HOUSE BILL NO. 553

INTRODUCED BY G. VANCE

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING LAWS RELATED TO THE STATE COMPENSATION INSURANCE FUND; PROVIDING FOR RATE REVIEW BY THE INSURANCE COMMISSIONER; REQUIRING CONFORMITY BY THE STATE COMPENSATION INSURANCE FUND WITH RATING ORGANIZATIONS AND CLASSIFICATION CATEGORIES USED BY PRIVATE INSURERS; REQUIRING THE CLASSIFICATION AND REVIEW COMMITTEE TO PROVIDE CERTAIN CLASSIFICATIONS REFLECTING STATE FUND'S CURRENT USAGE; REVISING DUTIES AND POWERS OF THE STATE FUND BOARD; REQUIRING MARKET CONDUCT AND FINANCIAL EXAMINATIONS; REQUIRING RATE CHANGES TO REFLECT CERTAIN STATUTORY OR REGULATORY CHANGES; REVISING REGULATION AND OVERSIGHT; AMENDING SECTIONS 33-1-102, 33-2-708, 33-16-303, 33-16-1002, 33-16-1008, 33-16-1012, 33-16-1020, 33-16-1021, 33-16-1035, 39-71-206, 39-71-435, 39-71-2311, 39-71-2314, 39-71-2315, 39-71-2316, 39-71-2323, 39-71-2330, 39-71-2351, AND 39-71-2363, MCA; REPEALING SECTIONS 33-16-1024 AND 39-71-2362, MCA; AND PROVIDING EFFECTIVE DATES, APPLICABILITY DATES, AND A TERMINATION DATE."

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

Section 1. 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~~ Except as expressly provided, this code does not apply to workers' compensation insurance ~~programs~~ plan No. 1, provided for in Title 39, chapter 71, ~~parts~~ part 21, ~~and~~ or plan No. 3, the state fund, provided for in Title 39, chapter 71, part 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) (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 2. 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:

(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) 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 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 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.

(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. The commissioner shall also annually collect a fee of $1,900 from the state compensation insurance fund.

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

(i) nonresident insurance producer's license:

(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) 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 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 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.

(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 3. Section 33-16-303, MCA, is amended to read:

"33-16-303. Use of rates, rating systems, underwriting rules, and policy or bond forms of rating or advisory organizations -- agreements to adhere to. (1) Members and subscribers of rating or advisory organizations may use the rates, rating systems, underwriting rules, or policy or bond forms of those organizations, either consistently or intermittently, but, except as provided in 33-16-105, 33-16-302, 33-16-305, 33-16-307, 33-16-1008, ~~and~~ 33-16-1020 through 33-16-1023, and 33-16-1025 through 33-16-1036, may not agree with each other or rating organizations or others to adhere to the organizations' rates, systems, rules, or policy or bond forms.

(2) The fact that two or more admitted insurers, whether or not members or subscribers of a rating or advisory organization, use, either consistently or intermittently, the rates or rating systems made or adopted by

a rating organization or the underwriting rules or policy or bond forms prepared by a rating or advisory organization is not sufficient in itself to support a finding that an agreement prohibited under subsection (1) exists and may be used only for the purpose of supplementing or explaining direct evidence of the existence of any agreement."

Section 4. Section 33-16-1002, MCA, is amended to read:

"33-16-1002. Applicability of part. (1) This part, together and in conjunction with parts 1 through 4 of this chapter, applies to the making of premium rates for workers' compensation insurance issued under compensation plan No. 2 of the Workers' Compensation Act, Title 39, chapter 71, part 22, or related employer's liability insurance~~, but~~.

(2) Unless specifically stated otherwise, this part, not in conjunction with parts 1 through 4 of this chapter but in conjunction with Title 39, chapter 71, part 23, applies to the making of premium rates for workers' compensation insurance issued under plan No. 3, the state fund, provided for in Title 39, chapter 71, part 23, or related employer's liability insurance.

(3) This part does not apply to reinsurance."

Section 5. Section 33-16-1008, MCA, is amended to read:

"33-16-1008. Definitions. As used in this part, the following definitions apply:

(1) "Accepted actuarial standards" means the standards adopted by the casualty actuarial society in its Statement of Principles Regarding Property and Casualty Insurance Ratemaking and the Standards of Practice adopted by the actuarial standards board.

(2) (a) "Advisory organization" means a person or organization that either has two or more member insurers or is controlled either directly or indirectly by two or more insurers and that assists insurers in ratemaking-related activities.

(b) The term does not include a joint underwriting association, any actuarial or legal consultant, or any employee of an insurer or insurers under common control or management or their employees or manager.

(c) As used in this subsection (2), two or more insurers who have a common ownership or operate in this state under common management or control constitute a single insurer.

(3) "Classification system" means the plan, system, or arrangement for recognizing differences in exposure to hazards among industries, occupations, or operations of insurance policyholders.

(4) "Contingencies" means provisions in rates to recognize the uncertainty of the estimates of losses, loss adjustment expenses, other operating expenses, and investment income and profit that comprise those rates. The provisions may be explicit, including but not limited to a specific charge to reflect systematic variations of estimated costs from expected costs, or implicit, including but not limited to a consideration in selecting a single estimate from a reasonable range of estimates, or both.

(5) "Developed losses" means adjusted losses, including loss adjustment expenses, using accepted actuarial standards to eliminate the effect of differences between current payment or reserve estimates and those needed to provide actual ultimate loss payments, including loss adjustment expense payments.

(6) "Expenses" means the portion of a rate that is attributable to acquisition, filed supervision and collection expenses, general expenses and taxes, licenses, or fees.

(7) "Experience rating" means a rating procedure using past insurance experience of the individual policyholder to forecast future losses by measuring the policyholder's loss experience against the loss experience of policyholders in the same classification to produce a prospective premium credit, debit, or unity modification.

(8) "Insurer" means a person licensed to write workers' compensation insurance as a plan No. 2 insurer or as plan No. 3, the state fund, under the laws of the state.

(9) "Loss trending" means a procedure for projecting developed losses to the average date of loss for the period during which the policies are to be effective, including loss ratio trending.

(10) "Market" means the interaction in this state between buyers and plan No. 2 sellers of workers' compensation and employer's liability insurance pursuant to all the provisions of this part. For the purposes of 33-16-1020(5), the term includes, among sellers of workers' compensation policies, plan No. 3, the state fund.

(11) (a) "Prospective loss costs" means historical aggregate losses and loss adjustment expenses, including all assessments that are loss-based and excluding any separately stated policyholder surcharges, projected through development to their ultimate value and through trending to a future point in time and ascertained by accepted actuarial standards.

(b) The term does not include provisions for profit or expenses other than loss adjustment expenses and assessments that are loss-based.

(12) "Pure premium rate" means the portion of the rate that represents the loss cost per unit of exposure, including loss adjustment expense.

(13) (a) "Rate" or "rates" means rate of premium, policy and membership fee, or any other charge made by an insurer for or in connection with a contract or policy of workers' compensation and employer's liability

insurance, prior to application of individual risk variations based on loss or expense considerations.

(b) The term does not include minimum premiums.

(14) "Reserve estimates" means provisions for insurer obligations for future payments of loss or loss adjustment expenses.

(15) "Statistical plan" means the plan, system, or arrangement that is used in collecting data.

(16) "Supplementary rate information" means a manual or plan of rates, statistical plan, classification system, minimum premium, policy fee, rating rule, rate-related underwriting rule, and any other information needed to determine the applicable premium for an individual insured that is consistent with the purposes of this part and with rules prescribed by rule of the commissioner.

(17) "Supporting information" means the experience and judgment of the filer and the experience or data of other insurers or advisory organizations relied on by the filer, the interpretation of any statistical data relied on by the filer, descriptions of methods used in making the rates, and any other similar information required to be filed by the commissioner."

Section 6. Section 33-16-1012, MCA, is amended to read:

"33-16-1012. Functions and powers of classification review committee -- hearings -- rulemaking. (1) The classification review committee shall:

(a) meet not less than semiannually to conduct its business;

(b) make the final determination regarding the establishment or revision of all classifications in accordance with the procedures set forth in Title 2, chapter 4, part 3~~;~~. The classifications must include classifications for state agencies, municipal government, and community service workers and a single classification for agriculture for use by plan No. 2 and plan No. 3 insurers.

(c) publish material and pamphlets as it considers appropriate;

(d) act as a review committee concerning objections filed by a policyholder or insurer in relation to classifications assigned to a policyholder according to rules governing the issuance or application of classifications; and

(e) make rules as may be necessary for the conduct of any business that is subject to notice and hearings. The rules must be published and adopted as provided in Title 2, chapter 4, part 3, and must be published in the Administrative Rules of Montana as part of the rules promulgated by the commissioner of insurance.

(2) (a) The initial hearing conducted by the committee pursuant to subsection (1)(d) must be informal and nonbinding upon the parties and must be conducted pursuant to rules of procedure that the committee considers to be appropriate. The committee shall issue its written advisory decision within 30 days of the conclusion of the hearing and send a written copy of the decision by first-class mail, postage prepaid, to each party. Each party to the informal hearing shall notify the committee and each other party of the notifying party's intent to be bound or not bound by the committee's advisory decision, and the notice must be made within 30 days of the date the committee mails the written copy of the decision to the parties.

(b) A party who is aggrieved by the advisory decision of the committee, or by the refusal of a party to be bound by the committee's advisory decision rendered after a hearing conducted pursuant to subsection (2)(a) may, within 30 days after the expiration of the 30-day notice deadline specified in subsection (2)(a), initiate an informal contested case proceeding pursuant to 2-4-604 before the committee, and the committee shall hear the matter in a de novo administrative proceeding as provided in Title 2, chapter 4, part 6. The committee may, in its discretion or at the request of any party, appoint a hearings examiner. If a hearings examiner is appointed, the examiner shall take evidence and prepare proposed findings of fact and conclusions of law that the committee may accept, reject, or modify, in whole or in part, based on the evidence produced during the informal contested case proceeding.

(c) A party who is aggrieved by a decision of the committee rendered after a hearing conducted pursuant to subsection (2)(b) may petition the workers' compensation court for judicial review of the decision pursuant to Title 2, chapter 4, part 7.

(3) The committee is subject to the provisions of Title 2, chapter 3, parts 1 and 2."

Section 7. Section 33-16-1020, MCA, is amended to read:

"33-16-1020. Competitive market -- hearing. (1) A competitive market is presumed to exist unless the commissioner, after hearing, issues an order stating that a reasonable degree of competition does not exist in the market. The order may not expire later than 1 year after issuance.

(2) In determining whether a reasonable degree of competition exists, the commissioner shall consider the following factors:

(a) the number of insurers actively engaged in providing coverage;

(b) market shares and changes in market shares;

(c) ease of entry into the market;

(d) market concentration among plan No. 2 insurers as measured by the Herfindahl-Hirschman index;

(e) whether long-term profitability for insurers in the market is unreasonably high in relation to the risks being insured;

(f) whether long-term profitability for insurers in the market is reasonable in relation to industries of comparable business risks; and

(g) generally accepted and relevant tests relating to competitive market structure, market performance, and market conduct.

(3) The workers' compensation insurance market may not be determined to be noncompetitive if the market concentration of the 50 largest insurers writing workers' compensation insurance under plan No. 2 satisfied the U.S. department of justice merger guidelines for an unconcentrated market.

(4) The commissioner's determinations must be made on the basis of findings of fact and conclusions of law.

(5) When calculating the Herfindahl-Hirschman index as provided in subsection (2)(d), the commissioner shall:

(a) provide a separate analysis for informational purposes only that includes a measurement of market concentration incorporating the state compensation insurance fund market share; and

(b) combine in the separate analysis required under this subsection (5) the market share of any affiliated plan No. 2 insurers that engage in joint or cooperative underwriting. The information gathered under this subsection (5)(b) is informational unless the report indicates a highly concentrated market for plan No. 2 insurers, which the commissioner may further investigate."

Section 8. Section 33-16-1021, MCA, is amended to read:

"33-16-1021. Ratemaking standards -- review by commissioner. (1) Rates may not be excessive, inadequate, or unfairly discriminatory.

(2) Rates in a competitive market are not excessive. Rates in a noncompetitive market are excessive if they are likely to produce a long-run profit that is unreasonably high in relation to services rendered.

(3) A rate may not be determined to be inadequate unless:

(a) it is clearly insufficient to sustain projected losses and expenses;

(b) the rate is unreasonably low and the use of the rate by the insurer has had or, if continued, will tend to create a monopoly in the market; or

(c) funds equal to the full, ultimate cost of anticipated losses and loss adjustment expenses are not produced when prospective loss costs are applied to anticipated payrolls.

(4) Unfair discrimination exists if, after allowing for practical limitations, price differentials fail to reflect equitably the differences in expected losses and expenses. A rate is not unfairly discriminatory because different premiums result for policyholders with different loss exposures or expense levels.

(5) In determining whether rates comply with standards under subsection (1), consideration must be given to:

(a) past and prospective loss experience within and outside Montana, in accordance with accepted actuarial principles;

(b) catastrophe hazards and contingencies;

(c) past and prospective expenses within and outside Montana;

(d) loadings for leveling premium rates over time for dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers;

(e) a reasonable margin for underwriting profit or, in the case of the state fund, contribution to equity; and

(f) all other relevant factors within and outside Montana.

(6) The systems of expense provisions included in the rates for use by an insurer or group of insurers may differ from those of any other insurer or group of insurers to reflect the requirements of the operating methods of the insurer or group of insurers.

(7) (a) The rate filed by plan No. 2 insurers may contain provisions of contingencies and an allowance permitting a reasonable profit. In determining the reasonableness of a profit, consideration must be given to all investment income attributable to premiums and the reserves associated with those premiums.

(b) The rate filed by plan No. 3, the state fund, must be set at amounts sufficient, when invested, to carry the estimated cost of all claims to maturity, to meet the reasonable expenses of conducting the business of the state fund, and to amass and maintain an excess of surplus, as determined by the board under 39-71-2330.

(8) The commissioner may investigate and determine whether rates in Montana are excessive, inadequate, or unfairly discriminatory. In any investigation and determination, the commissioner shall also consider the factors specified in 33-16-1020."

Section 9. Section 33-16-1035, MCA, is amended to read:

"33-16-1035. Penalties -- suspension of license. (1) The commissioner may impose upon a person

or organization that violates 33-16-1020 through 33-16-1023 or 33-16-1025 through 33-16-1036 a penalty of not more than $500 for each violation.

(2) If the commissioner determines that the violation is willful, the commissioner may impose a penalty of not more than $1,000 for each violation in addition to any other penalty provided by law.

(3) (a) ~~The~~ Except as provided in subsection (3)(b), the commissioner may suspend the license of an insurer or an advisory organization that fails to comply with any order within the time set by the order or extension granted by the commissioner. The commissioner may not suspend a license for failure to comply with an order until the time prescribed for appeal from the order has expired or, if appealed, until the order has been affirmed. The commissioner may determine the period of a suspension, which remains in effect for the period unless modified or rescinded or until the order upon which the suspension is based is modified, rescinded, or reversed.

(b) The commissioner may not take any action under this title against plan No. 3, the state fund, but may impose the other penalties described in subsections (1) and (2).

(4) Unless a consent decree has been entered, a penalty may not be imposed ~~nor may~~ or a license may not be suspended or revoked unless the commissioner, following a hearing, issues a written order with findings of fact. The hearing must be held at least 10 days after written notice to the person or organization specifying the alleged violation.

(5) A party aggrieved by an order or decision of the commissioner may, within 30 days after receiving the commissioner's notice, make a written request for a hearing."

Section 10. Section 39-71-206, MCA, is amended to read:

"39-71-206. Legal advisers of department and state fund -- investigative and prosecution services -- dissemination of criminal justice information. (1) The attorney general is the legal adviser of the department and the state fund and shall represent either entity in all proceedings if requested by the department or state fund. The department and state fund may employ other attorneys or legal advisers as they consider necessary.

(2) As provided in 2-15-2015, the attorney general shall provide investigative and prosecution services to the state fund with respect to violations of this chapter.

(3) If surveillance is used for claims examination or investigation of fraud, the state fund or the department of labor and industry may share information about the surveillance with a health care provider without otherwise receiving authorization for dissemination of the information even if the information may be considered confidential criminal justice information as defined in 44-5-103. Dissemination of information by a health care

provider or a claims examiner must be treated as confidential but does not rise to the level of confidential criminal justice information until referred for prosecution."

Section 11. Section 39-71-435, MCA, is amended to read:

"39-71-435. Workers' compensation and employers' liability insurance -- optional deductibles. (1) An insurer issuing a workers' compensation or an employer's liability insurance policy may offer to the policyholder, as part of the policy or by endorsement, optional deductibles for benefits payable under the policy consistent with the standards contained in subsection (3).

(2) The advisory organization designated under 33-16-1023 may develop and file a deductible plan or plans on behalf of its members consistent with the standards contained in subsection (3).

(3) The commissioner of insurance shall approve a deductible plan that is in accordance with the following standards:

(a) Claimants' rights are properly protected and claimants' benefits are paid without regard to the deductible.

(b) Premium reductions reflect the type and level of the deductible, consistent with accepted actuarial standards.

(c) Premium reductions for deductibles are determined before application of any experience modification, premium surcharge, or premium discount.

(d) Recognition is given to policyholder characteristics, including but not limited to size, financial capabilities, nature of activities, and number of employees.

(e) The policyholder is liable to the insurer for the deductible amount in regard to benefits paid for compensable claims.

(f) The insurer pays all of the deductible amount applicable to a compensable claim to the person or provider entitled to benefits and then seeks reimbursement from the policyholder for the applicable deductible amount.

(g) Failure by the policyholder to reimburse deductible amounts to the insurer is treated under the policy as nonpayment of premium.

(h) Losses subject to the deductible must be reported and recorded as losses for purposes of calculating rates for a policyholder on the same basis as losses under policies providing first dollar coverage.

~~(4) The state compensation insurance fund, plan No. 3, may adopt the plan filed by the designated~~

~~advisory organization or adopt an optional deductible plan that meets the requirements of this section.~~

~~(5)~~(4) For purposes of 39-71-201 and 39-71-915, liability for assessments must be ascertained without regard to application of any deductible, whether the employer or the insurer pays the losses. For all other taxes and assessments based on premium, the amount of premium or assessment must be determined after application of the deductible."

Section 12. Section 39-71-2311, MCA, is amended to read:

"39-71-2311. Intent and purpose of plan -- expense constant defined. (1) It is the intent and purpose of the state fund to allow employers an option to insure their liability for workers' compensation and occupational disease coverage with the state fund. The state fund must be neither more nor less than self-supporting. Premium rates must be set at least annually, in accordance with 39-71-2330, at a level sufficient to ensure the adequate funding of the insurance program, including the costs of administration, benefits, and adequate reserves, during and at the end of the period for which the rates will be in effect. In determining premium rates, the state fund shall make every effort to adequately predict future costs. When the costs of a factor influencing rates are unclear and difficult to predict, the state fund shall use a prediction calculated to be more than likely to cover those costs rather than less than likely to cover those costs. The prediction must take into account the goal of pooling risk and may not place an undue burden on employers that are not eligible for the tier with the lowest-rated premium for workers' compensation purposes.

(2) Unnecessary surpluses that are created by the imposition of premiums found to have been set higher than necessary because of a high estimate of the cost of a factor or factors may be refunded by the declaration of a dividend as provided in this part. For the purpose of keeping the state fund solvent, the board ~~of directors~~ may implement multiple rating tiers as provided in 39-71-2330 and may assess an expense constant, a minimum premium, or both.

(3) As used in this section, "expense constant" means a premium charge applied to each workers' compensation policy to pay expenses related to issuing, servicing, maintaining, recording, and auditing the policy."

Section 13. Section 39-71-2314, MCA, is amended to read:

"39-71-2314. State fund subject to laws applying to state agencies. The state fund is subject to laws that generally apply to state agencies, including but not limited to Title 2, chapters 2, 3, 4 (only as provided in

~~39-71-2316~~ 2-4-702(2)(c)), and 6, and Title 5, chapter 13. The state fund is not exempt from a law that applies to state agencies unless that law specifically exempts the state fund by name and clearly states that it is exempt from that law."

Section 14. Section 39-71-2315, MCA, is amended to read:

"39-71-2315. Management of state fund -- powers and duties of the board -- business plan required. (1) (a) ~~The~~ Except as provided in subsection (1)(b), the management and control of the state fund is vested ~~solely~~ in the board.

(b) The authority to determine whether state fund rates are excessive, inadequate, or unfairly discriminatory is vested in the commissioner of insurance under 33-16-1021.

(2) ~~The~~ Except as provided in subsection (1)(b), the board is vested with ~~full~~ power, authority, and jurisdiction over the state fund. The board may perform all acts necessary or convenient in the exercise of ~~any~~ its power, authority, or jurisdiction over the state fund~~, either~~ in the administration of the state fund ~~or in~~. In connection with the insurance business to be carried on under Title 33, chapter 16, part 10, and the provisions of this part, ~~as fully and completely~~ the board shall act, unless otherwise provided by statute, as the governing body of a private mutual insurance carrier~~,~~ in order to fulfill the objectives and intent of this part. Bonds may not be issued by the board, the state fund, or the executive director.

(3) The board shall adopt a business plan no later than June 30 for the next fiscal year. At a minimum, the plan must include:

(a) specific goals for the fiscal year for financial performance. The standard for measurement of financial performances must include an evaluation of premium to surplus.

(b) specific goals for the fiscal year for operating performance. Goals must include but not be limited to specific performance standards for staff in the area of senior management, underwriting, and claims administration. Goals must, in general, maximize efficiency, economy, and equity as allowed by law.

(4) The business plan must be available upon request to the general public for a fee not to exceed the actual cost of publication. However, performance goals relating to a specific employment position are confidential and not available to the public.

(5) No sooner than July 1 or later than October 31, the board shall convene a public meeting to review the performance of the state fund, using the business plan for comparison of all the established goals and targets. The board shall publish, by November 30 of each year, a report of the state fund's actual performance as

compared to the business plan.

(6) The ~~state fund~~ board ~~of directors~~ shall establish in-house guidelines for procurement of insurance-related services and shall include guidelines for the solicitation of submissions of information regarding insurance-related services from more than one vendor. The board may include guidelines for the circumstances when business necessity or expedience may preclude the solicitation of submissions from more than one vendor. The board may also include in the guidelines the exemptions to the procurement process in 18-4-132."

Section 15. Section 39-71-2316, MCA, is amended to read:

"39-71-2316. Powers of state fund. (1) For the purposes of carrying out its functions, the state fund may:

(a) insure any employer for workers' compensation and occupational disease liability as the coverage is required by the laws of this state and, as part of the coverage, provide related employers' liability insurance upon approval of the board;

(b) sue and be sued;

(c) enter into contracts relating to the administration of the state fund, including claims management, servicing, and payment;

(d) collect and disburse money received;

(e) adopt classifications established as provided in 33-16-1012 and charge premiums for the classifications so that the state fund will be neither more nor less than self-supporting. Premium rates for classifications may be adopted and changed only by using ~~a~~ the process, ~~a~~ procedure, formulas, and factors set forth in ~~rules adopted under Title 2, chapter 4, parts 2 through 4. After the rules have been adopted, the state fund need not follow the rulemaking provisions of Title 2, chapter 4, when changing classifications and premium rates. The contested case rights and provisions of Title 2, chapter 4, do not apply to an employer's classification or premium rate~~ Title 33, chapter 16, part 10, and rules implementing Title 33, chapter 16, part 10. The state fund ~~is required to~~ shall belong to ~~a~~ the licensed workers' compensation advisory organization ~~or a licensed workers' compensation rating organization under Title 33, chapter 16, part 4,~~ determined under 33-16-1023 and ~~may~~ shall use the classifications of employment adopted by the designated workers' compensation advisory organization, as provided in ~~Title 33, chapter 16, part 10, and corresponding rates as a basis for setting its own rates~~ 33-16-1023. Except as provided in Title 33, chapter 16, part 10, a workers' compensation advisory organization or a licensed workers' compensation rating organization under Title 33, chapter 16, part 4, or other person may

not, without first obtaining the written permission of the employer, use, sell, or distribute an employer's specific payroll or loss information, including but not limited to experience modification factors.

(f) pay the amounts determined to be due under a policy of insurance issued by the state fund;

(g) hire personnel;

(h) declare dividends if there is an excess of assets over liabilities. ~~However, dividends~~ Dividends must be proportionately distributed among policyholders, taking into account loss experience and premiums paid. Dividends may not be paid until adequate actuarially determined reserves are set aside.

(i) adopt and implement one or more alternative personal leave plans pursuant to 39-71-2328;

(j) upon approval of the board, contract with licensed resident insurance producers;

(k) upon approval of the board, enter into agreements with licensed workers' compensation insurers, insurance associations, or insurance producers to provide workers' compensation coverage in other states to Montana-domiciled employers insured with the state fund;

(l) upon approval of the board, expend funds for ~~scholarship, educational, or charitable purposes;~~ safety training for policyholders. Expenditures for safety training, including educational seminars, must be specific to policyholders' needs and may not include athletic sponsorships or conference promotional items or advertising with general messages about the state fund.

(m) upon approval of the board, including terms and conditions, provide employers coverage under the federal Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 901, et seq., the federal Merchant Marine Act, 1920 (Jones Act), 46 U.S.C. 688, and the federal Employers' Liability Act, 45 U.S.C. 51, et seq.;

(n) perform all insurance-related functions ~~and exercise all powers~~ of a private insurance carrier that are necessary, appropriate, or convenient for the administration of the state fund.

(2) The state fund shall include a provision in every policy of insurance issued pursuant to this part that incorporates the restriction on the use and transfer of money collected by the state fund as provided for in 39-71-2320."

Section 16. Section 39-71-2323, MCA, is amended to read:

"39-71-2323. Surplus in state fund -- payment of dividends. Subject to the provisions of 39-71-2316, if at the end of any fiscal year there exists in the state fund account created by 39-71-2321 for claims for injuries resulting from accidents that occur on or after July 1, 1990, an excess of assets over liabilities, including necessary reserves and an appropriate surplus as determined by the board in accordance with 39-71-2330, and

if the excess may be refunded safely, then the board, after consultation with the independent actuary engaged pursuant to 39-71-2330 and after notifying the legislative finance committee provided for in 5-12-201, may declare a dividend. The ~~rules of the state fund must~~ board shall prescribe the manner of ~~payment~~ making dividend payments in accordance with the guidelines in 39-71-2316 to those employers who have paid premiums into the state fund in excess of liabilities."

Section 17. Section 39-71-2330, MCA, is amended to read:

"39-71-2330. Rate setting -- surplus -- multiple rating tiers. (1) ~~The~~ Subject to 33-16-1021, the board has the authority to establish the rates to be charged by the state fund for insurance. The board shall engage the services of an independent actuary who is a member in good standing with the American academy of actuaries to develop and recommend actuarially sound rates. Rates must be set at amounts sufficient, when invested, to carry the estimated cost of all claims to maturity, to meet the reasonable expenses of conducting the business of the state fund, and to amass and maintain an excess of surplus over the amount produced by the national association of insurance commissioners' risk-based capital company action level requirements for a casualty insurer.

(2) Because surplus is desirable in the insurance business, the board shall annually determine the level of surplus that must be maintained by the state fund pursuant to this section, but shall maintain a minimum surplus of 25% of annual earned premium. The state fund shall use the amount of the surplus above the risk-based capital company action level requirements to secure the state fund against various risks inherent in or affecting the business of insurance and not accounted for or only partially measured by the risk-based capital company action level requirements.

(3) The board may implement multiple rating tiers for classifications that take into consideration losses, premium size, and other factors relevant in placing an employer within a rating tier."

Section 18. Section 39-71-2351, MCA, is amended to read:

"39-71-2351. Purpose of separation of state fund liability as of July 1, 1990, and of separate funding of claims before and on or after that date. (1) An unfunded liability exists in the state fund. It has existed since at least the mid-1980s and has grown each year. There have been numerous attempts to solve the problem by legislation and other methods. These attempts have alleviated the problem somewhat, but the problem has not been solved.

(2) The legislature has determined that it is necessary to the public welfare to make workers' compensation insurance available to all employers through the state fund as the insurer of last resort. In making this insurance available, the state fund has incurred the unfunded liability. The legislature has determined that the most cost-effective and efficient way to provide a source of funding for and to ensure payment of the unfunded liability and the best way to administer the unfunded liability is to separate the liability of the state fund on the basis of whether a claim is for an injury resulting from an accident that occurred before July 1, 1990, or an accident that occurs on or after that date.

(3) The legislature further determines that in order to prevent the creation of a new unfunded liability with respect to claims for injuries for accidents that occur on or after July 1, 1990, ~~certain duties of the state fund should be clarified and legislative~~ oversight of the state fund ~~should be increased~~ by persons familiar with insurance, particularly workers' compensation insurance, is prudent and that regulation by only the board and oversight by only the legislative auditor and information gathered by legislative liaisons provides insufficient perspective for evaluating the state fund's practices in comparison to practices of plan No. 2 insurers. Evaluation of rates considered to be excessive, inadequate, or unfairly discriminatory is best handled by the commissioner of insurance."

NEW SECTION. **Section 19. Examinations.** (1) The commissioner of insurance provided for in 2-15-1903 shall examine the affairs, records, accounts, transactions, and assets of the state fund as necessary to ascertain its financial condition and its ability to fulfill its obligations, shall examine its claims reservation process to determine if reserving for developed losses as defined in 33-16-1008 is routinely above or below paid claims, and shall examine whether the state fund has complied with the provisions of this chapter. The examination must be performed at least every 5 years and must be carried out pursuant to 33-1-401, 33-1-408 through 33-1-410, 33-1-413(1) and (2), and 33-16-1020(2)(g).

(2) The cost of the examination must be paid by the state fund. The state fund may coordinate with the commissioner of insurance for the timing of the examinations in order to apportion the costs of business over time and not directly to premiums in any 1 year.

(3) The commissioner may not take any action to suspend, revoke, or liquidate assets of the state fund as a result of an examination but shall report findings to the governor and to the legislature.

NEW SECTION. **Section 20. Transition ratemaking.** (1) Except as provided in subsection (2), until

July 1, 2013, at each board meeting subsequent to the filing of a loss costs rate or rating plan by the advisory organization designated pursuant to 33-16-1023, the board shall adopt a rate that matches the net percentage rate decrease or increase filed by the designated advisory organization.

(2) If a decrease in the loss costs rate or rating plan would cause the surplus to fall below 25% of the annual earned premium, the board shall adopt rates that allow a surplus of no more than 25% of the annual earned premium.

(3) The board shall meet at a time that allows adoption of a rate for policies issued or renewed on or after July 1, 2011, and shall adopt rates as provided in subsection (1) and subject to subsection (2) that incorporate the percentage loss costs rate filed by the advisory organization designated pursuant to 33-16-1023 for the policies issued on or renewed by July 1, 2011.

Section 21. Section 39-71-2363, MCA, is amended to read:

"39-71-2363. Agency law -- submission of budget -- annual report. (1) The state fund is subject to state laws applying to state agencies, except as otherwise provided by law, and it is exempt from the provisions of The Legislative Finance Act in Title 5, chapter 12, except as provided in subsection (2), and from the provisions of Title 17, chapter 7, parts 1 through 4. The state fund may use the debt collection procedures provided in Title 17, chapter 4, part 1.

(2) (a) Except as provided in 2-15-2015, the executive director shall annually submit to the board for its approval an estimated budget of the entire expense of administering the state fund for the succeeding fiscal year, with due regard to the business interests and contract obligations of the state fund. The administrative expenditures approved by the board, minus loss adjustment expenses, may not exceed 15% of the earned annual premiums in the prior fiscal year. A copy of the approved budget must be delivered to the governor and the legislature.

(b) The board may approve administrative expenditures in excess of 15% of the earned annual premium of the prior fiscal year, but the excess amount approved may not exceed one-half of the investment income earned in the prior fiscal year.

~~(b)~~(c) Upon approval of the estimated budget for the succeeding fiscal year, the state fund shall, no later than October 1 of each year, submit the approved annual budget for review to the legislative finance committee established under 5-12-201. The report to the legislative finance committee must contain a description of dividends and the analysis for determining the excess surplus as provided in subsection (2)(d).

~~(c)~~(d) Dividends may not be included as administrative expenditures as provided in subsection (2)(a), but are a disbursement of excess surplus pursuant to 39-71-2323 after a determination by the state fund of income from operations.

(3) The board shall submit an annual financial report to the governor and to the legislature as provided in 5-11-210, indicating the business done by the state fund during the previous year and containing a statement of the estimated liabilities of the state fund as determined by an independent actuary."

NEW SECTION. **Section 22. Repealer.** The following sections of the Montana Code Annotated are repealed:

33-16-1024. Plan No. 3 membership in licensed workers' compensation advisory organization -- reporting requirements.

39-71-2362. Authority of legislative auditor with respect to state fund.

NEW SECTION. **Section 23. Codification instruction.** [Sections 19 and 20] are intended to be codified as an integral part of Title 39, chapter 71, part 23, and the provisions of Title 39, chapter 71, part 23, apply to [sections 19 and 20].

NEW SECTION. **Section 24. Effective dates -- applicability.** (1) [Sections 20 and 23] and this section are effective on passage and approval, and [section 20] applies to policies issued on or after July 1, 2011.

(2) [Sections 6, 10, and 21] are effective July 1, 2011.

(3) [Sections 1 through 5, 7 through 9, 11 through 19, and 22] are effective July 1, 2013, and apply to policies issued or renewed on or after July 1, 2013.

NEW SECTION. **Section 25. Termination.** [Section 20] terminates on July 1, 2013.

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