectly, a:~~

~~(a) rebate, discount, abatement, credit, or reduction of the premium named in the insurance policy;~~

~~(b) special favor or advantage in the dividends or other benefits to accrue on the policy; or~~

~~(c) valuable consideration or inducement not specified in the policy, except to the extent provided for in an applicable filing with the commissioner as provided by law.~~

~~(2) An insured named in a policy or an employee of the insured may not knowingly receive or accept, directly or indirectly, a:~~

~~(a) rebate, discount, abatement, credit, or reduction of premium;~~

~~(b) special favor or advantage; or~~

~~(c) valuable consideration or inducement.~~

~~(3) An insurer may not make or permit unfair discrimination in the premium or rates charged for insurance, in the dividends or other benefits payable on insurance, or in any other of the terms and conditions of the insurance either between insureds or property having like insuring or risk characteristics or between insureds because of race, color, creed, religion, or national origin.~~

~~(4) This section may not be construed as prohibiting the payment of commissions or other compensation to duly licensed insurance producers or as prohibiting an insurer from allowing or returning lawful dividends, savings, or unabsorbed premium deposits to its participating policyholders, members, or subscribers.~~

~~(5) An insurer may not make or permit unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, canceling, or~~

~~limiting the amount of insurance coverage on a property or casualty risk because of the geographic location of the risk, unless:~~

~~(a) the refusal, cancellation, or limitation is for a business purpose that is not a mere pretext for unfair discrimination; or~~

~~(b) the refusal, cancellation, or limitation is required by law or regulatory mandate.~~

~~(6) An insurer may not make or permit unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, canceling, or limiting the amount of insurance coverage on a residential property risk or on the personal property contained in the residential property, because of the age of the residential property, unless:~~

~~(a) the refusal, cancellation, or limitation is for a business purpose that is not a mere pretext for unfair discrimination; or~~

~~(b) the refusal, cancellation, or limitation is required by law or regulatory mandate.~~

~~(7) An insurer may not refuse to insure, refuse to continue to insure, or limit the amount of coverage available to an individual because of the sex or marital status of the individual. However, an insurer may take marital status into account for the purpose of defining persons eligible for dependents' benefits.~~

~~(8) An insurer may not terminate or modify coverage or refuse to issue or refuse to renew a property or casualty policy or contract of insurance solely because the applicant or insured or any employee of either is mentally or physically impaired. However, this subsection does not apply to accident and health insurance sold by a casualty insurer, and this subsection may not be interpreted to modify any other provision of law relating to the termination, modification, issuance, or renewal of any insurance policy or contract.~~

~~(9) An insurer may not refuse to insure, refuse to continue to insure, charge higher rates, or limit the amount of coverage available to an individual based solely on adverse information contained in a driving record that is 3 years old or older. However, an insurer may provide discounts to an insured based on favorable aspects of an insured's claims history that is 3 years old or older.~~

~~(10) An insurer may not charge points on, refuse to issue,~~ REFUSE TO ISSUE, ~~refuse to renew, remove an existing discount on, or surcharge a private passenger motor vehicle policy because of a claim submitted under the insured's policy if the insured was not at fault.~~

~~(11) (a) For the purposes of this subsection (11), "credit history" means that portion of a credit~~

~~report or background report that addresses the applicant's or insured's debt payment history or lack of history but does not include public information including convictions, lawsuits, bankruptcies, or similar public information.~~

~~(b) An insurer writing automobile or homeowner insurance may not refuse to insure, refuse to continue to insure, charge higher rates, or limit the scope or amount of coverage or benefits available to an individual based solely on the insurer's knowledge of the individual's credit history unless:~~

~~(i) the insurer possesses substantial documentation that credit history is significantly correlated with the types of risks insured or to be insured;~~

~~(ii) the insurer sends written communication to the individual disclosing that the insurance coverage was declined, not renewed, or limited in scope or amount of coverage or benefits because of credit information relating to the applicant or the insured; and~~

~~(iii) upon subsequent request of the individual, mailed within 10 days of receipt of the denial, nonrenewal, or limitation, the insurer provides the individual with a copy of the credit report at issue or the name and address of a third party from whom the individual may obtain a copy of the credit report, within 10 days of receipt of the request.~~

~~(c) The provisions of this subsection (11) are not intended to conflict with any disclosure provisions of state law or the federal Truth in Lending Act applicable to lending institutions, credit bureaus, or other credit service organizations that maintain or distribute credit histories on insurance applicants or policyholders."~~

~~**Section 27.** Section 33-18-301, MCA, is amended to read:~~

~~**"33-18-301. Prohibited relations with mortuaries.** (1) A life insurer and its officers, employees, or representatives may not own, manage, supervise, operate, or maintain any mortuary, funeral, or undertaking establishment in Montana.~~

~~(2) A life insurer may not contract or agree with any funeral director, mortuary, or undertaker that the funeral director, undertaker, or mortuary shall conduct the funeral or be named beneficiary of any person insured by 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; and~~

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

~~(d)(4)~~ any 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) ~~(6)~~.

~~(5) An insured may designate a funeral director, mortuary, or undertaker as a specific beneficiary only when the cash value of the policy adversely affects the insured's financial condition for the purpose of determining the availability of medicaid benefits.~~

~~(4)(6) 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 both."~~

Section 28. Section 33-20-101, MCA, is amended to read:

"**33-20-101. Scope.** (1) Except as provided in subsection (2), parts 1 through 5 of this chapter apply only to contracts of life insurance and annuities, other than reinsurance, group life insurance, and group annuities.

(2) Sections 33-20-114 and 33-20-131 also apply to group life insurance and group annuities."

Section 29. Section 33-22-107, MCA, is amended to read:

"**33-22-107. Premium increase restriction -- exception.** (1) An insurer or a health service corporation that issues a policy, certificate, or membership contract covering a resident of this state may not increase a premium in an individual's or an ~~individual group's~~ individual's group disability insurance policy more frequently than once during a 12-month period unless failure to increase the premium more frequently than once during the 12-month period would:

(a) place the insurer in violation of the laws of this state; or

(b) cause the financial impairment of the insurer to the extent that further transaction of insurance by the insurer injures or is hazardous to its policyholders or to the public.

(2) Subsection (1) does not apply to a premium increase necessitated by a state or federal law, court decision, or rule adopted by an agency of competent jurisdiction of the state or federal government."

Section 30. 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 or the person's dependents or family members covered under the policy ceases because of termination of the person's employment or of the person's membership in the class or classes eligible for coverage under the policy or as a result of a person's employer discontinuing the employer's business or as a result of a person's 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 the person is not insured under another major medical disability insurance policy or plan, the person is entitled to have issued to the person by the insurer, without evidence of insurability, group coverage or an individual policy 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 the person or 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. In addition, the insurer shall make available a conversion policy as required by subsection (4).

(3) The premium on the individual policy or group policy must be at no more than 200% of the insurer's then customary rate applicable to the coverage of the individual or group policy. The customary rate is that rate that is normally issued for medically underwritten policies without discount for healthy lifestyles.

(4) The insurer shall also make available ~~an individual~~ a conversion policy, certificate, or membership contract that provides at least the level of benefits provided by the insurer's lowest cost basic health benefit plan, as defined in 33-22-1803. If the insurer is not a small employer carrier under part 18, the insurer shall make available ~~an individual~~ a conversion policy, certificate, or membership contract that provides equivalent benefits to a basic health benefit plan. The conversion rate may not exceed 150% of the highest rate charged for that plan."

Section 31. Section 33-22-903, MCA, is amended to read:

"**33-22-903. Definitions.** As used in this part, the following definitions apply:

(1) "Applicant" means:

(a) in the case of an individual medicare supplement policy, the person who seeks to contract for insurance benefits; and

(b) in the case of a group medicare supplement policy, the proposed certificate holder.

(2) "Certificate" means a certificate delivered or issued for delivery in this state under a group medicare supplement policy.

(3) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(4) "Entity" means an insurer as defined in 33-1-201, a health service corporation as defined in 33-30-101, and a health maintenance organization as defined in 33-31-102.

(5) "Health care expenses":

(a) means expenses of a health maintenance organization associated with the delivery of health care services that are analogous to incurred losses of an insurer;

(b) does not include home office and overhead costs, advertising costs, commissions and other acquisition costs, taxes, capital costs, administrative costs, or claims processing costs.

(6) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any entity delivering or issuing for delivery in this state medicare supplement policies or certificates.

(7) "Medicare" means Health Insurance for the Aged, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

(8) "Medicare supplement policy" means a group or individual policy of disability insurance or a subscriber contract of a health service corporation, other than a policy issued pursuant to a contract under ~~42 U.S.C. 1395l or 1395mm~~ 42 U.S.C. 1395ss(g)(1), or a policy issued under a demonstration project authorized pursuant to amendments to the federal Social Security Act, that is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare. The term does not include:

(a) a policy or contract of one or more employers or labor organizations or of the trustees of a fund established by one or more employers or labor organizations, or a combination of employers, organizations, and trustees, for employees or former employees, or a combination of current and former employees, or

for members or former members, or a combination of current and former members, of the labor organizations; or

(b) individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when the group or individual policy or contract includes provisions that are inconsistent with the requirements of this part or policies issued to employees or members as additions to franchise plans in existence on April 8, 1981.

(9) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer."

Section 32. Section 33-22-907, MCA, is amended to read:

"**33-22-907. Disclosure standards -- informational brochure -- rules.** (1) In order to provide for full and fair disclosure in the sale of medicare supplement policies and certificates, a medicare supplement policy may not be delivered or issued for delivery in this state and a certificate may not be delivered pursuant to a group medicare supplement policy delivered or issued for delivery in this state unless an outline of coverage is delivered to the applicant at the time that application is made. The outline of coverage must be filed with the commissioner as required by 33-1-501. The filing must be made at least 60 days in advance of the date that the outline of coverage is delivered to any resident of this state.

(2) (a) The commissioner shall prescribe the format and content of the outline of coverage required by subsection (1).

(b) For purposes of this section, "format" means style, arrangements, and overall appearance, including such items as the size, color, and prominence of type and the arrangement of text and captions.

(c) The outline of coverage must include:

(i) a description of the principal benefits and coverage provided in the policy or certificate;

(ii) a statement of the exceptions, reductions, and limitations contained in the policy or certificate;

(iii) a statement of the renewal provisions, including any reservation by the issuer of a right to change premiums and disclosure of the existence of any automatic renewal premium increases based on the policyholder's or certificate holder's age;

(iv) a statement that the outline of coverage is a summary of the policy or certificate issued or applied for and that the policy or certificate should be consulted to determine governing contractual provisions.

(3) The commissioner may prescribe by rule a standard form and the contents of an informational brochure for persons eligible for medicare, which is intended to improve the buyer's ability to select the most appropriate coverage and to improve the buyer's understanding of medicare. Except in the case of direct response insurance policies, the commissioner may require by rule that the information brochure be provided to any prospective insureds eligible for medicare at the same time that the outline of coverage is delivered. With respect to direct response insurance policies, the commissioner may require by rule that the prescribed brochure be provided upon request, but not later than the time of policy delivery, to any prospective insureds eligible for medicare.

(4) The commissioner may adopt reasonable rules for captions or notice requirements, determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not medicare supplement coverages, for all accident and sickness insurance policies sold to persons eligible for medicare, other than:

(a) medicare supplement policies or certificates; or

(b) disability income policies~~;~~

~~(c) basic, catastrophic, or major medical expense policies;~~

~~(d) single premium, nonrenewable policies; or~~

~~(e) other policies excepted in 33-22-903(8)~~.

(5) The commissioner may further adopt reasonable rules to govern the full and fair disclosure of the information in connection with the replacement of accident and sickness policies or certificates by persons eligible for medicare.

(6) As soon as practicable, but no later than 30 days before the annual effective date of a medicare benefit change, every entity providing medicare supplement insurance or benefits to a resident of this state shall notify its policyholders and certificate holders, in a format that the commissioner prescribes by rule, of the changes that it has made to the medicare supplement policy or certificate."

Section 33. Section 33-22-910, MCA, is amended to read:

"**33-22-910. Filing requirements for advertising.** Every issuer of medicare supplement policies or certificates in this state shall provide to the commissioner for the commissioner's ~~review or~~ approval a copy of any medicare supplement advertising intended for use in this state, whether through written, radio, or television medium."

Section 34. 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 carriers of disability insurance, including excess of loss and stop loss disability insurance.

(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 health benefit plan, except a uniform health benefit plan, developed by a small employer carrier, that has a lower benefit value than the small employer carrier's standard benefit plan and that provides the benefits required by 33-22-1827.

(6) "Benefit equivalency" means a method developed by the small employer carrier for comparing the types of health care services and articles covered under a health benefit plan with the types of health care services required to be covered under a uniform, basic, or standard health benefit plan.

(7) "Benefit value" means an actuarially based method developed by the small employer carrier for comparing the value of determinable contingencies covered under a health benefit plan with the value of determinable contingencies required under a uniform, basic, or standard health benefit plan.

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

(9) "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, and a health maintenance organization. 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.

(10) "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.

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

(12) "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 as a dependent in the health benefit plan covering the employee.

(13) "Eligible employee" means an employee who works on a full-time basis with a normal workweek of 30 hours or more, except that at the sole discretion of the employer, the term may include an employee who works on a full-time basis with a normal workweek of between 20 and 40 hours as long as this eligibility criteria is applied uniformly among all of the employer's employees. 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.

(14) "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.

(15) "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 or any other limited benefit plan;

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

(c) automobile medical payment insurance.

(16) "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.

(17) "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:

(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;

(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.

(18) "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.

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

(20) "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.

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

(22) "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 minimum 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 minimum basic health benefit plan, provided that the policy has been in effect for a period of at least 1 year.

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

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

(25) "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.

(26) "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 small employer member of its association or any employee of its small employer members who applies for coverage as part of a group.

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

(28) "Standard health benefit plan" means a health benefit plan that is developed by a small employer carrier and that contains the provisions required pursuant to 33-22-1828."

Section 35. 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 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 the premiums necessary to recover one-half of the expenses for the calendar year. For purposes of this section, expenses include administrative expenses, one-half of the program net loss for the previous calendar year, and the actuarially anticipated claims to be incurred, 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 shall annually review the methodology established under subsection (6)(a), including the system of classification and any rating factors, to ensure that it is actuarially sound and 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, and the actuarially anticipated losses for the calendar year. The sum of one-half of the program net loss for the previous calendar year plus the anticipated net loss for the calendar year must equal the total assessment amount. If the program net loss for the previous calendar year is zero or less, the total assessment amount must equal the actuarially anticipated losses for the calendar year.

(b) (i) Each assessable carrier shall share in the program in an amount determined by multiplying

the total assessment amount by a fraction, the numerator of which is the number of individuals in this state covered under disability insurance by the assessable carrier and the denominator of which is the number of all individuals in this state covered under disability insurance by all assessable carriers.

(ii) The board shall make a reasonable effort to ensure that each insured individual is counted only once for the purpose of assessment. The board shall require each assessable carrier that provides excess of loss or stop loss insurance to include in its count of insured individuals all individuals whose coverage is reinsured in whole or in part, including coverage under excess of loss or stop loss insurance. The board shall allow an assessable carrier who is an excess of loss or stop loss insurer to exclude from its count of insured individuals those who have been counted by a primary disability insurer or by a primary reinsurer.

(iii) ~~The board shall base each assessable carrier's assessment on reports filed with the commissioner as required by 33-22-1820.~~ The board may use any reasonable method of estimating the number of individuals insured by an assessable carrier if the specific number is unknown.

(c) The board shall make an annual determination in accordance with this section of each assessable carrier's liability for its share of the contribution to the program and, except as otherwise provided by this section, make an annual assessment against each assessable carrier to the extent of that liability. Payment of an 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.

(d) The board may establish and maintain program reserves not to exceed five times the actuarially anticipated losses for the calendar year.

(e) If the sum of the reinsurance premiums and assessments in any calendar year exceeds the sum of the administrative expenses and incurred claims for that year, the board may proportionately credit the excess to assessable carriers or it may place the excess in program reserves, subject to the limits in subsection (8)(d).

(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 36. Section 33-22-1820, MCA, is amended to read:

"**33-22-1820. Periodic market evaluation -- report.** The ~~board shall~~ commissioner may study and report at least every 3 years to the ~~commissioner~~ governor or other interested persons on the effectiveness of this part. The report must analyze the effectiveness of this part in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the small employer health insurance markets. The report must address whether carriers and producers are fairly and actively marketing or issuing health benefit plans to small employers in fulfillment of the purposes of this part. The report may contain recommendations for market conduct or other regulatory standards or action."

Section 37. Section 33-22-1828, MCA, is amended to read:

"**33-22-1828. Benefits required in standard benefit plan.** (1) The minimum benefits must be equal

to at least 75% of the covered expenses in excess of an annual deductible that does not exceed $500 per person or $1,000 per family. The coverage must include a limitation of $2,000 per person or $4,000 per family on the total annual out-of-pocket expenses for services covered. The coverage may be subject to a maximum lifetime benefit, but a maximum, if any, may not be less than $1 million.

(2) The commissioner may not require coverage in a standard health benefit plan for any benefit unless other provisions of Title 33, chapter 22, 30, or 31, specifically require coverage for the benefit. A small employer carrier may offer coverage for additional services and articles.

(3) A standard health benefit plan provided by a health maintenance organization or a basic health benefit plan with a restricted network provision must provide a comparable level of benefits to those required by subsection (1), as determined by the ~~benefit equivalency and~~ benefit value."

Section 38. 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 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: 33-3-308; 33-3-701 through 33-3-704; 33-17-101; 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 33-3-701 through 33-3-704~~.

(2) A law of this state other than the provisions of this chapter applicable to health service corporations must be construed in accordance with the fundamental nature of a health service corporation, and in the event of a conflict the provisions of this chapter prevail."

Section 39. Section 33-30-107, MCA, is amended to read:

"**33-30-107. Annual statement.** (1) On or before March 1 of each year, each health service corporation shall file an annual statement for the preceding year on 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.

(4) The commissioner may, after notice and hearing, suspend or revoke a health ~~maintenance~~ SERVICE CORPORATION'S ~~organization's~~ license or impose a fine not to exceed $100 a day and not to exceed $1,000 upon a health ~~maintenance organization~~ SERVICE CORPORATION that fails to file an annual statement as required by this part."

Section 40. 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 the prohibition of pecuniary interest under 33-3-308 or the material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance organization must be considered an insurer for the purposes of 33-3-308 and 33-3-701 through 33-3-704."

Section 41. Section 33-31-211, MCA, is amended to read:

"**33-31-211. Annual statement -- revocation for failure to file -- penalty for false swearing.** (1) Unless it is operated by an insurer or a health service corporation as a plan, each authorized health maintenance organization 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. The statement must be in the general form and content required by the commissioner. The statement must be verified by the oath of at least two principal officers of the health maintenance organization. The commissioner may ~~in his discretion~~ waive any verification under oath.

(2) At the time of filing its annual statement, the health maintenance organization shall pay the commissioner the fee for filing its statement as prescribed in 33-31-212. The commissioner may refuse to accept the fee for continuance of the insurer's certificate of authority, as provided in 33-31-212, may impose a penalty of $100, or may ~~in his discretion~~ suspend or revoke the certificate of authority of a health maintenance organization that fails to file an annual statement when due. Each day that the insurer fails to file its annual statement constitutes a separate violation. The total penalty may not exceed $1,000.

(3) The commissioner may, after notice and hearing, impose a fine not to exceed $5,000 ~~per~~ for each violation upon a director, officer, partner, member, insurance producer, or employee of a health maintenance organization who knowingly subscribes to or concurs in making or publishing an annual statement required by law that contains a material statement ~~which~~ that is false.

(4) The commissioner may require ~~such~~ reports ~~as he~~ that the commissioner considers reasonably necessary and appropriate to enable ~~him~~ the commissioner to carry out ~~his~~ the commissioner's duties under this chapter, including but not limited to a statement of operations, transactions, and affairs of a health maintenance organization operated by an insurer or a health service corporation as a plan."

NEW SECTION. **Section 42. Uniform claim forms and procedures.** ~~(1)~~ The commissioner of insurance, after consultation with the health care advisory council, may adopt by rule uniform health insurance claim forms and uniform standards and procedures for the use of the forms and processing of claims, including the submission of claims by means of an electronic claims processing system.

~~(2) The commissioner may contract with a private or public entity to administer and operate an electronic claims processing system. If the commissioner elects to contract for administration and operation of the system, the commissioner shall award a contract according to Title 18, chapter 4.~~

~~NEW SECTION. **Section 42. Statute of limitations.** The period prescribed for the commencement of a civil or administrative action by the commissioner for alleged violation of Title 33 is within 2 years of the commissioner's discovery of the facts constituting the alleged violation.~~

~~NEW SECTION. **Section 43. Filing or making false statements.** (1) A person may not purposely or knowingly make or cause to be made, in any document filed with the commissioner or in any proceeding before the commissioner, any statement that is, at the time and in the light of the circumstances under which it is made, false or misleading in any material respect.~~

~~(2) A person found to have willfully violated subsection (1) is subject to a fine of up to $5,000 and, if applicable, may be subject to the criminal laws of this state.~~

~~NEW SECTION. **Section 44. Credit life and disability applications.** (1) The insurance producer who effects the sale of a policy or certificate of credit life and disability insurance shall sign the application.~~

~~(2) An insurance company may not accept an application for credit life and disability insurance unless the application is signed by the insurance producer who effected the sale.~~

~~(3) This section does not apply to policies or certificates subject to the provisions of 33-21-204.~~

~~NEW SECTION. **Section 44. Service contract insurance.** (1) Service contract insurance is a contract or agreement for a separately stated consideration or for a specific duration to:~~

~~(a) perform the repair, replacement, or maintenance of property; or~~

~~(b) indemnify for repair, replacement, or maintenance of property.~~

~~(2) Service contract insurance does not include contracts or agreements that:~~

~~(a) are indemnified only by the seller or manufacturer; and~~

~~(b) insure only the inherent quality of the product.~~

NEW SECTION. **Section 43. Loss and loss expense reserves for property and casualty insurance.** (1) (a) In determining the financial condition of a property and casualty insurer for the purpose of applying the provisions of this chapter and in any financial statement or report of an insurer, loss reserves and loss expense reserves at least equal to the amounts required under the provisions of this section must be included in the insurer's liabilities. The date from which the determination, statement, or report is made

is, for the purpose of this part, the date of determination.

(b) Accepted actuarial standards as adopted by the actuarial standards board must be taken into consideration for the purpose of determining the loss reserves and loss expense reserves.

(2) Except as provided in subsections (3) and (4), the reserves for all outstanding losses and loss expenses must include the following:

(a) the aggregate estimated amounts due or to become due on account of all known losses, claims, and loss expenses incurred but not paid, including the estimated liability on any notice received by the insurer of the occurrence of any event that may result in a loss; and

(b) the aggregate amounts of liability for all losses and loss expenses incurred for which notice has not been received, estimated in accordance with the insurer's prior experience, if any, or otherwise in accordance with Montana industry ~~data~~ EXPERIENCE, OR COUNTRYWIDE INDUSTRY EXPERIENCE IF THIS STATE'S EXPERIENCE IS NOT CREDIBLE, FOR SIMILAR CONTRACTS OF INSURANCE. The estimated liabilities for losses under all bonds, policies, or contracts of fidelity insurance may not be less than 10% of the net premiums in force, and the estimated liabilities for all of those losses under all the insurer's surety contracts may not be less than 5% of the net premiums in force.

(3) Except as provided in subsection (4), tabular reserves for outstanding losses under policies of workers' compensation insurance may be actuarially calculated for both indemnity and medical payments. The loss adjustment expenses are not eligible for discounting. Tabular reserves are those reserves that are:

(a) calculated using discounts determined with reference to actuarial tables, which incorporate mortality, interest, not to exceed 4%, remarriage, and other contingencies applied to a reasonably determinable payment stream associated with lifetime benefit cases; or

(b) annuities certain, such as those arising from structured settlements.

(4) Whenever, in the judgment of the commissioner, the loss and loss expense reserves of any property and casualty insurer doing business in this state, calculated in accordance with the provisions of this section, are inadequate or excessive, the commissioner may prescribe any other method that will produce adequate and reasonable reserves.

(5) The excess, if any, of statutory reserves over statement reserves must be calculated in accordance with the annual statement instructions adopted by the national association of insurance commissioners.

NEW SECTION. **Section 44. Repealer.** Sections 33-2-515, 33-2-536, 33-2-721, 33-2-722, 33-2-723, 33-4-404, 33-4-409, 33-22-1201, 33-22-1202, 33-22-1203, 33-22-1204, and 33-22-1205, MCA, are repealed.

NEW SECTION. **Section 45. Codification instruction.** (1) [Section ~~42~~ 41 43] is intended to be codified as an integral part of Title 50, chapter 4, part 5, and the provisions of Title 50, chapter 4, part 5, apply to [section ~~42~~ 41 43].

~~(2) [Sections 43 and 44 42 AND 43] are intended to be codified as an integral part of Title 33, chapter 1, part 3, and the provisions of Title 33, chapter 1, part 3, apply to [sections 43 and 44 42 AND 43].~~

~~(3) [Section 45 44] is intended to be codified as an integral part of Title 33, chapter 21, part 1, and the provisions of Title 33, chapter 21, part 1, apply to [section 45 44].~~

~~(4)~~(2) ~~[Section 46 45 44] is intended to be codified as an integral part of Title 33, chapter 1, part 2, and the provisions of Title 33, chapter 1, part 2, apply to [section 46 45 44].~~

~~(5)~~(3)(2) [Section ~~47~~ ~~46~~ ~~45~~ 44] 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 ~~47~~ ~~46~~ ~~45~~ 44].

NEW SECTION. **Section 46. 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 47. EFFECTIVE DATES.** (1) EXCEPT AS PROVIDED IN SUBSECTION (2), [THIS ACT] IS EFFECTIVE OCTOBER 1, 1997.

(2) [SECTION 9] AND THIS SECTION ARE EFFECTIVE ON PASSAGE AND APPROVAL.

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