HOUSE BILL NO. 445

INTRODUCED BY C. SMITH

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING MONTANANS AN OPTION OF PURCHASING OUT-OF-STATE INDIVIDUAL OR GROUP HEALTH INSURANCE POLICIES; REMOVING CERTAIN MONTANA REQUIREMENTS AND REGULATORY PROVISIONS FROM POLICIES SOLD IN THIS STATE BY OUT-OF-STATE INSURERS OR LOCAL AGENTS ACTING ON THEIR BEHALF; ALLOWING IN-STATE INSURERS A WAIVER TO PROVIDE SIMILARLY LIMITED POLICIES UNDER CERTAIN CONDITIONS; REQUIRING LICENSE FEES PAID BY CERTAIN OUT-OF-STATE INSURERS ON THE LIMITED POLICIES TO BE DIVIDED BETWEEN THIS STATE AND THE OUT-OF-STATE INSURER'S DOMICILIARY STATE; PROVIDING THE INSURANCE COMMISSIONER WITH RULEMAKING AUTHORITY; EXEMPTING OUT-OF-STATE OR SIMILARLY LIMITED IN-STATE POLICIES FROM THE UNISEX NONDISCRIMINATION STATUTE; AMENDING SECTIONS 33-1-102, 33-1-501, 33-1-502, 33-2-708, 33-22-1513, AND 49-2-309, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE AND AN APPLICABILITY DATE."

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

NEW SECTION. **Section 1. Legislative intent to allow purchase of out-of-state health insurance policies.** The legislature recognizes that the McCarran-Ferguson Act of 1945, 15 U.S.C.1011 through 1015, gives states the right to regulate insurance unless specifically provided otherwise by federal law. The legislature also recognizes that affordable health care coverage is affected by many factors, including the extent of regulatory barriers imposed on insurers and the number and the type of mandates placed on insurers to cover certain types of services or recognize certain medical providers or processes. The legislature has the option of repealing mandates or regulatory provisions or allowing the sale of out-of-state health insurance policies in this state with certain provisions. It is the intent of the legislature that residents of this state have a broad, flexible marketplace of competitive options to buy health insurance policies, including those that are sold by insurers regulated in other states.

NEW SECTION. **Section 2. Out-of-state health insurance policy offers -- mandate exemption -- regulation -- rules.** (1) A foreign insurer, as defined in 33-1-201, may sell, offer, and provide a health plan in the

individual or group market to a resident in this state if the foreign insurer:

(a) offers the same health plan in its domiciliary state and is in compliance with all applicable laws, regulations, and other requirements of its domiciliary state;

(b) obtains a certificate of authority to do business as a foreign insurer in this state as provided in 33-2-101, 33-2-115, and 33-2-708. The provisions of 33-1-401, 33-1-402, 33-1-411, 33-1-601, 33-1-615, 33-1-701, 33-1-711, 33-2-105, 33-2-116 through 33-2-122, 33-2-126, 33-2-127, and 33-2-705 apply as they relate to certificates of authority;

(c) provides the insurance commissioner in this state with documentation of compliance under its domiciliary state, as provided in subsection (1)(a);

(d) submits the form filed in its domiciliary state for each policy to be sold in this state; and

(e) provides a notice in prominent type on any policy sold under the provisions of [sections 1 through 4] that the policy:

(i) is regulated under the laws of the state in which the insurer is domiciled, providing the name of that state and that state's insurance commissioner for the purposes of benefit questions and disputes or complaints;

(ii) is subject to the laws of the domiciliary state, and not this state, relating to insolvency, underwriting, cancellation or conversion of policies, limitations of coverage, waiting periods, unfair trade practices, information privacy, an outline of coverage and any restrictions regarding coverage or health care providers, enforcement of contractual benefits and payment requirements, and any rating and renewability provisions that may affect premiums and renewal;

(iii) is subject to dispute resolution in the domiciliary state, including that any remedy through judicial action is to be in a court of the foreign insurer's domiciliary state unless otherwise provided in the policy; and

(iv) is not subject to the antidiscrimination provisions of 49-2-309 or any mandates required under this state's laws but may be subject to other mandates under the domiciliary state's laws. If the policy is subject to mandates in the foreign domiciliary state, other than federally imposed mandates, the policy notice must state each mandate that applies to the policy.

(2) A managing general agent defined in 33-2-1501 or an insurance producer or administrator licensed in this state may engage in sales, adjustment or payment of claims, or consultation on behalf of a foreign insurer selling policies under [sections 1 through 4] if authorized by that foreign insurer.

(3) A foreign insurer offering policies in this state under [sections 1 through 4] is subject to the following provisions:

(a) Title 33, chapter 1, part 1, 33-1-201, and Title 33, chapter 1, parts 3 through 8 and 11 through 13;

(b) Title 33, chapter 2, part 1, except 33-2-108 through 33-2-112, and Title 33, chapter 2, parts 7 and 16; and

(c) Title 33, chapter 17, parts 1, 4, 6, and 10.

(4) A foreign insurer offering a health plan under [sections 1 through 4] is subject to the assessments and requirements under Title 33, chapter 22, part 15.

(5) The provisions of 49-2-309 do not apply to a health plan sold under [sections 1 through 4].

(6) The commissioner may adopt rules to implement this section. The rules may not directly or indirectly apply greater responsibilities or requirements on foreign insurers than on domestic insurers. In addition, the rules may not modify coverage or benefit requirements or restrict underwriting requirements or premium ratings in a way that conflicts with the foreign insurer's domiciliary state's regulations.

NEW SECTION. **Section 3. Waiver for domestic insurers -- reciprocity -- rules.** (1) A domestic insurer that provides health insurance in the individual or the group market may apply to the commissioner for a waiver to offer a policy similar to a policy offered by a foreign insurer under [sections 1 through 4]. To obtain the waiver, the domestic insurer shall provide at least one health plan that complies with Title 33, meets the requirements of this section, and is of the same type as the policy intended to be competitive with the foreign insurer's policy under [sections 1 through 4].

(2) The commissioner shall grant a waiver if all of the following conditions are met:

(a) a foreign insurer that is not affiliated with the domestic insurer seeking the waiver is offering a health plan in this state under [sections 1 through 4];

(b) the domestic insurer has submitted a request for a waiver and a policy form meeting the requirements of [sections 1 through 4] along with documentation of the corresponding health plan that meets the requirements of Title 33, as provided in subsection (1);

(c) the commissioner determines that the domestic insurer's proposed health plan is comparable in plan design to at least one health plan offered by a foreign insurer under [sections 1 through 4];

(d) the domestic insurer complies with the provisions of Title 33 applicable to domestic insurers, except for those listed under subsection (3), and includes in any policy issued under the provisions of [sections 1 through 4] the notice required of a foreign insurer under [section 2(1)(e)]; and

(e) the foreign insurer's domiciliary state offers reciprocity to domestic insurers under conditions similar

to [sections 1 through 4]. If the foreign insurer's domiciliary state offers reciprocity as provided in this subsection (2)(e), the domestic insurer is subject to the provisions of subsection (2)(d) regarding policies sold in the foreign insurer's domiciliary state unless otherwise provided by the foreign insurer's domiciliary state for policies sold in that state.

(3) (a) Except as provided in subsection (3)(b), a health benefit plan under this section is not subject to Title 33, chapter 22.

(b) The following provisions apply to health plans under this section:

(i) [sections 1 through 4];

(ii) 33-22-133 through 33-22-135 to the extent that federal requirements apply;

(iii) 33-22-140;

(iv) format, content, and other requirements for individual policies provided for in 33-22-201, 33-22-202, 33-22-204 through 33-22-215, 33-22-221 through 33-22-228, and 33-22-230 through 33-22-232;

(v) 33-22-301 and 33-22-504 to the extent that the Newborns' and Mothers' Health Protection Act of 1996 applies; and

(vi) 33-22-706 to the extent that 42 U.S.C. 300gg-5 applies to mental health coverage.

(4) A policy sold by a foreign or a domestic insurer under [sections 1 through 4] may not be used as a comparison if a provision in Title 33, chapter 22, requires a lowest cost or fewest benefits comparison.

(5) The commissioner shall write rules implementing this section. The rules may not directly or indirectly impose restrictions contrary to the intent of [section 1] or expand the commissioner's authority over a domestic insurer seeking to offer plans under [sections 1 through 4].

NEW SECTION. **Section 4. Marketing.** The commissioner shall establish fair marketing standards for any material used to advertise or sell in this state a health plan offered under [sections 1 through 4]. The standards must be consistent with any standards that apply to other health plans regulated by this state.

Section 5. Section 33-1-102, MCA, is amended to read:

"33-1-102. Compliance required -- exceptions -- health service corporations -- health maintenance organizations -- governmental insurance programs -- service contracts. (1) A person may not transact a business of insurance in Montana or a business relative to a subject resident, located, or to be performed in Montana without complying with the applicable provisions of this code.

(2) The provisions of this code do not apply with respect to:

(a) domestic farm mutual insurers as identified in chapter 4, except as stated in chapter 4;

(b) domestic benevolent associations as identified in chapter 6, except as stated in chapter 6; and

(c) fraternal benefit societies, except as stated in chapter 7.

(3) This code applies to health service corporations as prescribed in 33-30-102. The existence of the corporations is governed by Title 35, chapter 2, and related sections of the Montana Code Annotated.

(4) This code does not apply to health maintenance organizations or to managed care community networks, as defined in 53-6-702, to the extent that the existence and operations of those organizations are governed by chapter 31 or to the extent that the existence and operations of those networks are governed by Title 53, chapter 6, part 7. The department of public health and human services is responsible to protect the interests of consumers by providing complaint, appeal, and grievance procedures relating to managed care community networks and health maintenance organizations under contract to provide services under Title 53, chapter 6.

(5) This code does not apply to workers' compensation insurance programs provided for in Title 39, chapter 71, parts 21 and 23, and related sections.

(6) The department of public health and human services may limit the amount, scope, and duration of services for programs established under Title 53 that are provided under contract by entities subject to this title. The department of public health and human services may establish more restrictive eligibility requirements and fewer services than may be required by this title.

(7) Except as otherwise provided in Title 33, chapter 22, this code does not apply to the state employee group insurance program established in Title 2, chapter 18, part 8.

(8) This code does not apply to insurance funded through the state self-insurance reserve fund provided for in 2-9-202.

(9) (a) Except as otherwise provided in Title 33, chapter 22, this code does not apply to any arrangement, plan, or interlocal agreement between political subdivisions of this state in which the political subdivisions undertake to separately or jointly indemnify one another by way of a pooling, joint retention, deductible, or self-insurance plan.

(b) Except as otherwise provided in Title 33, chapter 22, this code does not apply to any arrangement, plan, or interlocal agreement between political subdivisions of this state or any arrangement, plan, or program of a single political subdivision of this state in which the political subdivision provides to its officers, elected officials, or employees disability insurance or life insurance through a self-funded program.

(10) (a) This code does not apply to the marketing of, sale of, offering for sale of, issuance of, making of, proposal to make, and administration of a service contract.

(b) A "service contract" means a contract or agreement for a separately stated consideration for a specific duration to perform the repair, replacement, or maintenance of property or to indemnify for the repair, replacement, or maintenance of property if an operational or structural failure is due to a defect in materials or manufacturing or to normal wear and tear, with or without an additional provision for incidental payment or indemnity under limited circumstances, including but not limited to towing, rental, and emergency road service. A service contract may provide for the repair, replacement, or maintenance of property for damage resulting from power surges or accidental damage from handling. A service contract does not include motor club service as defined in 61-12-301.

(11) Except as otherwise provided, foreign insurers offering health insurance policies provided for in [sections 1 through 4] are not subject to this code.

~~(11)~~(12) (a) Subject to 33-18-201 and 33-18-242, this code does not apply to insurance for ambulance services sold by a county, city, or town or to insurance sold by a third party if the county, city, or town is liable for the financial risk under the contract with the third party as provided in 7-34-103.

(b) If the financial risk for ambulance service insurance is with an entity other than the county, city, or town, the entity is subject to the provisions of this code."

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

"33-1-501. Filing of forms -- approval -- review of disapproval or withdrawal of approval -- application. (1) (a) (i) An insurance policy or annuity contract form, certificate, enrollment form, application form, printed rider or endorsement form, or form of renewal certificate may not be delivered or issued for delivery in Montana unless the form and, for the purposes of disability insurance, an outline of coverage as required by 33-22-244 and 33-22-521 have been filed with and approved by the commissioner and, if required, the regulatory official of the state of domicile of the insurer. For a policy offered or sold under [sections 1 through 4] by a foreign insurer, a filing of the form and the provisions required in the notice pursuant to [section 2] suffice to meet the outline of coverage otherwise required by 33-22-244, 33-22-521, 33-22-907, and this subsection (1)(a).

(ii) This provision does not apply to surety bonds or policies, riders, endorsements, or forms of unique character designed for and used with relation to insurance upon a particular subject or that relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or disability insurance policies and

are used at the request of the individual policyholder, contract holder, or certificate holder. Forms for use in property, marine, other than ocean marine and foreign trade coverages, casualty, and surety insurance coverages may be filed by a rating organization on behalf of its members and subscribers or by a member or subscriber on its own behalf.

(b) A filing required by subsection (1)(a) must be submitted by an officer of the insurer with a certification in a form prescribed by the commissioner. The certification must state that to the best of the officer's knowledge and belief, the policy, contract form, certificate, enrollment form, application form, printed rider or endorsement form, or form of renewal certificate complies with the applicable provisions of Title 33.

(c) The approval of an insurance policy or annuity contract form, certificate, enrollment form, application form, or other related insurance form by the state of domicile may be waived by the commissioner if the commissioner considers the requirements of subsection (1)(a) unnecessary for the protection of Montana insurance consumers. A form filed under [sections 1 through 4] is not subject to approval by the commissioner. If the requirement is waived, an insurer shall notify the commissioner in writing within 10 days of disapproval, denial, or withdrawal of approval of a form by the state of domicile.

(2) (a) The filing must be made not less than 60 days before delivery and must be delivered by hand or sent by certified mail with a return receipt requested. The commissioner's office shall mark a filing with the date of receipt by the commissioner's office.

(b) (i) If after 60 days from the date of receipt by the commissioner's office the commissioner has not approved or disapproved the form by a notice pursuant to the provisions in subsection (4), the form is considered approved for all purposes, subject to subsection (2)(c).

(ii) The running of the 60-day period is tolled for a period commencing on the date that the commissioner notifies the insurer of problems or questions and requests additional information from the insurer concerning a form filed pursuant to subsection (1)(a) and ending on the date that the insurer submits its response to the commissioner.

(iii) For purposes of tolling the 60-day period as provided in subsection (2)(b)(ii), the commissioner's request notification may be made electronically.

(c) In a letter separate from the original filing and delivered by hand or sent by certified mail with return receipt requested, the insurer shall notify the commissioner, at least 10 days before the use of the form in the market, that the insurer believes that:

(i) the form has been or will be considered approved; and

(ii) the insurer will begin marketing the form in Montana.

(d) The commissioner's office shall mark a letter received pursuant to subsection (2)(c) with the date of receipt by the commissioner's office.

(3) Approval of a form by the commissioner constitutes a waiver of any unexpired portion of the waiting period.

(4) The commissioner may at any time, after notice and for cause shown, withdraw any approval. Notice by the commissioner disapproving a form or withdrawing a previous approval must state the grounds for disapproval or withdrawal in sufficient detail to inform the insurer of the specific reason or reasons for and the legal authority supporting the disapproval or withdrawal of approval in whole or in part. The disapproval or withdrawal of approval does not take effect unless it is issued after the commissioner has reviewed the form and provided notice to the person who filed the form pursuant to 33-1-314 and this subsection.

(5) After the date of the insurer's receipt of notice of disapproval or withdrawal of approval by the commissioner, the insurer may not deliver the form or issue the form for delivery in Montana.

(6) The insurer may request a hearing, as provided for in 33-1-701, for unresolved disputes regarding a disapproval or a withdrawal of approval.

(7) The provisions of subsections (3) through (6) do not apply to forms filed under [sections 1 through 4]. Further, the commissioner may exempt from the requirements of this section, for so long as the commissioner considers proper, an insurance document, form, or type of document or form to which, in the commissioner's opinion, this section may not practicably be applied or the filing and approval of which are not desirable or necessary for the protection of the public.

(8) This section applies to a form used by a domestic insurer for delivery in a jurisdiction outside Montana if the insurance supervisory official of the jurisdiction informs the commissioner that the form is not subject to approval or disapproval by the official and upon the commissioner's order requiring the form to be submitted to the commissioner for the purpose. The same standards apply to these forms as apply to forms for domestic use.

(9) Section 33-1-502 and this section do not apply to:

(a) reinsurance;

(b) policies or contracts not issued for delivery in Montana or delivered in Montana, except as provided in subsection (8) and except for forms filed under [sections 1 through 4] unless otherwise provided;

(c) ocean marine and foreign trade insurances.

(10) Except as provided in chapter 21, group certificates that are delivered or issued for delivery in

Montana for group insurance policies effectuated and delivered outside Montana but covering persons resident in Montana must be filed with the commissioner upon request. The certificates, except as provided in [sections 1 through 4], must meet the minimum provisions mandated by Montana if Montana law prevails over conflicting provisions of other state law."

Section 7. Section 33-1-502, MCA, is amended to read:

"33-1-502. Grounds for disapproval. ~~The~~ Except for forms filed under [sections 1 through 4], the commissioner shall disapprove any form filed under 33-1-501 or withdraw any previous approval of a form only if the form:

(1) is in any respect in violation of or does not comply with this code;

(2) contains or incorporates by reference, where the incorporation is otherwise permissible, any inconsistent, ambiguous, or misleading clauses or exceptions and conditions that deceptively affect the risk purported to be assumed in the general coverage of the contract, including a provision in a casualty insurance form permitting defense costs within limits, except as permitted by the commissioner;

(3) has any title, heading, or other indication of its provisions that is misleading;

(4) is printed or otherwise reproduced in a manner that renders any provision of the form substantially illegible;

(5) contains any provision that violates the provisions of 49-2-309."

Section 8. Section 33-2-708, MCA, is amended to read:

"33-2-708. (Temporary) Fees and licenses. (1) (a) Except as provided in 33-17-212(2), the commissioner shall collect a fee of $1,900 from each insurer applying for or annually renewing a certificate of authority to conduct the business of insurance in Montana.

(b) The commissioner shall collect certain additional fees as follows:

(i) nonresident insurance producer's license but only if the nonresident insurance producer is selling policies other than under [sections 1 through 4]:

(A) application for original license, including issuance of license, if issued, $100;

(B) biennial renewal of license, $50;

(C) lapsed license reinstatement fee, $100;

(ii) resident insurance producer's license lapsed license reinstatement fee, $100;

(iii) surplus lines insurance producer's license:

(A) application for original license and for issuance of license, if issued, $50;

(B) biennial renewal of license, $100;

(C) lapsed license reinstatement fee, $200;

(iv) insurance adjuster's license:

(A) application for original license, including issuance of license, if issued, $50;

(B) biennial renewal of license, $100;

(C) lapsed license reinstatement fee, $200;

(v) insurance consultant's license:

(A) application for original license, including issuance of license, if issued, $50;

(B) biennial renewal of license, $100;

(C) lapsed license reinstatement fee, $200;

(vi) viatical settlement broker's license:

(A) application for original license, including issuance of license, if issued, $50;

(B) biennial renewal of license, $100;

(C) lapsed license reinstatement fee, $200;

(vii) resident and nonresident rental car entity producer's license:

(A) application for original license, including issuance of license, if issued, $100;

(B) quarterly filing fee, $25;

(viii) an original notification fee for a life insurance producer acting as a viatical settlement broker, in accordance with 33-20-1303(2)(b), $50;

(ix) unless otherwise licensed under subsection (1)(b)(i), a license for a nonresident insurance producer offering or selling policies only under [sections 1 through 4], including:

(A) application for an original license and issuance of the license, if issued, $100;

(B) biennial renewal of the license, $50;

(C) a lapsed license reinstatement fee, $100;

~~(ix)~~(x) 50 cents for each page for copies of documents on file in the commissioner's office.

(c) The commissioner may adopt rules to determine the date by which a nonresident insurance producer, a surplus lines insurance producer, an insurance adjuster, or an insurance consultant is required to pay the fee for the biennial renewal of a license.

(2) (a) The commissioner shall charge a fee of $75 for each course or program submitted for review as required by 33-17-1204 and 33-17-1205, but may not charge more than $1,500 to a sponsoring organization submitting courses or programs for review in any biennium.

(b) Insurers and associations composed of members of the insurance industry are exempt from the charge in subsection (2)(a).

(3) (a) Except as provided in subsection (3)(b), the commissioner shall promptly deposit with the state treasurer to the credit of the general fund all fines and penalties and those amounts received pursuant to 33-2-311, 33-2-705, 33-28-201, and 50-3-109.

(b) ~~The~~ Except as provided in subsection (3)(d), the commissioner shall deposit 16.67% of the money collected under 33-2-705 in the special revenue account provided for in 53-4-1115.

(c) ~~All~~ Except as provided in subsection (3)(d), all other fees collected by the commissioner pursuant to Title 33 and the rules adopted under Title 33 must be deposited in the state special revenue fund to the credit of the state auditor's office.

(d) The commissioner shall distribute one-half the money collected under 33-2-705 paid on premiums from policies sold by foreign insurers under [sections 1 through 4] and one-half the licensing fees paid by a foreign insurer offering or selling policies under [sections 1 through 4] to the domiciliary state of the foreign insurer.

(4) All fees are considered fully earned when received. In the event of overpayment, only those amounts in excess of $10 will be refunded. (Terminates June 30, 2013--sec. 35(2), Ch. 486, L. 2009.)

33-2-708. (Effective July 1, 2013) Fees and licenses. (1) (a) Except as provided in 33-17-212(2), the commissioner shall collect a fee of $1,900 from each insurer applying for or annually renewing a certificate of authority to conduct the business of insurance in Montana.

(b) The commissioner shall collect certain additional fees as follows:

(i) nonresident insurance producer's license but only if the nonresident insurance producer is selling policies other than under [sections 1 through 4]:

(A) application for original license, including issuance of license, if issued, $100;

(B) biennial renewal of license, $50;

(C) lapsed license reinstatement fee, $100;

(ii) resident insurance producer's license lapsed license reinstatement fee, $100;

(iii) surplus lines insurance producer's license:

(A) application for original license and for issuance of license, if issued, $50;

(B) biennial renewal of license, $100;

(C) lapsed license reinstatement fee, $200;

(iv) insurance adjuster's license:

(A) application for original license, including issuance of license, if issued, $50;

(B) biennial renewal of license, $100;

(C) lapsed license reinstatement fee, $200;

(v) insurance consultant's license:

(A) application for original license, including issuance of license, if issued, $50;

(B) biennial renewal of license, $100;

(C) lapsed license reinstatement fee, $200;

(vi) viatical settlement broker's license:

(A) application for original license, including issuance of license, if issued, $50;

(B) biennial renewal of license, $100;

(C) lapsed license reinstatement fee, $200;

(vii) resident and nonresident rental car entity producer's license:

(A) application for original license, including issuance of license, if issued, $100;

(B) quarterly filing fee, $25;

(viii) an original notification fee for a life insurance producer acting as a viatical settlement broker, in accordance with 33-20-1303(2)(b), $50;

(ix) unless otherwise licensed under subsection (1)(b)(i), a license for a nonresident insurance producer offering or selling policies only under [sections 1 through 4], including:

(A) application for an original license and issuance of the license, if issued, $100;

(B) biennial renewal of the license, $50;

(C) a lapsed license reinstatement fee, $100;

~~(ix)~~(x) 50 cents for each page for copies of documents on file in the commissioner's office.

(c) The commissioner may adopt rules to determine the date by which a nonresident insurance producer, a surplus lines insurance producer, an insurance adjuster, or an insurance consultant is required to pay the fee for the biennial renewal of a license.

(2) (a) The commissioner shall charge a fee of $75 for each course or program submitted for review as

required by 33-17-1204 and 33-17-1205, but may not charge more than $1,500 to a sponsoring organization submitting courses or programs for review in any biennium.

(b) Insurers and associations composed of members of the insurance industry are exempt from the charge in subsection (2)(a).

(3) (a) Except as provided in subsection (3)(b), the commissioner shall promptly deposit with the state treasurer to the credit of the general fund all fines and penalties and those amounts received pursuant to 33-2-311, 33-2-705, 33-28-201, and 50-3-109.

(b) ~~The~~ Except as provided in subsection (3)(d), the commissioner shall deposit 33% of the money collected under 33-2-705 in the special revenue account provided for in 53-4-1115.

(c) ~~All~~ Except as provided in subsection (3)(d), all other fees collected by the commissioner pursuant to Title 33 and the rules adopted under Title 33 must be deposited in the state special revenue fund to the credit of the state auditor's office.

(d) The commissioner shall distribute one-half the money collected under 33-2-705 paid on premiums from policies sold by foreign insurers under [sections 1 through 4] and one-half the licensing fees paid by a foreign insurer offering or selling policies under [sections 1 through 4] to the domiciliary state of the foreign insurer.

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

Section 9. Section 33-22-1513, MCA, is amended to read:

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

(2) Upon application by a federally defined eligible individual or a TAA-eligible individual to the lead carrier for an association portability plan, the association may not:

(a) decline to offer an association portability plan; or

(b) except as provided in subsection (3), impose a preexisting condition exclusion with respect to an individual's association portability plan coverage if application for association portability plan coverage is made within 63 days following termination of the applicant's most recent prior creditable coverage.

(3) The association may impose a preexisting condition exclusion as provided in 33-22-1516 with respect

to a TAA-eligible individual's association portability plan coverage if that individual does not meet the requirements defining a qualified TAA-eligible individual.

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

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

(6) (a) Each participating member of the association shall share the losses because of claims expenses of the association plan and the association portability plan for plans issued or approved for issuance by the association and shall share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs in the following manner:

(i) Each participating member of the association must be assessed by the association on an annual basis an amount not to exceed 1% of the association member's total disability insurance premium received from or on behalf of Montana residents as determined by the commissioner. Assessments made under this subsection (6)(a) or funds from any other source must be allocated to the association plan and the association portability plan in proportion to the needs of the two plans. If the needs of the association plan and the association portability plan exceed the funds generated by the 1% assessment, the association is then authorized to spend any funds appropriated by the legislature for the support of the plans. Any appropriation to the association may be expended for the operation of the association plan or the association portability plan.

(ii) (A) Payment of an assessment is due within 30 days of receipt by a member of a written notice of the annual assessment. After 30 days, the association shall charge a member:

(I) a late payment penalty of 1.5% a month or fraction of a month on the unpaid assessment, not to exceed 18% of the assessment due;

(II) interest at the rate of 12% a year on the unpaid assessment, to be accrued at 1% a month or fraction of a month; or

(III) both of the charges in subsections (6)(a)(ii)(A)(I) and (6)(a)(ii)(A)(II).

(B) Failure by a contributing member to tender the association assessment within the 30-day period is grounds for termination of membership. A member terminated for failure to tender the association assessment

is ineligible to write health care benefit policies or contracts in this state ~~under~~ as provided in 33-22-1503(2).

(iii) An association member that ceases to do disability insurance business within the state remains liable for assessments through the calendar year in which the member ceased doing disability insurance business. The association may decline to levy an assessment against an association member if the assessment, as determined pursuant to this section, would not exceed $50.

(b) For purposes of this subsection (6), "total disability insurance premium" does not include premiums received from disability income insurance, credit disability insurance, disability waiver insurance, life insurance, medicare risk or other similar medicare health maintenance organization payments, or medicaid health maintenance organization payments.

(c) Any income in excess of the incurred or estimated claims expenses of the association plan and the association portability plan and the operating and administrative expenses of the association must be held at interest and used by the association to offset past and future losses because of claims expenses of the association plan and the association portability plan or be allocated to reduce association plan and association portability plan premiums.

(7) The proportion of the annual assessment allocated to the operation and expenses of the association plan, not to include any amount of late payment penalty or interest charged, may be offset by an association member against the premium tax payable by that association member pursuant to 33-2-705 for the year in which the annual assessment is levied. The offset against the premium tax paid by a foreign insurer on policies issued under [sections 1 through 4] may be taken only against the amount of premium tax paid and retained in Montana. The commissioner shall report to the office of budget and program planning, as a part of the information required by 17-7-111, the total amount of premium tax offset claimed by association members during the preceding biennium. The proportion of the annual assessment allocated to the operation and expenses of the association portability plan and levied against an association member may not be offset against the premium tax payable by that association member.

(8) The association may also accept funding from the federal government, private foundations, and other private funding sources."

Section 10. Section 49-2-309, MCA, is amended to read:

"49-2-309. Discrimination in insurance and retirement plans. (1) ~~It~~ Except as provided in subsection (2), it is an unlawful discriminatory practice for a financial institution or person to discriminate solely on the basis

of sex or marital status in the issuance or operation of any type of insurance policy, plan, or coverage or in any pension or retirement plan, program, or coverage, including discrimination in regard to rates or premiums and payments or benefits.

(2) This section does not apply to:

(a) any insurance policy, plan, or coverage or to any pension or retirement plan, program, or coverage in effect prior to October 1, 1985; or

(b) any health plan offered under the provisions of [sections 1 through 4].

(3) It is not a violation of the prohibition against marital status discrimination in this section for an employer to provide greater or additional contributions to a bona fide group insurance plan for employees with dependents than to those employees without dependents or with fewer dependents."

NEW SECTION. **Section 11. Codification instruction.** [Sections 1 through 4] are intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to [sections 1 through 4].

NEW SECTION. **Section 12. Effective date -- applicability.** [This act] is effective January 1, 2012, and applies to policies issued under [sections 1 through 4] on or after January 1, 2012.

- END -