HOUSE BILL NO. 137

INTRODUCED BY M. FUNK

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING LAWS PERTAINING TO THE STATE AUDITOR; GENERALLY REVISING INSURANCE LAWS; GENERALLY REVISING SECURITIES LAWS; ALLOWING CAPTIVE INSURANCE MERGERS; REMOVING CITATIONS TO INSURE MONTANA; REMOVING SUNSET PROVISIONS IN THE SECURITIES ACT APPLYING TO THE SECURITIES RESTITUTION FUND; ADDING HEALTH SERVICE CORPORATIONS AND HEALTH MAINTENANCE ORGANIZATIONS TO PROVISIONS APPLYING TO SUPERVISION, REHABILITATION, AND LIQUIDATION; ADDING DOMESTIC MUTUAL INSURERS AND DOMESTIC STOCK INSURERS TO INSOLVENCY ASSET DISTRIBUTION; REQUIRING A PLAN OF DISSOLUTION FOR A DOMESTIC MUTUAL INSURER; ALLOWING CORPORATE SUBSIDIARIES FOR FARM MUTUAL INSURERS; ALLOWING STATE MUTUAL INSURERS TO CHANGE STATUS TO COUNTY MUTUAL INSURERS; AMENDING LAWS PERTAINING TO INSURANCE PRODUCER EXCHANGE CONTINUING EDUCATION; AMENDING LIFE INSURANCE LAWS PERTAINING TO MORTUARIES; AMENDING NOTICE REQUIREMENTS PERTAINING TO INSURERS COVERED UNDER HIPAA; AMENDING LAWS PERTAINING TO MEDICARE SUPPLEMENT POLICY SOLICITATIONS; AMENDING CAPTIVE INSURER BUSINESS ENTITY LAWS; REQUIRING QUARTERLY FINANCIAL STATEMENTS TO BE FILED; REVISING REFERENCES TO PHYSICIANS AND HEALTH CARE PROVIDERS; REVISING UTILIZATION REVIEW PLAN SUBMISSIONS TO THE INSURANCE COMMISSIONER; REVISING DATES FOR EXTERNAL REVIEWS; AMENDING LAWS PERTAINING TO SPECIAL CLASSIFICATIONS AND EXPERIENCE RATING FOR STATE FUND; REPEALING LAWS RELATING TO A SMALL BUSINESS HEALTH INSURANCE POOL; AMENDING SECTIONS 15-30-2110, 15-30-2618, 15-31-511, 30-10-115, 30-10-209, 33-1-501, 33-1-502, 33-2-1304, 33-2-1363, 33-3-601, 33-3-602, 33-3-603, 33-4-103, 33-4-204, 33-17-243, 33-17-301, 33-18-301, 33-18-609, 33-19-105, 33-19-202, 33-22-301, 33-22-906, 33-22-1815, 33-22-1816, 33-28-101, 33-28-105, 33-28-109, 33-28-306, 33-30-102, 33-31-111, 33-31-211, 33-31-212, 33-31-401, 33-32-102, 33-32-103, 33-32-403, 33-32-410, 33-32-412, 33-32-417, 33-32-423, 35-1-217, 35-1-931, 35-1-932, 35-2-119, 35-2-720, 35-2-721, 39-71-2316, 39-71-2375, 45-6-301, 53-4-1004, AND 53-6-1201, MCA; REPEALING SECTIONS 15-30-2368, 15-31-130, 33-22-2001, 33-22-2002, 33-22-2003, 33-22-2004, 33-22-2005, 33-22-2006, 33-22-2007, 33-22-2008, 33-22-2009, 53-2-216, AND 53-2-217, MCA; REPEALING SECTION 16,

CHAPTER 58, LAWS OF 2011; AND PROVIDING EFFECTIVE DATES."

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

NEW SECTION. **Section 1. Captive mergers.** (1) A merger between captive stock insurers must meet the requirements of 33-3-217 and 33-28-105, except that the commissioner may provide notice to the public of the merger in place of holding a hearing, at the commissioner's discretion.

(2) A merger between captive mutual insurers must meet the requirements of 33-3-218 and 33-28-105, except that the commissioner may provide notice to the public of the merger in place of holding a hearing, at the commissioner's discretion.

Section 2. Section 15-30-2110, MCA, is amended to read:

"15-30-2110. Adjusted gross income. (1) Subject to subsection (14), adjusted gross income is the taxpayer's federal adjusted gross income as defined in section 62 of the Internal Revenue Code, 26 U.S.C. 62, and in addition includes the following:

(a) (i) interest received on obligations of another state or territory or county, municipality, district, or other political subdivision of another state, except to the extent that the interest is exempt from taxation by Montana under federal law;

(ii) exempt-interest dividends as defined in section 852(b)(5) of the Internal Revenue Code, 26 U.S.C. 852(b)(5), that are attributable to the interest referred to in subsection (1)(a)(i);

(b) refunds received of federal income tax, to the extent that the deduction of the tax resulted in a reduction of Montana income tax liability as determined under subsection (15);

(c) that portion of a shareholder's income under subchapter S. of Chapter 1 of the Internal Revenue Code that has been reduced by any federal taxes paid by the subchapter S. corporation on the income;

(d) depreciation or amortization taken on a title plant as defined in 33-25-105;

(e) the recovery during the tax year of an amount deducted in any prior tax year to the extent that the amount recovered reduced the taxpayer's Montana income tax in the year deducted;

(f) if the state taxable distribution of an estate or trust is greater than the federal taxable distribution of the same estate or trust, the difference between the state taxable distribution and the federal taxable distribution of the same estate or trust for the same tax period; and

(g) except for exempt-interest dividends described in subsection (2)(a)(ii), the amount of any dividend to the extent that the dividend is not included in federal adjusted gross income.

(2) Notwithstanding the provisions of the Internal Revenue Code, adjusted gross income does not include the following, which are exempt from taxation under this chapter:

(a) (i) all interest income from obligations of the United States government, the state of Montana, or a county, municipality, district, or other political subdivision of the state and any other interest income that is exempt from taxation by Montana under federal law;

(ii) exempt-interest dividends as defined in section 852(b)(5) of the Internal Revenue Code, 26 U.S.C. 852(b)(5), that are attributable to the interest referred to in subsection (2)(a)(i);

(b) interest income earned by a taxpayer who is 65 years of age or older in a tax year up to and including $800 for a taxpayer filing a separate return and $1,600 for each joint return;

(c) (i) except as provided in subsection (2)(c)(ii) and subject to subsection (16), the first $4,070 of all pension and annuity income received as defined in 15-30-2101;

(ii) subject to subsection (16), for pension and annuity income described under subsection (2)(c)(i), as follows:

(A) each taxpayer filing singly, head of household, or married filing separately shall reduce the total amount of the exclusion provided in subsection (2)(c)(i) by $2 for every $1 of federal adjusted gross income in excess of $33,910 as shown on the taxpayer's return;

(B) in the case of married taxpayers filing jointly, if both taxpayers are receiving pension or annuity income or if only one taxpayer is receiving pension or annuity income, the exclusion claimed as provided in subsection (2)(c)(i) must be reduced by $2 for every $1 of federal adjusted gross income in excess of $33,910 as shown on their joint return;

(d) all Montana income tax refunds or tax refund credits;

(e) gain required to be recognized by a liquidating corporation under 15-31-113(1)(a)(ii);

(f) all tips or gratuities that are covered by section 3402(k) or service charges that are covered by section 3401 of the Internal Revenue Code of 1954, 26 U.S.C. 3402(k) or 3401, as amended and applicable on January 1, 1983, received by a person for services rendered to patrons of premises licensed to provide food, beverage, or lodging;

(g) all benefits received under the workers' compensation laws;

(h) all health insurance premiums paid by an employer for an employee if attributed as income to the

employee under federal law;

(i) all money received because of a settlement agreement or judgment in a lawsuit brought against a manufacturer or distributor of "agent orange" for damages resulting from exposure to "agent orange";

(j) principal and income in a medical care savings account established in accordance with 15-61-201 or withdrawn from an account for eligible medical expenses, as defined in 15-61-102, of the taxpayer or a dependent of the taxpayer or for the long-term care of the taxpayer or a dependent of the taxpayer;

(k) principal and income in a first-time home buyer savings account established in accordance with 15-63-201 or withdrawn from an account for eligible costs, as provided in 15-63-202(7), for the first-time purchase of a single-family residence;

(l) contributions or earnings withdrawn from a family education savings account or from a qualified tuition program established and maintained by another state as provided by section 529(b)(1)(A)(ii) of the Internal Revenue Code, 26 U.S.C. 529(b)(1)(A)(ii), for qualified higher education expenses, as defined in 15-62-103, of a designated beneficiary;

(m) the recovery during the tax year of any amount deducted in any prior tax year to the extent that the recovered amount did not reduce the taxpayer's Montana income tax in the year deducted;

(n) if the federal taxable distribution of an estate or trust is greater than the state taxable distribution of the same estate or trust, the difference between the federal taxable distribution and the state taxable distribution of the same estate or trust for the same tax period;

(o) deposits, not exceeding the amount set forth in 15-30-3003, deposited in a Montana farm and ranch risk management account, as provided in 15-30-3001 through 15-30-3005, in any tax year for which a deduction is not provided for federal income tax purposes;

(p) income of a dependent child that is included in the taxpayer's federal adjusted gross income pursuant to the Internal Revenue Code. The child is required to file a Montana personal income tax return if the child and taxpayer meet the filing requirements in 15-30-2602.

(q) principal and income deposited in a health care expense trust account, as defined in 2-18-1303, or withdrawn from the account for payment of qualified health care expenses as defined in 2-18-1303;

~~(r) that part of the refundable credit provided in 33-22-2006 that reduces Montana tax below zero;~~

~~(s)~~(r) the amount of the gain recognized from the sale or exchange of a mobile home park as provided in 15-31-163; and

~~(t)~~(s) the amount of a scholarship to an eligible student by a student scholarship organization pursuant

to 15-30-3104.

(3) A shareholder of a DISC that is exempt from the corporate income tax under 15-31-102(1)(l) shall include in the shareholder's adjusted gross income the earnings and profits of the DISC in the same manner as provided by section 995 of the Internal Revenue Code, 26 U.S.C. 995, for all periods for which the DISC election is effective.

(4) A taxpayer who, in determining federal adjusted gross income, has reduced the taxpayer's business deductions by an amount for wages and salaries for which a federal tax credit was elected under sections 38 and 51(a) of the Internal Revenue Code, 26 U.S.C. 38 and 51(a), is allowed to deduct the amount of the wages and salaries paid regardless of the credit taken. The deduction must be made in the year that the wages and salaries were used to compute the credit. In the case of a partnership or small business corporation, the deduction must be made to determine the amount of income or loss of the partnership or small business corporation.

(5) Married taxpayers filing a joint federal return who are required to include part of their social security benefits or part of their tier 1 railroad retirement benefits in federal adjusted gross income may split the federal base used in calculation of federal taxable social security benefits or federal taxable tier 1 railroad retirement benefits when they file separate Montana income tax returns. The federal base must be split equally on the Montana return.

(6) Married taxpayers filing a joint federal return who are allowed a capital loss deduction under section 1211 of the Internal Revenue Code, 26 U.S.C. 1211, and who file separate Montana income tax returns may claim the same amount of the capital loss deduction that is allowed on the federal return. If the allowable capital loss is clearly attributable to one spouse, the loss must be shown on that spouse's return; otherwise, the loss must be split equally on each return.

(7) In the case of passive and rental income losses, married taxpayers filing a joint federal return and who file separate Montana income tax returns are not required to recompute allowable passive losses according to the federal passive activity rules for married taxpayers filing separately under section 469 of the Internal Revenue Code, 26 U.S.C. 469. If the allowable passive loss is clearly attributable to one spouse, the loss must be shown on that spouse's return; otherwise, the loss must be split equally on each return.

(8) Married taxpayers filing a joint federal return in which one or both of the taxpayers are allowed a deduction for an individual retirement contribution under section 219 of the Internal Revenue Code, 26 U.S.C. 219, and who file separate Montana income tax returns may claim the same amount of the deduction that is allowed on the federal return. The deduction must be attributed to the spouse who made the contribution.

(9) (a) Married taxpayers filing a joint federal return who are allowed a deduction for interest paid for a qualified education loan under section 221 of the Internal Revenue Code, 26 U.S.C. 221, and who file separate Montana income tax returns may claim the same amount of the deduction that is allowed on the federal return. The deduction may be split equally on each return or in proportion to each taxpayer's share of federal adjusted gross income.

(b) Married taxpayers filing a joint federal return who are allowed a deduction for qualified tuition and related expenses under section 222 of the Internal Revenue Code, 26 U.S.C. 222, and who file separate Montana income tax returns may claim the same amount of the deduction that is allowed on the federal return. The deduction may be split equally on each return or in proportion to each taxpayer's share of federal adjusted gross income.

(10) A taxpayer receiving retirement disability benefits who has not attained 65 years of age by the end of the tax year and who has retired as permanently and totally disabled may exclude from adjusted gross income up to $100 a week received as wages or payments in lieu of wages for a period during which the employee is absent from work due to the disability. If the adjusted gross income before this exclusion exceeds $15,000, the excess reduces the exclusion by an equal amount. This limitation affects the amount of exclusion, but not the taxpayer's eligibility for the exclusion. If eligible, married individuals shall apply the exclusion separately, but the limitation for income exceeding $15,000 is determined with respect to the spouses on their combined adjusted gross income. For the purpose of this subsection, "permanently and totally disabled" means unable to engage in any substantial gainful activity by reason of any medically determined physical or mental impairment lasting or expected to last at least 12 months.

(11) (a) An individual who contributes to one or more accounts established under the Montana family education savings program or to a qualified tuition program established and maintained by another state as provided by section 529(b)(1)(A)(ii) of the Internal Revenue Code, 26 U.S.C. 529(b)(1)(A)(ii), may reduce adjusted gross income by the lesser of $3,000 or the amount of the contribution. In the case of married taxpayers, each spouse is entitled to a reduction, not in excess of $3,000, for the spouses' contributions to the accounts. Spouses may jointly elect to treat half of the total contributions made by the spouses as being made by each spouse. The reduction in adjusted gross income under this subsection applies only with respect to contributions to an account of which the account owner is the taxpayer, the taxpayer's spouse, or the taxpayer's child or stepchild if the taxpayer's child or stepchild is a Montana resident. The provisions of subsection (1)(e) do not apply with respect to withdrawals of contributions that reduced adjusted gross income.

(b) Contributions made pursuant to this subsection (11) are subject to the recapture tax provided in 15-62-208.

(12) (a) An individual who contributes to one or more accounts established under the Montana achieving a better life experience program or to a qualified program established and maintained by another state as provided by section 529A(e)(7) of the Internal Revenue Code, 26 U.S.C. 529A(e)(7), may reduce adjusted gross income by the lesser of $3,000 or the amount of the contribution. In the case of married taxpayers, each spouse is entitled to a reduction, not to exceed $3,000, for the spouses' contributions to the accounts. Spouses may jointly elect to treat one-half of the total contributions made by the spouses as being made by each spouse. The reduction in adjusted gross income under this subsection (12)(a) applies only with respect to contributions to an account for which the account owner is the taxpayer, the taxpayer's spouse, or the taxpayer's child or stepchild if the taxpayer's child or stepchild is a Montana resident. The provisions of subsection (1)(e) do not apply with respect to withdrawals of contributions that reduced adjusted gross income.

(b) Contributions made pursuant to this subsection (12) are subject to the recapture tax provided in 53-25-118.

(13) (a) A taxpayer may exclude the amount of the loan payment received pursuant to subsection (13)(a)(iv), not to exceed $5,000, from the taxpayer's adjusted gross income if the taxpayer:

(i) is a health care professional licensed in Montana as provided in Title 37;

(ii) is serving a significant portion of a designated geographic area, special population, or facility population in a federally designated health professional shortage area, a medically underserved area or population, or a federal nursing shortage county as determined by the secretary of health and human services or by the governor;

(iii) has had a student loan incurred as a result of health-related education; and

(iv) has received a loan payment during the tax year made on the taxpayer's behalf by a loan repayment program described in subsection (13)(b) as an incentive to practice in Montana.

(b) For the purposes of subsection (13)(a), a loan repayment program includes a federal, state, or qualified private program. A qualified private loan repayment program includes a licensed health care facility, as defined in 50-5-101, that makes student loan payments on behalf of the person who is employed by the facility as a licensed health care professional.

(14) Notwithstanding the provisions of subsection (1), adjusted gross income does not include 40% of capital gains on the sale or exchange of capital assets before December 31, 1986, as capital gains are

determined under subchapter P. of Chapter 1 of the Internal Revenue Code as it read on December 31, 1986.

(15) A refund received of federal income tax referred to in subsection (1)(b) must be allocated in the following order as applicable:

(a) to federal income tax in a prior tax year that was not deducted on the state tax return in that prior tax year;

(b) to federal income tax in a prior tax year that was deducted on the state tax return in that prior tax year but did not result in a reduction in state income tax liability in that prior tax year; and

(c) to federal income tax in a prior tax year that was deducted on the state tax return in that prior tax year and that reduced the taxpayer's state income tax liability in that prior tax year.

(16) By November 1 of each year, the department shall multiply the amount of pension and annuity income contained in subsection (2)(c)(i) and the federal adjusted gross income amounts in subsection (2)(c)(ii) by the inflation factor for the following tax year, rounded to the nearest $10. The resulting amounts are effective for that following tax year and must be used as the basis for the exemption determined under subsection (2)(c). (Subsection (2)(f) terminates on occurrence of contingency--sec. 3, Ch. 634, L. 1983; subsection (2)(o) terminates on occurrence of contingency--sec. 9, Ch. 262, L. 2001; subsection ~~(2)(t)~~ (2)(s) terminates December 31, 2023--sec. 33, Ch. 457, L. 2015.)"

Section 3. Section 15-30-2618, MCA, is amended to read:

"15-30-2618. Confidentiality of tax records. (1) Except as provided in 5-12-303, 15-1-106, 17-7-111, and subsections (8) and (9) of this section, in accordance with a proper judicial order, or as otherwise provided by law, it is unlawful to divulge or make known in any manner:

(a) the amount of income or any particulars set forth or disclosed in any individual report or individual return required under this chapter or any other information secured in the administration of this chapter; or

(b) any federal return or federal return information disclosed on any return or report required by rule of the department or under this chapter.

(2) (a) The officers charged with the custody of the reports and returns may not be required to produce them or evidence of anything contained in them in an action or proceeding in a court, except in an action or proceeding:

(i) to which the department is a party under the provisions of this chapter or any other taxing act; or

(ii) on behalf of a party to any action or proceedings under the provisions of this chapter or other taxes

when the reports or facts shown by the reports are directly involved in the action or proceedings.

(b) The court may require the production of and may admit in evidence only as much of the reports or of the facts shown by the reports as are pertinent to the action or proceedings.

(3) This section does not prohibit:

(a) the delivery to a taxpayer or the taxpayer's authorized representative of a certified copy of any return or report filed in connection with the taxpayer's tax;

(b) the publication of statistics classified to prevent the identification of particular reports or returns and the items of particular reports or returns; or

(c) the inspection by the attorney general or other legal representative of the state of the report or return of any taxpayer who brings an action to set aside or review the tax based on the report or return or against whom an action or proceeding has been instituted in accordance with the provisions of 15-30-2630.

(4) The department may deliver to a taxpayer's spouse the taxpayer's return or information related to the return for a tax year if the spouse and the taxpayer filed the return with the filing status of married filing separately on the same return. The information being provided to the spouse or reported on the return, including subsequent adjustments or amendments to the return, must be treated in the same manner as if the spouse and the taxpayer filed the return using a joint filing status for that tax year.

(5) Reports and returns must be preserved for at least 3 years and may be preserved until the department orders them to be destroyed.

(6) Any offense against subsections (1) through (5) is punishable by a fine not exceeding $500. If the offender is an officer or employee of the state, the offender must be dismissed from office or employment and may not hold any public office or public employment in this state for a period of 1 year after dismissal or, in the case of a former officer or employee, for 1 year after conviction.

(7) This section may not be construed to prohibit the department from providing taxpayer return information and information from employers' payroll withholding reports to:

(a) the department of labor and industry to be used for the purpose of investigation and prevention of noncompliance, tax evasion, fraud, and abuse under the unemployment insurance laws; or

(b) the state fund to be used for the purpose of investigation and prevention of noncompliance, fraud, and abuse under the workers' compensation program.

(8) The department may permit the commissioner of internal revenue of the United States or the proper officer of any state imposing a tax on the incomes of individuals or the authorized representative of either officer

to inspect the return of income of any individual or may furnish to the officer or an authorized representative an abstract of the return of income of any individual or supply the officer with information concerning an item of income contained in a return or disclosed by the report of an investigation of the income or return of income of an individual, but the permission may be granted or information furnished only if the statutes of the United States or of the other state grant substantially similar privileges to the proper officer of this state charged with the administration of this chapter.

(9) On written request to the director or a designee of the director, the department shall furnish:

(a) to the department of justice all information necessary to identify those persons qualifying for the additional exemption for blindness pursuant to 15-30-2114(4), for the purpose of enabling the department of justice to administer the provisions of 61-5-105;

(b) to the department of public health and human services information acquired under 15-30-2616, pertaining to an applicant for public assistance, reasonably necessary for the prevention and detection of public assistance fraud and abuse, provided notice to the applicant has been given;

(c) to the department of labor and industry for the purpose of prevention and detection of fraud and abuse in and eligibility for benefits under the unemployment compensation and workers' compensation programs information on whether a taxpayer who is the subject of an ongoing investigation by the department of labor and industry is an employee, an independent contractor, or self-employed;

(d) to the department of fish, wildlife, and parks specific information that is available from income tax returns and required under 87-2-102 to establish the residency requirements of an applicant for hunting and fishing licenses;

(e) to the board of regents information required under 20-26-1111;

(f) to the legislative fiscal analyst and the office of budget and program planning individual income tax information as provided in 5-12-303, 15-1-106, and 17-7-111. The information provided to the office of budget and program planning must be the same as the information provided to the legislative fiscal analyst.

(g) to the department of transportation farm income information based on the most recent income tax return filed by an applicant applying for a refund under 15-70-430, provided that notice to the applicant has been given as provided in 15-70-430. The information obtained by the department of transportation is subject to the same restrictions on disclosure as are individual income tax returns.

~~(h) to the commissioner of insurance's office all information necessary for the administration of the small business health insurance tax credit provided for in Title 33, chapter 22, part 20;~~

~~(i)~~(h) to the department of commerce tax information about a taxpayer whose debt is assigned to the department of revenue for offset or collection pursuant to the terms of Title 17, chapter 4, part 1. The information provided to the department of commerce must be used for the purposes of preventing and detecting fraud or abuse and determining eligibility for grants or loans.

~~(j)~~(i) to the superintendent of public instruction information required under 20-9-905. (Subsection ~~(9)(j)~~ (9)(i) terminates December 31, 2023--sec. 33, Ch. 457, L. 2015.)"

Section 4. Section 15-31-511, MCA, is amended to read:

"15-31-511. Confidentiality of tax records. (1) Except as provided in this section, in accordance with a proper judicial order, or as otherwise provided by law, it is unlawful to divulge or make known in any manner:

(a) the amount of income or any particulars set forth or disclosed in any return or report required under this chapter or any other information relating to taxation secured in the administration of this chapter; or

(b) any federal return or information in or disclosed on a federal return or report required by law or rule of the department under this chapter.

(2) (a) An officer or employee charged with custody of returns and reports required by this chapter may not be ordered to produce any of them or evidence of anything contained in them in any administrative proceeding or action or proceeding in any court, except:

(i) in an action or proceeding in which the department is a party under the provisions of this chapter; or

(ii) in any other tax proceeding or on behalf of a party to an action or proceeding under the provisions of this chapter when the returns or reports or facts shown in them are directly pertinent to the action or proceeding.

(b) If the production of a return, report, or information contained in them is ordered, the court shall limit production of and the admission of returns, reports, or facts shown in them to the matters directly pertinent to the action or proceeding.

(3) This section does not prohibit:

(a) the delivery of a certified copy of any return or report filed in connection with a return to the taxpayer who filed the return or report or to the taxpayer's authorized representative;

(b) the publication of statistics prepared in a manner that prevents the identification of particular returns, reports, or items from returns or reports;

(c) the inspection of returns and reports by the attorney general or other legal representative of the state in the course of an administrative proceeding or litigation under this chapter;

(d) access to information under subsection (4);

(e) the director of revenue from permitting a representative of the commissioner of internal revenue of the United States or a representative of a proper officer of any state imposing a tax on the income of a taxpayer to inspect the returns or reports of a corporation. The department may also furnish those persons abstracts of income, returns, and reports; information concerning any item in a return or report; and any item disclosed by an investigation of the income or return of a corporation. The director of revenue may not furnish that information to a person representing the United States or another state unless the United States or the other state grants substantially similar privileges to an officer of this state charged with the administration of this chapter.

~~(f) the disclosure of information to the commissioner of insurance's office that is necessary for the administration of the small business health insurance tax credit provided for in Title 33, chapter 22, part 20.~~

(4) On written request to the director or a designee of the director, the department shall:

(a) allow the inspection of returns and reports by the legislative auditor, but the information furnished to the legislative auditor is subject to the same restrictions on disclosure outside that office as provided in subsection (1);

(b) provide corporate income tax and alternative corporate income tax information, including any information that may be required under Title 15, chapter 30, part 33, to the legislative fiscal analyst, as provided in 5-12-303 or 15-1-106, and the office of budget and program planning, as provided in 15-1-106 or 17-7-111. The information furnished to the legislative fiscal analyst and the office of budget and program planning is subject to the same restrictions on disclosure outside those offices as provided in subsection (1).

(c) provide to the department of commerce tax information about a taxpayer whose debt is assigned to the department of revenue for offset or collection pursuant to the terms of Title 17, chapter 4, part 1. The information provided to the department of commerce must be used for the purposes of preventing and detecting fraud or abuse and determining eligibility for grants or loans.

(d) furnish to the superintendent of public instruction information required under 20-9-905.

(5) A person convicted of violating this section shall be fined not to exceed $500. If a public officer or public employee is convicted of violating this section, the person is dismissed from office or employment and may not hold any public office or public employment in the state for a period of 1 year after dismissal or, in the case of a former officer or employee, for 1 year after conviction. (Subsection (4)(d) terminates December 31, 2023--sec. 33, Ch. 457, L. 2015.)"

Section 5. Section 30-10-115, MCA, is amended to read:

"30-10-115. Deposits to general fund -- exceptions. (1) Except as provided in subsection (2), all fees and miscellaneous charges received by the commissioner pursuant to parts 1 through 3 of this chapter must be deposited in the general fund.

(2) (a) All 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 subsection (2)(a) to the state special revenue account may be used only to defray the expenses of the state auditor's office in discharging its administrative and regulatory powers and duties in relation to notice filing under 30-10-209(1)(d) and examinations.

(b) Any fees in excess of the amount required for the purposes listed in subsection (2)(a) must be deposited in the general fund.

(c) ~~From March 7, 2013, through June 30, 2017,~~ 4.5% of the total fees collected annually under 30-10-209(1)(b) must be deposited in the securities restitution assistance fund provided for in 30-10-1004. The remainder must be deposited in the general fund. ~~On or after July 1, 2017, all fees collected annually under 30-10-209(1)(b) must be deposited in the general fund.~~"

Section 6. 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 notice filing fee to be calculated as provided in subsections (1)(a) through (1)(c). The 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) (a) Except as provided in subsection (6)(b), all fees, miscellaneous charges, fines, and penalties collected by the commissioner pursuant to parts 1 through 3 of this chapter and the rules adopted under parts 1 through 3 of this chapter must be deposited in the general fund.

(b) ~~From March 7, 2013, through June 30, 2017, the~~ The fees collected under subsection (1)(b), the notice filing fees provided for in subsection (1)(d), and the amounts collected for examination costs under

30-10-210 are subject to deposit as provided in 30-10-115(2). ~~On or after July 1, 2017, the notice filing fees provided for in subsection (1)(d) and the amounts collected for examination costs under 30-10-210 are subject to deposit as provided in 30-10-115(2).~~"

Section 7. Section 33-1-115, MCA, is amended to read:

"33-1-115. Operation of state fund as authorized insurer -- issuance of certificate of authority -- exceptions -- use of calendar year -- risk-based capital -- reporting requirements. (1) The state fund provided for in 39-71-2313 is an authorized insurer and, except as provided in this section, is subject to the provisions in Title 33 that are generally applicable to authorized workers' compensation insurers in this state and the provisions of Title 39, chapter 71, part 23.

(2) (a) The commissioner shall issue a certificate of authority to the state fund to write workers' compensation insurance coverages, as provided in 39-71-2316, and except as otherwise provided in this section the requirements of Title 33, chapter 2, part 1, do not apply. The certificate of authority must be continuously renewed by the commissioner.

(b) The state fund shall pay the annual fee under 33-2-708, provide the surplus funds required under 33-2-109 and 33-2-110, and provide to the commissioner the available documentation and information that is provided by other insurers when applying for a certificate of authority under 33-2-115.

(c) The state fund is subject to the reporting requirements under 33-2-705 but is not subject to the tax on net premiums.

(3) (a) The state fund, as the guaranteed market for workers' compensation insurance for employers pursuant to 39-71-2313, is not subject to:

(i) formation requirements of an insurer under Title 33, chapter 3;

(ii) revocation or suspension of its certificate of authority under any provision of Title 33 or any order or any provision that requires forfeiture of the state fund's obligation to insure employers as required in 39-71-2313;

(iii) liquidation or dissolution under Title 33;

(iv) participation in the guaranty association provided for in Title 33, chapter 10;

(v) 33-12-104; or

(vi) any assessment of punitive or exemplary damages.

(b) The state fund is subject to 33-16-1023~~, except as provided in 39-71-2316(1)(e), (1)(f), and (1)(g)~~.

(4) The state fund shall complete financial reporting and accounting on a calendar year basis.

(5) (a) If the state fund's risk-based capital falls below the company action level RBC as defined in 33-2-1902, the commissioner shall issue a report to the governor, the state fund board of directors, and to the legislature. If the legislature is not in session, the report must go to the economic affairs interim committee and to the legislative auditor. The report must provide a description of the RBC measurement, the regulatory implications of the state fund falling below the RBC criteria, and the state fund's corrective action plan. If the commissioner is reporting on a regulatory action level RBC event, the report must include the state fund's corrective action plan, results of any examination or analysis by the commissioner, and any corrective orders issued by the commissioner.

(b) If the state fund fails to comply with any lawful order of the commissioner, the commissioner may initiate supervision proceedings under Title 33, chapter 2, part 13, against state fund. If the state fund fails to comply with the commissioner's lawful supervision order under this subsection (5)(b), the commissioner may institute rehabilitation proceedings under Title 33, chapter 2, part 13, only if the commissioner is petitioning for rehabilitation based on the grounds provided in 33-2-1321(1) or (2).

(6) The state fund shall annually transfer funds to the commissioner, out of its surplus, for all necessary staffing and related expenses for a full-time attorney licensed to practice law in Montana and a full-time examiner qualified by education, training, experience, and high professional competence to examine the state fund pursuant to Title 33, chapter 1, part 4, and this section. The attorney and examiner must be employees of the commissioner.

(7) For the purposes of this section, the term "guaranteed market" has the definition provided in 39-71-2312."

Section 8. Section 33-1-501, MCA, is amended to read:

"33-1-501. Filing of forms -- approval -- review of disapproval or withdrawal of approval -- application. (1) (a) An insurance policy or annuity contract form, certificate, enrollment form, application form, printed rider or endorsement form, or form of renewal certificate may not be delivered or issued for delivery in Montana unless the form and, for the purposes of disability insurance, an outline of coverage as required by 33-22-244 and 33-22-521 have been filed with and approved by the commissioner and, if required, the regulatory official of the state of domicile of the insurer or the interstate insurance product regulation commission provided for in 33-39-101. This provision does not apply to surety bonds or policies, riders, endorsements, or forms of unique character designed for and used with relation to insurance upon a particular subject or that relate to the

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

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

(c) The approval of an insurance policy or annuity contract form, certificate, enrollment form, application form, or other related insurance form by the state of domicile may be waived by the commissioner if the commissioner considers the requirements of subsection (1)(a) unnecessary for the protection of Montana insurance consumers. If the requirement is waived, an insurer shall notify the commissioner in writing within 10 days of disapproval, denial, or withdrawal of approval of a form by the state of domicile.

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

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

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

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

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

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

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

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

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

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

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

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

(7) The commissioner may exempt from the requirements of this section, for so long as the commissioner considers proper, an insurance document, form, or type of document or form to which, in the commissioner's opinion, this section may not practicably be applied or the filing and approval of which are not desirable or necessary for the protection of the public.

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

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

(a) reinsurance;

(b) policies or contracts not issued for delivery in Montana or delivered in Montana, except as provided in subsection (8);

(c) ocean marine and foreign trade insurances.

(10) Except as provided in chapter 21, group certificates that are delivered or issued for delivery in Montana for group insurance policies effectuated and delivered outside Montana but covering persons resident

in Montana must be filed with the commissioner ~~upon request~~. The certificates must meet the minimum provisions mandated by Montana if Montana law prevails over conflicting provisions of other state law."

Section 9. Section 33-1-502, MCA, is amended to read:

"33-1-502. Grounds for disapproval. The commissioner shall disapprove any form filed under 33-1-501 or withdraw any previous approval of a form only if the form:

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

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

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

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

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

Section 10. Section 33-2-1304, MCA, is amended to read:

"33-2-1304. To whom proceedings may be applied. The proceedings authorized by this part may be applied to:

(1) all insurers who are doing or have done insurance business in this state and against whom claims arising from that business may exist now or in the future;

(2) all insurers who purport to do an insurance business in this state;

(3) all insurers who have insureds resident in this state;

(4) all other persons organized or in the process of organizing with the intent to do an insurance business in this state;

(5) all nonprofit service plans, ~~and all~~ fraternal benefit societies and beneficial societies, health service corporations, and health maintenance organizations; ~~or~~ and

(6) all title insurance companies."

Section 11. Section 33-2-1363, MCA, is amended to read:

"33-2-1363. Domiciliary liquidator's proposal to distribute assets. (1) Within 120 days of a final determination of insolvency of an insurer by a court of competent jurisdiction of this state, the liquidator shall make application to the court for approval of a proposal to disburse assets out of marshalled assets, from time to time as assets become available, to a guaranty association or foreign guaranty association having obligations because of the insolvency. If the liquidator determines that there are insufficient assets to disburse, the application required by this section must be considered satisfied by a filing by the liquidator stating the reasons for this determination.

(2) The proposal must at least include provisions for:

(a) reserving amounts for the payment of expenses of administration and the payment of claims of secured creditors, to the extent of the value of the security held, and claims falling within the priorities established in 33-2-1371, class 1;

(b) disbursement of the assets marshalled to date and subsequent disbursement of assets as they become available;

(c) equitable allocation of disbursements to each of the guaranty associations and foreign guaranty associations entitled to a disbursement;

(d) the securing by the liquidator from each of the associations entitled to disbursements pursuant to this section of an agreement to return to the liquidator assets, together with income earned on assets previously disbursed, as may be required to pay claims of secured creditors and claims falling within the priorities established in 33-2-1371 in accordance with the priorities. A bond may not be required of the association.

(e) a full report to be made by each association to the liquidator accounting for all assets disbursed to the association, all disbursements made from the assets, any interest earned by the association on the assets, and any other matter that the court may direct~~.~~;

(f) compliance with Title 33, chapter 3, part 6, if the insurer being liquidated is a domestic stock insurer or a domestic mutual insurer.

(3) The liquidator's proposal must provide for disbursements to the associations in amounts estimated at least equal to the claim payments made or to be made by the associations for which the associations could assert a claim against the liquidator and must provide that if the assets available for disbursement from time to time do not equal or exceed the amount of claim payments made or to be made by the association, then disbursements must be in the amount of available assets.

(4) The liquidator's proposal must, with respect to an insolvent insurer writing life or health insurance or annuities, provide for disbursements of assets to any guaranty association or any foreign guaranty association

covering life or health insurance or annuities or to any other entity or organization reinsuring, assuming, or guaranteeing policies or contracts of insurance under the acts creating the associations.

(5) Notice of the application must be given to the association in each of the states and to the commissioners of insurance of each of the states. Any notice must be considered to have been given when deposited in the United States certified mail, first-class postage prepaid, at least 30 days prior to submission of the application to the court. Action on the application may be taken by the court if the required notice has been given and if the liquidator's proposal complies with subsections (2)(a) and (2)(b)."

Section 12. Section 33-3-601, MCA, is amended to read:

"33-3-601. Voluntary dissolution of domestic insurers -- plan of dissolution. (1) At least 60 days before ~~an~~ a domestic stock insurer submits a proposed voluntary dissolution to shareholders or policyholders under 35-1-932 or voluntarily dissolves under 35-1-931, the insurer must file the plan for dissolution with the commissioner. The commissioner may require the submission of additional information to establish the financial condition of the insurer or other facts relevant to the proposed dissolution. If the shareholders or policyholders adopt the resolution to dissolve, the commissioner shall, within 30 days after the adoption of the resolution, begin to examine the insurer. The commissioner shall approve the dissolution unless, after a hearing, the commissioner finds the insurer is insolvent or may become insolvent in the process of dissolution. If the commissioner approves the voluntary dissolution, the insurer may dissolve under ~~35-1-931 through 35-1-935~~ Title 35, chapter 1, part 9, except that 35-1-938(4) does not apply. The papers required by 35-1-931 through 35-1-935 to be filed with the secretary of state must instead be filed with the commissioner. The duties required by 35-1-217 to be performed by the secretary of state must instead be performed by the commissioner. If the commissioner does not approve the voluntary dissolution, the commissioner shall petition the court for liquidation or rehabilitation under Title 33, chapter 2, part 13~~, of this title~~.

(2) At least 60 days before a domestic mutual insurer submits a proposed voluntary dissolution to the board or members under 35-2-721 or voluntarily dissolves under 35-2-720, the insurer must file the plan for dissolution with the commissioner. The commissioner may require the submission of additional information to establish the financial condition of the insurer or other facts relevant to the proposed dissolution. If the board or members adopt the resolution to dissolve, the commissioner shall, within 30 days after the adoption of the resolution, begin to examine the insurer. The commissioner shall approve the dissolution unless, after a hearing, the commissioner finds the insurer is insolvent or may become insolvent in the process of dissolution. If the

commissioner approves the voluntary dissolution, the insurer may dissolve under Title 35, chapter 2, part 7, except that 35-2-728(1)(d) does not apply. The papers required by 35-2-720 through 35-2-725 to be filed with the secretary of state must instead be filed with the commissioner. The duties required by 35-2-119 to be performed by the secretary of state must instead be performed by the commissioner. If the commissioner does not approve the voluntary dissolution, the commissioner shall petition the court for liquidation or rehabilitation under Title 33, chapter 2, part 13."

Section 13. Section 33-3-602, MCA, is amended to read:

"33-3-602. Conversion to involuntary liquidation. An insurer may at any time during liquidation under ~~35-1-931 and 35-1-932~~ Title 35, chapter 1, part 9, or Title 35, chapter 2, part 7, apply to the commissioner to have the liquidation continued under the commissioner's supervision. Upon receipt of the application, the commissioner shall apply to the court for liquidation under 33-2-1341."

Section 14. Section 33-3-603, MCA, is amended to read:

"33-3-603. Revocation of voluntary dissolution. If an insurer revokes the voluntary dissolution proceedings under 35-1-934 or 35-2-724, the insurer shall file a copy of the revocation of voluntary dissolution proceedings with the commissioner."

Section 15. Section 33-4-103, MCA, is amended to read:

"33-4-103. Corporate powers in general. (1) An insurance corporation formed under this chapter or existing on January 1, 1961, and of a type which might be formed under this chapter shall have the same capacity to act possessed by individuals but with authority to perform only such lawful acts as are necessary or proper to accomplish its purposes.

(2) Without affecting the authority contained in subsection (1) above, every such corporation shall have the following corporate powers:

(a) to have succession by its corporate name for the period stated in its articles;

(b) to sue and be sued in its corporate name;

(c) to adopt, use, and alter a corporate seal;

(d) to acquire, hold, sell, use, dispose of, pledge, or mortgage any such property as its purpose may require, subject to any limitation prescribed by law or the articles of incorporation;

(e) to transact insurance;

(f) to conduct its affairs through its directors, officers, employees, insurance producers, and representatives thereunto duly authorized;

(g) to make bylaws not inconsistent with law for the exercise of its corporate powers, the management, regulation, and government of its affairs and property, including but not limited to calling and holding of meetings of its directors or members, and to modify or amend such bylaws;

(h) to exercise, subject to law and the express provisions of the articles of incorporation, all such incidental and subsidiary powers as may be necessary or convenient to the attainment of the objectives set forth in such articles;

(i) to dissolve and wind up or be dissolved and wound up in the manner provided by law.

(3) An insurance corporation formed under this chapter may also form a subsidiary entity for the purpose of acting as an insurance producer, transacting insurance underwritten by other insurers. The subsidiary entity shall comply with all laws in Title 33, including the licensing requirements of chapter 17. Funds used by an insurance corporation formed under this chapter for a subsidiary entity insurance producer are considered as operational expenses and not investments for purposes of 33-4-403."

Section 16. Section 33-4-204, MCA, is amended to read:

"33-4-204. Amendment of articles -- change ~~from county mutual insurer to state mutual insurer~~ of status. (1) A farm mutual insurer may, by a vote of two-thirds of its members present at any annual meeting or at any special meeting called for that purpose, amend its articles of incorporation to extend its corporate duration or any other particular within the scope of this chapter by causing amended articles to be filed in the same form and manner as required for original articles of incorporation.

(2) (a) A county mutual insurer may change its status to that of a state mutual insurer by amending its articles of incorporation pursuant to the requirements of this section.

(b) A county mutual insurer that changes its status to that of a state mutual insurer shall conform with all requirements for a state mutual insurer under this chapter upon its articles of amendment being certified by the commissioner~~, including the requirements of 33-4-206(2) and 33-4-401(1)~~.

(3) (a) A state mutual insurer may change its status to that of a county mutual insurer by amending its articles of incorporation pursuant this section.

(b) A state mutual insurer that changes its status to that of a county mutual insurer shall conform with

all requirements for a county mutual insurer under this chapter upon its articles of amendment being certified by the commissioner.

~~(3)~~(4) The commissioner shall review the amended articles for compliance with this title. The amended articles of incorporation may be signed only by the president and secretary of the corporation and attested by the corporate seal. Notice of the proposed amendment must be contained in the notice of the annual or special meeting."

Section 17. Section 33-17-243, MCA, is amended to read:

"33-17-243. Producer exchange training ~~-- continuing education~~ -- certification for exchange sales. (1) A producer may not sell, solicit, or negotiate insurance through an exchange on or after October 1, 2013, without first completing the initial producer exchange training and certification program provided for in this section ~~and subsequently completing continuing education in every 24-month period,~~ as prescribed and approved by the commissioner.

~~(2) The continuing education required under this section must be counted toward the total number of hours required in 33-17-1203.~~

~~(3)~~(2) The producer exchange training and certification program ~~and the continuing education courses~~ required in this section must consist of topics related to health insurance offered within an exchange, including but not limited to:

(a) the levels of coverage provided in an exchange;

(b) the eligibility requirements for individuals to purchase insurance through an exchange;

(c) the eligibility requirements for employers to make insurance available to their employees through a small business health options program;

(d) the individual eligibility requirements for medicaid and the healthy Montana kids plan, as provided in Title 53; and

(e) the use of enrollment forms used in an exchange."

Section 18. Section 33-17-301, MCA, is amended to read:

"33-17-301. Adjuster license -- qualifications -- catastrophe adjustments -- education and examination exemption. (1) ~~An individual~~ A person may not act as or purport to be an adjuster in this state unless the ~~individual~~ person holds an adjuster license. ~~An individual~~ A person shall apply to the commissioner

for an adjuster license in a form approved by the commissioner. The commissioner shall issue the license to ~~individuals~~ persons qualified to be licensed under this section.

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

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

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

(ii) if not a resident of this state, shall designate a home state in which the adjuster does not maintain a place of business or residence if:

(A) the adjuster's principal state of business or residence does not offer adjuster licensure; and

(B) the adjuster qualifies for the license as if the adjuster were a resident of the designated home state;

(c) except as provided in subsection (4), 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;

(e) shall submit to a licensing background examination that meets the requirements provided in 33-17-220; and

(f) 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 business entity, whether or not organized under the laws of this state, may be licensed under this section if each individual who is to exercise the license powers is separately licensed or is named in the business entity license and is qualified for an individual license under this section.

(4) (a) Subject to the provisions of subsection (4)(b), an individual who applies for a nonresident license under this section in this state and who was previously licensed in another state may not be required to complete any prelicensing education or examination requirements.

(b) The exemption in subsection (4)(a) is available only if the individual is currently licensed in the other state or the individual's application is received within 90 days of the cancellation of the individual's previous license and the other state issues a certification or the state's database records indicate that, at the time of the cancellation, the individual was in good standing in that state.

(5) 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 business entity 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.

(6) A license issued under this section 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.

(7) For purposes of this section, "adjuster" includes adjusters and public adjusters as defined in 33-17-102."

Section 19. Section 33-18-301, MCA, is amended to read:

"33-18-301. Prohibited relations with mortuaries. (1) A life insurer and its board of directors, officers, employees, or representatives that sell any life insurance, other than funeral insurance as defined in 33-20-1501(1)(c)(ii), may not own, manage, supervise, operate, or maintain any mortuary, funeral, or undertaking establishment in Montana.

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

(b) ~~This subsection (2) does not prohibit a~~ A life insurer may not ~~from selling, soliciting, or negotiating~~ sell, solicit, or negotiate life insurance, except stand-alone funeral insurance~~,~~ as ~~defined~~ provided in 33-20-1501~~(1)(c)(ii)~~, through a funeral director, mortician, undertaker, or any employee of a mortuary or undertaker ~~if the funeral director, mortician, undertaker or employee of a mortuary or undertaker, through whom the sale, solicitation, or negotiation occurs, is an insurance producer licensed and qualified under 33-17-214~~.

(c) A life insurer that sells, solicits, or negotiates funeral insurance, as defined in 33-20-1501(1)(c)(ii), through a funeral director, mortician, undertaker, or any employee of a mortuary or undertaker shall comply with the provisions of 33-20-1501 and 33-20-1502.

(3) A funeral insurance policy or certificate and any solicitation material for the policy must comply with 33-20-1501.

(4) An attempt by the insurer or its representative to require the insured to designate a specific beneficiary, including but not limited to a funeral director, mortician, mortuary, or undertaker, constitutes a violation of this section punishable as a misdemeanor pursuant to subsection (5).

(5) A funeral director, mortician, or undertaker or any employee of a mortuary or undertaker who seeks

to sell, solicit, or negotiate funeral insurance shall comply with this code, including the requirements of Title 33, chapter 17, and Title 33, chapter 20, part 15.

~~(5)~~(6) Each violation of this section constitutes a misdemeanor punishable by a fine of not more than $1,000 or by imprisonment for not more than 6 months, or both."

Section 20. Section 33-18-609, MCA, is amended to read:

"33-18-609. Filing. (1) Insurers that use insurance scores to underwrite ~~and~~ or rate risks shall file their scoring models or other scoring processes with the commissioner. A third party may file scoring models on behalf of insurers.

(2) A filing relating to credit information is considered a trade secret under the laws of this state."

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) 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 or security standards for the protection of electronic health information as to any use or disclosure of personal information that is covered under the HIPAA privacy and security regulations, except for the following provisions:

(a) A notice of insurance information practices described as 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) The reasons for an adverse underwriting 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 the licensee is a HIPAA-covered entity.

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

(5) A business associate, as defined in the HIPAA privacy regulations, 45 CFR 160.103, 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 activity of the business associate that falls outside of the scope of that agreement 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, 2011:

(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 and security 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 33-19-202, MCA, is amended to read:

"33-19-202. Notice of insurance information practices -- delivery of notice. A licensee shall provide a clear and conspicuous notice of information practices that accurately reflects its privacy policies and practices to individuals about whom personal information is collected and disclosed by the licensee in connection with insurance transactions as follows:

(1) (a) Except as provided in subsection (2), in the case of a policyholder or certificate holder, a notice must be delivered by an insurance institution:

(i) in the case of policies issued after July 1, 2001, no later than at the time of the delivery of the insurance policy or certificate, unless the notice delivered to the policyholder or certificate holder pursuant to subsection (5)(a) when the policyholder or certificate holder was an applicant is still accurate;

(ii) ~~at least annually, the 12-month period for which may be defined by the insurance institution and must be used consistently. The notice to certificate holders required in this subsection (1)(a)(ii) is not required if the insurance institution has not had any communication, including receiving a claim, from a certificate holder since the initial or last annual notice provided to the certificate holder.~~ within 30 days after any change in the insurance institution's privacy policies or practices; and

(iii) in the case of a policy renewed after July 1, 2001, no later than the policy renewal date, except that notice is not required in connection with a policy renewal if a notice meeting the requirements of this section has been given within the previous 12 months.

(b) When a policyholder or certificate holder obtains a new insurance product or service or when a policy is reinstated and any notices already provided are no longer accurate with respect to the new product, service, or reinstatement, a new or revised and accurate notice must be delivered to the policyholder or certificate holder no later than the time that the product or service is provided by the licensee or at the time of reinstatement.

(2) (a) An insurance institution is not required to meet the requirements of this section with respect to certificate holders until the insurance institution has personally identifiable information regarding the certificate holder.

(b) Until the notice requirements of subsection (1) are met, a third-party administrator or other agent or representative of an insurance institution may not disclose personal information, except as allowed in 33-19-306(2).

(3) The notice required in subsection (1) must be in writing and must state:

(a) the categories of personal information that may be collected from persons other than the individual or individuals covered;

(b) if a licensee discloses personal or privileged information to a third party without an authorization pursuant to an exception in 33-19-306 or 33-19-307, a separate description of the categories of information and the categories of third parties to whom the licensee discloses personal information;

(c) the categories of personal information about a former policyholder or certificate holder that the licensee discloses pursuant to 33-19-306 and 33-19-307 and the categories of persons to whom the disclosure may be made;

(d) any disclosure that the licensee makes pursuant to section 603(d)(2)(A)(iii) of the Fair Credit Reporting Act, 15 U.S.C. 1681, et seq.; and

(e) the licensee's policies and practices with respect to protecting the confidentiality and security of personal and privileged information.

(4) The following information must be contained in the initial notice delivered at the time of application and in any subsequent ~~annual~~ notice ~~if the policy renews periodically~~:

(a) a description of the rights established under 33-19-301 and 33-19-302 and the manner in which those rights may be exercised;

(b) that information obtained from a report prepared by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons if the licensee collects or uses information from or discloses personal information to an insurance-support organization; and

(c) that an individual is entitled to receive, upon written request to the licensee, a record of any subsequent disclosures of medical record information, as described in 33-19-301, made by the licensee pursuant to 33-19-306 and 33-19-307.

(5) In the case of individuals who are not policyholders or certificate holders:

(a) except as provided in subsection (8), in the case of an applicant, an insurance institution shall provide a notice as described in subsection (3) when the applicant submits an application;

(b) for all other individuals, a notice must be given when a licensee seeks an authorization pursuant to 33-19-306(2) to make a disclosure that is not allowed by a disclosure exception provided for in 33-19-306(3) through (24) or 33-19-307. A notice given pursuant to this subsection (5)(b) may be in an abbreviated form and must state that:

(i) personal information may be collected from persons other than the individual or individuals proposed for coverage;

(ii) the information as well as other personal or privileged information subsequently collected by the insurance institution or insurance producer may in certain circumstances be disclosed to third parties without authorization;

(iii) a right of access and correction exists with respect to all personal information collected; and

(iv) the notice prescribed in subsection (3) must be furnished upon request. The abbreviated notice provided for in this subsection (5)(b) must explain a reasonable means by which an individual may obtain that notice.

(6) The obligations imposed by this section upon a licensee may be satisfied:

(a) by another licensee authorized to act on its behalf;

(b) by sending a notice to the primary policyholder of an individual policy or to the primary certificate holder.

(7) A licensee shall provide a notice required by this section so that an intended recipient can reasonably be expected to receive actual notice in writing or, if the intended recipient agrees, electronically, as follows:

(a) by hand-delivering a printed copy of the notice to the intended recipient;

(b) by mailing a printed copy of the notice to the last-known address of the individual separately or in a policy, billing, or other written communication; or

(c) for an individual who has agreed to conduct transactions electronically, as provided in applicable law, by posting the notice on the electronic site and requiring the individual to acknowledge receipt of the notice as a necessary step to obtaining a particular insurance product or service.

(8) An insurance institution may provide the notice required in subsection (5)(a) telephonically if an application is submitted by telephone. A telephone notice under this subsection may be in abbreviated form as provided for in subsections (5)(b)(i) through (5)(b)(iv).

(9) A licensee may satisfy the notice requirements in this section through the use of combined or separate notices. If more than one notice form is used, the licensee shall refer the individual to state specific notice forms that may be used. Any national notice form must give individuals clear and conspicuous notice that when state law is more protective of individuals than federal privacy law, the licensee will protect information in accordance with state law."

Section 23. Section 33-22-301, MCA, is amended to read:

"33-22-301. Coverage of newborn under disability policy. (1) Each policy of disability insurance or certificate issued must contain a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any insured.

(2) The coverage for newborn infants must be the same as provided by the policy for the other covered persons. However, ~~that~~ for newborn infants there may not be waiting or elimination periods. A deductible or reduction in benefits applicable to the coverage for newborn infants is not permissible unless it conforms and is consistent with the deductible or reduction in benefits applicable to all other covered persons.

(3) A policy or certificate of insurance may not be issued or amended in this state if it contains any

disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an insured from and after the moment of birth.

(4) The policy or contract may require notification of the birth of a child and payment of a required premium or subscription fee to be furnished to the insurer or nonprofit or indemnity corporation within 31 days of the birth in order to have the coverage extend beyond 31 days."

Section 24. Section 33-22-906, MCA, is amended to read:

"33-22-906. Loss ratio standards and filing requirements -- limits on compensation. (1) Medicare supplement policies and certificates must return to policyholders or certificate holders benefits that are reasonable in relation to the premium charged. The commissioner shall adopt reasonable rules to establish minimum standards for loss ratios of medicare supplement policies and certificates on the basis of incurred claims experience or incurred health care expenses, where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and earned premiums for the entire period for which rates are computed to provide coverage and in accordance with accepted actuarial principles and practices. ~~For purposes of rules adopted pursuant to this section, medicare supplement policies and certificates issued as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising, must be treated as group policies.~~ Every entity providing medicare supplement insurance benefits to a resident of this state shall make premium adjustments:

(a) necessary to produce an expected loss ratio under the policy or certificate that meets the minimum loss ratio standards for medicare supplement policies and certificates as established by rule; and

(b) expected to result in a loss ratio at least as great as that originally anticipated by the entity when it established current premiums for the medicare supplement policy or certificate.

(2) The commissioner shall by rule establish the timing and manner of the premium adjustments. Every entity providing medicare supplement policies or certificates in this state shall annually file with the commissioner its rates, rating schedule, and supporting documentation demonstrating that it is in compliance with the applicable loss ratio standards of this part. An entity transacting medicare supplement insurance in this state may not adjust its rates more than twice a year and may not adjust its rates for the first year a policy is in force, except to allow for changes in federal laws or regulations relating to medicare. Each filing of rates and rating schedules must demonstrate that the actual and expected losses in relation to premiums complies with the requirements of this part.

(3) An entity may not provide compensation to its insurance producers that is greater than the renewal compensation that would be paid on an existing policy or certificate if:

(a) the existing policy or certificate were replaced by another policy or certificate with the same insurer and the new benefits are substantially similar to the benefits under the old policy or certificate; and

(b) the old policy or certificate was issued by the same insurer or insurance group."

Section 25. Section 33-22-1815, MCA, is amended to read:

"33-22-1815. Qualifications for voluntary purchasing pool. A voluntary purchasing pool of disability insurance purchasers may be formed solely for the purpose of obtaining disability insurance upon compliance with the following provisions:

(1) It contains at least 51 eligible employees.

(2) It establishes requirements for membership. The voluntary purchasing pool shall accept for membership any small employers and may accept for membership any employers with at least 51 eligible employees that otherwise meet the requirements for membership. However, the voluntary purchasing pool may not exclude any small employers that otherwise meet the requirements for membership on the basis of claim experience, occupation, or health status.

(3) It holds an open enrollment period at least once a year during which new members can join the voluntary purchasing pool.

(4) It offers coverage to eligible employees of member employers and to the employees' dependents. Coverage may not be limited to certain employees of member small employers except as provided in 33-22-1811(3)(c).

(5) It does not assume any risk or form self-insurance plans among its members.

(6) (a) Disability insurance policies, certificates, or contracts offered through the voluntary purchasing pool must rate the entire purchasing pool group as a whole and charge each insured person based on a community rate within the common group, adjusted for case characteristics as permitted by the laws governing group disability insurance.

(b) ~~Except for the rates for the small business health insurance pool established in 33-22-2001, rates~~ Rates for voluntary purchasing pool groups must be set pursuant to the provisions of 33-22-1809.

(c) At its discretion, premiums may be paid to the disability insurance policies, certificates, or contracts by the voluntary purchasing pool or by member employers.

(7) A person marketing disability insurance policies, certificates, or contracts for a voluntary purchasing pool must be licensed as an insurance producer."

Section 26. Section 33-22-1816, MCA, is amended to read:

"33-22-1816. Commissioner powers and duties -- application for registration -- reporting insolvency. (1) The commissioner shall develop forms for registration of an organization as a voluntary purchasing pool.

(2) An organization seeking to be registered as a voluntary purchasing pool shall make application to the commissioner. The commissioner shall register an organization as a voluntary purchasing pool upon proof of fulfillment of the qualifications provided in 33-22-1815.

(3) Except as provided in subsection (5), on March 1 of each year, the voluntary purchasing pool shall provide a report and financial statement for the previous calendar year to the commissioner so that the commissioner may determine:

(a) whether the operation of the voluntary purchasing pool is fiscally sound;

(b) whether the voluntary purchasing pool is bearing any risk; and

(c) the number of individuals covered.

(4) The annual report of the voluntary purchasing pool must disclose its total administrative cost.

(5) A voluntary purchasing pool may choose to operate on a fiscal year other than on the calendar year. A voluntary purchasing pool that establishes a fiscal year that is other than the calendar year shall provide the report required in subsection (3) to the commissioner within 60 days of the voluntary purchasing pool's fiscal yearend.

~~(6) The commissioner may exempt the small business health insurance purchasing pool established in 33-22-2001 from the reporting requirements under subsection (3).~~"

Section 27. Section 33-28-101, MCA, is amended to read:

"33-28-101. Definitions. As used in this chapter, unless the context requires otherwise, the following definitions apply:

(1) "Affiliated company" means any company in the same corporate system as a parent, an industrial insured, or a member by virtue of common ownership, control, operation, or management.

(2) "Association" means any legal association of sole proprietorships or business entities that has been

in continuous existence for at least 1 year unless the 1-year requirement is waived by the commissioner and the members of which collectively, or the association itself:

(a) owns, controls, or holds with power to vote all of the outstanding voting securities of an association captive insurance company incorporated as a stock insurer;

(b) has complete voting control over an association captive insurance company incorporated as a mutual insurer;

(c) constitutes all of the subscribers of an association captive insurance company formed as a reciprocal insurer; or

(d) owns, controls, or holds with power to vote all of the outstanding ownership interests of an association captive insurance company organized as a limited liability company.

(3) "Association captive insurance company" means any company that insures risks of the members and the affiliated companies of members.

(4) "Branch business" means any insurance business transacted by a branch captive insurance company in this state.

(5) "Branch captive insurance company" means any foreign captive insurance company authorized by the commissioner to transact the business of insurance in this state through a business unit with a principal place of business in this state.

(6) "Branch operations" means any business operations of a branch captive insurance company in this state.

(7) (a) "Business entity" means a corporation, limited liability company, ~~partnership, limited partnership, limited liability partnership,~~ or other legal entity formed by an organizational document.

(b) The term does not include a sole proprietor.

(8) "Captive insurance company" means any pure captive insurance company, association captive insurance company, protected cell captive insurance company, incorporated cell captive insurance company, special purpose captive insurance company, or industrial insured captive insurance company formed or authorized under the provisions of this chapter.

(9) "Captive reinsurance company" means a captive insurance company authorized in this state that reinsures the risk ceded by any other insurer.

(10) "Captive risk retention group" means a captive insurance risk retention group formed under the laws of this chapter and pursuant to Title 33, chapter 11.

(11) "Cash equivalent" means any short-term, highly liquid investment that is:

(a) readily convertible to known amounts of cash; and

(b) so near to its maturity that it presents insignificant risk of changes in value because of changes in interest rates. Only an investment with an original maturity of 3 months or less qualifies as a cash equivalent.

(12) (a) "Controlled unaffiliated business entity" means a business entity or sole proprietorship:

(i) that is not in a parent's corporate system consisting of the parent and affiliated companies;

(ii) that has an existing, controlling contractual relationship with the parent or an affiliated company; and

(iii) whose risks are managed by a pure captive insurance company.

(b) The commissioner may promulgate rules that further define a controlled unaffiliated business entity.

(13) "Excess workers' compensation insurance" means, in the case of an employer that has insured or self-insured its workers' compensation risks in accordance with applicable state or federal law, insurance that is in excess of a specified per-incident or aggregate limit established by the commissioner.

(14) "Foreign captive insurance company" means any captive insurance company formed under the laws of any jurisdiction other than this state.

(15) "Incorporated cell" means a protected cell of an incorporated cell captive insurance company that is organized as a corporation or other legal entity separate from the incorporated cell captive insurance company.

(16) "Incorporated cell captive insurance company" means a protected cell captive insurance company that is established as a corporate or other legal entity separate from its incorporated cell that is organized as a separate legal entity.

(17) "Industrial insured" means an insured:

(a) who procures the insurance of any risk or risks by use of the services of a full-time employee acting as an insurance manager or buyer;

(b) whose aggregate annual premiums for insurance on all risks total at least $25,000; and

(c) who has at least 25 full-time employees.

(18) "Industrial insured captive insurance company" means any company that insures risks of the industrial insureds that comprise the industrial insured group and their affiliated companies.

(19) "Industrial insured group" means any group that meets either of the following:

(a) the group collectively:

(i) owns, controls, or holds with power to vote all of the outstanding voting securities of an industrial insured captive insurance company incorporated as a stock insurer; or

(ii) has complete voting control over an industrial insured captive insurance company incorporated as a mutual insurer; or

(b) the group is a captive risk retention group.

(20) "Member" means a sole proprietorship or business entity that belongs to an association.

(21) "Mutual insurer" means a business entity without capital stock and with a governing body elected by the policyholders.

(22) "Organizational document" means articles of incorporation, articles of organization, a partnership agreement, a subscribers' agreement, a charter, or any other document that establishes a business entity.

(23) "Parent" means a sole proprietorship, business entity, or individual that directly or indirectly owns, controls, or holds with power to vote more than 50% of the outstanding voting securities of a captive insurance company.

(24) "Participant" means a sole proprietorship or business entity and any affiliates that are insured by a protected cell captive insurance company in which the losses of the participant are limited through a participant contract to the participant's share of the assets of one or more protected cells identified in the participant contract.

(25) "Participant contract" means a contract by which a protected cell captive insurance company insures the risks of a participant and limits the losses of each participant in the contract.

(26) "Protected cell" means a separate account established by a protected cell captive insurance company formed or authorized under the provisions of this chapter, in which an identified pool of assets and liabilities are segregated and insulated, as provided in this chapter, from the remainder of the protected cell captive insurance company's assets and liabilities in accordance with the terms of one or more participant contracts to fund the liability of the protected cell captive insurance company with respect to the participants as set forth in the participant contracts.

(27) "Protected cell assets" means all assets, contract rights, and general intangibles identified with and attributable to a specific protected cell of a protected cell captive insurance company.

(28) "Protected cell captive insurance company" means any captive insurance company:

(a) in which the minimum capital and surplus required by applicable law are provided by one or more sponsors;

(b) that is formed or authorized under the provisions of this chapter;

(c) that insures the risks of separate participants through participant contracts; and

(d) that funds its liability to each participant through one or more protected cells and segregates the

assets of each protected cell from the assets of other protected cells and from the assets of the protected cell captive insurance company's general account.

(29) "Protected cell liabilities" means all liabilities and other obligations identified with and attributable to a specific protected cell of a protected cell captive insurance company.

(30) "Pure captive insurance company" means any company that insures risks of its parent and affiliated companies and controlled unaffiliated business entities.

(31) "Sole proprietorship" means an individual doing business in a noncorporate form.

(32) "Special purpose captive insurance company" means a captive insurance company that is formed or authorized under this chapter that does not meet the definition of any other type of captive insurance company defined in this section or is formed by, on behalf of, or for the benefit of a political subdivision of this state.

(33) "Sponsor" means any entity that meets the requirements of 33-28-301 and 33-28-302 and is approved by the commissioner to provide all or part of the capital and surplus required by the applicable law and to organize and operate a protected cell captive insurance company."

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

"33-28-105. Formation of captive insurance companies. (1) A captive insurance company must be formed or organized as a business entity as provided in this chapter.

(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 members of its association or associations;

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

(d) organized as a <u>manager-managed</u> limited liability company.

(3) A captive insurance company incorporated or organized in this state must be incorporated or organized by at least one incorporator or organizer who is a resident of this state.

(4) (a) In the case of a captive insurance company formed as a business entity and before the organizational documents are transmitted to the secretary of state, the organizers shall file a copy of the proposed organizational documents and a petition with the commissioner requesting the commissioner to issue a certificate that finds that the establishment and maintenance of the proposed business entity 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 any officers, directors, or managing members; and

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

(b) If the commissioner does not issue a certificate or finds that the proposed organizational documents 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 organizational documents and shall return the draft to the proposed organizers, together with a written statement explaining the refusal.

(c) If the commissioner issues a certificate and approves the draft organizational documents, the commissioner shall forward the certificate and an approved draft of organizational documents to the proposed organizers. The organizers shall prepare two sets of the approved organizational documents and shall file one set 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) (a) At least one of the members of the board of directors of a captive insurance company must be a resident of this state. A captive risk retention group must have a minimum of five directors.

(b) In the case of a captive insurance company formed as a limited liability company, at least one of the managers must be a resident of the state. A captive risk retention group formed as a limited liability company must have a minimum of five managers.

(c) In case of a reciprocal insurer, at least one of the members of the subscribers' advisory committee must be a resident of the state. A captive risk retention group formed as a reciprocal insurer must have a minimum of five members of the subscribers' advisory committee.

(7) (a) A captive insurance company formed as a corporation or another business entity has the privileges and is subject to the provisions of general corporation law or the laws governing other business entities, as well as the applicable provisions contained in this chapter.

(b) In the event of conflict between the provisions of general corporation law or the laws governing other business entities 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) (i) 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.

(ii) 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.

(d) A captive risk retention group has the privileges and is subject to the provisions of Title 33, chapter 11, and this chapter. If there is a conflict between Title 33, chapter 11, and this chapter, the provisions of this chapter prevail.

(9) Except as provided in [section 1] and 33-28-306, the provisions of Title 33, chapter 3, pertaining to mergers, consolidations, conversions, mutualizations, and voluntary dissolutions apply in determining the procedures to be followed by captive insurance companies in carrying out any of those transactions.

(10) (a) 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 authorization and maintenance of the branch operation will promote the general good of the state. The foreign captive insurance company shall apply to the secretary of state for a certificate of authority to transact business in this state after the commissioner's certificate is issued.

(b) A branch captive insurance company established pursuant to the provisions of this chapter to write in this state only insurance or reinsurance of the employee benefit business of its parent and affiliated companies is subject to provisions of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001, et seq. In addition to the general provisions of this chapter, the provisions of this section apply to branch captive insurance

companies.

(c) A branch captive insurance company may not do any insurance business in this state unless it maintains the principal place of business for its branch operations in this state."

Section 29. Section 33-28-109, MCA, is amended to read:

"33-28-109. Suspension or revocation of certificate of authority. (1) The certificate of authority of a captive insurance company doing insurance business in this state may be suspended by the commissioner for any of the following reasons:

(a) insolvency or impairment of capital or surplus;

(b) failure to meet and maintain the requirements of 33-28-104;

(c) refusal or failure to submit an annual report, as required by 33-28-107, or any other report or statement required by law or by lawful order of the commissioner;

(d) failure to comply with the provisions of its own charter, bylaws, or other organizational document;

(e) failure to submit to examination or to perform any legal obligation as required by 33-28-108;

(f) use of methods that, although not otherwise specifically prohibited by law, nevertheless render its operation detrimental or its condition unsound with respect to the public or to its policyholders;

(g) failure to pay the tax provided for in 33-28-201; or

(h) failure otherwise to comply with the laws of this state.

(2) If the commissioner finds, upon examination, hearing, or other evidence, that any captive insurance company has committed any of the acts specified in subsection (1), the commissioner may suspend or revoke the company's certificate of authority if the commissioner considers it in the best interest of the public or the policyholders of the captive insurance company.

(3) If the certificate of authority has not been terminated within the period of suspension, the company's certificate of authority may be reinstated if the commissioner finds that the causes of the suspension have been removed or that the insurer is otherwise in compliance with the requirements of this code."

Section 30. Section 33-28-306, MCA, is amended to read:

"33-28-306. Conversion to or merger with reciprocal insurer. (1) An association captive insurance company or industrial insured group formed as a stock or mutual insurer may be converted to or merged with a reciprocal insurer in accordance with the provisions of this section.

(2) A plan for conversion or merger must:

(a) be fair and equitable to the shareholders, in the case of a stock insurer, or the policyholders, in the case of a mutual insurer; and

(b) provide for the purchase of the shares of any nonconsenting shareholder of a stock insurer or the policyholder interest of any nonconsenting policyholder of a mutual insurer.

(3) In order to convert to a reciprocal insurer, the conversion must be accomplished under a reasonable plan and procedure approved by the commissioner. The commissioner may not approve the plan unless it:

(a) provides for a hearing upon notice to the insurer, directors, officers, and stockholders or policyholders who have the right to appear at the hearing, unless the commissioner waives or modifies the requirements for the hearing;

(b) provides for the conversion of the existing stockholder or policyholder interests into subscriber interests in the resulting reciprocal insurer proportionate to stockholder or policyholder interests;

(c) (i) in the case of a stock insurer, is approved, by a majority of the shareholders who are entitled to vote and who are represented at a regular or special meeting at which a quorum is present either in person or by proxy; or

(ii) in the case of a mutual insurer, by a majority of the voting interests of the policyholders who are represented at a regular or special meeting at which a quorum is present either in person or by proxy; and

(d) meets the requirements of 33-28-105.

(4) If the commissioner approves a plan of conversion, the certificate of authority for the converting insurer must be amended to state that it is a reciprocal insurer. The conversion is effective and the corporate existence of the converting entity ceases to exist on the date on which the amended certificate is issued to the attorney-in-fact of the reciprocal insurer. The resulting reciprocal insurer shall notify the secretary of state of the conversion.

~~(5) The commissioner may not approve a plan for a merger unless it:~~

~~(a) meets the requirements of:~~

~~(i) 33-3-217, with respect to the merger with a captive stock insurer; or~~

~~(ii) 33-3-218, with respect to the merger with a captive mutual insurer; and~~

~~(b) meets the requirements of 33-28-105.~~"

Section 31. Section 33-30-102, MCA, is amended to read:

"33-30-102. Application of this chapter -- construction of other related laws. (1) All health service corporations are subject to the provisions of this chapter. In addition to the provisions contained in this chapter, other chapters and provisions of this title apply to health service corporations as follows: 33-2-1212; 33-3-307; 33-3-308; 33-3-401; 33-3-431; 33-3-701 through 33-3-704; 33-17-101; Title 33, chapter 2, ~~part~~ parts 13 and 19; Title 33, chapter 17, parts 2 and 10 through 12; and Title 33, chapters 1, 15, 18, 19, 22, and 32, except 33-22-111.

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

Section 32. Section 33-31-111, MCA, is amended to read:

"33-31-111. Statutory construction and relationship to other laws. (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to a health maintenance organization authorized to transact business under this chapter. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives is not a violation of any law relating to solicitation or advertising by health professionals.

(3) A health maintenance organization authorized under this chapter is not practicing medicine and is exempt from Title 37, chapter 3, relating to the practice of medicine.

(4) This chapter does not exempt a health maintenance organization from the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

(5) This section does not exempt a health maintenance organization from the prohibition of pecuniary interest under 33-3-308 or the material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance organization must be considered an insurer for the purposes of 33-3-308 and 33-3-701 through 33-3-704.

(6) This section does not exempt a health maintenance organization from:

(a) prohibitions against interference with certain communications as provided under Title 33, chapter 1, part 8;

(b) the provisions of Title 33, chapter 22, part 19;

(c) the requirements of 33-22-134 and 33-22-135;

(d) network adequacy and quality assurance requirements provided under chapter 36; or

(e) the requirements of Title 33, chapter 18, part 9.

(7) Title 33, chapter 1, parts 12 and 13, Title 33, chapter 2, ~~part~~ parts 13 and 19, 33-2-1114, 33-2-1211, 33-2-1212, 33-3-401, 33-3-422, 33-3-431, 33-15-308, Title 33, chapter 17, Title 33, chapter 19, 33-22-107, 33-22-129, 33-22-131, 33-22-136, 33-22-137, 33-22-138, 33-22-139, 33-22-141, 33-22-142, 33-22-152, 33-22-153, 33-22-156 through 33-22-159, 33-22-244, 33-22-246, 33-22-247, 33-22-514, 33-22-515, 33-22-521, 33-22-523, 33-22-524, 33-22-526, 33-22-706, Title 33, chapter 32[, and Title 33, chapter 40, part 1,] apply to health maintenance organizations. (Bracketed language in (7) terminates December 31, 2017--sec. 14, Ch. 363, L. 2013.)"

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

"33-31-211. Annual statements -- revocation for failure to file -- penalty for false swearing. (1) Unless it is operated by an insurer or a health service corporation as a plan, each authorized health maintenance organization shall annually on or before March 1 file with the commissioner a full and true statement of its financial condition, transactions, and affairs as of the preceding December 31. The statement must be in the general form and content required by the commissioner. The statement must be completed in accordance with the national association of insurance commissioners' annual statement instructions and the Accounting Practices and Procedures Manual of the national association of insurance commissioners. The statement must be verified by the oath of at least two principal officers of the health maintenance organization. The commissioner may waive any verification under oath. ~~In addition, a health maintenance organization shall, unless it is operated by an insurer or a health service corporation as a plan, annually file on or before June 1 an audited financial statement. A health maintenance organization's audited financial statement must comply with rules adopted by the commissioner concerning audited financial statements.~~

(2) In addition to the annual statement and unless it is operated by an insurer or a health service corporation as a plan, each authorized health maintenance organization shall file quarterly financial statements electronically with the national association of insurance commissioners. The dates for the electronic submission of the quarterly financial statements are March 1 for the first quarter, May 15 for the second quarter, August 15 for the third quarter, and November 15 for the fourth quarter.

~~(2)~~(3) At the time of filing the annual statement required by March 1, the health maintenance organization shall pay the commissioner the fee for filing the statement as prescribed in 33-31-212. The commissioner may refuse to accept the fee for continuance of the insurer's certificate of authority, as provided in 33-31-212, may impose a penalty of $100, or may suspend or revoke the certificate of authority of a health maintenance organization that fails to file an annual statement when due. Each day that the insurer fails to file its annual statement constitutes a separate violation. The total penalty may not exceed $1,000.

~~(3)~~(4) The commissioner may, after notice and hearing, impose a fine not to exceed $5,000 for each violation upon a director, officer, partner, member, insurance producer, or employee of a health maintenance organization who knowingly subscribes to or concurs in making or publishing an annual statement or quarterly financial statement required by law that contains a material statement that is false.

~~(4)~~(5) The commissioner may require reports considered reasonably necessary and appropriate to enable the commissioner to carry out the duties required of the commissioner under this chapter, including but not limited to a statement of operations, transactions, and affairs of a health maintenance organization operated by an insurer or a health service corporation as a plan."

Section 34. Section 33-31-212, MCA, is amended to read:

"33-31-212. Fees. (1) Each health maintenance organization shall pay to the commissioner the following fees:

(a) for filing an application for a certificate of authority or amendment to a certificate of authority, $300;

(b) for filing an amendment to the organization documents that requires approval, $25;

(c) for filing each annual statement, $25;

(d) for annual continuation of certificate of authority, $300.

(2) All fees, miscellaneous charges, fines, penalties, and those amounts received pursuant to 33-31-211~~(3)~~(4) and 33-31-405 collected by the commissioner pursuant to this chapter and the rules adopted under this chapter must be deposited in the state special revenue fund to the credit of the state auditor's office."

Section 35. Section 33-31-401, MCA, is amended to read:

"33-31-401. Examination. (1) The commissioner may examine the affairs of a health maintenance organization as often as is reasonably necessary to protect the interests of the people of this state. The commissioner shall make an examination at least once every ~~3~~ 5 years. ~~The~~ Similarly, the commissioner shall

examine a health maintenance organization operated by an insurer or health service corporation as a plan at least once every 5 years. The provisions of 33-1-408 and 33-1-409 apply to examinations under this section.

(2) Each authorized health maintenance organization and provider shall submit its relevant books and records for the examinations and in every way facilitate the examinations. For the purpose of examination, the commissioner may administer oaths to and examine the officers and insurance producers of the health maintenance organization and the principals of the providers concerning their business.

(3) (a) Upon presentation of a detailed account of the charges and expenses of examinations by the commissioner, the health maintenance organization being examined shall pay to the examiner as necessarily incurred on account of the examination the actual travel expenses, a reasonable living-expense allowance, and a per diem, all at reasonable rates customary therefor and as established or adopted by the commissioner. The commissioner may present an account periodically during the course of the examination or at the termination of the examination as the commissioner considers proper. A person may not pay and an examiner may not accept any additional emolument on account of any examination.

(b) If a health maintenance organization fails to pay the charges and expenses as referred to in subsection (3)(a), the commissioner shall pay them out of the funds of the commissioner in the same manner as other disbursements of funds. The amount paid is a lien upon all of the person's assets and property in this state and may be recovered by suit by the attorney general on behalf of the state and restored to the appropriate fund.

(4) In lieu of an examination, the commissioner may accept the report of an examination made by the commissioner of another state."

Section 36. Section 33-32-102, MCA, is amended to read:

"33-32-102. Definitions. As used in this chapter, the following definitions apply:

(1) "Adverse determination", except as provided in 33-32-402, means:

(a) a determination by a health insurance issuer or its designated utilization review organization that, based on the provided information and after application of any utilization review technique, a requested benefit under the health insurance issuer's health plan is denied, reduced, or terminated or that payment is not made in whole or in part for the requested benefit because the requested benefit does not meet the health insurance issuer's requirement for medical necessity, appropriateness, health care setting, level of care, or level of effectiveness or is determined to be experimental or investigational;

(b) a denial, reduction, termination, or failure to provide or make payment in whole or in part for a

requested benefit based on a determination by a health insurance issuer or its designated utilization review organization of a person's eligibility to participate in the health insurance issuer's health plan;

(c) any prospective review or retrospective review of a benefit determination that denies, reduces, or terminates or fails to provide or make payment in whole or in part for a benefit; or

(d) a rescission of coverage determination.

(2) "Ambulatory review" means a utilization review of health care services performed or provided in an outpatient setting.

(3) "Authorized representative" means:

(a) a person to whom a covered person has given express written consent to represent the covered person;

(b) a person authorized by law to provided substituted consent for a covered person; or

(c) a family member of the covered person or the covered person's treating health care provider only if the covered person is unable to provide consent.

(4) "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or otherwise complex health conditions.

(5) "Certification" means a determination by a health insurance issuer or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based on the information provided, satisfies the health insurance issuer's requirements for medical necessity, appropriateness, health care setting, level of care, and level of effectiveness.

(6) "Clinical peer" means a physician or other health care provider who:

(a) holds a nonrestricted license in a state of the United States; and

(b) is trained or works in the same or a similar specialty to the specialty that typically manages the medical condition, procedure, or treatment under review.

(7) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by a health insurance issuer to determine the necessity and appropriateness of health care services.

(8) "Concurrent review" means a utilization review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional, or another inpatient or outpatient health care setting.

(9) "Cost sharing" means the share of costs that a covered member pays under the health insurance issuer's health plan, including maximum out-of-pocket, deductibles, coinsurance, copayments, or similar charges,

but does not include premiums, balance billing amounts for out-of-network providers, or the cost of noncovered services.

(10) "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health plan.

(11) "Covered person" means a policyholder, a certificate holder, a member, a subscriber, an enrollee, or another individual participating in a health plan.

(12) "Discharge planning" means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives after discharge from a facility.

(13) "Emergency medical condition" has the meaning provided in 33-36-103.

(14) "Emergency services" has the meaning provided in 33-36-103.

(15) "External review" describes the set of procedures provided for in Title 33, chapter 32, part 4.

(16) "Final adverse determination" means an adverse determination involving a covered benefit that has been upheld by a health insurance issuer or its designated utilization review organization at the completion of the health insurance issuer's internal grievance process as provided in Title 33, chapter 32, part 3.

(17) "Grievance" means a written complaint or an oral complaint if the complaint involves an urgent care request submitted by or on behalf of a covered person regarding:

(a) availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(b) claims payment, handling, or reimbursement for health care services; or

(c) matters pertaining to the contractual relationship between a covered person and a health insurance issuer.

(18) "Health care provider" or "provider" means a person, corporation, facility, or institution licensed by the state to provide, or otherwise lawfully providing, health care services, including but not limited to:

(a) a physician, <u>physician assistant,</u> health care facility as defined in 50-5-101, osteopath, dentist, nurse, optometrist, chiropractor, podiatrist, physical therapist, psychologist, licensed social worker, speech pathologist, audiologist, licensed addiction counselor, or licensed professional counselor; and

(b) an officer, employee, or agent of a person described in subsection (18)(a) acting in the course and scope of employment.

(19) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(20) "Health insurance issuer" has the meaning provided in 33-22-140.

(21) "Network" means the group of participating providers providing services to a managed care plan.

(22) "Participating provider" means a health care provider who, under a contract with a health insurance issuer or with its contractor or subcontractor, has agreed to provide health care services to covered persons with the expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health insurance issuer.

(23) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, or any similar entity or combination of entities in this subsection.

(24) "Prospective review" means a utilization review conducted prior to an admission or a course of treatment.

(25) (a) "Rescission" means a cancellation or the discontinuance of coverage under a health plan that has a retroactive effect.

(b) The term does not include a cancellation or discontinuance under a health plan if the cancellation or discontinuance of coverage:

(i) has only a prospective effect; or

(ii) is effective retroactively to the extent that the cancellation or discontinuance is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

(26) (a) "Retrospective review" means a review of medical necessity conducted after services have been provided to a covered person.

(b) The term does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

(27) "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a health care provider other than the one originally making a recommendation for a proposed health care service to assess the clinical necessity and appropriateness of the initial proposed health care service.

(28) "Stabilize" means, with respect to an emergency condition, to ensure that no material deterioration of the condition is, within a reasonable medical probability, likely to result from or occur during the transfer of the individual from a facility.

(29) (a) "Urgent care request" means a request for a health care service or course of treatment with respect to which the time periods for making a nonurgent care request determination could:

(i) seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

(ii) subject the covered person, in the opinion of a ~~physician~~ health care provider with knowledge of the covered person's medical condition, to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

(b) Except as provided in subsection (29)(c), in determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the health insurance issuer shall apply the judgment of a prudent lay person who possesses an average knowledge of health and medicine.

(c) Any request that a ~~physician~~ health care provider with knowledge of the covered person's medical condition determines is an urgent care request within the meaning of subsection (29)(a) must be treated as an urgent care request.

(30) "Utilization review" means a set of formal techniques designed to monitor the use of or to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinions, certification, concurrent review, case management, discharge planning, or retrospective review.

(31) "Utilization review organization" means an entity that conducts utilization review, other than a health insurance issuer performing a review for its own health plans."

Section 37. Section 33-32-103, MCA, is amended to read:

"33-32-103. Utilization review plan. An entity covered under the provisions of this chapter may not conduct a utilization review of health care services provided or to be provided to a patient covered under a contract or plan for health care services issued in this state unless that entity, at all times, maintains and can provide at the commissioner's request ~~with the commissioner~~ a current utilization review plan that includes:

(1) a description of review criteria, standards, and procedures to be used in evaluating proposed or delivered health care services that, to the extent possible, must:

(a) be based on nationally recognized criteria, standards, and procedures;

(b) reflect community standards of care, except that a utilization review plan for health care services under the medicaid program provided for in Title 53 need not reflect community standards of care;

(c) ensure quality of care; and

(d) ensure access to needed health care services;

(2) policies and procedures to ensure that a representative of the entity conducting the utilization review is reasonably accessible to patients and health care providers at all times;

(3) policies and procedures to ensure compliance with all applicable state and federal laws to protect the confidentiality of individual medical records;

(4) a copy of the materials designed to inform applicable patients and health care providers of the requirements of the utilization review plan; and

(5) any other information that may be required by the commissioner that is necessary to implement this chapter."

Section 38. Section 33-32-403, MCA, is amended to read:

"33-32-403. Notice of right to external review. (1) A health insurance issuer shall:

(a) notify the covered person or, if applicable, the covered person's authorized representative in writing of the covered person's right to request an external review pursuant to 33-32-410, 33-32-411, or 33-32-412; and

(b) include the appropriate statements and information described in subsection (4) at the same time that the health insurance issuer sends written notice of:

(i) an adverse determination upon completion of the health insurance issuer's utilization review process described in Title 33, chapter 32, part 2; and

(ii) a final adverse determination.

(2) The health insurance issuer shall include in the written notice required under subsection (1) the following, or substantially equivalent, language:

"We have denied your request for the provision of or payment for a health care service or course of treatment. You have the right to have our decision reviewed by health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or level of effectiveness of the health care service or treatment you requested. You may exercise this right by submitting a request for external review to us [insert address and telephone number of the unit of the health insurance issuer that administers the external review program]."

(3) (a) The commissioner may prescribe the form and content of the notice required under this section.

(b) The notice must also include the following information:

(i) information sufficient to identify the claim involved, including the date of service, the health care provider, and, if applicable, the claim amount; and

(ii) a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning. On receiving a request for a diagnosis or treatment code, the health insurance issuer shall provide the information as soon as practicable. A health insurance issuer may not consider a request for the diagnosis code and treatment information, in itself, to be a request for an external review as outlined in this part.

(4) The health insurance issuer shall include in the notice required under subsection (1) a statement that:

(a) for a notice related to an adverse determination:

(i) the covered person or, if applicable, the covered person's authorized representative may file a grievance under the health insurance issuer's internal grievance process provided for in 33-32-308;

(ii) if the health insurance issuer has not issued a written decision to the covered person or the covered person's authorized representative within the time period provided in 33-32-308 or 33-32-309, as applicable, after the date the covered person or the covered person's authorized representative files the grievance with the health insurance issuer and the covered person or the covered person's authorized representative has not requested or agreed to a delay, the covered person or the covered person's authorized representative may file a request for external review pursuant to 33-32-404. Under those conditions, the covered person or the covered person's authorized representative is considered to have exhausted the health insurance issuer's internal grievance process for the purposes of 33-32-307.

(iii) the covered person or the covered person's authorized representative may file a request for an expedited external review to be conducted pursuant to 33-32-411 or 33-32-412, as applicable, under the following circumstances:

(A) a review under 33-32-411 may be requested if the covered person has a medical condition with regard to which the timeframe for completion of an expedited grievance review of an adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and

(B) a review under 33-32-412 may be requested if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating health care provider certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated. The ~~physician's~~ health care provider's certification must be submitted at the same time that the covered person or the covered person's authorized representative

files a request for an expedited review of a grievance involving an adverse determination. However, the independent review organization assigned to conduct the expedited external review is responsible for determining whether the covered person is required to complete the expedited review of the grievance before the expedited external review can begin.

(iv) informs the covered person or the covered person's authorized representative of the other exhaustion methods listed in 33-32-405;

(b) for a notice related to a final adverse determination, the covered person or the covered person's authorized representative may file a request for:

(i) an expedited external review under 33-32-411 if the covered person has a medical condition for which the timeframe for completion of a standard external review under 33-32-410 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function;

(ii) an expedited external review under 33-32-411 if the covered person has received emergency services and has not been discharged from a facility and the request concerns an admission, the availability of care, a continued stay, or a health care service for which the covered person received emergency services;

(iii) a standard external review under 33-32-412 if the denial of coverage was based on a determination that the recommended or requested health care service or treatment is experimental or investigational; or

(iv) an expedited external review under 33-32-412 if a covered person to which subsection (4)(b)(iii) applies attaches a written certification from the covered person's treating health care provider that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

(5) In addition to the information to be provided in subsections (1) and (2), the health insurance issuer shall:

(a) include a description of both the standard and the expedited external review procedures as required by the disclosure requirements under 33-32-423, highlighting the provisions in the external review procedures that give the covered person or, if applicable, the covered person's authorized representative the opportunity to submit additional information and including any forms used to process an external review; and

(b) state that the commissioner's office is available to assist covered persons with the external review process. This statement must include the commissioner's contact information.

(6) Among the forms provided under this section, the health insurance issuer shall include an authorization form or other document approved by the commissioner that complies with the requirements of 45

CFR 164.508 and 33-19-206, by which the covered person, for purposes of conducting an external review under this part, authorizes the health insurance issuer and the covered person's treating health care provider to disclose protected health information, including medical records, concerning the covered person for the purposes of the external review."

Section 39. Section 33-32-410, MCA, is amended to read:

"33-32-410. Standard external review. (1) Within ~~4 months~~ 120 days after the date of receipt of a notice of an adverse determination or a final adverse determination pursuant to 33-32-403, a covered person or, if applicable, the covered person's authorized representative may file a request for an external review with the health insurance issuer.

(2) Within 5 business days after the date of receipt of the external review request, the health insurance issuer shall complete a preliminary review of the request to determine whether:

(a) the individual is or was a covered person in the health plan at the time the health care service or treatment was requested or, in the case of a retrospective review, was a covered person in the health plan at the time the health care service or treatment was provided;

(b) the health care service or treatment that is the subject of the adverse determination or the final adverse determination is a covered service under the covered person's health plan but is not covered because of a determination by the health insurance issuer that the health care service or treatment does not meet the health insurance issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or level of effectiveness;

(c) the covered person has exhausted the health insurance issuer's internal grievance process as set forth in Title 33, chapter 32, part 3, or the covered person is exempt under 33-32-307(2); and

(d) the covered person or the covered person's authorized representative has provided all of the information and forms required to process an external review.

(3) (a) Within 1 business day after completion of the preliminary review, the health insurance issuer shall notify the covered person or, if applicable, the covered person's authorized representative in writing as to whether:

(i) the request is complete; and

(ii) the request is eligible for external review.

(b) (i) If the request is not complete, the health insurance issuer shall inform the covered person or, if applicable, the covered person's authorized representative in writing and include in the notice the information or

materials that are needed to make the request complete.

(ii) If the request is not eligible for external review, the health insurance issuer shall inform the covered person or, if applicable, the covered person's authorized representative in writing and include in the notice the reasons for the request's ineligibility.

(4) (a) The commissioner may specify the form for the health insurance issuer's notice of initial determination under subsection (3) and any supporting information to be included in the notice.

(b) The notice of initial determination provided under subsection (3) must include a statement informing the covered person or, if applicable, the covered person's authorized representative of the right to appeal to the commissioner a health insurance issuer's initial determination that the external review request is ineligible for review.

(5) (a) If the commissioner receives an appeal under subsection (4), the commissioner may require a referral for external review, notwithstanding a health insurance issuer's initial determination that the request is ineligible.

(b) A determination by the commissioner under subsection (5)(a) must be based on the terms of the covered person's health plan and all applicable provisions of Title 33, chapter 32, parts 2 through 4.

(6) (a) If the request is eligible for external review, the health insurance issuer shall within 1 business day assign an independent review organization on a random basis, or using another method of assignment that ensures the independence and impartiality of the assignment process, from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to 33-32-416 to conduct the external review.

(b) In making the assignment, the health insurance issuer shall consider whether an independent review organization is qualified to conduct the particular external review based on the nature of the health care service or treatment that is the subject of the adverse determination or final adverse determination.

(c) The health insurance issuer shall also take into account other circumstances, including conflict of interest concerns pursuant to 33-32-417(4).

(7) The assigned independent review organization, in reaching its decision, is not bound by any decisions or conclusions reached during the health insurance issuer's utilization review process set forth in Title 33, chapter 32, part 2, or the health insurance issuer's internal grievance process set forth in Title 33, chapter 32, part 3.

(8) Within 1 business day of assigning an independent review organization pursuant to subsection (6),

the health insurance issuer shall notify, in writing, the covered person or, if applicable, the covered person's authorized representative that the health insurance issuer initiated an external review.

(9) The health insurance issuer shall include in the notice provided to the covered person or, if applicable, the covered person's authorized representative a statement that the covered person or the covered person's authorized representative may submit in writing to the assigned independent review organization within 10 business days following the date of receipt of the notice provided pursuant to subsection (8) any additional information for the independent review organization to consider when conducting the external review. The independent review organization shall accept and consider information submitted within 10 business days after the date of receipt of the notice and may accept and consider additional information submitted after the 10 business days.

(10) Within 5 business days after assigning an independent review organization pursuant to subsection (6), the health insurance issuer or its designated utilization review organization shall provide to the assigned independent review organization the medical records, documents, and any information used in making the adverse determination or final adverse determination.

(11) Except as provided in subsection (12), failure by the health insurance issuer or its designated utilization review organization to provide the documents and information within the time specified in subsection (10) may not delay the conduct of the external review.

(12) (a) If the health insurance issuer or its designated utilization review organization fails to provide the documents and information within the time specified in subsection (10), the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(b) Within 1 business day after making a decision under subsection (12)(a), the independent review organization shall notify the covered person or, if applicable, the covered person's authorized representative as well as the health insurance issuer.

(13) If the provisions of subsection (12) do not apply, the assigned independent review organization shall review all of the information and documents received pursuant to subsection (10) and any other information submitted in writing to the independent review organization by the covered person or, if applicable, the covered person's authorized representative pursuant to subsection (9).

(14) On receipt of any information submitted by the covered person or, if applicable, the covered person's authorized representative pursuant to subsection (9), the assigned independent review organization shall within

1 business day after receipt forward the information to the health insurance issuer.

(15) On receipt of the information, if any, forwarded as provided in subsection (14), the health insurance issuer may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(16) Reconsideration by the health insurance issuer of its adverse determination or final adverse determination pursuant to subsection (15) may not delay or terminate the external review.

(17) The external review may be terminated only if the health insurance issuer decides, on completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service or treatment that is the subject of the adverse determination or final adverse determination.

(18) (a) Within 1 business day after making a decision to reverse its adverse determination or final adverse determination, as provided in subsection (17), the health insurance issuer shall notify the following in writing of its decision:

(i) the covered person or, if applicable, the covered person's authorized representative; and

(ii) the assigned independent review organization.

(b) The assigned independent review organization shall terminate the external review on receipt of the notice from the health insurance issuer sent pursuant to subsection (18)(a).

(19) In addition to the documents and information provided pursuant to subsection (10), the assigned independent review organization shall consider the following information and documents in making a decision, to the extent the information or documents are available:

(a) the covered person's medical records;

(b) the attending health care professional's recommendation;

(c) consulting reports from appropriate health care professionals and other documents submitted by the health insurance issuer, the covered person, the covered person's authorized representative, or the covered person's treating health care provider;

(d) the terms of coverage under the covered person's health plan with the health insurance issuer to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health plan with the health insurance issuer;

(e) the most appropriate practice guidelines, which must include generally accepted practice guidelines, evidence-based standards, or any other practice guidelines developed by the federal government or national or

professional medical societies, boards, and associations;

(f) any applicable clinical review criteria developed and used by the health insurance issuer or its designated utilization review organization; and

(g) the opinion of the independent review organization's clinical peer after considering the provisions of subsections (19)(a) through (19)(f) to the extent the information or documents are available.

(20) Within 45 days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to:

(a) the covered person or, if applicable, the covered person's authorized representative; and

(b) the health insurance issuer.

(21) The independent review organization shall include in the notice sent pursuant to subsection (20):

(a) a general description of the reason for the request for the external review;

(b) the date the independent review organization received the assignment from the health insurance issuer to conduct the external review;

(c) the time period over which the external review was conducted;

(d) the date of the independent review organization's decision;

(e) the principal reasons for the decision;

(f) the rationale for the decision; and

(g) references to the evidence or documentation, including the evidence-based standards, considered in reaching the decision.

(22) If a notice of a decision under subsection (20) reverses the adverse determination or final adverse determination, the health insurance issuer shall immediately approve the coverage that was the subject of the adverse determination or final adverse determination."

Section 40. Section 33-32-412, MCA, is amended to read:

"33-32-412. External review of adverse determinations for experimental or investigational treatment -- expedited external review. (1) Within ~~4 months~~ 120 days after the date when a covered person or, if applicable, the covered person's authorized representative receives notice pursuant to 33-32-403 of an adverse determination or final adverse determination that involves a denial of coverage because a health insurance issuer determined that the health care service or treatment recommended or requested is experimental

or investigational, the covered person or the covered person's authorized representative may file a request for an external review with the health insurance issuer.

(2) (a) A covered person or, if applicable, the covered person's authorized representative may make an oral request for an expedited external review of the adverse determination or final adverse determination pursuant to subsection (1) if the covered person's treating health care provider certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

(b) (i) Upon receipt of a request for an expedited external review, the health insurance issuer shall immediately determine and notify the covered person or, if applicable, the covered person's authorized representative whether the request meets the review requirements of subsection (4).

(ii) The commissioner may specify the form for the health insurance issuer's notice of initial determination under subsection (2)(b)(i) and any supporting information to be included in the notice.

(iii) The notice of initial determination under subsection (2)(b)(i) must include a statement informing the covered person or, if applicable, the covered person's authorized representative of the right to appeal to the commissioner a health insurance issuer's initial determination that the external review request is ineligible for review. The notice must also provide contact information for the commissioner's office.

(c) (i) The commissioner may determine that a request is eligible for external review under 33-32-404 or subsection (4) of this section and may require a referral for external review, notwithstanding a health insurance issuer's initial determination that the request is ineligible.

(ii) A determination by the commissioner under subsection (2)(c)(i) must be based on the terms of the covered person's health plan and all applicable provisions of Title 33, chapter 32, parts 2 through 4.

(d) (i) If the request is eligible for expedited external review, the health insurance issuer shall immediately assign an independent review organization on a random basis, or using another method of assignment that ensures the independence and impartiality of the assignment process, from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to 33-32-416 to conduct the external review.

(ii) In making the assignment, the health insurance issuer shall consider whether an independent review organization is qualified to conduct the particular external review based on the nature of the health care service or treatment that is the subject of the adverse determination or final adverse determination.

(iii) The health insurance issuer shall also take into account other circumstances, including conflict of

interest concerns pursuant to 33-32-417(4).

(e) Upon assigning an independent review organization, the health insurance issuer or its designated utilization review organization shall provide or transmit to the assigned independent review organization electronically, by telephone, by facsimile, or by any other available expeditious method all necessary documents and information used in making the adverse determination or final adverse determination.

(3) Upon receipt of a request for standard external review, the health insurance issuer shall, within 5 business days, determine whether the request meets the eligibility requirements of subsection (4).

(4) In accordance with the timeframes in subsections (2)(b) and (3), the health insurance issuer shall conduct and complete a preliminary review of the request to determine whether:

(a) the individual is or was a covered person in the health plan at the time the health care service or treatment was recommended or requested or, in the case of a retrospective review, was a covered person in the health plan at the time the health care service or treatment was provided;

(b) the recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination:

(i) is a covered benefit under the covered person's health plan except for the health insurance issuer's determination that the service or treatment is experimental or investigational for a particular medical condition; and

(ii) is not explicitly listed as an excluded benefit under the covered person's health plan;

(c) the covered person's treating health care provider has certified that one of the following situations is applicable:

(i) standard health care services or treatments have not been effective in improving the condition of the covered person;

(ii) standard health care services or treatments are not medically appropriate for the covered person; or

(iii) there is no available standard health care service or treatment covered by the health insurance issuer that is more beneficial than the recommended or requested health care service or treatment described in subsection (4)(d);

(d) (i) the covered person's treating health care provider has recommended a health care service or treatment that the ~~physician~~ health care provider certifies, in writing, is likely to be more beneficial to the covered person, in the ~~physician's~~ health care provider's opinion, than any available standard health care services or treatments; or

(ii) a physician who is licensed, board-certified, or eligible to take the examination to become board-certified and is qualified to practice in the area of medicine appropriate to treat the covered person's condition has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the covered person who is subject to the adverse determination or final adverse determination is likely to be more beneficial to the covered person than any available standard health care services or treatments; and

(e) the covered person has exhausted the health insurance issuer's internal grievance process provided in Title 33, chapter 32, part 3, or the covered person is exempt under 33-32-307(2).

(5) (a) Within 1 business day after completion of the preliminary review, the health insurance issuer shall notify the covered person or, if applicable, the covered person's authorized representative in writing as to whether:

(i) the request is complete; and

(ii) the request is eligible for external review.

(b) (i) If the request is not complete, the health insurance issuer shall inform the covered person or, if applicable, the covered person's authorized representative in writing and include in the notice the information or materials that are needed to make the request complete.

(ii) If the request is not eligible for external review, the health insurance issuer shall inform the covered person or, if applicable, the covered person's authorized representative in writing and include in the notice the reasons for the request's ineligibility.

(6) (a) The commissioner may specify the form for the health insurance issuer's notice of initial determination under subsection (5) and any supporting information to be included in the notice.

(b) The notice of initial determination provided under subsection (5) must include a statement informing the covered person or, if applicable, the covered person's authorized representative of the right to appeal to the commissioner a health insurance issuer's initial determination that the external review request is ineligible for review. The notice must also provide contact information for the commissioner's office.

(7) If a request for external review is determined eligible for external review, the health insurance issuer shall notify the covered person or, if applicable, the covered person's authorized representative.

(8) (a) If the request is eligible for external review, the health insurance issuer shall within 1 business day assign an independent review organization on a random basis, or using another method of assignment that ensures the independence and impartiality of the assignment process, from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to 33-32-416 to conduct the

external review.

(b) In making the assignment, the health insurance issuer shall consider whether an independent review organization is qualified to conduct the particular external review based on the nature of the health care service or treatment that is the subject of the adverse determination or final adverse determination.

(c) The health insurance issuer shall also take into account other circumstances, including conflict of interest concerns pursuant to 33-32-417(4).

(9) Within 1 business day of assigning an independent review organization pursuant to subsection (2)(d) or (8), the health insurance issuer shall notify in writing the covered person or, if applicable, the covered person's authorized representative that the health insurance issuer initiated an external review.

(10) The health insurance issuer shall include in the notice provided to the covered person or, if applicable, the covered person's authorized representative a statement that the covered person or, if applicable, the covered person's authorized representative may submit in writing to the assigned independent review organization within 10 business days following the date of receipt of the notice provided pursuant to subsection (9) any additional information for the independent review organization to consider when conducting the external review. The independent review organization shall accept and consider information submitted within 10 business days after the date of receipt of the notice and may accept and consider additional information submitted after the 10 business days.

(11) Within 1 business day after the receipt of the notice of assignment to conduct the external review pursuant to subsection (9), the assigned independent review organization shall~~:~~

~~(a)~~ select a clinical peer, or multiple peers if medically appropriate under the circumstances, to conduct the external review~~; and~~

~~(b) make a decision, based on the opinion of the clinical peers, to uphold or reverse the adverse determination or final adverse determination~~.

(12) (a) In selecting clinical peers to conduct the external review, the assigned independent review organization shall select physicians or other health care providers who meet the minimum qualifications described in 33-32-417 and who, through clinical experience in the past 3 years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

(b) The choice of the physicians or other health care providers to conduct the external review may not be made by the covered person, the covered person's authorized representative, if applicable, or the health insurance issuer.

(13) (a) In accordance with subsection (20), each clinical peer shall provide a written opinion to the assigned independent review organization on whether the recommended or requested health care service or treatment should be covered.

(b) In reaching an opinion, clinical peers are not bound by any decisions or conclusions reached during the health insurance issuer's utilization review process provided for in Title 33, chapter 32, part 2, or in the health insurance issuer's internal grievance process provided for in Title 33, chapter 32, part 3.

(14) (a) Within 5 business days after assigning an independent review organization pursuant to subsection (9), the health insurance issuer or its designated utilization review organization shall provide to the assigned independent review organization any documents and information considered in making the adverse determination or the final adverse determination.

(b) Except as provided in subsection (15), failure by the health insurance issuer or its designated utilization review organization to provide the documents and information within the time specified in subsection (14)(a) may not delay the conduct of the external review.

(15) (a) If the health insurance issuer or its designated utilization review organization fails to provide the documents and information within the time specified in subsection (14)(a), the assigned independent review organization may terminate the external review and decide to reverse the adverse determination or final adverse determination.

(b) Immediately upon making the determination under subsection (15)(a), the independent review organization shall notify the covered person or, if applicable, the covered person's authorized representative, the health insurance issuer, and the commissioner.

(16) On receipt of any information submitted by the covered person or, if applicable, the covered person's authorized representative pursuant to subsection (10), the assigned independent review organization shall, within 1 business day after the receipt of the information, forward the information to the health insurance issuer.

(17) (a) On receipt of the information required to be forwarded pursuant to subsection (16), the health insurance issuer may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(b) Reconsideration by the health insurance issuer of its adverse determination or final adverse determination pursuant to subsection (17)(a) may not delay or terminate the external review.

(18) (a) The external review may be terminated only if the health insurance issuer decides, on completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage

or payment for the recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination.

(b) Immediately upon making the decision to reverse its adverse determination or final adverse determination, as provided in subsection (18)(a), the health insurance issuer shall notify the covered person or, if applicable, the covered person's authorized representative, the assigned independent review organization, and the commissioner in writing of its decision.

(c) The assigned independent review organization shall terminate the external review on receipt of the notice from the health insurance issuer pursuant to subsection (18)(b).

(19) Each clinical peer selected pursuant to subsection (12) shall review all of the information and documents received pursuant to subsection (14) and any other information submitted in writing by the covered person or, if applicable, the covered person's authorized representative pursuant to subsection (10).

(20) (a) Except as provided in subsection (20)(c), within 20 days after being selected in accordance with subsection (12) to conduct the external review, each clinical peer shall provide an opinion to the assigned independent review organization pursuant to subsection (21) on whether the recommended or requested health care service or treatment should be covered.

(b) Except for an opinion provided pursuant to subsection (20)(c), each clinical peer's opinion must be in writing and must include the following information:

(i) a description of the covered person's medical condition;

(ii) a description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than not to be more beneficial to the covered person than any available standard health care services or treatments and that the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;

(iii) a description and analysis of any medical or scientific evidence considered in reaching the opinion;

(iv) a description and analysis of any evidence-based standard; and

(v) information on whether the clinical peer's rationale for the opinion is based on subsection (21)(a) or (21)(b).

(c) (i) For an expedited external review, each clinical peer shall provide an opinion orally or in writing to the assigned independent review organization as expeditiously as the covered person's medical condition or circumstances require but no later than 5 calendar days after the clinical peer was selected in accordance with

subsection (12).

(ii) If the opinion provided pursuant to subsection (20)(c)(i) was not in writing, the clinical peer shall provide to the assigned independent review organization written confirmation of the opinion within 48 hours after the date the opinion was delivered and include the information required under subsection (20)(b).

(21) In addition to the documents and information provided under this section, each clinical peer selected pursuant to subsection (12) shall consider the following information in reaching an opinion as required in subsection (20) to the extent that the information is available and the clinical peer considers the information to be appropriate:

(a) the covered person's pertinent medical records;

(b) the attending ~~physician's or health care professional's~~ health care provider's recommendation;

(c) consulting reports from appropriate health care professionals and other documents submitted by the health insurance issuer, the covered person, the covered person's authorized representative, or the covered person's treating ~~physician or~~ health care provider;

(d) the terms of coverage under the covered person's health plan with the health insurance issuer. The terms of coverage must be analyzed to ensure that, except for the health insurance issuer's determination that the recommended or requested health care service or treatment that is the subject of the opinion is experimental or investigational, the clinical peer's opinion is not contrary to the terms of coverage under the covered person's health benefit plan with the health insurance issuer; and

(e) whether:

(i) the recommended or requested health care service or treatment has been approved by the food and drug administration, if applicable, for the condition;

(ii) the recommended or requested health care service or treatment is typically covered by other insurers or payers, such as medicare; or

(iii) medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be more beneficial to the covered person than any available standard health care service or treatment and that the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

(22) (a) Except as provided in subsection (22)(b), within 20 days after the date of receiving the opinion of each clinical peer pursuant to subsection (20), the assigned independent review organization shall make a

decision and provide written notice of the decision to the covered person or, if applicable, the covered person's authorized representative as well as the health insurance issuer ~~and the commissioner~~.

(b) (i) For an expedited external review, within 48 hours after the date of receiving the opinion of each clinical peer pursuant to subsection (20), the assigned independent review organization, in accordance with subsection (22)(c), shall make a decision and provide notice of the decision orally or in writing to the recipients listed in subsection (22)(a).

(ii) If the notice provided under subsection (22)(b)(i) was not in writing, within 48 hours after the date of providing that notice the assigned independent review organization shall provide written confirmation of the decision to the recipients listed in subsection (22)(a) and include the information set forth in subsection (22)(d).

(c) (i) If a majority of the clinical peers respond that the recommended or requested health care service or treatment should be covered, the independent review organization shall make a decision to reverse the health insurance issuer's adverse determination or final adverse determination.

(ii) If a majority of the clinical peers respond that the recommended or requested health care service or treatment should not be covered, the independent review organization shall make a decision to uphold the health insurance issuer's adverse determination or final adverse determination.

(iii) If the clinical peers are evenly split as to whether the recommended or requested health care service or treatment should be covered, the independent review organization shall obtain the opinion of an additional clinical peer to help the independent review organization make a decision based on the opinions of a majority of the clinical peers pursuant to subsections (22)(c)(i) or (22)(c)(ii).

(iv) The additional clinical peer selected under (22)(c)(iii) shall use the same information to reach an opinion as used by the clinical peers who have already submitted their opinions pursuant to subsection (20).

(v) The selection of the additional clinical peer under subsection (22)(c)(iii) may not extend the time within which the assigned independent review organization is required to make a decision based on the opinions of the clinical peers.

(d) The independent review organization shall include in the notice provided pursuant to subsection (22)(b):

(i) a general description of the reason for the request for external review;

(ii) the written opinion of each clinical peer, including the opinion of each clinical peer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;

(iii) the date on which the independent review organization was assigned by the commissioner to conduct the external review;

(iv) the time period during which the external review was conducted;

(v) the date of the independent review organization's decision; and

(vi) the principal rationale for its decision.

(e) On receipt of a notice of a decision pursuant to subsection (22)(c)(i) reversing the adverse determination or final adverse determination, the health insurance issuer shall immediately approve coverage of the recommended or requested health care service or treatment that was the subject of the adverse determination or final adverse determination."

Section 41. Section 33-32-417, MCA, is amended to read:

"33-32-417. Minimum qualifications for independent review organizations. (1) To be approved to conduct external reviews as provided in 33-32-416, an independent review organization shall establish and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in 33-32-410 through 33-32-412. The written policies and procedures must include, at a minimum:

(a) a quality assurance mechanism that ensures:

(i) that external reviews are conducted within the specified timeframes and that required notices are provided in a timely manner;

(ii) that the independent review organization is unbiased;

(iii) both the selection of qualified and impartial clinical peers to conduct external reviews on behalf of the independent review organization and the suitable matching of reviewers to specific cases;

(iv) that the independent review organization employs or contracts with an adequate number of clinical peers to meet the objective of qualified, impartial reviews;

(v) the confidentiality of medical and treatment records as well as clinical review criteria; and

(vi) that any person employed by or under contract with the independent review organization adheres to the requirements of this part;

(b) a toll-free telephone service to receive information related to external reviews on a 24-hour-a-day, 7-day-a-week basis. The telephone service must be capable of accepting, recording, or providing appropriate instruction to incoming telephone callers during other-than-normal business hours.

(c) an agreement to maintain and provide to the commissioner the information required under 33-32-421.

(2) All clinical peers assigned by an independent review organization to conduct external reviews must:

(a) be ~~physicians or other~~ appropriate health care providers; and

(b) meet the following minimum qualifications:

(i) be an expert in the treatment of the covered person's medical condition that is the subject of the external review;

(ii) be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical conditions of the covered person;

(iii) hold a nonrestricted professional license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in one or more areas appropriate to the subject of the external review; and

(iv) have no history of disciplinary actions or sanctions, including participation restrictions or a loss of staff privileges either taken or pending by any hospital, government agency, governmental unit, or regulatory body if the disciplinary actions or sanctions raise a substantial question as to the clinical peer's physical, mental, or professional competence or moral character.

(3) In addition to the requirements in subsection (1), an independent review organization may not own or control, be a subsidiary of, or in any way be owned or controlled by or exercise control over a health plan, a health insurance issuer, a national, state, or local trade association of health plans, or a national, state, or local trade association of health care providers.

(4) (a) In addition to the requirements in subsections (1) through (3), to be approved under 33-32-416 to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical peer assigned by the independent review organization to conduct the external review may have a material professional, familial, or financial conflict of interest with any of the following:

(i) the health insurance issuer that is the subject of the external review;

(ii) the covered person whose treatment is the subject of the external review or, if applicable, the covered person's authorized representative;

(iii) any officer, director, or management employee of the health insurance issuer that is the subject of the external review;

(iv) the health care provider, the health care provider's medical group, or the independent practice association recommending the health care service or treatment that is the subject of the external review;

(v) the facility at which the recommended health care service or treatment would be provided; or

(vi) the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review.

(b) In determining whether an independent review organization or a clinical peer assigned by the independent review organization to conduct the external review has a material professional, familial, or financial conflict of interest, the commissioner shall take into consideration:

(i) situations in which the independent review organization to be assigned to conduct an external review of a specified case or a clinical peer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent professional, familial, or financial relationship or connection with a person described in subsection (4)(a) if the characteristics of that relationship or connection do not pose a material professional, familial, or financial conflict of interest that otherwise would result in the disapproval of the independent review organization or of the clinical peer from conducting the external review; and

(ii) whether other medical expertise is available within a reasonable timeframe.

(5) (a) An independent review organization that is accredited by a nationally recognized private accrediting entity that has independent review accreditation standards determined by the commissioner to be equivalent to or exceed the minimum qualifications of this section is presumed to be in compliance with this section and eligible for approval under 33-32-416. However, the commissioner shall also consider the conflict of interest provisions of subsection (4).

(b) The commissioner shall initially and periodically review the independent review organization accreditation standards of a nationally recognized private accrediting entity to determine whether the entity's standards are and continue to be equivalent to or exceed the minimum qualifications established under this section. The commissioner may accept a review conducted by the NAIC for the determination under this subsection (5)(b).

(c) On request, a nationally recognized private accrediting entity shall make its current independent review organization accreditation standards available to the commissioner or the NAIC to enable the commissioner to determine if the entity's standards are equivalent to or exceed the minimum qualifications established under this section. The commissioner may exclude any private accrediting entity that is not reviewed by the NAIC."

Section 42. Section 33-32-423, MCA, is amended to read:

"33-32-423. Disclosure requirements. (1) Each health insurance issuer shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to covered persons.

(2) The disclosure required under subsection (1) must:

(a) be in a format prescribed by the commissioner; and

(b) include a statement that informs the covered person of the right of the covered person or, if applicable, the covered person's authorized representative to file a request for an external review of an adverse determination or final adverse determination with the ~~commissioner~~ health insurance issuer. The statement may explain that external review is available when the adverse determination or final adverse determination involves an issue of medical necessity, appropriateness, health care setting, level of care, or level of effectiveness. The statement must include the telephone number and address of the commissioner.

(3) In addition to the requirements under subsection (2), the statement must inform the covered person that, when filing a request for an external review, the covered person or, if applicable, the covered person's authorized representative is required to authorize the release of any medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review."

Section 43. Section 35-1-217, MCA, is amended to read:

"35-1-217. Filing requirements. All of the following requirements must be met before a document may be filed under this section by the secretary of state:

(1) A document that is required or permitted by this chapter to be filed in the office of the secretary of state must satisfy the requirements of this section and of any other section that adds to or varies these requirements.

(2) The document must contain the information required by this chapter. It may contain other information as well.

(3) The document must be typewritten or printed.

(4) The document must be in the English language. A corporate name need not be in English if it is written in English letters or Arabic or Roman numerals.

(5) (a) Except as provided in subsection (5)(b), the document must be executed:

(i) by the presiding officer of the board of directors of a domestic or foreign corporation, by its president,

or by another of its officers;

(ii) if directors have not been selected or the corporation has not been formed, by an incorporator; or

(iii) if the corporation is in the hands of a receiver, trustee, or other court-appointed fiduciary, by that fiduciary.

(b) A corporation's annual report may be executed as provided in subsection (5)(a) or by the corporation's authorized agent.

(6) The person executing the document shall sign the document and state beneath or opposite the person's signature the person's name and the capacity in which the person signs. The document may but need not contain the corporate seal, an attestation by the secretary or an assistant secretary, or an acknowledgment, verification, or proof.

(7) The document must be in or on the prescribed form if the secretary of state has prescribed a mandatory form for the document under rules adopted pursuant to 35-1-1315.

(8) ~~The~~ Except as provided in 33-3-601, the document must be delivered to the office of the secretary of state for filing and must be accompanied by:

(a) the correct filing fee; and

(b) any franchise tax, license fee, or penalty required by this chapter, rules promulgated under this chapter, or other law."

Section 44. Section 35-1-931, MCA, is amended to read:

"35-1-931. Dissolution by incorporators or initial directors. (1) A majority of the incorporators or initial directors of a corporation that has not issued shares or has not commenced business may dissolve the corporation by delivering to the secretary of state, for filing, articles of dissolution that set forth:

~~(1)~~(a) the name of the corporation;

~~(2)~~(b) the date of its incorporation;

~~(3)~~(c) either that none of the corporation's shares have been issued or that the corporation has not commenced business;

~~(4)~~(d) that any debt of the corporation does not remain unpaid;

~~(5)~~(e) if shares were issued, that the net assets of the corporation remaining after winding up of the corporation's business and affairs have been distributed to the shareholders; and

~~(6)~~(f) that a majority of the incorporators or initial directors authorized the dissolution.

(2) In addition to the requirements under this part, a domestic stock insurer shall comply with the provisions of Title 33, chapter 3, part 6."

Section 45. Section 35-1-932, MCA, is amended to read:

"35-1-932. Dissolution by board of directors and shareholders. (1) A corporation's board of directors may propose dissolution for submission to the shareholders.

(2) For a proposal to dissolve to be adopted:

(a) the board of directors shall recommend dissolution to the shareholders unless the board of directors determines that because of conflict of interest or other special circumstances it should make no recommendation and communicates the basis for its determination to the shareholders; and

(b) the shareholders entitled to vote shall approve the proposal to dissolve as provided in subsection (5).

(3) The board of directors may condition its submission of the proposal for dissolution on any basis.

(4) The corporation shall notify each shareholder, whether or not entitled to vote, of the proposed shareholders' meeting in accordance with 35-1-520. The notice must also state that the purpose or one of the purposes of the meeting is to consider dissolving the corporation.

(5) Unless the articles of incorporation, or the board of directors acting pursuant to subsection (3), requires a greater vote or a vote by voting groups to be adopted, the proposal to dissolve must be approved by an affirmative vote of two-thirds, or a majority if authorized by subsection (6), of all the votes entitled to be cast on that proposal.

(6) A majority of votes cast by the shareholders is sufficient to constitute approval by the corporation if a statement to that effect is included in the articles of incorporation but only if:

(a) the statement is included in the articles of incorporation at the time the initial articles of incorporation were filed; or

(b) the statement is included in an amendment to the articles of incorporation approved by an affirmative vote of two-thirds of the votes entitled to be cast on the amendment pursuant to 35-1-227.

(7) In addition to the requirements under this part, a domestic stock insurer shall comply with the provisions of Title 33, chapter 3, part 6."

Section 46. Section 35-2-119, MCA, is amended to read:

"35-2-119. Filing requirements. All of the following requirements must be met before a document may

be filed under this section by the secretary of state:

(1) A document that is required or permitted by this chapter to be filed in the office of the secretary of state must satisfy the requirements of this section and of any other section that adds to or varies these requirements.

(2) The document must contain the information required by this chapter. The document may contain other information as well.

(3) The document must be typewritten or printed unless an electronic form is allowed by the secretary of state.

(4) The document must be in the English language. However, a corporate name does not need to be in English if it is written in English letters or Arabic or Roman numerals.

(5) (a) Except as provided in subsection (5)(b), the document must be executed:

(i) by the presiding officer of the corporation's board of directors, its president, or another of its officers;

(ii) if directors have not been selected or the corporation has not been formed, by an incorporator; or

(iii) if the corporation is in the hands of a receiver, trustee, or other court-appointed fiduciary, by that fiduciary.

(b) (i) A corporation's annual report may be executed as provided in subsection (5)(a) or by the corporation's authorized agent.

(ii) For the purposes of this subsection (5)(b), "authorized agent" means any individual granted permission by an entity to execute a document on behalf of the entity. The entity is responsible for maintaining a record of the permission granted to an authorized agent.

(6) The person executing the document shall sign the document and state beneath or opposite the signature the person's name and the capacity in which the person signs. The document may but does not need to contain the corporate seal, an attestation by the secretary or an assistant secretary, or an acknowledgment, verification, or proof.

(7) The document must be in or on the prescribed form if the secretary of state has prescribed a mandatory form for a document under 35-2-1108.

(8) ~~The~~ Except as provided in 33-3-601, the document must be delivered to the office of the secretary of state for filing and must be accompanied by:

(a) the correct filing fee; and

(b) any franchise tax, license fee, or penalty required by this chapter, rules promulgated under this

chapter, or other law."

Section 47. Section 35-2-720, MCA, is amended to read:

"35-2-720. Dissolution by incorporators or directors and third persons. (1) A majority of the incorporators or directors of a corporation that does not have members may, subject to any approval required by the articles or bylaws, dissolve the corporation by delivering to the secretary of state articles of dissolution.

(2) The corporation shall give notice of any meeting at which dissolution will be approved. The notice must be in accordance with 35-2-429(3). The notice must also state that the purpose or one of the purposes of the meeting is to consider dissolution of the corporation.

(3) In approving dissolution, the incorporators or directors shall adopt a plan of dissolution indicating to whom the assets owned or held by the corporation will be distributed after all creditors have been paid.

(4) In addition to the requirements under this part, a domestic stock insurer shall comply with the provisions of Title 33, chapter 3, part 6."

Section 48. Section 35-2-721, MCA, is amended to read:

"35-2-721. Dissolution by directors, members, and third persons. (1) Unless this chapter, the articles, bylaws, or the board of directors or members, acting pursuant to subsection (1)(c), require a greater vote or voting by class, dissolution is authorized if it is approved:

(a) by the board;

(b) by the members, if any, by two-thirds of the votes cast or a majority of the voting power, whichever is less; and

(c) in writing, by any person or persons whose approval is required by a provision of the articles, as authorized by 35-2-232, for an amendment to the articles or bylaws.

(2) If the corporation does not have members, dissolution must be approved by a vote of a majority of the directors in office at the time the transaction is approved. In addition, the corporation shall provide notice of any directors' meeting at which approval is to be obtained in accordance with 35-2-429(3). The notice must also state that the purpose or one of the purposes of the meeting is to consider dissolution of the corporation and contain or be accompanied by a copy or summary of the plan of dissolution.

(3) The board may condition its submission of the proposed dissolution, and the members may condition their approval of the dissolution on receipt of a higher percentage of affirmative votes or on any other basis.

(4) If the board seeks to have dissolution approved by the members at a membership meeting, the corporation shall give notice to its members of the proposed membership meeting in accordance with 35-2-530. The notice must state that the purpose or one of the purposes of the meeting is to consider dissolving the corporation and must contain or be accompanied by a copy or summary of the plan of dissolution.

(5) If the board seeks to have dissolution approved by the members by written consent or written ballot, the material soliciting the approval must contain or be accompanied by a copy or summary of the plan of dissolution.

(6) The plan of dissolution must indicate to whom the assets owned or held by the corporation will be distributed after all creditors have been paid.

(7) In addition to the requirements under this part, a domestic stock insurer shall comply with the provisions of Title 33, chapter 3, part 6."

Section 49. Section 39-71-2316, MCA, is amended to read:

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

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

(b) sue and be sued;

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

(d) collect and disburse money received;

(e) ~~except as provided in subsection (1)(f),~~ use the uniform classification system as required in 33-16-1023 and charge premiums for the classifications so that the state fund will be neither more nor less than self-supporting;

~~(f) continue the use of special classification codes that were in use prior to January 1, 2016, for agriculture, municipalities, towns, cities, counties, and state agencies. The board shall file with the commissioner rates and supplementary rate information for these special classifications.~~

~~(g)~~(f) use the uniform experience rating plan provided for in 33-16-1023~~, except upon approval of the board may adopt experience modification thresholds for use by the state fund for its insured employers~~;

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

~~(i)~~(h) hire personnel;

~~(j)~~(i) declare dividends if there is an excess of assets over liabilities. However, dividends may not be paid until adequate actuarially determined reserves are set aside.

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

~~(l)~~(k) upon approval of the board, contract with licensed resident insurance producers;

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

~~(n)~~(m) upon approval of the board, expend funds for scholarship, educational, or charitable purposes;

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

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

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

Section 50. Section 39-71-2375, MCA, is amended to read:

"39-71-2375. Operation of state fund as authorized insurer -- issuance of certificate of authority -- exceptions -- use of calendar year -- risk-based capital -- reporting requirements. (1) The state fund provided for in 39-71-2313 is an authorized insurer and, except as provided in this section, is subject to the provisions in Title 33 that are generally applicable to authorized workers' compensation insurers in this state and the provisions of Title 39, chapter 71, part 23.

(2) (a) The commissioner shall issue a certificate of authority to the state fund to write workers' compensation insurance coverages, as provided in 39-71-2316, and except as otherwise provided in this section the requirements of Title 33, chapter 2, part 1, do not apply. The certificate of authority must be continuously renewed by the commissioner.

(b) The state fund shall pay the annual fee under 33-2-708, provide the surplus funds required under

33-2-109 and 33-2-110, and provide to the commissioner the available documentation and information that is provided by other insurers when applying for a certificate of authority under 33-2-115.

(c) The state fund is subject to the reporting requirements under 33-2-705 but is not subject to the tax on net premiums.

(3) (a) The state fund, as the guaranteed market for workers' compensation insurance for employers pursuant to 39-71-2313, is not subject to:

(i) formation requirements of an insurer under Title 33, chapter 3;

(ii) revocation or suspension of its certificate of authority under any provision of Title 33 or any order or any provision that requires forfeiture of the state fund's obligation to insure employers as required in 39-71-2313;

(iii) liquidation or dissolution under Title 33;

(iv) participation in the guaranty association provided for in Title 33, chapter 10;

(v) 33-12-104; or

(vi) any assessment of punitive or exemplary damages.

(b) The state fund is subject to 33-16-1023~~, except as provided in 39-71-2316(1)(e), (1)(f), and (1)(g)~~.

(4) The state fund shall complete financial reporting and accounting on a calendar year basis.

(5) (a) If the state fund's risk-based capital falls below the company action level RBC as defined in 33-2-1902, the commissioner shall issue a report to the governor, the state fund board of directors, and to the legislature. If the legislature is not in session, the report must go to the economic affairs interim committee and to the legislative auditor. The report must provide a description of the RBC measurement, the regulatory implications of the state fund falling below the RBC criteria, and the state fund's corrective action plan. If the commissioner is reporting on a regulatory action level RBC event, the report must include the state fund's corrective action plan, results of any examination or analysis by the commissioner, and any corrective orders issued by the commissioner.

(b) If the state fund fails to comply with any lawful order of the commissioner, the commissioner may initiate supervision proceedings under Title 33, chapter 2, part 13, against state fund. If the state fund fails to comply with the commissioner's lawful supervision order under this subsection (5)(b), the commissioner may institute rehabilitation proceedings under Title 33, chapter 2, part 13, only if the commissioner is petitioning for rehabilitation based on the grounds provided in 33-2-1321(1) or (2).

(6) The state fund shall annually transfer funds to the commissioner, out of its surplus, for all necessary staffing and related expenses for a full-time attorney licensed to practice law in Montana and a full-time examiner

qualified by education, training, experience, and high professional competence to examine the state fund pursuant to Title 33, chapter 1, part 4, and this section. The attorney and examiner must be employees of the commissioner.

(7) For the purposes of this section, the term "guaranteed market" has the definition provided in 39-71-2312."

Section 51. Section 45-6-301, MCA, is amended to read:

"45-6-301. Theft. (1) A person commits the offense of theft when the person purposely or knowingly obtains or exerts unauthorized control over property of the owner and:

(a) has the purpose of depriving the owner of the property;

(b) purposely or knowingly uses, conceals, or abandons the property in a manner that deprives the owner of the property; or

(c) uses, conceals, or abandons the property knowing that the use, concealment, or abandonment probably will deprive the owner of the property.

(2) A person commits the offense of theft when the person purposely or knowingly obtains by threat or deception control over property of the owner and:

(a) has the purpose of depriving the owner of the property;

(b) purposely or knowingly uses, conceals, or abandons the property in a manner that deprives the owner of the property; or

(c) uses, conceals, or abandons the property knowing that the use, concealment, or abandonment probably will deprive the owner of the property.

(3) A person commits the offense of theft when the person purposely or knowingly obtains control over stolen property knowing the property to have been stolen by another and:

(a) has the purpose of depriving the owner of the property;

(b) purposely or knowingly uses, conceals, or abandons the property in a manner that deprives the owner of the property; or

(c) uses, conceals, or abandons the property knowing that the use, concealment, or abandonment probably will deprive the owner of the property.

(4) A person commits the offense of theft when the person purposely or knowingly obtains or exerts unauthorized control over any part of any public assistance provided under Title 52 or 53 by a state or county

agency, regardless of the original source of assistance, by means of:

(a) a knowingly false statement, representation, or impersonation; or

(b) a fraudulent scheme or device.

(5) A person commits the offense of theft when the person purposely or knowingly obtains or exerts or helps another obtain or exert unauthorized control over any part of any benefits provided under Title 39, chapter 71, by means of:

(a) a knowingly false statement, representation, or impersonation; or

(b) deception or other fraudulent action.

(6) (a) A person commits the offense of theft when the person purposely or knowingly commits insurance fraud as provided in 33-1-1202 or 33-1-1302; or

(b) purposely or knowingly diverts or misappropriates insurance premiums as provided in 33-17-1102~~;~~ ~~or~~

~~(c) purposely or knowingly receives small business health insurance premium incentive payments or premium assistance payments or tax credits under Title 33, chapter 22, part 20, to which the person is not entitled~~.

(7) A person commits the offense of theft of property by embezzlement when, with the purpose to deprive the owner of the property, the person:

(a) purposely or knowingly obtains or exerts unauthorized control over property of the person's employer or over property entrusted to the person; or

(b) purposely or knowingly obtains by deception control over property of the person's employer or over property entrusted to the person.

(8) (a) Except as provided in subsection (8)(b), a person convicted of the offense of theft of property not exceeding $1,500 in value shall be fined an amount not to exceed $1,500 or be imprisoned in the county jail for a term not to exceed 6 months, or both. A person convicted of a second offense shall be fined $1,500 or be imprisoned in the county jail for a term not to exceed 6 months, or both. A person convicted of a third or subsequent offense shall be fined $1,500 and be imprisoned in the county jail for a term of not less than 30 days or more than 6 months.

(b) (i) Except as provided in subsection (8)(c), a person convicted of the offense of theft of property exceeding $1,500 in value or theft of any amount of anhydrous ammonia for the purpose of manufacturing dangerous drugs shall be fined an amount not to exceed $50,000 or be imprisoned in a state prison for a term

not to exceed 10 years, or both.

(ii) A person convicted of the theft of any commonly domesticated hoofed animal shall be fined an amount of not less than $5,000 or more than $50,000 or be imprisoned in a state prison for a term not to exceed 10 years, or both. If a prison term is deferred, the court shall order the offender to perform 416 hours of community service during a 1-year period, in the offender's county of residence. In addition to the fine and imprisonment, the offender's property is subject to criminal forfeiture pursuant to 45-6-328 and 45-6-329.

(c) A person convicted of the offense of theft of property exceeding $10,000 in value by embezzlement shall be imprisoned in a state prison for a term of not less than 1 year or more than 10 years and may be fined an amount not to exceed $50,000. The court may, in its discretion, place the person on probation with the requirement that restitution be made under terms set by the court. If the terms are not met, the required prison term may be ordered.

(9) Amounts involved in thefts committed pursuant to a common scheme or the same transaction, whether from the same person or several persons, may be aggregated in determining the value of the property."

Section 52. Section 53-4-1004, MCA, is amended to read:

"53-4-1004. (Temporary) Eligibility for program -- rulemaking. (1) To be considered eligible for the program, a child:

(a) must be 18 years of age or younger;

(b) must have a combined family income at or below 250% of the federal poverty level or at a lower level determined by the department of public health and human services as provided in subsection (4);

(c) may not already be covered by private insurance that offers creditable coverage, as defined in 42 U.S.C. 300gg(c), for 3 months prior to enrollment in the program or since birth, whichever period is less~~[, except that the break in coverage is waived for a covered dependent whose coverage moves from the purchasing pool provided under Title 33, chapter 22, part 20, to coverage under this part]~~;

(d) may not be eligible for medicaid benefits; and

(e) must be a United States citizen or qualified alien and a Montana resident.

(2) The department of public health and human services shall adopt rules that establish the program's criteria for residency. The criteria must conform as nearly as practicable with the residency requirements for medicaid eligibility.

(3) Subject to 53-4-1009(3), rules governing eligibility may also include financial standards and criteria

for income and resources, treatment of resources, and nonfinancial criteria.

(4) If the department determines that there is insufficient funding for the program, it may lower the percentage of the federal poverty level established in subsection (1)(b) in order to reduce the number of persons who may be eligible to participate or may limit the amount, scope, or duration of specific services provided. (Terminates on occurrence of contingency--sec. 15, Ch. 571, L. 1999; sec. 14, I.M. No. 155, approved November 4, 2008~~; bracketed language void on occurrence of contingency--sec. 7, Ch. 87, L. 2009~~.)"

Section 53. Section 53-6-1201, MCA, is amended to read:

"53-6-1201. Special revenue fund -- health and medicaid initiatives. (1) There is a health and medicaid initiatives account in the state special revenue fund established by 17-2-102. This account is to be administered by the department of public health and human services.

(2) There must be deposited in the account:

(a) money from cigarette taxes deposited under 16-11-119(1)(d);

(b) money from taxes on tobacco products other than cigarettes deposited under 16-11-119(3)(b); and

(c) any interest and income earned on the account.

(3) This account may be used only to provide funding for:

(a) the state funds necessary to take full advantage of available federal matching funds in order to administer the plan and maximize enrollment of eligible children under the healthy Montana kids plan, provided for under Title 53, chapter 4, part 11, and to provide outreach to the eligible children;

(b) a new need-based prescription drug program established by the legislature for children, seniors, chronically ill, and disabled persons that does not supplant similar services provided under any existing program;

(c) increased medicaid services and medicaid provider rates. The increased revenue is intended to increase medicaid services and medicaid provider rates and not to supplant the general fund in the trended traditional level of appropriation for medicaid services and medicaid provider rates.

(d) an offset to loss of revenue to the general fund as a result of new tax credits~~;~~.

~~(e) funding new programs to assist eligible small employers with the costs of providing health insurance benefits to eligible employees;~~

~~(f) the cost of administering the tax credit, the purchasing pool, and the premium incentive payments and premium assistance payments as provided in Title 33, chapter 22, part 20; and~~

~~(g) providing a state match for the medicaid program for premium incentive payments or premium~~

~~assistance payments to the extent that a waiver is granted by federal law as provided in 53-2-216.~~

(4) (a) On or before July 1, the budget director shall calculate a balance required to sustain each program in subsection (3) for each fiscal year of the biennium. If the budget director certifies that the reserve balance will be sufficient, then the agencies may expend the revenue for the programs as appropriated. If the budget director determines that the reserve balance of the revenue will not support the level of appropriation, the budget director shall notify each agency. Upon receipt of the notification, the agency shall adjust the operating budget for the program to reflect the available revenue as determined by the budget director.

(b) Until the programs or credits described in subsections (3)(b) and (3)(d) ~~through (3)(g)~~ are established, the funding must be used exclusively for the purposes described in subsections (3)(a) and (3)(c).

(5) The phrase "trended traditional level of appropriation", as used in subsection (3)(c), means the appropriation amounts, including supplemental appropriations, as those amounts were set based on eligibility standards, services authorized, and payment amount during the past five biennial budgets.

(6) The department of public health and human services may adopt rules to implement this section."

NEW SECTION. **Section 54. Repealer.** The following sections of the Montana Code Annotated are repealed:

15-30-2368.	Tax credit for health insurance premiums paid -- eligible small employers -- pass-through entities.
15-31-130.	Tax credit for health insurance premiums paid -- eligible small employers -- corporations.
33-22-2001.	Establishment of small business health insurance pool -- intent.
33-22-2002.	Small business health insurance pool -- definitions.
33-22-2003.	Board of directors -- composition -- appointment -- compensation.
33-22-2004.	Powers and duties of board.
33-22-2005.	Duties of commissioner -- rulemaking authority.
33-22-2006.	Premium incentive payments, premium assistance payments, and tax credits for small employer health insurance premiums paid -- eligibility for small group coverage -- amounts.
33-22-2007.	Filing for tax credit -- filing for premium incentive payments and premium assistance payments.
33-22-2008.	Registration -- funding limitations -- transfers -- maximum number -- waiting list -- information transfer for tax credits.
33-22-2009.	Penalties.

53-2-216. Health insurance premium assistance -- legislative intent -- application for section 1115 waiver -- duties of board of directors of small business health insurance pool, commissioner of insurance, and department of public health and human services.

53-2-217. Contingency on expenditure.

NEW SECTION. **Section 55. Repealer.** Section 16, Chapter 58, Laws of 2011, is repealed.

NEW SECTION. **Section 56. Codification instruction.** [Section 1] is intended to be codified as an integral part of Title 33, chapter 28, part 1, and the provisions of Title 33, chapter 28, part 1, apply to [section 1].

NEW SECTION. **Section 57. Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **Section 58. Effective dates.** (1) Except as provided in subsection (2), [this act] is effective October 1, 2017.

(2) [Sections 5, 6, 55, and this section] are effective on passage and approval.

- END -