HOUSE BILL NO. 188

INTRODUCED BY BERGREN

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING THE SECURITIES AND INSURANCE LAWS ADMINISTERED BY THE STATE AUDITOR; CLARIFYING A DEPOSITORY FOR SECURITIES EXAMINATION COSTS; CLARIFYING VARIOUS ACCOUNT, MORTALITY TABLE, AND MANUAL REFERENCES; REVISING THE APPLICABILITY OF CERTAIN REPORTING PENALTY PROVISIONS; EXCLUDING CERTAIN UNALLOCATED ANNUITY CONTRACTS FROM THE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACCOUNT; CHANGING A REFERENCE TO SURPLUS LINES PRODUCER FEE; ADDING A PRIME RATE FACTOR TO CERTAIN INTEREST RATE PAYMENTS; ALLOWING INCLUSION OF THE HIGHWAY TRAFFIC SAFETY FEE IN A PREMIUM REDUCTION; REVISING THE DEFINITION OF "CONSULTANT"; CHANGING REFERENCES TO APPLICATION FORMS; SPECIFYING HOW CRIMINAL BACKGROUND CHECKS MAY BE HANDLED; CLARIFYING APPLICATION OF CONTINUING EDUCATION PROVISIONS TO INDIVIDUALS AND REMOVING A CARRYFORWARD PROVISION; ADDING REPORTING AND COMPLIANCE REQUIREMENTS FOR RENTAL VEHICLE ENTITIES; LIMITING INTEREST DUE ON CLAIMS; REVISING THE DATE FOR AN EXEMPTION RELATED TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY PRIVACY REGULATIONS; CLARIFYING INCONTESTABILITY OF CERTAIN LIFE INSURANCE EXCHANGE OR CONVERSION POLICIES; INCLUDING INTENT NOTIFICATION IN CHARITABLE GIFT ANNUITY REQUIREMENTS; REVISING DOWNWARD THE NUMBER OF EMPLOYEES NECESSARY FOR CERTAIN GROUP INSURANCE POLICIES; CLARIFYING POLICY COVERAGE OF NEWBORNS; CLARIFYING THE DEFINITION OF "CREDITABLE COVERAGE"; EXCLUDING EXCEPTED BENEFIT PLANS FROM CONVERSION REQUIREMENTS; DEFINING RESIDENCY FOR THE COMPREHENSIVE HEALTH ASSOCIATION; CLARIFYING RULEMAKING AUTHORITY RELATED TO THE COMPREHENSIVE HEALTH ASSOCIATION; CLARIFYING REFERENCES TO THE COMPREHENSIVE HEALTH ASSOCIATION PORTABILITY PLAN; CLARIFYING PERMISSIBLE OFFSET FOR PERSONAL PROPERTY LOSS; CLARIFYING PROVISIONS THAT APPLY JOINTLY TO A CAPTIVE INSURANCE COMPANY FORMED AS A RECIPROCAL INSURER; REPEALING VALUATION PROVISIONS FOR BONDS, CERTAIN SECURITIES, PROPERTY, AND PURCHASE MONEY MORTGAGES; AMENDING SECTIONS 30-10-115, 30-10-209, 33-2-305, 33-2-523, 33-2-701, 33-3-431, 33-4-101, 33-10-203, 33-12-107, 33-16-222, 33-17-102, 33-17-211, 33-17-220, 33-17-301, 33-17-401, 33-17-503, 33-17-1203, 33-17-1205, 33-17-1502,

33-18-232, 33-19-105, 33-20-105, 33-20-704, 33-20-1101, 33-22-101, 33-22-140, 33-22-508, 33-22-1501, 33-22-1502, 33-22-1513, 33-22-1514, 33-22-1515, 33-22-1516, 33-22-1517, 33-22-1803, 33-24-103, 33-28-105, AND 33-28-202, MCA; REPEALING SECTIONS 33-2-532, 33-2-533, 33-2-534, AND 33-2-535, MCA; AND PROVIDING AN APPLICABILITY DATE."

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

Section 1. Section 30-10-115, MCA, is amended to read:

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

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

Section 2. Section 30-10-209, MCA, is amended to read:

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

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

(b) Each succeeding year, a registration of securities or a notice filing of a federal covered security may be renewed, prior to its termination date, for an additional year upon consent of the commissioner and payment of a renewal fee to be computed at 1/10 of 1% of the aggregate offering price of the securities that are to be offered in this state during that year. The renewal fee may not be less than $200 or more than $1,000. The registration or the notice filing may be amended to increase the amount of securities to be offered.

(c) If a registrant or issuer of federal covered securities sells securities in excess of the aggregate amount registered for sale in this state, or for which a notice filing has been submitted, the registrant or issuer

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

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

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

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

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

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

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

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

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

Section 3. Section 33-2-305, MCA, is amended to read:

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

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

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

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

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

(3) The licensee shall renew the license on a form prescribed by the commissioner. The commissioner may establish rules for biennial renewal of the license. A license lapses if not renewed.

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

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

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

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

Section 4. Section 33-2-523, MCA, is amended to read:

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

(2) Except as otherwise provided in 33-2-524, 33-2-525, and 33-2-537(2), the minimum standard for the valuation of all the policies and contracts issued prior to October 1, 1995, ~~must be~~ is the standard provided by the laws in effect prior to October 1, 1995. Except as otherwise provided in 33-2-524, 33-2-525, and 33-2-537(2), the minimum standard for the valuation of all policies and contracts ~~must be~~ is the commissioner's reserve valuation methods defined in 33-2-525, 33-2-526(3) and (4), and 33-2-537, 5% interest for group annuity and pure endowment contracts, and 3 1/2% interest for all other policies and contracts or, in the case of life insurance

policies and contracts other than annuity and pure endowment contracts issued on or after March 17, 1973, 4% interest for all other policies issued prior to July 1, 1979, 5 1/2% interest for single-premium life insurance policies, and 4 1/2% interest for all other policies issued on or after July 1, 1979, and the following tables:

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

(i) the ~~commissioner's~~ 1941 commissioners standard ordinary mortality table for policies issued prior to the operative date of 33-20-206, as amended, and the ~~commissioner's~~ 1958 commissioners standard ordinary mortality table for policies issued on or after that operative date but prior to January 1, 1989, except that for any category of the policies issued on female risks, modified net premiums and present values, referred to in 33-2-525 and 33-2-526, may be calculated, at the option of the insurer, with the approval of the commissioner, according to an age younger than the actual age of the insured; ~~or~~

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

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

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

(C) any ordinary mortality table adopted after ~~1980~~ 2001 by the national association of insurance commissioners that is approved by the commissioner by rule for use in determining the minimum standard of valuation for policies; or

(iii) for policies issued on or after [the effective date of this act], the 2001 commissioners standard ordinary mortality table; or

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

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

(d) for group annuity and pure endowment contracts, excluding any disability and accidental death benefits in the policies, the group annuity mortality table for 1951, any modification of the table approved by the

commissioner, or, at the option of the insurer, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts;

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

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

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

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

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

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

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

(B) for policies issued on or after January 1, 1961, and prior to January 1, 1966, ~~either such~~ a table referenced in subsection (2)(f)(i)(A) or, at the option of the insurer, the intercompany double indemnity mortality table; and

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

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

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

Section 5. Section 33-2-701, MCA, is amended to read:

"33-2-701. Annual statement -- revocation or fine for failure to file -- penalty for perjury. (1) Each authorized insurer shall annually on or before March 1 file with the commissioner a full and true statement of ~~its~~ the authorized insurer's financial condition, transactions, and affairs as of the preceding December 31. The statement must be:

(a) in the general form and context as is required or not disapproved by the commissioner, as is in current use for similar reports to states in general with respect to the type of insurer and kinds of insurance to be reported upon, and as supplemented for additional information required by the commissioner~~. The statement must be~~;

(b) completed in accordance with the annual statement instructions and the ~~accounting practices and procedures manual~~ Accounting Practices and Procedures Manual of the national association of insurance commissioners~~. The statement must be~~;

(c) accompanied by an actuarial opinion attesting to the adequacy of the insurer's reserves~~. The statement must be~~;

(d) verified by the oath of the insurer's president or vice president and secretary or, if a reciprocal insurer, by the oath of the attorney-in-fact or its like officers if a corporation. The commissioner may waive the verification under oath.

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

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

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

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

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

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

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

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

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

$1,000."

Section 6. Section 33-3-431, MCA, is amended to read:

"33-3-431. Borrowed surplus. (1) A domestic stock or mutual insurer may borrow money to defray the expenses of ~~its~~ the insurer's organization, to provide ~~it~~ the insurer with surplus funds, or for any purpose of ~~its~~ the insurer's business upon a written agreement that the money is required to be repaid only out of the insurer's surplus in excess of that stipulated in the agreement. The agreement may provide for interest at a rate not to exceed the greater ~~than~~ of the rate established in 25-9-205~~, and~~ or a rate that is 6 percentage points per year higher than the prime rate of major New York banks as published in the Wall Street Journal edition dated 3 business days prior to the execution of the agreement. The agreement must specify whether the interest constitutes a liability of the insurer ~~must be stipulated in the agreement~~. A commission or promotion expense may not be paid in connection with a loan of the type described in this section.

(2) Money borrowed, together with the interest if stipulated in the agreement, does not form a part of the insurer's legal liabilities except as to ~~its~~ the insurer's surplus in excess of the amount stipulated in the agreement or the basis of any setoff. However, until the money or interest, or both, are repaid, financial statements filed or published by the insurer must show as a footnote the amount then unpaid together with any interest accrued but unpaid.

(3) A loan of this type to a mutual or stock insurer is subject to the commissioner's approval. The insurer shall, in advance of the loan, file with the commissioner a statement of the purpose of the loan and a copy of the proposed loan agreement. The loan and agreement are approved unless within 15 days after filing the insurer is notified of the commissioner's disapproval and reasons for the disapproval. The commissioner shall disapprove any proposed loan or agreement if the commissioner finds the loan is unnecessary or excessive for the purpose intended or that the terms of the loan agreement are not fair and equitable to the parties, and to other similar lenders, if any, to the insurer, or that the information filed by the insurer is inadequate.

(4) A loan to a mutual or stock insurer or a substantial portion of the loan must be repaid by the insurer when ~~it~~ the loan is no longer reasonably necessary for the purpose originally intended. Repayment of either principal or interest on the loan may not be made by a mutual or stock insurer unless approved in advance by the commissioner.

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

Section 7. Section 33-4-101, MCA, is amended to read:

"33-4-101. Scope of chapter -- provisions applicable. (1) The chapter applies to:

(a) all domestic mutual hail, fire, and other casualty insurers of farm property and stock and rural buildings formed and immediately prior to January 1, 1961, lawfully transacting insurance under sections 40-1501 through 40-1517 of the Revised Codes of Montana, 1947;

(b) all domestic mutual rural insurers formed and immediately prior to January 1, 1961, lawfully transacting insurance under sections 40-1601 through 40-1625 of the Revised Codes of Montana, 1947;

(c) all insurers formed under this chapter.

(2) The insurance laws of this state do not apply to or govern, either directly or indirectly, domestic farm mutual insurers except as provided in this chapter.

(3) The following chapters and sections of this title apply to farm mutual insurers to the extent applicable and not inconsistent with the express provisions of this chapter and the reasonable implications of the express provisions of this chapter: chapter 1, parts 1 through 4, 7, 12, and 13; 33-2-112; 33-2-501; 33-2-502; ~~33-2-532 through 33-2-535;~~ 33-2-708; 33-2-1212; chapter 2, parts 13 and 16; 33-2-1501; 33-2-1517(2); 33-3-218; 33-3-308; 33-3-309; 33-3-401; 33-3-402; 33-3-431; 33-3-436; and chapters 18 and 19."

Section 8. Section 33-10-203, MCA, is amended to read:

"33-10-203. Creation of the association -- accounts -- supervision by commissioner. (1) There is created a nonprofit legal entity to be known as the Montana life and health insurance guaranty association. ~~All~~ A member ~~insurers~~ insurer must be and remain ~~members~~ a member of the association as a condition of ~~their~~ the member's authority to transact insurance in this state. The association shall perform ~~its~~ functions under the plan of operation established and approved under 33-10-216 and shall exercise ~~its~~ powers through a board of directors established under 33-10-204.

(2) For purposes of administration and assessment, the association shall maintain two accounts:

(a) the health insurance account; and

(b) the life insurance and annuity account that includes the following subaccounts:

(i) the life insurance account;

(ii) the annuity account that includes contracts owned by a governmental retirement plan or the plan's trustee established under section 401, 403(b), or 457 of the Internal Revenue Code, but does not otherwise include unallocated annuities; and

(iii) the unallocated annuity account that must ~~include~~ exclude unallocated annuity contracts owned by

a governmental retirement benefit plan or the plan's trustee established under section 401, 403(b), or 457 of the Internal Revenue Code.

(3) The association is under the immediate supervision of the commissioner and is subject to the applicable provisions of the insurance laws of this state."

Section 9. Section 33-12-107, MCA, is amended to read:

"33-12-107. Valuation of investments. For the purposes of this chapter, the value or amount of an investment acquired or held under this chapter or an investment practice engaged in under this chapter, unless otherwise specified in statute, must be the value at which assets of an insurer are required to be reported for statutory accounting purposes as determined in accordance with procedures prescribed in published accounting and valuation standards of the NAIC, including the Purposes and Procedures Manual of the Securities Valuation Office, the Valuation of Securities Manual, the Accounting Practices and Procedures Manual, the ~~Annual Statement Instructions~~ annual statement instructions, or any successor valuation procedures officially adopted by the NAIC."

Section 10. Section 33-16-222, MCA, is amended to read:

"33-16-222. Requirement for rate reduction. (1) Any rates, rating schedules, or rating manuals for liability, bodily injury, or collision coverages of a motor vehicle insurance policy filed with the insurance department must provide for an appropriate premium reduction as determined by the insurer for an insured operator of a covered vehicle who is 55 years of age or older and who has successfully completed a highway traffic safety program as provided by 61-2-102 and 61-2-103.

(2) ~~Any discount~~ In addition to providing a premium reduction, an insurer may reimburse the fee for participating in the highway traffic safety program.

(3) The premium reduction used by the insurer is presumed appropriate unless credible data demonstrates otherwise."

Section 11. Section 33-17-102, MCA, is amended to read:

"33-17-102. Definitions. As used in this title, the following definitions apply:

(1) (a) "Adjuster" means a person who, on behalf of the insurer, for compensation as an independent contractor or as the employee of an independent contractor or for a fee or commission investigates and negotiates the settlement of claims arising under insurance contracts or otherwise acts on behalf of the insurer.

(b) The term does not include a:

(i) licensed attorney who is qualified to practice law in this state;

(ii) salaried employee of an insurer or of a managing general agent;

(iii) licensed insurance producer who adjusts or assists in adjustment of losses arising under policies issued by the insurer; or

(iv) licensed third-party administrator who adjusts or assists in adjustment of losses arising under policies issued by the insurer.

(2) "Adjuster license" means a document issued by the commissioner that authorizes a person to act as an adjuster.

(3) (a) "Administrator" means a person who collects charges or premiums from residents of this state in connection with life, disability, property, or casualty insurance or annuities or who adjusts or settles claims on these coverages.

(b) The term does not include:

(i) an employer on behalf of its employees or on behalf of the employees of one or more subsidiaries of affiliated corporations of the employer;

(ii) a union on behalf of its members;

(iii) (A) an insurer that is either authorized in this state or acting as an insurer with respect to a policy lawfully issued and delivered by ~~it~~ the insurer in and pursuant to the laws of a state in which the insurer is authorized to transact insurance; or

(B) a health service corporation as defined in 33-30-101;

(iv) a life, disability, property, or casualty insurance producer who is licensed in this state and whose activities are limited exclusively to the sale of insurance;

(v) a creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors;

(vi) a trust established in conformity with 29 U.S.C. 186 or the trustees, agents, and employees of the trust;

(vii) a trust exempt from taxation under section 501(a) of the Internal Revenue Code or the trustees and employees of the trust;

(viii) a custodian acting pursuant to a custodian account that meets the requirements of section 401(f) of the Internal Revenue Code or the agents and employees of the custodian;

(ix) a bank, credit union, or other financial institution that is subject to supervision or examination by

federal or state banking authorities;

(x) a company that issues credit cards and that advances for and collects premiums or charges from ~~its~~ the company's credit card holders who have authorized ~~it~~ the company to do so, if the company does not adjust or settle claims;

(xi) a person who adjusts or settles claims in the normal course of the person's practice or employment as an attorney and who does not collect charges or premiums in connection with life or disability insurance or annuities; or

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

(4) "Administrator license" means a document issued by the commissioner that authorizes a person to act as an administrator.

(5) (a) "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity.

(b) The term does not include an individual.

(6) "Consultant" means ~~a person~~ an individual who for a fee examines, appraises, reviews, ~~or~~ evaluates, makes recommendations, or gives advice regarding an insurance policy, annuity, or pension contract, plan, or program ~~or who makes recommendations or gives advice on an insurance policy, annuity, or pension contract, plan, or program~~.

(7) "Consultant license" means a document issued by the commissioner that authorizes ~~a person~~ an individual to act as an insurance consultant.

(8) "Individual" means a natural person.

(9) "Insurance producer", except as provided in 33-17-103, means a person required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

(10) "Lapse" means the expiration of the license for failure to renew by the biennial renewal date.

(11) "License" means a document issued by the commissioner that authorizes a person to act as an insurance producer for the lines of authority specified in the document. The license itself does not create actual, apparent, or inherent authority in the holder to represent or commit an insurer to a binding agreement.

(12) "Limited line credit insurance" includes credit life insurance, credit disability insurance, credit property insurance, credit unemployment insurance, involuntary unemployment insurance, mortgage life insurance, mortgage guaranty insurance, mortgage disability insurance, gap insurance, and any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing the credit

obligation and that the commissioner determines should be designated as a form of limited line credit insurance.

(13) "Limited line credit insurance producer" means a person who sells, solicits, or negotiates one or more forms of limited line credit insurance coverage to individuals through a master, corporate, group, or individual policy.

(14) "Limited lines insurance" means those lines of insurance that the commissioner finds necessary to recognize for the purposes of complying with 33-17-401(3).

(15) "Limited lines producer" means a person authorized by the commissioner to sell, solicit, or negotiate limited lines insurance.

(16) "Lines of authority" means any kind of insurance as defined in Title 33.

(17) "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms, or conditions of the contract if the person engaged in negotiation either sells insurance or obtains insurance from insurers for purchasers.

(18) "Person" means an individual or a business entity.

(19) "Public adjuster" means an adjuster employed by and representing the interests of the insured.

(20) "Sell" means to exchange a contract of insurance by any means, for money or ~~its~~ the equivalent, on behalf of an insurance company.

(21) "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance.

(22) "Suspend" means to bar the use of a person's license for a period of time.

(23) "Uniform application" means the national association of insurance commissioners' uniform application for resident and nonresident insurance producer licensing.

(24) "Uniform business entity application" means the national association of insurance commissioners uniform business entity application for resident and nonresident business entities."

Section 12. Section 33-17-211, MCA, is amended to read:

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

(a) is 18 years of age or older;

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

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

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

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

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

(g) has experience or training or otherwise is qualified in the kind or kinds of insurance for which the applicant applies to be licensed and is reasonably familiar with the provisions of this code that govern the applicant's operations as an insurance producer;

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

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

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

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

(i) has completed a background examination pursuant to 33-17-220.

(2) A resident or nonresident business entity acting as an insurance producer is required to obtain an insurance producer's license. Application must be made ~~using the uniform business entity application~~ in a form approved by the commissioner. ~~In order to~~ To approve the application, the commissioner shall verify that:

(a) the business entity has paid the appropriate fee; and

(b) the business entity has designated an individual licensed insurance producer who is responsible for the business entity's compliance with the insurance laws of this state.

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

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

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

an individual listed in the license.

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

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

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

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

(4) The commissioner may license as a resident insurance producer an association of licensed Montana insurance producers, whether or not incorporated, formed and existing substantially for purposes other than insurance. The license must be used solely for the purpose of enabling the association to place, as a resident insurance producer, insurance of the properties, interests, and risks of the state of Montana and of other public agencies, bodies, and institutions and to receive the customary commission for the placement. The president and secretary of the association shall apply for the license in the name of the association, and the commissioner shall issue the license to the association in ~~its~~ the association's name alone. The fee for the license is the same as that required by 33-2-708(1)(a). The commissioner may, after a hearing with notice to the association, revoke the license if the commissioner finds that continuation of the license is not in the public interest or that a ground listed in 33-17-1001 exists.

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

Section 13. Section 33-17-220, MCA, is amended to read:

"33-17-220. Licensing background examination -- entity registry criteria. (1) (a) Each applicant shall obtain a complete background examination. The applicant or insurer shall pay the cost of the background examination. The background examination report must provide information to confirm:

(i) the applicant's:

(A) identity;

(B) current address;

(C) professional license certification; and

(D) military service; and

(ii) (A) existing or ongoing criminal investigations and court records relating to the applicant; and

(B) regulatory agencies' disciplinary actions concerning the applicant.

(b) The background examination is confidential and may not be held as part of the licensee's public file.

~~(2) An entity may not conduct licensing background examinations unless the entity maintains a current filing with the commissioner. The filing must:~~

~~(a) contain a description of the criteria, standards, and procedures used in conducting the background examination;~~

~~(b) ensure that the examination will be based on nationally recognized criteria, standards, and procedures; and~~

~~(c) ensure confidentiality of the applicant's information.~~

~~(3)~~(2) For the purpose of obtaining a state and a federal criminal records check pursuant to subsection (1), the commissioner may require a person applying for a license to submit a full set of fingerprints to the commissioner. The commissioner shall submit the fingerprints to the Montana department of justice. The Montana department of justice may exchange this fingerprint data with the federal bureau of investigation.

(3) The commissioner may require fingerprints to be collected and remitted in an electronic format to facilitate periodic resubmission of fingerprints.

(4) The commissioner may contract for the collection, transmission, and retention of fingerprints and may agree to a reasonable fee charged by a contractor for these services. If the commissioner contracts for services, the fee for collecting, transmitting, and retaining of fingerprints must be paid directly to the contractor by the applicant or insurer.

(5) The commissioner is authorized to receive criminal history record information in lieu of the Montana department of justice relating to fingerprints submitted to the federal bureau of investigation.

(6) The commissioner may adopt rules to further implement this section, including but not limited to rules on the length of time that a background examination is valid and rules for the electronic filing of fingerprints."

Section 14. Section 33-17-301, MCA, is amended to read:

"33-17-301. Adjuster license -- qualifications -- catastrophe adjustments -- public adjuster. (1) An individual may not act as or purport to be an adjuster in this state unless licensed as an adjuster under this chapter. An individual shall apply to the commissioner for an adjuster license ~~to the commissioner according to forms that~~ in a form approved by the commissioner ~~prescribes and furnishes~~. The commissioner shall issue the adjuster license to individuals qualified to be licensed as an adjuster.

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

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

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

(c) shall pass an adjuster licensing examination as prescribed by the commissioner and pay the fee pursuant to 33-2-708;

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

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

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

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

(5) An adjuster license continues in force until lapsed, suspended, revoked, or terminated. The licensee shall renew the license by the biennial renewal date and pay the appropriate fee or the license will lapse. The biennial fee is established pursuant to 33-2-708.

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

Section 15. Section 33-17-401, MCA, is amended to read:

"33-17-401. Nonresident insurance producer -- license. (1) A nonresident person, unless denied licensure pursuant to 33-17-1001, must be granted a license if:

(a) the person is currently licensed as a resident and is in good standing in the person's home state;

(b) the person has submitted the proper request for licensure and has paid the fees required by 33-2-708;

(c) the person has submitted or transmitted to the commissioner the application for licensure that the person submitted to the person's home state or a completed ~~uniform~~ application in a form approved by the

commissioner; and

(d) the person's home state awards nonresident insurance producer licenses to residents of this state on the same basis.

(2) A person licensed as a surplus lines producer in that person's home state must receive a nonresident surplus lines producer license upon meeting the requirements of subsection (1). Except for subsection (1), this section does not amend or supersede any provision of the surplus lines insurance law established in Title 33, chapter 2, part 3.

(3) A person licensed as a limited line credit insurance producer or other type of limited lines producer in that person's home state must receive a nonresident limited lines producer license upon meeting the requirements of subsection (1), granting the same scope of authority as granted under the license issued by the producer's home state. For the purposes of this subsection, limited lines insurance is any authority granted by a nonresident's home state that restricts the authority of the licensee to less than the total authority prescribed in the associated major lines pursuant to 33-17-214(2)(a) through (2)(e).

(4) If a nonresident insurance producer's state of residence suspends, revokes, or terminates the insurance producer's insurance license in that state, the insurance producer's Montana nonresident license automatically terminates. The nonresident insurance producer shall notify the commissioner that the insurance producer's state of residence has suspended, revoked, or terminated the insurance producer's insurance license in that state."

Section 16. Section 33-17-503, MCA, is amended to read:

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

(a) properly file with the office of the commissioner a written application ~~on forms~~ in a form approved by the commissioner ~~prescribes~~; and

(b) pay a fee pursuant to 33-2-708, which the commissioner shall forward to the state treasurer to be deposited in the state special revenue fund to the credit of the state auditor's office.

(2) A consultant license continues in force until lapsed, suspended, revoked, or terminated."

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

"33-17-1203. Continuing education -- basic requirements -- exceptions. (1) Unless exempt under subsection ~~(4)~~ (3):

(a) ~~a person~~ an individual licensed to act as an insurance producer or as a consultant other than ~~a person~~ an individual licensed for limited lines credit insurance shall, during each 24-month period, complete at least 24 credit hours of approved continuing education;

(b) ~~a person~~ an individual licensed to act as an insurance producer only for limited lines credit insurance shall, during each biennium, complete 5 credit hours of approved continuing education in the areas of insurance law, ethics, or limited lines credit insurance;

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

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

~~(3)~~(2) The commissioner may, for good cause, grant an extension of time, not to exceed 1 year, during which the requirements imposed by subsection (1) may be completed.

~~(4)~~(3) The minimum continuing education requirements do not apply to:

(a) ~~a person~~ an individual holding a temporary license issued under 33-17-216; or

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

Section 18. Section 33-17-1205, MCA, is amended to read:

"33-17-1205. Compliance -- failure to comply -- rulemaking authority. (1) Each ~~person~~ individual subject to the requirements of 33-17-1203 shall file biennially in a format supplied by the commissioner certification as to the approved courses, lectures, seminars, and instructional programs successfully completed by that ~~person~~ individual during the preceding biennium.

(2) If ~~a person~~ an individual fails to comply with this section, the ~~person's~~ individual's license lapses. An individual with a lapsed license may not conduct insurance business under another person's license, including a business entity license affiliation.

(3) In the continuing education affidavit, an insurance producer shall report to the commissioner the final disposition of any administrative action or the final disposition of any criminal action taken against the insurance producer in another jurisdiction or by another governmental agency in this state. As used in this subsection, "final disposition of any criminal action" means a plea agreement or sentence and judgment.

(4) Each person providing approved courses, lectures, seminars, and instructional programs, including

insurance company education programs, shall file annually with the commissioner an alphabetical list of the names and addresses of all ~~persons~~ individuals who have successfully completed an approved continuing education activity during the preceding calendar year.

(5) The commissioner may, following the process provided for in 33-1-314, withdraw approval of all courses, lectures, seminars, and instructional programs of any person that fails to comply with subsection (4). The commissioner may, after having conducted a hearing pursuant to 33-1-701, impose a fine upon a person that has failed to comply with subsection (4). The fine may not exceed the penalty permitted by 33-1-317.

(6) The commissioner may adopt rules establishing the requirements for biennial filing and reporting of continuing education credits."

Section 19. Section 33-17-1502, MCA, is amended to read:

"33-17-1502. Rental vehicle entity license -- customer service representative requirements -- recordkeeping. (1) A rental vehicle entity may obtain an insurance license as a business entity.

(2) A rental vehicle entity shall designate an individual licensed insurance producer who is responsible for the rental vehicle entity's compliance with the insurance laws of this state.

~~(2)~~(3) A rental vehicle entity or customer service representative may not present rental vehicle insurance information to renters unless the rental vehicle entity is licensed and the customer service representative has been trained as required under 33-17-1503.

~~(3)~~(4) A customer service representative may present rental vehicle insurance information only on behalf of a rental vehicle entity.

~~(4)~~(5) A rental vehicle entity shall supervise a customer service representative who provides rental vehicle insurance under the provisions of this part.

(6) A rental vehicle entity shall submit to the commissioner ~~a quarterly~~ AN ANNUAL report listing each customer service representative presenting rental vehicle insurance information to the public."

Section 20. Section 33-18-232, MCA, is amended to read:

"33-18-232. Time for payment of claims. (1) An insurer shall pay or deny a claim within 30 days after receipt of a proof of loss unless the insurer makes a reasonable request for additional information or documents in order to evaluate the claim. If an insurer makes a reasonable request for additional information or documents, the insurer shall pay or deny the claim within 60 days of receiving the proof of loss unless the insurer has notified the insured, the insured's assignee, or the claimant of the reasons for failure to pay the claim in full or unless the

insurer has a reasonable belief that insurance fraud has been committed and the insurer has reported the possible insurance fraud to the commissioner. This section does not eliminate an insurer's right to conduct a thorough investigation of all the facts necessary to determine payment of a claim.

(2) If an insurer fails to comply with this section and the insurer is liable for payment of the claim, the insurer shall pay an amount equal to the amount of the claim due plus 10% annual interest calculated from the date on which the claim was due. For purposes of calculating the amount of interest, a claim is considered due 30 days after the insurer's receipt of the proof of loss or 60 days after receipt of the proof of loss if the insurer made a reasonable request for information or documents. Interest payments must be made to the person who receives the claims payment. Interest is payable under this subsection only if the amount of interest due on a claim exceeds $5.

(3) A private cause of action under 33-18-201 or 33-18-242 may not be based on the compliance or noncompliance with the requirements of this section and evidence of compliance or noncompliance with this section is not admissible in any private action based on 33-18-201 or 33-18-242."

Section 21. Section 33-19-105, MCA, is amended to read:

"33-19-105. Exemption based on federal standards for privacy of individually identifiable health information -- notice to commissioner required -- rules. (1) ~~Beginning on April 17, 2003, the~~ The obligations imposed under this chapter do not apply to a licensee that is a covered entity under the provisions of federal regulations that are part of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, parts 160 and 164, standards for privacy of individually identifiable health information as to any use or disclosure of personal information that is covered under the HIPAA privacy regulations, except for the following provisions:

(a) ~~Notices~~ A notice of insurance information practices described as ~~notices~~ a notice of privacy practices for protected health information under HIPAA privacy regulations must be delivered annually, as provided for in 33-19-202(1).

(b) To the extent that an insurer collects, discloses, or uses personal information that is not covered under the HIPAA notice of privacy practices, a separate Montana specific notice must be delivered pursuant to the provisions of 33-19-202.

(c) A disclosure authorization remains valid for a period that does not exceed 24 months, as provided for in 33-19-206(2).

(d) ~~Reasons~~ The reasons for an adverse underwriting ~~decisions~~ decision must be specified, as provided

for in 33-19-303.

(e) Disclosure of underwriting information is required, as provided for in 33-19-308.

(2) The commissioner may adopt rules regarding the exceptions from the exemption provisions described in subsection (1), including additional exceptions that embody substantive provisions of this chapter but would not be preempted by HIPAA privacy regulations.

(3) If a licensee considers itself exempt from a provision of this chapter for the reason provided in subsection (1), the licensee shall give written notice to the commissioner of that exemption and a brief statement describing why ~~it~~ the licensee is a HIPAA-covered entity.

(4) A licensee may claim an exemption only ~~as to~~ for those lines of business that are subject to HIPAA privacy regulations. All other lines of business are subject to this chapter.

(5) A third-party administrator that is a party to a valid business associate agreement required by HIPAA privacy regulations is exempt from the provisions of this chapter, but only as to the scope of that particular agreement. Any ~~activities~~ activity of the third-party administrator that ~~fall~~ falls outside of the scope of that agreement ~~are~~ is subject to the provisions of this chapter.

(6) The commissioner retains the authority to conduct complete market conduct examinations of the licensee as to the privacy policies and practices that are subject to state privacy laws.

(7) Beginning July 1, ~~2005~~ 2007:

(a) if a licensee is subject to and in compliance with a federal regulation that is part of the federal health insurance portability and accountability privacy regulations, 45 CFR, parts 160 and 164, and the federal regulation with which the licensee complies is inconsistent with a provision of this chapter and not less protective of consumer privacy, the licensee is exempt from compliance with the inconsistent provision of this chapter;

(b) if a licensee considers itself exempt from a provision of this chapter for the reason provided in subsection (7)(a), the licensee shall give written notice to the commissioner of that exemption, unless the requirements of this subsection (7) are preempted by HIPAA privacy regulations. The notice must include a statement of the reason for the claimed exemption."

Section 22. Section 33-20-105, MCA, is amended to read:

"33-20-105. Incontestability. (1) There must be a provision that the policy, exclusive of provisions relating to disability benefits or to additional benefits in the event of death by accident or accidental means, is incontestable, except for nonpayment of premiums, after ~~it~~ the policy has been in force during the lifetime of the insured for a period of 2 years from ~~its~~ the policy date of issue.

(2) (a) ~~A policy~~ Life insurance coverage issued ~~in connection with~~ as the result of an exchange or a conversion of existing life insurance coverage with the same insurer or its subsidiaries is incontestable ~~from the time of issue~~, except for nonpayment of premiums, under the following conditions:

(i) the person who is covered is alive, and

(ii) the policy that is being exchanged or converted has been in effect for 2 years from the date of issue.

(b) This subsection (2) does not apply to any amount of insurance provided by the new policy that exceeds the coverage amount that was exchanged or converted."

Section 23. Section 33-20-704, MCA, is amended to read:

"33-20-704. Notice to commissioner. (1) A charitable organization that issues or intends to issue qualified charitable gift annuities shall notify the commissioner in writing ~~within 90 days after April 24, 2003, or~~ prior to the date ~~on which it enters~~ of entering into the organization's first qualified charitable gift annuity agreement and shall notify the commissioner on March 1 of each year in which the charitable organization issues or intends to issue qualified charitable gift annuities. The notice must:

(a) be signed by an officer or director of the organization;

(b) identify the organization;

(c) certify that:

(i) the organization is a charitable organization; and

(ii) the annuities issued by the organization are qualified charitable gift annuities.

(2) The organization is not required to submit additional information except:

(a) within 30 days of receipt of a written request, to provide the commissioner with financial documents verifying information that was provided to the commissioner in the notice; or

(b) to enable the commissioner to determine appropriate penalties that may be applicable under 33-20-705."

Section 24. Section 33-20-1101, MCA, is amended to read:

"33-20-1101. Employee groups. ~~The~~ (1) Subject to the requirements in subsections (2) through (5), the lives of a group of individuals may be insured under a policy issued to an employer or to the trustees of a fund established by an employer~~, which employer or trustees shall be deemed the policyholder,~~ to insure employees of the employer for the benefit of persons other than the employer~~, subject to the following requirements:~~. The employer or trustees must be considered the policyholder.

~~(1)~~(2) (a) The employees eligible for insurance under the policy ~~shall~~ must be all of the employees of the employer or all of any class or classes ~~thereof~~ of the employer determined by conditions pertaining to their employment. The policy may provide that the term "employees" ~~shall include~~ includes:

(i) the employees of one or more subsidiary corporations and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietors, or partnerships if the business of the employer and of ~~such~~ the employer's affiliated corporations, proprietors, or partnerships is under common control~~. The policy may provide that the term "employees" shall include~~;

(ii) the individual proprietor or partners if the employer is an individual proprietor or a partnership~~. The policy may provide that the term "employees" shall include~~; or

(iii) retired employees. ~~No~~

(b) A director of a corporate employer ~~shall be~~ is not eligible for insurance under the policy unless ~~such person~~ the director is otherwise eligible as a bona fide employee of the corporation by performing services other than the usual duties of a director. ~~No~~

(c) An individual proprietor or partner ~~shall be~~ is not eligible for insurance under the policy unless ~~he~~ the individual proprietor or partner is actively engaged in and devotes a substantial part of ~~his time~~ working hours to the conduct of the business of the proprietor or partnership.

~~(2)~~(3) The premium for the policy ~~shall~~ must be paid by the policyholder, either wholly from the employer's funds or funds contributed by ~~him~~ the employer or partly from ~~such~~ the employer's funds and ~~partly~~ from funds contributed by the insured employees. ~~No~~ A policy may not be issued ~~on which~~ if the entire premium is to be derived from funds contributed by the insured employees. A policy on which part of the premium is to be derived from funds contributed by the insured employees may be placed in force only if at least 75% of the then eligible employees, excluding any as to whom evidence of individual insurability is not satisfactory to the insurer, elect to make the required contribution. A policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

~~(3)~~(4) The policy must cover at least ~~10~~ two employees at date of issue.

~~(4)~~(5) The ~~amounts~~ amount of insurance under the policy must be based upon ~~some~~ a plan precluding individual selection either by the employees or by the employer or trustees."

Section 25. Section 33-22-101, MCA, is amended to read:

"33-22-101. Exceptions to scope. ~~Parts~~ (1) Subject to subsection (2), parts 1 through 4 of this chapter,

except 33-22-107, 33-22-110, 33-22-111, 33-22-114, 33-22-125, 33-22-129, 33-22-130 through 33-22-136, 33-22-140, 33-22-141, 33-22-142, 33-22-243, and 33-22-304, and part 19 of this chapter do not apply to or affect:

~~(1)~~(a) any policy of liability or workers' compensation insurance with or without supplementary expense coverage;

~~(2)~~(b) any group or blanket policy;

~~(3)~~(c) life insurance, endowment, or annuity contracts or supplemental contracts that contain only those provisions relating to disability insurance that:

~~(a)~~(i) provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means; or

~~(b)~~(ii) operate to safeguard contracts against lapse or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract;

~~(4)~~(d) reinsurance.

(2) Section 33-22-301 applies to blanket policies."

Section 26. Section 33-22-140, MCA, is amended to read:

"33-22-140. Definitions. As used in this chapter, unless the context requires otherwise, the following definitions apply:

(1) "Beneficiary" has the meaning given the term by 29 U.S.C. 1002(33).

(2) "Church plan" has the meaning given the term by 29 U.S.C. 1002(33).

(3) "COBRA continuation provision" means:

(a) section 4980B of the Internal Revenue Code, 26 U.S.C. 4980B, other than subsection (f)(1) of that section as ~~it~~ that subsection relates to pediatric vaccines;

(b) Title I, subtitle B, part 6, excluding section 609, of the Employee Retirement Income Security Act of 1974, Public Law 93-406; or

(c) Title XXII of the Public Health Service Act, 42 U.S.C. 300dd, et seq.

(4) (a) "Creditable coverage" means coverage of the individual under any of the following:

(i) a group health plan;

(ii) health insurance coverage;

(iii) Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1395c through 1395i-4 or 42 U.S.C. 1395j through 1395w-4;

(iv) Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, other than coverage consisting solely of a benefit under section 1928, 42 U.S.C. 1396s;

(v) Title 10, chapter 55, United States Code;

(vi) a medical care program of the Indian health service or of a tribal organization;

(vii) the Montana comprehensive health association provided for in 33-22-1503;

(viii) a health plan offered under Title 5, chapter 89, of the United States Code;

(ix) a public health plan;

(x) a health benefit plan under section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e);

(xi) a high-risk pool in any state.

(b) Creditable coverage does not include coverage consisting solely of coverage of excepted benefits.

(5) "Elimination rider" means a provision attached to a policy that excludes coverage for a specific condition that would otherwise be covered under the policy.

(6) "Enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for enrollment.

(7) "Excepted benefits" means:

(a) coverage only for accident or disability income insurance, or both;

(b) coverage issued as a supplement to liability insurance;

(c) liability insurance, including general liability insurance and automobile liability insurance;

(d) workers' compensation or similar insurance;

(e) automobile medical payment insurance;

(f) credit-only insurance;

(g) coverage for onsite medical clinics;

(h) other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits, as approved by the commissioner;

(i) if offered separately, any of the following:

(i) limited-scope dental or vision benefits;

(ii) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these types of care; or

(iii) other similar, limited benefits as approved by the commissioner;

(j) if offered as independent, noncoordinated benefits, any of the following:

(i) coverage only for a specified disease or illness; or

(ii) hospital indemnity or other fixed indemnity insurance;

(k) if offered as a separate insurance policy:

(i) medicare supplement coverage;

(ii) coverage supplemental to the coverage provided under Title 10, chapter 55, of the United States Code; and

(iii) similar supplemental coverage provided under a group health plan.

(8) "Federally defined eligible individual" means an individual:

(a) for whom, as of the date on which the individual seeks coverage in the group market or individual market or under an association portability plan, as defined in 33-22-1501, the aggregate of the periods of creditable coverage is 18 months or more;

(b) whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with any of those plans;

(c) who is not eligible for coverage under:

(i) a group health plan;

(ii) Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1395c through 1395i-4 or 42 U.S.C. 1395j through 1395w-4; or

(iii) a state plan under Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, or a successor program;

(d) who does not have other health insurance coverage;

(e) for whom the most recent coverage within the period of aggregate creditable coverage was not terminated for factors relating to nonpayment of premiums or fraud;

(f) who, if offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, elected that coverage; and

(g) who has exhausted continuation coverage under the COBRA continuation provision or program described in subsection (8)(f) if the individual elected the continuation coverage described in subsection (8)(f).

(9) "Group health insurance coverage" means health insurance coverage offered in connection with a group health plan or health insurance coverage offered to an eligible group as described in 33-22-501.

(10) "Group health plan" means an employee welfare benefit plan, as defined in, 29 U.S.C. 1002(1), to the extent that the plan provides medical care and items and services paid for as medical care to employees or their dependents, directly or through insurance, reimbursement, or otherwise.

(11) "Health insurance coverage" means benefits consisting of medical care, including items and services paid for as medical care, that are provided directly, through insurance, reimbursement, or otherwise, under a policy, certificate, membership contract, or health care services agreement offered by a health insurance issuer.

(12) "Health insurance issuer" means an insurer, a health service corporation, or a health maintenance organization.

(13) "Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.

(14) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with group health insurance coverage.

(15) "Large employer" means, in connection with a group health plan, with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least ~~2~~ two employees on the first day of the plan year.

(16) "Large group market" means the health insurance market under which individuals obtain health insurance coverage directly or through any arrangement on behalf of themselves and their dependents through a group health plan or group health insurance coverage issued to a large employer.

(17) "Late enrollee" means an eligible employee or dependent, other than a special enrollee under 33-22-523, who requests enrollment in a group health plan following the initial enrollment period during which the individual was entitled to enroll under the terms of the group health plan if the initial enrollment period was a period of at least 30 days. However, an eligible employee or dependent is not considered a late enrollee if a court has ordered that coverage be provided for a spouse, minor, or dependent child under a covered employee's health benefit plan and a request for enrollment is made within 30 days after issuance of the court order.

(18) "Medical care" means:

(a) the diagnosis, cure, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body;

(b) transportation primarily for and essential to medical care referred to in subsection (18)(a); or

(c) insurance covering medical care referred to in subsections (18)(a) and (18)(b).

(19) "Network plan" means health insurance coverage offered by a health insurance issuer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the issuer.

(20) "Plan sponsor" has the meaning provided under section 3(16)(B) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1002(16)(B).

(21) "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on presence of a condition before the enrollment date coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the enrollment date.

(22) "Small group market" means the health insurance market under which individuals obtain health insurance coverage directly or through an arrangement, on behalf of themselves and their dependents, through a group health plan or group health insurance coverage maintained by a small employer as defined in 33-22-1803.

(23) "Waiting period" means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the group health plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the group health plan."

Section 27. Section 33-22-508, MCA, is amended to read:

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

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

(3) The individual policy or group policy, at the option of the insured, may be on any form then customarily issued by the insurer to individual or group policyholders, with the exception of a policy the eligibility

for which is determined by affiliation other than by employment with a common entity. In addition, the insurer or conversion carrier shall make available a conversion policy as required by subsection (6).

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

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

(6) The insurer or conversion carrier shall also make available a conversion policy, certificate, or membership contract that provides at least the level of benefits provided by the insurer's lowest cost basic health benefit plan, as defined in 33-22-1803. If the insurer or conversion carrier is not a small employer carrier under part 18, the insurer shall make available a conversion policy, certificate, or membership contract that provides equivalent benefits to a basic health benefit plan as provided in 33-22-1827. The conversion rate may not exceed 150% of the highest rate charged for that plan. This subsection does not apply to disability plans that provide only excepted benefits as defined in 33-22-140.

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

Section 28. Section 33-22-1501, MCA, is amended to read:

"33-22-1501. Definitions. As used in this part, the following definitions apply:

(1) "Association" means the comprehensive health association created by 33-22-1503.

(2) "Association plan" means a policy of insurance coverage that is offered by the association and that is certified by the association as required by 33-22-1521.

(3) "Association plan premium" means the charge determined pursuant to 33-22-1512 for membership in the association plan based on the benefits provided in 33-22-1521.

(4) "Association portability plan" means a policy of insurance coverage that is offered by the association to a federally defined eligible individual.

(5) "Association portability plan premium" means the charge determined by the association and approved

by the commissioner for an association portability plan.

(6) "Block of business" means a separate risk pool grouping of covered individuals, enrollees, and dependents as defined by rules of the commissioner.

(7) (a) "Eligible person" means an individual who:

(i) is a resident of this state and applies for coverage under the association plan;

(ii) is not eligible for any other form of health insurance coverage or health service benefits, except:

(A) for coverage consisting solely of excepted benefits, as defined in 33-22-140; or

(B) subject to eligibility limitations adopted pursuant to ~~33-22-1502(1)(b)~~ 33-22-1502(2), if the individual has coverage comparable to the association plan but is paying a premium or has received a renewal notice to pay a premium that is more than 150% of the average premium rate used to calculate the association plan premium rate pursuant to 33-22-1512(1); and

(iii) meets one or more of the following criteria:

(A) has, within 6 months prior to the date of application, been rejected for disability insurance or health service benefits by at least two insurers, societies, or health service corporations, unless the association waives this requirement; or

(B) has had a restrictive rider or preexisting conditions limitation, which limitation is required by at least two insurers, societies, or health service corporations, that has the effect of substantially reducing coverage from that received by a person considered a standard risk.

(b) The term does not apply to an individual who is certified as eligible for federal trade adjustment assistance or for pension benefit ~~guarantee~~ guaranty corporation assistance, as provided by the federal Trade Adjustment Assistance Reform Act of 2002, and is eligible for the association portability plan.

(8) "Federally defined eligible individual" means a person who is an individual enrolling in the association portability plan:

(a) for whom, as of the date on which the individual seeks coverage under the association portability plan, the aggregate of the periods of creditable coverage is 18 months or more and whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan;

(b) who does not have other health insurance coverage;

(c) who is not eligible for coverage under:

(i) a group health plan;

(ii) Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1395c through 1395i-4 or 42 U.S.C. 1395j through 1395w-4; or

(iii) a state plan under Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, or a successor program;

(d) for whom the most recent coverage was not terminated for factors relating to nonpayment of premiums or fraud;

(e) who, if offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, elected that coverage; and

(f) who has exhausted continuation coverage under the COBRA continuation provision or program described in subsection (8)(e) if the individual elected the continuation coverage described in subsection (8)(e).

(9) "Health service corporation" means a corporation operating pursuant to Title 33, chapter 30, and offering or selling contracts of disability insurance.

(10) "Insurance arrangement" means any plan, program, contract, or other arrangement to the extent not exempt from inclusion by virtue of the provisions of the federal Employee Retirement Income Security Act of 1974 under which one or more employers, unions, or other organizations provide to their employees or members, either directly or indirectly through a trust of a third-party administrator, health care services or benefits other than through an insurer.

(11) "Insurer" means a company operating pursuant to Title 33, chapter 2 or 3, and offering or selling policies or contracts of disability insurance, as provided in Title 33, chapter 22.

(12) "Lead carrier" means the licensed administrator or insurer selected by the association to administer the association plan.

(13) "Medicare" means coverage under both parts A and B of Title XVIII of the Social Security Act, 42 U.S.C. 1395, et seq., as amended.

(14) "Preexisting condition" means any condition for which an applicant for coverage under the association plan has received medical attention during the 3 years immediately preceding the filing of an application.

(15) "Qualified TAA-eligible individual" means an individual and any dependent of that individual, in addition to meeting the requirements specified in subsection ~~(17)~~ (18):

(a) who has 3 months of prior creditable coverage;

(b) whose application for association portability plan coverage is made within 63 days following termination of the applicant's most recent prior creditable coverage; and

(c) who, if eligible for COBRA, is not required to elect or exhaust continuation coverage under the COBRA continuation provision or under a similar state program.

(16) "Resident" means an individual who has been legally domiciled in this state for a period of at least 30 days, except that for a federally defined eligible individual there is no 30-day requirement. The criteria for determining residency must be specified in the association's operating rules.

~~(16)~~(17) "Society" means a fraternal benefit society operating pursuant to Title 33, chapter 7, and offering or selling certificates of disability insurance.

~~(17)~~(18) "TAA-eligible individual" means an individual and any dependent of that individual enrolling in the association portability plan:

(a) who is a resident of this state on the date of application to the pool;

(b) who has been certified as eligible for federal trade adjustment assistance and a health insurance tax credit or for pension benefit ~~guarantee~~ guaranty corporation assistance, as provided by the federal Trade Adjustment Assistance Reform Act of 2002;

(c) who does not have other health insurance coverage; and

(d) who is not covered under a group health plan maintained by an employer, including a group health plan available through a spouse, if the employer contributes 50% or more to the total cost of coverage."

Section 29. Section 33-22-1502, MCA, is amended to read:

"33-22-1502. Duties of commissioner -- rules. (1) The commissioner shall:

~~(1) adopt rules to carry out the provisions and purposes of this part, including rules:~~

~~(a) regarding late payment penalties or rates of interest charged on unpaid assessments; and~~

~~(b) that limit association plan eligibility under 33-22-1501(7)(a)(ii)(B) according to income level;~~

~~(2)~~(a) supervise the creation of the association within the limits described in 33-22-1503;

~~(3)~~(b) approve the selection of the lead carrier by the association and approve the association's contract with the lead carrier, including the association plan coverage and premiums to be charged;

~~(4)~~(c) conduct periodic audits to ensure the general accuracy of the financial data submitted by the lead carrier and the association; ~~and~~

~~(5)~~(d) undertake, directly or through contracts with other persons, studies or demonstration projects to develop awareness of the benefits of this part so that the residents of this state may best avail themselves of the health care benefits provided by this part; and

(e) adopt rules to carry out the provisions and purposes of this part, including rules regarding late payment penalties or rates of interest charged on an unpaid assessment.

(2) The commissioner may adopt rules that limit association plan eligibility under 33-22-1501(7)(a)(ii)(B)

according to income level."

Section 30. 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 33-22-1503(2).

(iii) An ~~associate~~ 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 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 31. Section 33-22-1514, MCA, is amended to read:

"33-22-1514. Administration of association plan -- rules. (1) The association shall select one lead carrier to issue the association plan and the association portability plan. The board of directors of the association shall prepare appropriate specifications and bid forms and may solicit bids from licensed administrators and the members of the association for the purpose of selecting the lead carrier. The selection of the lead carrier must be based upon criteria established by the board of directors.

(2) The lead carrier shall perform all administrative and claims payment functions required by this section upon the commissioner's approval of the policy forms and contracts submitted. The lead carrier shall provide these services for a period of at least 3 years, unless a request to terminate is approved by the association and the commissioner. The association and the commissioner shall approve or deny a request to terminate within 90 days of ~~its~~ the receipt of the request. A failure to make a final decision on a request to terminate within the specified period is considered an approval. The association shall invite submissions of policy forms from members of the association, including the lead carrier, 6 months prior to the expiration of each 3-year period. The association shall follow the procedure provided in subsection (1) in selecting a lead carrier for the subsequent 3-year period or, if a request to terminate is approved, on or before the end of the 3-year period.

(3) The lead carrier shall provide all eligible persons involved in the association plan and the association portability plan an individual certificate setting forth a statement as to the insurance protection to which the person is entitled, the method and place of filing claims, and to whom benefits are payable. The certificate must indicate that coverage was obtained through the association.

(4) The lead carrier shall submit to the association, the legislative finance committee, and the commissioner on a semiannual basis a report of the operation of the association plan and the association portability plan. The association ~~must~~ shall determine the specific information to be contained in the report prior to the effective date of the association plan and the association portability plan.

(5) The lead carrier shall pay all claims pursuant to this part and shall indicate that the claim was paid by the association plan or the association portability plan. Each claim payment must include information

specifying the procedure involved ~~in the event~~ if a dispute arises over the amount of payment ~~arises~~.

(6) The lead carrier must be reimbursed from the association plan and the association portability plan premiums received for its direct and indirect expenses. Direct and indirect expenses include a prorated reimbursement for the portion of the lead carrier's administrative, printing, claims administration, management, and building overhead expenses, which are assignable to the maintenance and administration of the association plan and the association portability plan. The association ~~must~~ shall approve cost accounting methods to substantiate the lead carrier's cost reports consistent with generally accepted accounting principles. Direct and indirect expenses may not include costs directly related to the original submission of policy forms prior to selection as the lead carrier.

(7) The lead carrier is, when carrying out its duties under this part, an independent contractor for the association and is individually liable for ~~its~~ the lead carrier's actions, subject to the laws of this state."

Section 32. Section 33-22-1515, MCA, is amended to read:

"33-22-1515. Solicitation of eligible persons. (1) The association, pursuant to a plan approved by the commissioner, shall disseminate appropriate information to the residents of this state regarding the existence of the association plan and the association portability plan and the means of enrollment. Means of communication may include use of the press, radio, and television, as well as publication in appropriate state offices and publications.

(2) The association shall devise and implement means of maintaining public awareness of this part and shall administer this part in a manner that facilitates public participation in the association plan and the association portability plan.

(3) All licensed disability insurance producers may engage in the selling or marketing of the association plan and the association portability plan. The lead carrier shall pay an insurance producer's referral fee of at least $25 to each licensed disability insurance producer who refers an applicant to the association plan and the association portability plan, if the applicant is accepted. The amount of the referral fee must be set by the board of directors of the association and is subject to the approval of the commissioner. The referral fees must be paid by the lead carrier from money received as premiums for the association plan and the association portability plan.

(4) An insurer, society, health maintenance organization, or health service corporation that rejects or applies underwriting restrictions to an applicant for disability insurance shall notify the applicant of the existence of the association plan, requirements for being accepted in the association plan, and the procedure for applying to the association plan."

Section 33. Section 33-22-1516, MCA, is amended to read:

"33-22-1516. Enrollment by eligible person. (1) The association plan must be open for enrollment by eligible persons. An eligible person may enroll in the plan by submission of a certificate of eligibility to the lead carrier. The certificate must provide:

(a) the name, address, and age of the applicant and length of the applicant's residence in this state;

(b) the name, address, and age of spouse and children, if any, ~~if they~~ for those who are to be insured;

(c) written evidence that the person fulfills all of the elements of an eligible person, as defined in 33-22-1501; and

(d) a designation of coverage desired.

(2) Within 30 days of receipt of the certificate, the lead carrier shall either reject the application for failing to comply with the requirements of subsection (1) or forward the eligible person a notice of acceptance and billing information. Insurance is effective on the first of the month following acceptance.

(3) An eligible person may not purchase more than one policy from the association plan or the association portability plan.

(4) A person who obtains coverage under the association plan may not be covered for any preexisting condition during the first 12 months of coverage under the association plan if the person was diagnosed or treated for that condition during the 3 years immediately preceding the filing of an application. The association may not apply a preexisting condition exclusion to coverage under the association portability plan if application for association portability plan coverage is made by a federally defined eligible individual or a qualified TAA-eligible individual within 63 days following termination of the applicant's most recent prior creditable coverage. The association shall waive any time period applicable to a preexisting condition exclusion for the ~~period of~~ time that any other eligible individual, including an individual who is eligible pursuant to 33-22-1501(7)(a)(ii)(B), was covered under the following types of coverage if the coverage was continuous to a date not more than 30 days prior to submission of an application for coverage under the association plan:

(a) an individual health insurance policy that includes coverage by an insurance company, a fraternal benefit society, a health service corporation, or a health maintenance organization that provides benefits similar to or exceeding the benefits provided by the association plan; or

(b) an employer-based health insurance benefit arrangement that provides benefits similar to or exceeding the benefits provided by the association plan."

Section 34. Section 33-22-1517, MCA, is amended to read:

"33-22-1517. Limitations on eligibility. An individual who purchases a policy of insurance pursuant to 33-22-1516 is no longer eligible for insurance under an association plan or association portability plan and is subject to cancellation of enrollment if the individual:

(1) fails to pay the premium for the policy of insurance purchased pursuant to 33-22-1516;

(2) changes residence from Montana to another state;

(3) exceeds the lifetime maximum benefit provided in the ~~association~~ plan; or

(4) enrolls under another disability insurance policy or plan for health service benefits. However, the individual may maintain enrollment in the association plan or the association portability plan during a waiting period applicable to preexisting conditions under the other policy or plan. If the individual maintains the association plan or the association portability plan during the waiting period, the association plan or the association portability plan may coordinate the benefits with the individual's new policy or plan and the benefits of the association plan or the association portability plan are considered secondary to the benefits available under the individual's new policy or plan."

Section 35. Section 33-22-1803, MCA, is amended to read:

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

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

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

(3) "Assessable carrier" means all carriers of disability insurance, including excess of loss and stop loss disability insurance.

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

(5) "Basic health benefit plan" means a health benefit plan, except a uniform health benefit plan, developed by a small employer carrier, that has a lower benefit value than the small employer carrier's standard

benefit plan and that provides the benefits required by 33-22-1827.

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

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

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

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

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

(d) makes health insurance coverage offered through the association available to a member regardless of a health status-related factor relating to the member or an individual eligible for coverage through a member; and

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

(8) "Carrier" means any person who provides a health benefit plan in this state subject to state insurance regulation. The term includes but is not limited to an insurance company, a fraternal benefit society, a health service corporation, and a health maintenance organization. For purposes of this part, companies that are affiliated companies or that are eligible to file a consolidated tax return must be treated as one carrier, except that the following may be considered as separate carriers:

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

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

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

(9) "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer,

provided that gender, claims experience, health status, and duration of coverage are not case characteristics for purposes of this part.

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

(11) "Dependent" means:

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

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

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

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

(12) (a) "Eligible employee" means an employee who works on a full-time basis with a normal workweek of 30 hours or more, except that at the sole discretion of the employer, the term may include an employee who works on a full-time basis with a normal workweek of between 20 and 40 hours as long as this eligibility criteria is applied uniformly among all of the employer's employees. The term includes a sole proprietor, a partner of a partnership, and an independent contractor if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer. The term also includes those persons eligible for coverage under 2-18-704.

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

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

(14) "Health benefit plan" means any hospital or medical policy or certificate providing for physical and mental health care issued by an insurance company, a fraternal benefit society, or a health service corporation or issued under a health maintenance organization subscriber contract. Health benefit plan does not include coverage of excepted benefits, as defined in 33-22-140, if coverage is provided under a separate policy, certificate, or contract of insurance.

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

(16) "New business premium rate" means, for each class of business for a rating period, the lowest

premium rate charged or offered or that could have been charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

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

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

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

(20) "Small employer" means a person, firm, corporation, partnership, or bona fide association that is actively engaged in business and that, with respect to a calendar year and a plan year, employed at least ~~2~~ two but not more than 50 eligible employees during the preceding calendar year and employed at least two employees on the first day of the plan year. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer must be based on the average number of employees reasonably expected to be employed by the employer in the current calendar year. In determining the number of eligible employees, companies are considered one employer if they:

(a) are affiliated companies;

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

(c) are members of a bona fide association.

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

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

Section 36. Section 33-24-103, MCA, is amended to read:

"33-24-103. Specific valuation -- loss equal to insured value. (1) This section applies to policies, except motor vehicle insurance policies, ~~which~~ that insure specific listed items of personal property against any loss or damage.

(2) If the insurer places specific valuations upon particular items of covered property and bases the premium charge on these valuations, then ~~he~~ the insurer shall compute any total loss or total damage to the property, when covered, at the stated valuation with no deductions or offsets except for the selected deductible in the policy."

Section 37. Section 33-28-105, MCA, is amended to read:

"33-28-105. Formation of captive insurance companies. (1) A pure captive insurance company or a sponsored captive insurance company must be incorporated as a stock insurer with its capital divided into shares and held by the stockholders.

(2) An association captive insurance company or an industrial insured captive insurance company may be:

(a) incorporated as a stock insurer with its capital divided into shares and held by the stockholders;

(b) incorporated as a mutual insurer without capital stock, the governing body of which is elected by the member organizations of its association or associations; or

(c) organized as a reciprocal insurer under Title 33, chapter 5.

(3) A captive insurance company incorporated or organized in this state may not have less than three incorporators, at least one of whom must be a resident of this state.

(4) (a) In the case of a captive insurance company formed as a corporation and before the articles of incorporation are transmitted to the secretary of state, the incorporators shall file a copy of the proposed articles of incorporation and a petition with the commissioner requesting the commissioner to issue a certificate that finds that the establishment and maintenance of the proposed corporation will promote the general good of the state. In reviewing the petition, the commissioner shall consider:

(i) the character, reputation, financial standing, and purposes of the incorporators;

(ii) the character, reputation, financial responsibility, insurance experience, and business qualifications of the officers and directors; and

(iii) any other factors that the commissioner considers appropriate.

(b) If the commissioner does not issue a certificate or finds that the proposed articles of incorporation of the captive insurance company do not meet the requirements of the applicable laws, including but not limited to 33-2-112, the commissioner shall refuse to approve the draft of the articles of incorporation and shall return the draft to the proposed incorporators, together with a written statement explaining the refusal.

(c) If the commissioner issues a certificate and approves the draft articles of incorporation, the

commissioner shall forward the certificate and an approved draft of articles of incorporation to the proposed incorporators. The incorporators shall prepare two sets of the approved articles of incorporation and shall file one set of articles of incorporation with the secretary of state as required by the applicable law and one set with the commissioner.

(5) The capital stock of a captive insurance company incorporated as a stock insurer may be authorized with no par value.

(6) At least one of the members of the board of directors of a captive insurance company must be a resident of this state.

(7) (a) A captive insurance company formed as a corporation has the privileges and is subject to the provisions of general corporation law, as well as the applicable provisions contained in this chapter.

(b) In the event of conflict between the provisions of general corporation law and this chapter, the provisions of this chapter control.

(8) (a) With respect to a captive insurance company formed as a reciprocal insurer, the organizers shall petition and request that the commissioner issue a certificate that finds that the establishment and maintenance of the proposed association will promote the general good of the state. In reviewing the petition, the commissioner shall consider:

(i) the character, reputation, financial standing, and purposes of the organizers;

(ii) the character, reputation, financial responsibility, insurance experience, and business qualifications of the attorney-in-fact; and

(iii) any other factors that the commissioner considers appropriate.

(b) The commissioner may either approve the petition and issue the certificate or reject the petition in a written statement of the reasons for the rejection.

(c) A captive insurance company formed as a reciprocal insurer has the privileges and is subject to the provisions of Title 33, chapter 5, in addition to the applicable provisions of this chapter. If there is a conflict between Title 33, chapter 5, and this chapter, the provisions of this chapter control. ~~If a reciprocal insurer is determined to be subject to other provisions of Title 33, chapter 5, the other provisions of chapter 5 are not applicable to a reciprocal captive insurance company formed under this chapter unless those provisions of chapter 5 are expressly made applicable to captive insurance companies.~~

(d) The subscribers' agreement or other organizing document of a captive insurance company formed as a reciprocal insurer may authorize a quorum of a subscribers' advisory committee to consist of at least one-third of the number of its members.

(9) Except as provided in 33-28-306, the provisions of Title 33 pertaining to mergers, consolidations, conversions, mutualizations, and redomestications apply in determining the procedures to be followed by captive insurance companies in carrying out any of those transactions.

(10) With respect to a branch captive insurance company, the foreign captive insurance company shall petition and request that the commissioner issue a certificate that finds that, after considering the character, reputation, financial responsibility, insurance experience, and business qualifications of the officers and directors of the foreign captive insurance company, the licensing and maintenance of the branch operation will promote the general good of the state. The foreign captive insurance company may apply to the secretary of state for a certificate of authority to transact business in this state after the commissioner's certificate is issued."

Section 38. Section 33-28-202, MCA, is amended to read:

"33-28-202. Legal investments. (1) An industrial insured captive insurance company and an association captive insurance company shall comply with the investment requirements contained in ~~33-2-532, 33-2-533,~~ Title 33, chapter 12, and the rules promulgated in accordance with these provisions. Notwithstanding any other provision of this title, the commissioner may approve the use of alternative reliable methods of valuation and rating.

(2) A pure captive insurance company is not subject to any restrictions on allowable investments, except that the commissioner may prohibit or limit any investment that threatens the solvency or liquidity of the company.

(3) Only a pure captive insurance company may make loans to its parent company or affiliates. Loans to a parent company or any affiliate may not be made without prior written approval of the commissioner and must be evidenced by a note in a form approved by the commissioner. Loans of minimum capital and surplus funds required by 33-28-104 are prohibited."

NEW SECTION. **Section 39. Repealer.** Sections 33-2-532, 33-2-533, 33-2-534, and 33-2-535, MCA, are repealed.

NEW SECTION. **Section 40. Applicability.** [Section 17] applies to continuing education reporting periods beginning January 1, 2006.

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