HOUSE BILL NO. 125

INTRODUCED BY H. KLOCK

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING SECURITIES AND INSURANCE LAWS; PROVIDING CONSISTENCY WITH THE MONTANA ADMINISTRATIVE PROCEDURE ACT FOR JUDICIAL REVIEW OF A SECURITIES COMMISSIONER'S ORDER; INCLUDING CONFIDENTIAL DOCUMENTS RECEIVED FROM ANOTHER STATE AGENCY AS AMONG THOSE MAINTAINED AS CONFIDENTIAL BY THE INSURANCE COMMISSIONER; REMOVING REGULATION OF EXCESS DEPOSITS BY INSURERS; APPLYING RISK-BASED CAPITAL REPORTING REQUIREMENTS TO CAPTIVE RISK RETENTION GROUPS; INCLUDING A TREND TEST FOR RISK-BASED CAPITAL REPORTING FOR PROPERTY AND CASUALTY INSURERS; REVISING THE SMALL BUSINESS HEALTH INSURANCE PURCHASING POOL AND TAX CREDIT PROGRAM; REVISING LAWS RELATED TO CAPTIVE INSURANCE COMPANIES; ELIMINATING A PENALTY PROVISION; ELIMINATING CERTAIN REQUIREMENTS FOR BASIC AND STANDARD HEALTH BENEFIT PLANS; AMENDING SECTIONS 15-30-2368, 15-31-130, 30-10-115, 30-10-209, 30-10-308, 33-1-311, 33-2-601, 33-2-1903, 33-2-1904, 33-4-309, 33-18-605, 33-22-508, 33-22-1803, 33-22-1821, 33-22-2002, 33-22-2004, 33-22-2006, 33-22-2008, 33-28-102, 33-28-107, 33-28-108, AND 33-28-207, MCA; REPEALING SECTIONS 33-2-609 ~~AND~~, 33-22-103, 33-22-1827, AND 33-22-1828, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

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

Section 1. Section 15-30-2368, MCA, is amended to read:

"15-30-2368. Tax credit for health insurance premiums paid -- eligible small employers -- pass-through entities. (1) There is a tax credit, determined under Title 33, chapter 22, part 20, for eligible small employers who are individuals against the taxes imposed in 15-30-2103 for qualifying premiums paid by the eligible small employer for coverage of eligible employees and eligible employees' spouses and dependents under a group health plan ~~as defined in 33-22-2002~~ subject to Title 33, chapter 22, part 20.

(2) If the employer is an S. corporation, the shareholders may claim a pro rata share of the tax credit. If the employer is a partnership, the credit may be claimed by the partners in the same proportion used to report

the partnership's income or loss for Montana income tax purposes."

Section 2. Section 15-31-130, MCA, is amended to read:

"15-31-130. Tax credit for health insurance premiums paid -- eligible small employers -- corporations. There is a tax credit, as determined under Title 33, chapter 22, part 20, for eligible small employers against the taxes imposed in 15-31-101 and 15-31-502 for qualifying premiums paid by the eligible small employer for coverage of eligible employees and eligible employees' spouses and dependents under a group health plan ~~as defined in 33-22-2002~~ subject to Title 33, chapter 22, part 20."

SECTION 3. SECTION 30-10-115, MCA, IS AMENDED TO READ:

"30-10-115. Deposits to general fund -- exception. (1) All fees and miscellaneous charges received by the commissioner pursuant to parts 1 through 3 of this chapter, except for ~~portfolio~~ notice filing fees described in 30-10-209(1)(d) and examination costs collected under 30-10-210, must be deposited in the general fund.

(2) All ~~portfolio~~ notice filing fees collected under 30-10-209(1)(d) and examination costs collected under 30-10-210 must be deposited in the state special revenue fund in an account to the credit of the state auditor's office. The funds allocated by this section to the state special revenue account may ~~only~~ be used only to defray the expenses of the state auditor's office in discharging its administrative and regulatory powers and duties in relation to ~~portfolio~~ notice filing under 33-10-209(1)(d) and examinations. Any excess fees must be deposited in the general fund."

SECTION 4. SECTION 30-10-209, MCA, IS AMENDED TO READ:

"30-10-209. Fees. The following fees must be paid in advance under the provisions of parts 1 through 3 of this chapter:

(1) (a) For the registration of securities by notification, coordination, or qualification~~,~~ or for notice filing of a federal covered security, there must be paid to the commissioner for the initial year of registration or notice filing a fee of $200 for the first $100,000 of initial issue or portion of the first $100,000 in this state, based on offering price, plus 1/10 of 1% for any excess over $100,000, with a maximum fee of $1,000.

(b) Each succeeding year, a registration of securities or a notice filing of a federal covered security may be renewed, prior to its termination date, for an additional year upon consent of the commissioner and payment of a renewal fee to be computed at 1/10 of 1% of the aggregate offering price of the securities that are to be

offered in this state during that year. The renewal fee may not be less than $200 or more than $1,000. The registration or the notice filing may be amended to increase the amount of securities to be offered.

(c) If a registrant or issuer of federal covered securities sells securities in excess of the aggregate amount registered for sale in this state~~,~~ or for which a notice filing has been submitted, the registrant or issuer may file an amendment to the registration statement or notice filing to include the excess sales. If the registrant or issuer of a federal covered security fails to file an amendment before the expiration date of the registration order or notice, the registrant or issuer shall pay a filing fee for the excess sales of three times the amount calculated in the manner specified in subsection (1)(b). Registration or notice of the excess securities is effective retroactively to the date of the existing registration or notice.

(d) Each series, portfolio, or other subdivision of an investment company or similar issuer is treated as a separate issuer of securities. The issuer shall pay a ~~portfolio~~ notice filing fee to be calculated as provided in subsections (1)(a) through (1)(c). The ~~portfolio~~ notice filing fee collected by the commissioner must be deposited in the state special revenue account provided for in 30-10-115. The issuer shall pay a fee of $50 for each filing made for the purpose of changing the name of a series, portfolio, or other subdivision of an investment company or similar issuer.

(2) (a) For registration of a broker-dealer or investment adviser, the fee is $200 for original registration and $200 for each annual renewal.

(b) For registration of a salesperson or investment adviser representative, the fee is $50 for original registration with each employer, $50 for each annual renewal, and $50 for each transfer. A salesperson who is registered as an investment adviser representative with a broker-dealer registered as an investment adviser is not required to pay the $50 fee to register as an investment adviser representative.

(c) For a federal covered adviser, the fee is $200 for the initial notice filing and $200 for each annual renewal.

(3) For certified or uncertified copies of any documents filed with the commissioner, the fee is the cost to the department.

(4) For a request for an exemption under 30-10-105(15), the fee must be established by the commissioner by rule. For a request for any other exemption or an exception to the provisions of parts 1 through 3 of this chapter, the fee is $50.

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

(6) Except for ~~portfolio~~ notice filing fees established in ~~this section~~ subsection (1)(d) and examination costs collected under 30-10-210, all fees, miscellaneous charges, fines, and penalties collected by the commissioner pursuant to parts 1 through 3 of this chapter and the rules adopted under parts 1 through 3 of this chapter must be deposited in the general fund."

Section 5. Section 30-10-308, MCA, is amended to read:

"30-10-308. Judicial review of orders. Any person aggrieved by a final order of the commissioner ~~may obtain a~~ is entitled to judicial review ~~of the order in any court of competent jurisdiction by filing in court, within 60 days after the entry of the order, a written petition praying that the order be modified or set aside in whole or in part. A copy of the petition shall be forthwith served upon the commissioner, and thereupon the commissioner shall certify and file in court a copy of the filing, testimony, and other evidence upon which the order was entered. When these have been filed, the court has exclusive jurisdiction to affirm, modify, enforce, or set aside the order, in whole or in part. The findings of the commissioner as to the facts, if supported by creditable evidence, are conclusive, unless appealed from. If either party applies to the court for leave to adduce additional evidence and shows to the satisfaction of the court that the additional evidence is material and that there were reasonable grounds for failure to adduce the evidence in the hearing before the commissioner, the court may order the taking of additional evidence in such manner and upon such conditions as the court may consider proper. The commencement of proceedings under this section does not, unless specifically ordered by the court, operate as a stay of the commissioner's order~~ as provided in Title 2, chapter 4, part 7."

Section 6. Section 33-1-311, MCA, is amended to read:

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

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

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

(4) The commissioner may conduct examinations and investigations of insurance matters, in addition to examinations and investigations expressly authorized, as the commissioner considers proper, to determine whether any person has violated any provision of the laws of this state or to secure information useful in the lawful

administration of any provision. The cost of additional examinations and investigations must be borne by the state.

(5) The commissioner shall maintain as confidential any information or document received from:

(a) the national association of insurance commissioners; or

(b) another state agency, an insurance department from another state, a federal agency, or a foreign government that treats the same information or document as confidential. The commissioner may provide information or documents, including information or documents that are confidential, to another state agency, the national association of insurance commissioners, a state or federal law enforcement agency, a federal agency, a foreign government, or an insurance department in another state, if the recipient agrees to maintain the confidentiality of the information or documents.

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

Section 7. Section 33-2-601, MCA, is amended to read:

"33-2-601. Authorized deposits of insurers. The following deposits of insurers when made through the commissioner ~~shall~~ must be accepted and held and ~~shall be~~ are subject to the provisions of this part:

(1) deposits required under this code for authority to transact insurance in this state;

(2) deposits of domestic insurers when ~~made pursuant to~~ required by the laws of other states, provinces, and countries as ~~requirement~~ a condition for the authority to transact insurance ~~in such state, province, or country~~; or

(3) deposits of reserves made by domestic life insurers under 33-2-531~~;~~

~~(4) deposits in such additional amounts as are permitted to be made under 33-2-609~~."

Section 8. Section 33-2-1903, MCA, is amended to read:

"33-2-1903. RBC reports. (1) ~~Except as provided in 33-28-107(4)(b), each~~ Each domestic insurer shall, on or before each March 1 filing date, prepare and submit to the commissioner a report of its RBC levels as of the end of the previous calendar year in a form and containing information as required by the RBC instructions. In addition, each domestic insurer shall file its RBC report:

(a) with the NAIC in accordance with the RBC instructions; and

(b) with the insurance commissioner in any state in which the insurer is authorized to do business if that insurance commissioner has notified the insurer of the request in writing, in which case the insurer shall file its RBC report not later than the later of:

(i) 15 days from the receipt of notice to file its RBC report with that state; or

(ii) the March 1 filing date.

(2) A life and disability insurer's RBC must be determined in accordance with the formula set forth in the RBC instructions. The formula must take into account and may adjust for the covariance between:

(a) the risk with respect to the insurer's assets;

(b) the risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

(c) the interest rate risk with respect to the insurer's business; and

(d) all other business risks and other relevant risks as are set forth in the RBC instructions and determined in each case by applying the factors in the manner set forth in the RBC instructions.

(3) A property and casualty insurer's RBC must be determined in accordance with the formula set forth in the RBC instructions. The formula ~~shall~~ must take into account and may ~~adjust~~ be adjusted for the covariance between:

(a) asset risk;

(b) credit risk;

(c) underwriting risk; and

(d) all other business risks and other relevant risks ~~that are~~ set forth in the RBC instructions and determined in each case by applying the factors in the manner set forth in the RBC instructions.

(4) An excess of capital over the amount produced by the risk-based capital requirements contained in this part and the formulas, schedules, and instructions referenced in 33-2-1906 through 33-2-1913 is desirable in the business of insurance. Accordingly, insurers should seek to maintain capital above the RBC levels required by this part. Additional capital is used and useful in the insurance business and helps to secure an insurer against various risks inherent in or affecting the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in this part.

(5) If a domestic insurer files an RBC report that in the judgment of the commissioner is inaccurate, the commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice must contain a statement of the reason for the adjustment. An RBC report ~~so~~ adjusted as provided in this subsection is referred to as an adjusted RBC report."

Section 9. Section 33-2-1904, MCA, is amended to read:

"33-2-1904. Company action level event. (1) "Company action level event" means any of the following

events:

(a) the filing of an RBC report by an insurer ~~which indicates~~ indicating that:

(i) the insurer's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC; ~~or~~

(ii) for a life or disability insurer, the insurer has total adjusted capital that:

(A) is greater than or equal to its company action level RBC but less than ~~the product of~~ its authorized control level RBC ~~and~~ multiplied by 2.5; and ~~that~~

(B) has a negative trend; or

(iii) for a property and casualty insurer, the insurer has total adjusted capital that:

(A) is greater than or equal to its company action level RBC but less than its authorized control level RBC multiplied by 3; and

(B) triggers the trend test determined in accordance with the trend test calculation included in the RBC instructions;

(b) the notification by the commissioner to the insurer of an adjusted RBC report that indicates an event in subsection (1)(a) if the insurer does not challenge the adjusted RBC report under 33-2-1908 or if the commissioner has rejected the insurer's challenge.

(2) In the event of a company action level event, the insurer shall prepare and submit to the commissioner an RBC plan that must:

(a) identify the conditions that contribute to the company action level event;

(b) contain proposals of corrective actions that the insurer intends to take and that would be expected to result in the elimination of the company action level event;

(c) provide projections of the insurer's financial results in the current year and at least the next 4 years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital, and surplus. The projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense, and benefit component.

(d) identify the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and

(e) identify the quality of and problems associated with the insurer's business, including but not limited to its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of

business, and use of reinsurance, if any, in each case.

(3) The RBC plan must be submitted:

(a) within 45 days of the company action level event; or

(b) if the insurer challenges an adjusted RBC report pursuant to 33-2-1908, within 45 days after notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(4) Within 60 days after ~~the submission by~~ an insurer ~~of~~ submits an RBC plan to the commissioner, the commissioner shall notify the insurer as to whether the RBC plan may be implemented or is unsatisfactory in the judgment of the commissioner. If the commissioner determines that the RBC plan is unsatisfactory, the notification to the insurer must set forth the reasons for the determination and may ~~set forth proposed~~ propose revisions ~~that will~~ intended to render the RBC plan satisfactory in the judgment of the commissioner. Upon notification from the commissioner, the insurer shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by the commissioner, and shall submit the revised RBC plan to the commissioner:

(a) within 45 days after the notification from the commissioner; or

(b) if the insurer challenges the notification from the commissioner under 33-2-1908, within 45 days after a notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(5) ~~In the event of a notification by~~ If the commissioner ~~to~~ notifies an insurer that the insurer's RBC plan or revised RBC plan is unsatisfactory, the commissioner may, at the commissioner's discretion, subject to the insurer's right to a hearing under 33-2-1908, specify in the notification that the notification constitutes a regulatory action level event.

(6) Each domestic insurer that files an RBC plan or revised RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in any state in which the insurer is authorized to do business if:

(a) the state has an RBC provision substantially similar to 33-2-1909(1); and

(b) the insurance commissioner of that state has notified the insurer in writing of its request for the filing, in which case the insurer shall file a copy of the RBC plan or revised RBC plan in that state by the later of:

(i) 15 days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with that state; or

(ii) the date on which the RBC plan or revised RBC plan is filed under subsections (3) and (4)."

SECTION 10. SECTION 33-4-309, MCA, IS AMENDED TO READ:

"33-4-309. Directors -- election and term. (1) Directors of a farm mutual insurer ~~shall~~ must be elected by its members by ballot or acclamation for terms not to exceed 3 years and ~~shall~~ hold office until their respective successors are elected and have qualified.

(2) ~~No~~ An individual ~~shall~~ may not serve as a director unless the individual is a member of the insurer."

Section 11. Section 33-18-605, MCA, is amended to read:

"33-18-605. Use of credit information. (1) An insurer authorized to do business in this state that uses credit information to underwrite or rate risks may not:

(a) use an insurance score that is calculated using income, gender, address, zip code, ethnic group, religion, marital status, or nationality of the consumer as a factor;

(b) deny, cancel, or not renew a policy of personal insurance on the basis of credit information without consideration of any other applicable underwriting factor independent of credit information and not expressly prohibited by subsection (1)(a);

(c) base an insured's renewal rates for personal insurance upon credit information without consideration of any other applicable factor independent of credit information;

(d) take an adverse action against a consumer because the consumer does not have a credit card account without consideration of any other applicable factor independent of credit information;

(e) consider an absence of credit information or an inability to calculate an insurance score in underwriting or rating personal insurance unless the insurer does one of the following:

(i) treats the consumer as otherwise approved by the commissioner if the insurer presents information that the absence or inability relates to the risk for the insurer;

(ii) treats the consumer as if the consumer had neutral credit information, as defined by the insurer; or

(iii) excludes the use of credit information as a factor and uses only other underwriting criteria;

(f) take an adverse action against a consumer based on credit information unless an insurer obtains and uses a credit report issued or an insurance score calculated within 90 days from the date that the policy is first written or renewal is issued;

(g) use credit information unless not later than every 36 months following the last time that the insurer obtained current credit information for the insured, the insurer recalculates the insurance score or obtains an updated credit report. Regardless of the requirements of this subsection (1)(g):

(i) at annual renewal, upon the request of a consumer or the consumer's agent, the insurer shall

reunderwrite and rerate the policy based upon a current credit report or insurance score. An insurer need not recalculate the insurance score or obtain the updated credit report of a consumer more frequently than once in a 12-month period.

(ii) the insurer has the discretion to obtain current credit information upon any renewal before the 36 months provided for in this subsection (1)(g), if consistent with its underwriting guidelines;

(iii) an insurer may but does not have to obtain current credit information for an insured, despite the requirements of subsection (1)(g)(i), if one of the following applies:

(A) the insurer is treating the consumer as otherwise approved by the commissioner;

(B) the insured is in the most favorably priced tier of the insurer within a group of affiliated insurers;

(C) credit was not used for underwriting or rating the insured when the policy was initially written;

(D) the insurer reevaluates the insured beginning not later than 36 months after inception and at similar succeeding times based upon other underwriting or rating factors, excluding credit information.

(h) use a credit report or an insurance score that treats any of the following as a negative factor for the purpose of underwriting or rating a policy of personal insurance:

(i) credit inquiries not initiated by the consumer or inquiries requested by the consumer for the consumer's own credit information;

(ii) inquiries relating to insurance coverage, if so identified on a consumer's credit report;

(iii) collection accounts with a medical industry code, if so identified on the consumer's credit report;

(iv) multiple-lender inquiries, if coded by the consumer reporting agency on the consumer's credit report as being from the home mortgage industry and made within 30 days of one another, unless only one inquiry is considered;

(v) multiple-lender inquiries, if coded by the consumer reporting agency on the consumer's credit report as being from the automobile lending industry and made within 30 days of one another, unless only one inquiry is considered;

(vi) the number of credit inquiries;

(vii) the consumer's use of a particular type of credit card, charge card, or debit card or the number of credit cards obtained by a consumer;

(viii) a loan if information from the credit report makes it evident that the loan is for the purchase of an automobile or a personal residence. However, an insurer may consider the bill payment history of any loan, the total number of loans, or both.

(ix) the consumer's total available line of credit or total debt. However, an insurer may consider:

(A) the consumer's bill payment history on the debt; or

(B) the total amount of outstanding debt if the outstanding debt exceeds the total line of credit.

(2) (a) An insurer shall, on written request from an applicant or an insured, provide reasonable underwriting or rating exceptions for a consumer whose credit report has been directly affected by an extraordinary event.

(b) An insurer may require reasonable written and independently verifiable documentation of the event and the effect of the event on the consumer's credit before granting an exception. An insurer is not required to consider repeated extraordinary events or extraordinary events the insurer reconsidered previously.

(c) An insurer may also consider granting an exception to a consumer for an extraordinary event not listed in this section.

(d) An insurer may not be considered to be out of compliance with its filed rules and rates as a result of granting an exception pursuant to this subsection (2).

(e) As used in this subsection (2), "extraordinary event" means:

(i) expenses related to a catastrophic injury or illness;

(ii) temporary loss of employment;

(iii) death of an immediate family member; or

(iv) theft of identity pursuant to 45-6-332."

SECTION 12. 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 the insurance on a person or the person's dependents or family members covered under the policy ceases because of termination of the person's membership in a group eligible for coverage under the policy, because of termination of the person's employment, 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 disability coverage or an individual disability policy or, in the absence of an individual disability policy issued

by the insurer, a group disability policy issued by the insurer on the person or on 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 the group coverage.

(2) A group insurer may meet the requirements of this section by contracting with another insurer to issue conversion policies as described in subsections (5) and (6). The conversion carrier must be authorized to act as an insurer in this state, and the commissioner shall approve the conversion policies pursuant to 33-1-501.

(3) 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 or conversion carrier shall make available a conversion policy as required by subsection (6).

(4) The premium for the individual policy or group policy must be at no more than 200% of the insurer's customary rate applicable to the group policy being terminated at the time of the conversion. If the person entitled to conversion under this section has been insured for more than 3 years, the premium may not be more than 150% of the customary rate of the policy being terminated at the time of the conversion. The customary rate is that rate that is normally issued for medically underwritten policies without discount for healthy lifestyles.

(5) A conversion carrier shall offer an individual or group conversion policy that provides the same schedule of benefits and covers the same eligible expenses as those being terminated. The premium for the policy must be calculated as described in subsection (4).

(6) The insurer or conversion carrier shall also make available 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 or conversion carrier is not a small employer carrier under part 18, the insurer shall make available a conversion policy, certificate, or membership contract that provides equivalent benefits to a basic health benefit plan as provided in 33-22-1827.~~ The conversion rate may not exceed 150% of the highest rate charged for that plan. This subsection does not apply to disability plans that provide only excepted benefits as defined in 33-22-140.

(7) The effective date and time of the conversion policy must be established to ensure that there is no break in coverage between the termination of the group policy coverage and the inception of the conversion policy."

SECTION 13. 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 value" means a numerical value based on the expected dollar value of benefits payable to an insured under a health benefit plan. The benefit value must be calculated by the small employer carrier using an actuarially based method and must take into account all health care expenses covered by the health benefit plan and all cost-sharing features of the health benefit plan, including deductibles, coinsurance, copayments, and the insured individual's maximum out-of-pocket expenses. The benefit value must apply equally to indemnity-type health benefit plans and to managed care health benefit plans, including health maintenance organization-type plans.

(7) "Bona fide association" means an association that:

(a) has been actively in existence for at least 5 years;

(b) was formed and has been maintained in good faith for purposes other than obtaining insurance;

(c) does not condition membership in the association on a health status-related factor relating to an individual, including an employee of an employer or a dependent of an employee;

(d) makes health insurance coverage offered through the association available to a member regardless

of a health status-related factor relating to the member or an individual eligible for coverage through a member; and

(e) does not make health insurance coverage offered through the association available other than in connection with a member of the association.

(8) "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.

(9) "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.

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

(11) "Dependent" means:

(a) a spouse;

(b) an unmarried child under 25 years of age:

(i) who is not an employee eligible for coverage under a group health plan offered by the child's employer for which the child's premium contribution amount is no greater than the premium amount for coverage as a dependent under a parent's individual or group health plan;

(ii) who is not a named subscriber, insured, enrollee, or covered individual under any other individual health insurance coverage, group health plan, government plan, church plan, or group health insurance;

(iii) who is not entitled to benefits under 42 U.S.C. 1395, et seq.; and

(iv) for whom the parent has requested coverage;

(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.

(12) (a) "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 also includes those persons eligible for coverage under 2-18-704.

(b) The term does not include an employee who works on a part-time, temporary, or substitute basis.

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

(14) (a) "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.

(b) The term does not include coverage of excepted benefits, as defined in 33-22-140, if coverage is provided under a separate policy, certificate, or contract of insurance.

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

(16) "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.

(17) "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.

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

(19) "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.

(20) "Small employer" means a person, firm, corporation, partnership, or bona fide association that is actively engaged in business and that, with respect to a calendar year and a plan year, employed at least two but not more than 50 eligible employees during the preceding calendar year and employed at least two employees on the first day of the plan year. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer must be based on the average number of employees reasonably expected to be employed by the employer in the current calendar year. 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 a bona fide association.

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

(22) "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 14. SECTION 33-22-1821, MCA, IS AMENDED TO READ:

"33-22-1821. Waiver of certain laws. ~~Except as provided in 33-22-1827, a~~ A small employer carrier may exclude any category of licensed health care practitioner and any benefit or coverage for health care services otherwise required by law or rule from a basic health benefit plan delivered or issued for delivery in this state."

Section 15. Section 33-22-2002, MCA, is amended to read:

"33-22-2002. Small business health insurance pool -- definitions. As used in this part, the following definitions apply:

(1) "Board" means the board of directors of the small business health insurance pool as provided for in

33-22-2003.

(2) "Dependent" has the meaning provided in 33-22-1803.

(3) (a) "Eligible small employer" means an employer who is sponsoring or will sponsor a group health plan and who employed at least two but not more than nine employees during the preceding calendar year and who employs at least two but not more than nine employees on the first day of the plan year.

(b) The term includes small employers who obtain group health plan coverage through a qualified association health plan.

(4) "Employee" means an eligible employee as defined in 33-22-1803.

(5) "Group health plan" ~~has the meaning provided in 33-22-140.~~ MEANS HEALTH INSURANCE COVERAGE OFFERED IN CONNECTION WITH A GROUP HEALTH PLAN OR HEALTH INSURANCE COVERAGE OFFERED TO AN ELIGIBLE GROUP AS DESCRIBED IN 33-22-501.

(6) "Premium" means the amount of money that a health insurance issuer charges to provide coverage under a group health plan.

(7) "Premium assistance payment" means a payment provided for in 33-22-2006 on behalf of employees who qualify to be applied on a monthly basis to premiums paid for group health plan coverage through the purchasing pool or through qualified association health plans.

(8) "Premium incentive payment" means a payment provided for in 33-22-2007(1)(b) to eligible small employers who qualify under 33-22-2007 to be applied to premiums paid on a monthly basis for group health plan coverage obtained through the purchasing pool or through qualified association health plans.

(9) "Purchasing pool" means the small business health insurance pool.

(10) "Qualified association health plan" means a plan established by an association whose members consist of employers who sponsor group health plans for their employees and purchase that coverage through an association that qualifies as a bona fide association, as defined in 33-22-1803, or nonbona fide, as provided for in administrative rule. A qualified association health plan is subject to applicable employer group health insurance law and must receive approval from the commissioner to operate as a qualified association health plan for the purposes of this part.

(11) "Related employers" means ~~persons having a relationship as described in section 267 of the Internal Revenue Code, 26 U.S.C. 267~~:

(a) affiliates or affiliated entities or persons who directly or indirectly, through one or more intermediaries, control, are controlled by, or are under common control with a specified entity or person; and

(b) entities or persons that are eligible to file a combined or joint tax return for purposes of state taxation.

(12) "Tax credit" means a refundable tax credit as provided for in 33-22-2008.

(13) "Tax year" means the taxpayer's tax year for federal income tax purposes."

Section 16. Section 33-22-2004, MCA, is amended to read:

"33-22-2004. Powers and duties of board. (1) The board shall:

(a) establish an operating plan that includes but is not limited to administrative and accounting procedures for the operation of the purchasing pool and a schedule for premium incentive and premium assistance payments and that complies with the powers and duties provided for in this section;

(b) require employers and employees to reapply for premium incentive payments or premium assistance payments on an annual basis;

(c) upon timely reapplication, give priority to employers and their employees who are already receiving the premium incentive payments and premium assistance payments~~;~~. If the reapplication is more than 30 days late, the priority will not be given and the employer will be added to the waiting list provided for in 33-22-2008.

(d) upon timely reapplication as provided in subsection (1)(c), allow employers to retain eligibility to receive premium incentive payments and premium assistance payments on behalf of their employees if the number of their employees goes over the maximum number, not to exceed nine employees, established by the commissioner in administrative rule;

(e) renew purchasing pool group health plan coverage for all employer groups, even if the employer group no longer receives or is eligible for a premium incentive or premium assistance payment;

(f) adopt a premium incentive payment schedule that is based on a percentage of the employer's share of the premium and apply the schedule uniformly to all registered eligible small employers who join the purchasing pool or obtain qualified association health plan coverage;

(g) adopt premium assistance payment amounts that, in combination with the premium incentive payments, are consistent with the amounts provided for in 33-22-2006 and 33-22-2008 or, with the assistance of the department of public health and human services, adopt a premium assistance payment schedule that is equitably proportional to the income or wage level for employees;

(h) establish criteria for determining which employees will be eligible for a premium assistance payment and the amount that the employees will receive from among those eligible small employer groups that have registered with the commissioner pursuant to 33-22-2008 and applied for coverage under the purchasing pool

group health plan or qualified association health plan. However, to the extent that federal funds are used to make some premium assistance payments, criteria for those payments must be consistent with any waiver requirements determined by the department of public health and human services pursuant to 53-2-216. Eligibility for employees is not limited to the waiver eligibility groups.

(i) make appropriate changes to eligibility or other elements in the operating plan as needed to reach the goal of expending 90% of the funding dedicated to premium incentive payments and premium assistance payments during the current biennium;

(j) limit the total amount of premium incentive payments and premium assistance payments paid to the amount of available state, federal, and private funding;

(k) approve no more than six fully insured group health plans with different benefit levels that will be offered to employers participating in the purchasing pool;

(l) prepare appropriate specifications and bid forms and solicit bids from health insurance issuers authorized to do business in this state;

(m) contract with no more than three health insurance issuers to underwrite the group health plans that will be offered through the purchasing pool;

(n) request that the department of public health and human services seek a federal waiver for medicaid matching funds for premium assistance payments based on the department's analysis, as provided in 53-2-216, if it is in the best interests of the purchasing pool;

(o) comply with the participation requirements provided for in 33-22-1811;

(p) meet at least four times annually; and

(q) within 2 years after the purchasing pool is established and considered stable by the board, examine the possibility of offering an opportunity for individual sole proprietors without employees to purchase insurance from the purchasing pool without premium incentive payments, premium assistance payments, or tax credits.

(2) The board may:

(a) borrow money;

(b) enter into contracts with insurers, administrators, or other persons;

(c) hire employees to perform the administrative tasks of the purchasing pool;

(d) assess its members for costs associated with administration of the purchasing pool and request that the commissioner transfer funds or request that the department of public health and human services transfer funds from the special revenue account, as provided in 53-6-1201, for that purpose;

(e) set contribution levels for employers;

(f) at least 30 days before the end of the current fiscal year, request that funds be transferred from the funds appropriated for premium incentive payments and premium assistance payments to the department of revenue for reimbursement of the general fund to offset tax credits if the number of eligible small employers seeking premium incentive payments and employees receiving premium assistance payments is insufficient to exhaust at least 90% of the appropriated funds for the premium incentive and assistance payments during a fiscal year;

(g) at least 90 days before the end of the current fiscal year, request that funds be transferred from the funds allocated for tax credits to the funds appropriated for premium incentive payments and premium assistance payments if the number of eligible small employers seeking tax credits is insufficient to exhaust at least 90% of the funds allocated for tax credits during a fiscal year;

(h) seek other federal, state, and private funding sources;

(i) accept all small employer groups who apply for coverage under the small business health insurance pool group health plan even if they are not eligible for any tax credit or premium incentive payment and have not been registered by the commissioner pursuant to 33-22-2008;

(j) receive from the commissioner's office or the department of public health and human services premium incentive payments on behalf of eligible small employers and premium assistance payments on behalf of employees, collect the employer or employee premiums from the employer or employees, and make premium payments to insurers on behalf of the eligible small employers and employees;

(k) request the commissioner to direct more than 30% of the available funding for premium incentives and premium assistance payments to qualified association health plan coverage instead of purchasing pool coverage; and

(l) pay appropriate commissions to licensed insurance producers who market purchasing pool coverage."

Section 17. Section 33-22-2006, MCA, is amended to read:

"33-22-2006. Premium incentive payments, premium assistance payments, and tax credits for small employer health insurance premiums paid -- eligibility for small group coverage -- amounts. (1) An employer is eligible to apply for premium incentive payments and premium assistance payments or a tax credit under this part if the employer and any related employers:

(a) did not have more than the number of employees established for eligibility by the commissioner at

the time of registering for premium incentive payments or premium assistance payments or a tax credit under 33-22-2008;

(b) provide or will provide a group health plan that meets the requirements of creditable coverage for the employer's and any related employer's employees;

(c) do not have delinquent state ~~income~~ tax liability owing to the department of revenue from previous years;

(d) have been registered as eligible small employer participants by the commissioner as provided in 33-22-2008; and

(e) do not have any employees, not including an owner, partner, or shareholder of the business, who received more than $75,000 in wages, as defined in 39-71-123, from the small employer or related employer in the prior tax year.

(2) An owner, partner, or shareholder of a business who received more than $75,000 in wages, as defined in 39-71-123, and those individuals' spouses who are employees are not eligible under this chapter for:

(a) any premium assistance payment. However, a premium incentive payment may be made for the premium share paid by the business for group health insurance coverage for:

(i) the owner, partner, or shareholder;

(ii) a spouse of those listed in subsection (2)(a)(i) who is also an employee of the business; or

(iii) dependents of those listed in subsection (2)(a)(i).

(b) a tax credit for group health insurance premiums paid by the business or the owner, partner, or shareholder for group health insurance coverage for the individual or the individual's dependents.

(3) An employee, including an owner, partner, or shareholder or any dependent of an employee, who is also eligible for the children's health insurance program provided for under Title 53, chapter 4, part 10, or medicaid under Title XIX of the Social Security Act may become ineligible to receive a premium assistance payment.

(4) The commissioner shall establish, by rule, the maximum number of employees that may be employed to qualify as a small employer under subsection (1). However, the number may not be less than two employees or more than nine employees. The maximum number may be different for employers seeking premium incentive payments and premium assistance payments than for employers seeking a tax credit. The number must be set to maximize the number of employees receiving coverage under this part. The commissioner may not change the maximum employee number more often than every 6 months. If the maximum number of allowable employees

is changed, the change does not disqualify registered employers with respect to the tax year for which the employer has registered.

(5) Except as provided in subsection (6), an eligible small employer may claim a tax credit in the following amounts:

(a) (i) not more than $100 each month for each employee and $100 each month for each employee's spouse, if the employer covers the employee's spouse, if the average age of the group is under 45 years of age; or

(ii) not more than $125 each month for each employee and $100 each month for each employee's spouse, if the employer covers the employee's spouse, if the average age of the group is 45 years of age or older; and

(b) not more than $40 each month for each dependent, other than the employee's spouse, if the employer is paying for coverage for the dependents, not to exceed two dependents of an employee in addition to the employee's spouse.

(6) An employer may not claim a tax credit:

(a) in excess of 50% of the total premiums paid by the employer for the qualifying small group;

(b) for premiums paid from a medical care savings account provided for in Title 15, chapter 61; or

(c) for premiums for which a deduction is claimed under 15-30-2131 or 15-31-114.

(7) An employer may not claim a premium incentive payment in excess of 50% of the total premiums paid by the employer for the qualifying small group."

Section 18. Section 33-22-2008, MCA, is amended to read:

"33-22-2008. Registration -- funding limitations -- transfers -- maximum number -- waiting list -- information transfer for tax credits. (1) (a) Each eligible small employer that proposes to apply for premium incentive payments and premium assistance payments or a tax credit under this part must be registered each year with the commissioner.

(b) An eligible small employer may submit a new application for the premium incentive payments and premium assistance payments or the tax credit anytime during the year, but in order to maintain the employer's registration for the next year, the registration application must be renewed each year.

~~(c) The commissioner shall begin accepting renewal applications on October 1 of each year and stop accepting renewal applications on October 31 of each year.~~

~~(d)~~(c) The registration application must include the number of individuals covered, as of the date of the registration application, under the small group health plan for which the employer is seeking premium incentive payments and premium assistance payments or a tax credit. If, after the initial registration, the number of individuals increases, the employer may apply to register the additional individuals, but those additional individuals may be added only at the discretion of the commissioner, who shall limit enrollment based on available funds.

~~(e)~~(d) A small employer is not eligible to apply for premium incentive payments and premium assistance payments or a tax credit for a number of employees, or the employees' spouses or dependents, over the number that has been established in 33-22-2006 as the maximum number of employees an employer may have in order to qualify for registration for the time period in question.

~~(f)~~(e) An employer's decision to apply for premium incentive payments and premium assistance payments or a tax credit is irrevocable for 12 months or until the purchasing pool group health plan or qualified association health plan renews its registration, whichever time period is less. An employer may choose to discontinue receiving any premium incentive payments and premium assistance payments or tax credits at any time.

(2) The commissioner shall register qualifying eligible small employers in the order in which applications are received and according to whether or not the application is for premium incentive payments and premium assistance payments or a tax credit. Initially, 60% of the available funding must be dedicated to provide and maintain premium incentive payments and premium assistance payments for eligible small employers who have not sponsored group health plans that provide creditable coverage in the previous 2 years and who chose to join the purchasing pool or a qualified association health plan and 40% of the available funding must be dedicated to tax credits for eligible small employers who currently sponsor a small group health plan that provides creditable coverage. Funding may be transferred from the allocated fund for premium incentive payments and premium assistance payments to the general fund for tax credits or from the funds allocated for tax credits to the allocated fund for premium incentive payments and premium assistance payments if the board requests the transfer as provided in 33-22-2004 and the commissioner approves the request.

(3) (a) The maximum number of eligible small employers is reached when the anticipated amount of claims for premium incentive payments and premium assistance payments and tax credits has reached 95% of the amount of money allocated for premium incentive payments and premium assistance payments and tax credits.

(b) The commissioner may establish a waiting list for applicants that are otherwise qualified for registration but cannot be registered because of a lack of money or because the maximum number of eligible small employers has been reached.

(c) The commissioner shall mail to each employer registered under this section a notice of registration containing a unique registration number and indicating eligibility for either premium incentive payments and premium assistance payments or a tax credit. The commissioner shall also issue to each employer that is eligible for premium incentive payments and premium assistance payments or the tax credit a certificate, placard, sticker, or other evidence of participation that may be publicly posted.

(d) The commissioner shall notify all persons who applied for registration and who were not accepted that they were not registered and the reason that they were not registered.

(4) A prospective participant shall apply for registration on a form provided by the commissioner. The prospective participant shall:

(a) provide the number of employees and whether the employer qualifies under 33-22-2006;

(b) provide information that is necessary to estimate the amount of the premium incentive payments and premium assistance payments payable to the applicant or the amount of the tax credit available to the applicant, such as the ages of employees or dependents, relationships of employees' dependents, and information required by the department of public health and human services for determination of eligibility for premium assistance payments matched by federal funds;

(c) indicate whether the prospective employer intends to pursue the claim as a tax credit through the income tax process or through premium incentive payments and premium assistance payments to be applied toward purchasing pool or eligible qualified association health plan coverage;

(d) indicate whether or not the employer previously sponsored a group health plan that provided creditable coverage and, if so, when and for how long; and

(e) provide any additional information determined by the commissioner to be necessary to support an application.

(5) Each year, small employer participants shall <u>timely</u> reregister with the commissioner in order to determine the participant's continued eligibility. <u>The commissioner shall accept applications for continued registration:</u>

<u>(a) for purchasing pool participants at any time within 12 months of the initial registration approval or within the time period for renewal of the coverage under this part, whichever is longer;</u>

(b) for tax credit participants on December 1 of each year. The commissioner shall stop accepting renewal applications for tax credit participants 60 calendar days later.

(6) The commissioner shall transmit to the department of revenue, at least annually, a list of eligible small employers that are taxpayers entitled to the tax credit and shall specify the taxpayer's name and tax identification number, the tax year to which the credit applies, the amount of the credit, and whether the credit is to be applied against taxes due on the taxpayer's return or paid as premium incentive payments or premium assistance payments. Unless there has been a finding of fraud or misrepresentation on the part of the taxpayer regarding issues relating to eligibility for the tax credit, the department of revenue may not redetermine or change the commissioner's determination regarding the taxpayer's entitlement to and amount of the tax credit.

(7) If the department of public health and human services receives approval for a section 1115 waiver as provided in 53-2-216, the commissioner shall work with the department of public health and human services with regard to eligibility determinations as required by federal law or waiver conditions.

(8) The commissioner may disclose the personal information of any individual applying for or receiving premium assistance, including that of an employee or a dependent of an employee, to the department of public health and human services for use in determining the individual's eligibility for the children's health insurance program provided for under Title 53, chapter 4, part 10, or medicaid under Title XIX of the Social Security Act. The department of public health and human services shall maintain the confidentiality of the personal information."

Section 19. Section 33-28-102, MCA, is amended to read:

"33-28-102. Licensing -- authority. (1) A captive insurance company, when permitted by its organizational document, may apply to the commissioner for a license to provide property insurance, casualty insurance, life insurance, disability income insurance, surety insurance, marine insurance, and health insurance coverage or a group health plan as defined in 33-22-140, except that:

(a) a pure captive insurance company may not insure any risks other than those of its parent and affiliated companies and controlled unaffiliated business entities;

(b) an industrial insured captive insurance company may not insure any risks other than those of the industrial insureds that comprise the industrial insured group and their affiliated companies;

(c) an association captive insurance company may not insure any risks other than those of the members or affiliated companies of members;

(d) a captive insurance company or a branch captive insurance company may not:

(i) provide personal lines of insurance, including but not limited to motor vehicle or homeowner's insurance coverage or any component of those coverages;

(ii) accept or cede reinsurance except as provided in 33-28-203;

(iii) provide health insurance coverage or a group health plan unless the captive insurance company or branch captive insurance company is only providing health insurance coverage or a group health plan for the parent company and its affiliated companies; or

(iv) write workers' compensation insurance on a direct basis; and

(e) a protected cell captive insurance company may not insure any risks other than those of its ~~participant affiliated companies and controlled unaffiliated business entities~~ participants.

(2) A captive insurance company may not write any insurance business unless:

(a) it first obtains from the commissioner a license authorizing it to do insurance business in this state;

(b) its board of directors, board of managing members, or a reciprocal insurer's subscribers' advisory committee holds at least one meeting each year in this state;

(c) it maintains its principal place of business in this state; and

(d) ~~(i)~~ it appoints a registered agent to accept service of process~~;~~,

~~(ii)~~ files the name and contact information and any subsequent changes regarding the registered agent ~~are filed~~ with the commissioner~~;~~, and

~~(iii) it~~ agrees that whenever the registered agent cannot be found with reasonable diligence, the commissioner's office may act as an agent of the captive insurance company with respect to any action or proceeding and may be served in accordance with 33-1-603.

(3) (a) Before receiving a license, a captive insurance company shall:

(i) with respect to a captive insurance company formed as a business entity:

(A) file with the commissioner a certified copy of its organizational documents, a statement under oath of an officer of the business entity showing its financial condition, and any other statements or documents required by the commissioner; and

(B) submit to the commissioner for approval a description of the coverages, deductibles, coverage limits, and rates, together with any additional information that the commissioner may reasonably require;

(ii) with respect to a captive insurance company formed as a reciprocal insurer:

(A) file with the commissioner a certified copy of the power of attorney of its attorney-in-fact, a certified

copy of its subscribers' agreement, a statement under oath of its attorney-in-fact showing its financial condition, and any other statements or documents required by the commissioner; and

(B) submit to the commissioner for approval a description of the coverages, deductibles, coverage limits, and rates, together with any additional information that the commissioner may reasonably require.

(b) ~~In the event of any~~ If there is a subsequent material change in any of the items in the description provided for in subsection (3)(a), the captive insurance company shall submit to the commissioner for approval an appropriate revision and may not offer any additional kinds of insurance until the commissioner approves a revision of the description ~~is approved by the commissioner~~. The captive insurance company shall inform the commissioner of any change in rates within 30 days of the adoption of the change.

(c) In addition to the information required by subsections (3)(a) and (3)(b), each applicant captive insurance company shall file with the commissioner evidence of the following:

(i) the amount and liquidity of its assets relative to the risks to be assumed;

(ii) the adequacy of the expertise, experience, and character of the person or persons who will manage it;

(iii) the overall soundness of its plan of operation;

(iv) the adequacy of the loss prevention programs of its parent, members, or industrial insureds as applicable; and

(v) any other factors considered relevant by the commissioner in ascertaining whether the proposed captive insurance company will be able to meet its policy obligations.

(d) In addition to the information required by this section, each applicant that is a protected cell captive insurance company shall file with the commissioner the following:

(i) a business plan demonstrating how the applicant will account for the loss and expense experience of each protected cell at a level of detail found to be sufficient by the commissioner and how it will report the experience to the commissioner;

(ii) a statement acknowledging that all financial records of the protected cell captive insurance company, including records pertaining to any protected cells, must be made available for inspection or examination by the commissioner or the commissioner's designated agent;

(iii) all contracts or sample contracts between the protected cell captive insurance company and any participants; and

(iv) evidence that expenses will be allocated to each protected cell in a fair and equitable manner.

(e) Information submitted pursuant to this subsection (3) must remain confidential and may not be made public by the commissioner or an employee or agent of the commissioner without the written consent of the company, except that:

(i) the information may be discoverable by a party in a civil action or contested case to which the captive insurance company that submitted the information is a party, upon a showing by the party seeking to discover the information that the information sought is relevant to and necessary for the furtherance of the action or case, the information sought is unavailable from other nonconfidential sources, and a subpoena issued by a judicial or administrative officer of competent jurisdiction has been submitted to the commissioner;

(ii) the commissioner may, in the commissioner's discretion, disclose the information to a public officer having jurisdiction over the regulation of insurance in another state or to a public official of the federal government, as long as the public official agrees in writing to maintain the confidentiality of the information and the laws of the state in which the public official serves, if applicable, require the information to be and to remain confidential.

(4) (a) Each captive insurance company shall pay to the commissioner a nonrefundable fee of $200 for the examining, investigating, and processing of its application for license, and the commissioner is authorized to retain legal, financial, and examination services from outside the department, the reasonable cost of which may be charged to the applicant.

(b) The provisions of Title 33, chapter 1, part 4, apply to examinations, investigations, and processing conducted under the authority of this section. In addition, each captive insurance company shall pay a license fee for the year of registration and a renewal fee for each subsequent year of $300.

(5) If the commissioner is satisfied that the documents and statements that the applicant captive insurance company has filed comply with the provisions of this chapter and applicable provisions of Title 33, the commissioner may grant a license authorizing the company to do insurance business in this state. The license is effective until March 1 of each year and may be renewed upon proper compliance with this chapter."

Section 20. Section 33-28-107, MCA, is amended to read:

"33-28-107. Reports and statements. (1) A captive insurance company is not required to make an annual report except as provided in this section.

(2) (a) Except as provided in subsection (2)(b), on or before March 1 of each year, each captive insurance company shall submit to the commissioner a report of its financial condition in a form and manner as

required by the commissioner, verified by oath of two of its executive officers.

(b) A pure captive insurance company, branch captive insurance company, or industrial insured captive company, excluding captive risk retention groups, may make written application for filing the required report on a fiscal yearend basis. If an alternative reporting date is granted:

(i) the required report is due 60 days after fiscal yearend; and

(ii) in order to provide sufficient information to support the premium tax return, a pure captive insurance company or industrial insured insurance company shall file a report acceptable to the commissioner prior to March 1 of each year for the prior calendar yearend.

(c) Each captive insurance company shall report using generally accepted accounting principles, unless the commissioner requires the use of statutory accounting principles, with any necessary or useful modifications or additions required by the commissioner. The commissioner may also require the report to be supplemented by additional information.

(d) On or before March 1 of each year, each branch captive insurance company shall submit to the commissioner a copy of all reports and statements required to be filed under the laws in which the foreign captive insurance company is formed, verified by oath of two of its executive officers. If the commissioner is satisfied that the annual report filed by the foreign captive insurance company in its domiciliary jurisdiction provides adequate information concerning the financial condition of the foreign captive insurance company, the commissioner may waive the requirement for completion of the captive annual statement for business written in the foreign jurisdiction.

(3) The commissioner shall consider financial statements filed pursuant to this section as confidential.

(4) (a) Captive risk retention groups shall file reports and statements in accordance with Title 33, chapter 2, part 7, except that a captive risk retention group may file using generally accepted accounting principles. The filing may include letters of credit that are established, issued, or confirmed by a bank chartered in this state, a member of the federal reserve system, or a bank chartered by another state if that state-chartered bank is acceptable to the commissioner.

~~(b) The commissioner may waive the RBC report required in 33-2-1903 for a captive risk retention group that files a report or statement pursuant to subsection (4)(a) or for a captive risk retention group that was formed in the last 2 years.~~

~~(c)~~(b) The filings in subsection (4)(a) are required on an annual and quarterly basis."

Section 21. Section 33-28-108, MCA, is amended to read:

"33-28-108. Examinations and investigations. (1) (a) ~~At least once in 3 years, or more frequently if the commissioner considers it prudent, the~~ The commissioner or some competent person appointed by the commissioner shall ~~visit each captive insurance company and thoroughly inspect and~~ examine ~~its~~ the affairs, transactions, accounts, records, and assets of each captive insurance company as often as the commissioner considers advisable but no less frequently than every 5 years ~~to ascertain its financial condition, its ability to fulfill its obligations, and whether it has complied with the provisions of this chapter.~~

~~(b) The commissioner, upon application and in the commissioner's discretion, may enlarge the 3-year period to 5 years if the captive insurance company is:~~

~~(i) subject to a comprehensive annual audit during the 5-year period of a scope satisfactory to the commissioner; and~~

~~(ii) the audit is conducted by independent auditors approved by the commissioner~~.

~~(c)~~(b) The expenses and charges of the examination must be paid to the commissioner by the company or companies examined.

(2) The provisions of Title 33, chapter 1, part 4, apply to examinations conducted under this section.

(3) Except as provided in subsection (4), all examination reports, preliminary examination reports or results, working papers, recorded information, documents, and their copies produced by, obtained by, or disclosed to the commissioner or any other person in the course of an examination made under this section are confidential, are not subject to subpoena, and may not be made public by the commissioner or an employee or agent of the commissioner without the written consent of the company or upon court order.

(4) (a) Subsection (3) does not prevent the commissioner from using information obtained pursuant to this section in furtherance of the commissioner's regulatory authority under Title 33. The commissioner may, in the commissioner's discretion, grant access to information obtained pursuant to this section to public officers having jurisdiction over the regulation of insurance in any other state or country or to law enforcement officers of this state or any other state or agency of the federal government at any time, as long as the officers receiving the information agree in writing to hold it in a manner consistent with this section.

(b) Captive risk retention group reports produced pursuant to the examination requirements of this section are public writings as defined in 2-6-101.

(5) Except as provided in subsection (6), the provisions of this section apply to all business written by a captive insurance company.

(6) The examination for a branch captive insurance company may only be of branch business and branch operations if the branch captive insurance company has satisfied the requirements of 33-28-107(2)(d) to the satisfaction of the commissioner.

(7) As a condition of licensure of a branch captive insurance company, the foreign captive insurance company shall grant authority to the commissioner for examination of the affairs of the foreign captive insurance company in the jurisdiction in which the foreign captive insurance company is formed."

Section 22. Section 33-28-207, MCA, is amended to read:

"33-28-207. Applicable laws. (1) The following apply to captive insurance companies:

(a) the definitions of commissioner and department provided in 33-1-202, property insurance provided in 33-1-210, casualty insurance provided in 33-1-206, life insurance provided in 33-1-208, health insurance coverage and group health plans provided in 33-22-140, and disability income insurance provided in 33-1-235;

(b) the limitation provided in 33-2-705 on the imposition of other taxes;

(c) the provisions relating to supervision, rehabilitation, and liquidation of insurance companies as provided for in Title 33, chapter 2, part 13;

(d) the provisions of 33-1-311, 33-1-603, 33-3-431, 33-18-201, 33-18-203, 33-18-205, and 33-18-242; ~~and~~ AND

~~(e) the provisions relating to insurance holding company systems in Title 33, chapter 2, part 11; and~~

~~(e)(f)~~(E) the provisions relating to dissolution and liquidation in Title 33, chapter 3, part 6, except that a pure captive insurance company may proceed with voluntary dissolution and liquidation after prior notice to and approval of the commissioner without following the provisions of Title 33, chapter 3, part 6.

(2) This chapter may not be construed as exempting a captive insurance company, its parent, or affiliated companies from compliance with the laws governing workers' compensation insurance.

(3) A captive insurance company or branch captive insurance company that writes health insurance coverage or group health plans as defined in 33-22-140 shall comply with applicable state and federal laws.

(4) The following provisions apply to captive risk retention groups:

(a) those relating to actuarial opinions in Title 33, chapter 1, part 14; ~~and~~

(b) those relating to risk-based capital in Title 33, chapter 2, part 19; AND

(C) THOSE RELATING TO INSURANCE HOLDING COMPANY SYSTEMS IN TITLE 33, CHAPTER 2, PART 11.

~~(4)~~(5) Except as expressly provided in this chapter, the provisions of Title 33 do not apply to captive

insurance companies."

NEW SECTION. **Section 23. Repealer.** The following sections of the Montana Code Annotated are repealed:

33-2-609. Excess deposits.

33-22-103. Violations.

33-22-1827. BENEFITS REQUIRED IN BASIC HEALTH BENEFIT PLAN.

33-22-1828. BENEFITS REQUIRED IN STANDARD BENEFIT PLAN.

NEW SECTION. **Section 24. 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 25. Effective date.** [This act] is effective on passage and approval.

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