HOUSE BILL NO. 64

INTRODUCED BY B. GRUBBS

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING LAWS RELATING TO INSURANCE FINANCIAL LAWS; REVISING THE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION; ADDING HEALTH SERVICE CORPORATIONS AND HEALTH MAINTENANCE ORGANIZATIONS TO THE ASSOCIATION; REVISING LAWS RELATED TO LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ADMINISTRATION; REVISING INSOLVENCY LAWS; REVISING LAWS RELATING TO REMOVAL OF A DIRECTOR AND CONFLICT OF INTEREST; AMENDING SECTIONS 33-10-202, 33-10-205, 33-10-210, 33-10-215, 33-10-216, 33-10-224, 33-10-227, 33-30-102, AND 33-31-111, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE AND AN APPLICABILITY DATE."

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

Section 1. Section 33-10-202, MCA, is amended to read:

"33-10-202. Definitions. As used in this part, the following definitions apply:

(1) "Account" means either of the two accounts created under 33-10-203.

(2) "Association" means the Montana life and health insurance guaranty association created under 33-10-203.

(3) "Authorized assessment" or "authorized" when used in the context of assessments means a specified amount of money authorized for collection from member insurers by a resolution of the board of directors established in 33-10-204. The authorized assessment may be called for immediately or in the future. The assessment is authorized when the board passes the resolution.

(4) "Benefit plan" means a benefit plan for a specific employee, union, or association of natural persons.

(5) "Called", when used in the context of assessments, means that the association has issued a notice to member insurers requiring that an authorized assessment be paid within the timeframe set forth within the notice. An authorized assessment becomes a called assessment when the association mails the notice to member insurers.

(6) "Contractual obligation" means an obligation under any of the following for which coverage is

provided in this part:

(a) a policy or contract;

(b) a certificate under a group policy or contract; or

(c) a portion of a policy or contract or a portion of a certificate.

(7) "Covered policy" means any policy or contract or portion of a policy or contract for which coverage is provided within the scope of this part.

(8) "Extracontractual claims" includes but is not limited to those claims relating to bad faith in the payment of claims, punitive or exemplary damages, or attorney fees and costs.

(9) "Health insurance coverage" has the same meaning as in 33-22-140, except that it does not include "excepted benefits" as defined in 33-22-140.

~~(9)~~(10) "Impaired insurer" means a member insurer that is not an insolvent insurer and that is placed under an order of rehabilitation or supervision by a court of competent jurisdiction.

~~(10)~~(11) "Insolvent insurer" means a member insurer that is placed under an order of liquidation by a court of competent jurisdiction upon a finding of insolvency.

(12) "Long-term care insurance" has the same meaning as provided in 33-22-1107.

~~(11)~~(13) (a) "Member insurer" means an insurer, health service corporation, or health maintenance organization that is licensed or that holds a certificate of authority to transact any kind of insurance in this state for which coverage is provided under this part and includes any insurer, health service corporation, or health maintenance organization whose license or certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn.

(b) The term does not include:

~~(i) a health service corporation;~~

~~(ii)~~(i) a hospital or medical service organization, whether for profit or not for profit;

~~(iii) a health maintenance organization;~~

~~(iv)~~(ii) a fraternal benefit society;

~~(v)~~(iii) a mandatory state pooling plan;

~~(vi)~~(iv) a mutual assessment company or any other person that operates on an assessment basis;

~~(vii)~~(v) an insurance exchange;

(vi) a multiple employer welfare arrangement as defined in 29 U.S.C. 1002;

~~(viii)~~(vii) an organization that has a certificate or license limited to the issuance of charitable gift annuities;

or

~~(ix)~~(viii) an entity similar to any of the entities listed in subsections ~~(11)(b)(i)~~ (13)(b)(i) through ~~(11)(b)(viii)~~ (13)(b)(vii).

~~(12)~~(14) "Moody's corporate bond yield average" means the monthly average corporates as published by Moody's investors service, inc., or its successor.

~~(13)~~(15) (a) "Owner", "contract owner", and "policyowner" mean the person who is identified as the legal owner under the terms of a policy or contract or who is vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and who is properly recorded as the owner on the books of the insurer.

(b) The terms do not include a person with a mere beneficial interest in a policy or a contract.

~~(14)~~(16) "Person" means any individual, corporation, limited liability company, partnership, association, governmental body or entity, or voluntary organization.

~~(15)~~(17) "Plan sponsor" means:

(a) the employer in the case of a benefit plan established or maintained by a single employer;

(b) the employee organization in the case of a benefit plan established or maintained by an employee organization; or

(c) in the case of a benefit plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan.

~~(16)~~(18) (a) "Premiums" means the amount or consideration received on covered policies or contracts less return premiums, considerations, and deposits, and less dividends and experience credits.

(b) The term does not include:

(i) amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided pursuant to this part, except that an assessable premium may not be reduced based on 33-10-224(2)(b) relating to interest limitations and 33-10-224(3)(b) relating to one individual, one participant, and one contract owner;

(ii) premiums in excess of $5 million on an unallocated annuity contract not issued under a governmental retirement benefit plan or the plan's trustee established under section 401, 403(b), or 457 of the Internal Revenue Code; or

(iii) premiums in excess of $5 million with respect to multiple nongroup policies of life insurance owned

by one owner, whether the policyowner is an individual, firm, corporation, or other person and whether the persons insured are officers, managers, employees, or other persons, regardless of the number of policies or contracts held by the owner.

~~(17)~~(19) "Principal place of business" means:

(a) in the case of a plan sponsor, the state in which more than 50% of the participants in the benefit plan are employed;

(b) if 50% of the participants of a benefit plan are not employed in a single state and for a person other than an individual, the single state in which the individuals who establish policies for the direction, control, and coordination of the operations of the entity as a whole primarily exercise that function, as determined by the association in its reasonable judgment by considering the following factors:

(i) the state in which the primary executive and administrative headquarters is located;

(ii) the state in which the principal office of the chief executive officer is located;

(iii) the state in which the board of directors or similar governing persons conduct its meetings;

(iv) the state in which the executive or management committee of the board of directors or similar governing person or persons conduct the majority of their meetings;

(v) the state from which the management of the overall operations is directed; and

(vi) in the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the above factors; or

(c) with respect to a plan sponsor defined in subsection ~~(15)~~ (17)(c), the principal place of business of the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of specific or clear designation of a principal place of business, is the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

~~(18)~~(20) "Receivership court" means the court in the insolvent or impaired insurer's state that has jurisdiction over the supervision, rehabilitation, or liquidation of the insurer.

~~(19)~~(21) "Resident" means a person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer. A person may be a resident of only one state, and in the case of a person other than an individual, the person is a resident of the state where its principal place

of business is located. Citizens of the United States who are either residents of foreign countries or residents of the possessions, territories, or protectorates of the United States and who do not have an association similar to the association created by this part must be considered residents of the state of domicile of the insurer that issued the policies or contracts.

~~(20)~~(22) "State" means a state, the District of Columbia, the Commonwealth of Puerto Rico, or a United States possession, territory, or protectorate.

~~(21)~~(23) "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

~~(22)~~(24) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or a life, health, or annuity contract.

~~(23)~~(25) "Unallocated annuity contract" means an annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of annuity benefits guaranteed to an individual by the insurer under the contract or certificate."

Section 2. Section 33-10-205, MCA, is amended to read:

"33-10-205. Powers and duties of association. (1) If a member insurer is an impaired insurer, the association, in its discretion and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer and that are approved by the commissioner, may:

(a) guarantee, assume, reissue, reinsure, or cause to be guaranteed, assumed, reissued, or reinsured any or all of the policies or contracts of the impaired insurer; and

(b) provide any money, pledges, loans, notes, guarantees, or other means to effectuate this section and ensure payment of the contractual obligations of the impaired insurer pending action under this section.

(2) If a member insurer is an insolvent insurer, the association, in its discretion, shall do one or more of the following:

(a) (i) guarantee, assume, reissue, or reinsure the policies or contracts of the insolvent insurer, cause the policies or contracts to be guaranteed, assumed, reissued, or reinsured, or ensure payment of the contractual obligations of the insolvent insurer; and

(ii) provide money, pledges, loans, notes, guarantees, or other means reasonably necessary to discharge the association's duties;

(b) provide coverage and benefits with respect to a covered policy or contract for life or health insurance or annuities by:

(i) ensuring~~, for payment of identical premiums,~~ payment of ~~identical~~ benefits~~, except for terms of conversion and renewability,~~ that would have been payable under the policies or contracts of the insolvent insurer for claims incurred:

(A) for group policies or contracts by not later than the earlier of the next renewal date, as specified in the policy or contract, or 45 days; or

(B) for nongroup policies, contracts, or annuities by the earlier of the next renewal date, if any, as specified in the policy or contract, or 1 year;

(ii) ensuring payment under subsection (2)(b)(i) not less than 30 days from the date on which the association becomes obligated with respect to the policies or contracts;

(iii) making diligent efforts to provide all known insureds and annuitants for nongroup policies and contracts or group policyowners with respect to group policies 30 days' notice of termination; and

(iv) (A) making available substitute coverage on an individual basis, with respect to nongroup life and health insurance policies and annuities covered by the association, to each known insured or annuitant or owner if other than the insured or annuitant and to an individual formerly insured or formerly an annuitant under a group policy if that individual is not eligible for replacement group coverage. This subsection (2)(b)(iv)(A) must be applied in accordance with the provisions of subsection (2)(b)(iv)(B), as applicable, if the insureds or annuitants had a right under law or if the terminated policy or annuity contained provisions to convert coverage to individual coverage or to continue an individual policy or annuity in force until a specified age or a specified time, during which the insurer had no right to unilaterally make changes in any provision of the policy or annuity or had a right only to make changes in premium by class.

(B) providing the substitute coverage required under subsection (2)(b)(iv)(A) either by issuing an alternative policy as provided in subsection (2)(b)(iv)(C) or reissuing the terminated coverage, as provided in subsection (2)(b)(iv)(D). Any reissued or alternative policy must be offered without requiring evidence of insurability and may not require a waiting period or exclusion that would not have applied under the terminated policy. The association may reinsure any reissued or alternative policy.

(C) submitting alternative policies or contracts adopted by the association to the commissioner ~~or the receivership court~~ for approval. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency. Alternative policies must contain at least the minimum

statutory provisions required in this state and provide benefits that are not unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates adopted by the association. The premium must be actuarially justified and reflect the amount of insurance to be provided and the age and class of risk of each insured. The premium may not reflect any changes in the health of the insured after the original policy was last underwritten. Alternative policies issued by the association must provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association.

(D) setting a premium at a premium different from that charged under the terminated policy if the association elects to reissue terminated coverage. The association shall set the premium in accordance with the amount of insurance provided and the age and class of risk. The premium must be actuarially justified and is subject to approval by the commissioner. A premium may also be set by a court of competent jurisdiction.

(c) cease any of its obligations with respect to coverage under any policy or contract of the impaired or insolvent insurer or under any reissued or alternative policy on the date the coverage or policy is replaced by another similar policy by the policyowner, the insured, or the association; or

(d) ensure the payment or crediting of a rate of interest consistent with 33-10-224(2)(b)(iii) when proceeding under this section with respect to a policy or contract carrying guaranteed minimum interest rates.

(3) Except for claims incurred or any net cash surrender value that may be due in accordance with the provisions of this part, the association's obligation under the policy or contract terminates within 31 days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage for nonpayment of premiums.

(4) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer belong to and are payable at the direction of the association. The association is liable only for unearned premiums due to policyowners or contract owners arising after the entry of the order of liquidation.

(5) If the association fails to act within a reasonable period of time, the commissioner has the powers and duties of the association under this part with respect to a domestic, foreign, or alien insolvent insurer.

(6) (a) In carrying out its duties under subsections (1) through (4), the association may, subject to approval by a court of competent jurisdiction, impose:

(i) permanent policy or contract liens in connection with a guarantee, assumption, or reinsurance agreement if the association finds that:

(A) the amounts that can be assessed under this part are less than the amounts needed to ensure full

and prompt performance of the association's duties under this part; or

(B) the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of permanent policy or contract liens to be in the public interest; or

(ii) temporary moratoriums or liens on payments of cash values and policy loans or any other right to withdraw funds held in conjunction with policies or contracts. This subsection (6)(a)(ii) also allows temporary moratoriums or liens on any contractual provisions for deferral of cash or policy loan value.

(b) If the receivership court imposes a temporary moratorium or moratorium charge on payment of cash values or policy loans or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans, or other rights for the period of the moratorium or moratorium charge imposed by the receivership court. This subsection (6)(b) does not apply to claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(7) The association is not liable under this part for any covered policy of a foreign or alien insurer whose domiciliary jurisdiction or state of entry provides protection by statute or regulation for residents of this state if that protection is substantially similar to that provided by this part for residents of other states.

(8) In carrying out its duties under this section, the association may, subject to the approval of the ~~receivership court~~ commissioner, issue substitute coverage for a policy or contract that provides an interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed for calculating returns or changes in value. The alternative policy or contract issued under this subsection (8):

(a) must provide in lieu of the index or other external reference in the original policy or contract:

(i) a fixed interest rate;

(ii) payment of dividends within minimum guarantees; or

(iii) a different method for calculating interest or changes in value;

(b) may not contain a requirement for evidence of insurability, a waiting period, or other exclusion that would not have applied under the replaced policy or contract; and

(c) must be substantially similar to the replaced policy or contract in all other material terms.

(9) In addition to other rights provided by law, the association may:

(a) enter into contracts that are necessary or proper to carry out the provisions and purposes of this part;

(b) sue or be sued, including taking any legal actions necessary or proper to recover any unpaid

assessments and to settle claims or potential claims against it;

(c) borrow money to effect the purposes of this part. Any notes or other evidence of indebtedness of the association not in default must be legal investments for domestic insurers and may be carried as admitted assets.

(d) employ or retain persons who are necessary to handle the financial transactions of the association and to perform other functions that become necessary or proper under this part;

(e) negotiate and contract with any liquidator, rehabilitator, supervisor, or ancillary receiver to carry out the powers and duties of the association;

(f) take legal action that may be necessary or appropriate to avoid or recover payment of improper claims;

(g) exercise, for the purposes of this part and to the extent approved by the commissioner, the powers of a domestic life or health insurer, but the association may not issue insurance policies or annuity contracts other than those issued to perform its obligations under this part;

(h) organize itself as a corporation or in any other legal form permitted by the laws of the state;

(i) request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this part with respect to the person. The person shall promptly comply with the request.

(j) unless prohibited or otherwise limited by another section in this title and in accordance with the terms and conditions of the policy or contract, file for actuarially justified rate or premium increases for any policy or contract for which it provides coverage under this part; and

~~(j)~~(k) take other necessary or appropriate action to discharge its duties and obligations under this part or to exercise its powers under this part.

(10) The association may render assistance and advice to the commissioner, upon request, concerning rehabilitation, liquidation, payment of claims, continuations of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.

(11) The association has standing to appear or intervene before any court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this part or before any court with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. The association's standing extends to all matters germane to the powers and duties of the association, including but not limited to proposals for reinsuring, modifying, or guaranteeing the covered policies or contracts of the impaired or insolvent insurer and the determination of the

covered policies or contracts. The association also has the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or before a court with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise.

(12) The association may join an organization of one or more other state associations of similar purposes to further the purposes and administer the powers and duties of the association.

(13) The board of directors of the association may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this part in an economical and efficient manner.

(14) When the association has arranged or offered to provide the benefits of this part to a covered person under a plan or arrangement that fulfills the association's obligations under this part, the person is not entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

(15) Venue in a suit against the association arising under this part is in the first judicial district of this state. The association is not required to give an appeal bond in an appeal that relates to a cause of action arising under this part.

(16) The protection provided by this part does not apply when any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer that is other than this state."

Section 3. Section 33-10-210, MCA, is amended to read:

"33-10-210. Unfair trade practice -- notice to policyowners. (1) It is a prohibited unfair trade practice for any person to make use in any manner of the protection afforded by this part in the sale of insurance.

(2) The association shall prepare a summary document, complying with subsection (3) and describing the general purposes and current limitations of this part. The document must be submitted to the commissioner for approval. Sixty days after receiving approval, a member insurer may not deliver a policy or contract described in 33-10-224(2)(a) to a policyowner or contract owner unless the document is delivered to the policyowner or contract owner prior to or at the time of delivery of the policy or contract. The document must be available upon request by a policyowner. The distribution, delivery, contents, or interpretation of this document does not mean that either the policy or the contract or the owner of the policy or contract would be covered in the event of the impairment or insolvency of a member insurer. The description document must be revised by the association as amendments to this part may require. Failure to receive this document does not give the policyowner, contract

owner, certificate holder, or insured any greater rights than those stated in this part.

(3) The document prepared under subsection (2) must contain a clear and conspicuous disclaimer on its face. The commissioner shall promulgate a rule establishing the form and content of the disclaimer. The disclaimer must:

(a) state the name and address of the life and health insurance guaranty association and insurance department;

(b) prominently warn the policyowner or contract owner that the life and health insurance guaranty association may not cover the policy or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in the state;

(c) state that the insurer and its insurance producers are prohibited by law from using the existence of the life and health insurance guaranty association for the purpose of sales, solicitation, or inducement to purchase any form of insurance;

(d) emphasize that the policyowner or contract owner should not rely on coverage under the life and health insurance guaranty association when selecting an insurer;

(e) provide other information as directed by the commissioner.

~~(4) An insurer or an insurance producer may not deliver a policy or contract described in 33-10-224(2)(a) and excluded under 33-10-224(2)(b) from coverage under this part unless the insurer or insurance producer, prior to or at the time of delivery, gives the policyowner or contract owner a separate written notice that clearly and conspicuously discloses that the policy or contract is not covered by the life and health insurance guaranty association.~~

~~(5) The commissioner shall by rule specify the form and content of the notice required under subsection (4).~~"

Section 4. Section 33-10-215, MCA, is amended to read:

"33-10-215. Duties and powers of commissioner. (1) In addition to the duties and powers enumerated elsewhere in this part, the commissioner shall:

~~(1)~~(a) notify the board of directors of the existence of an impaired or insolvent insurer ~~not later than 3 days~~ after ~~a determination~~ entry of an order of impairment or insolvency is ~~made~~ entered or the commissioner receives notice of impairment or insolvency;

~~(2)~~(b) upon request of the board of directors, provide the association with a statement of the premiums

in the appropriate states for each member insurer;

~~(3)~~(c) when an impairment or insolvency is declared and the amount of the impairment or insolvency is determined, serve a demand upon the impaired or insolvent insurer to make good the impairment or insolvency within a reasonable time. Notice to the impaired or insolvent insurer constitutes notice to its shareholders, if any. The failure of the insurer to promptly comply with the demand does not excuse the association from the performance of its powers and duties under this part.

~~(4) in any liquidation or rehabilitation proceeding involving a domestic insurer be appointed as the liquidator or rehabilitator. If a foreign or alien member insurer is subject to a liquidation proceeding in its domiciliary jurisdiction or state of entry, the commissioner must be appointed conservator.~~

~~(5)~~(2) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a fine on any member insurer that fails to pay an assessment when due. The fine may not exceed 5% of the unpaid assessment per month, except that the fine may not be less than $100 per month.

~~(6)~~(3) A final action of the board of directors may be appealed to the commissioner by a member insurer if the appeal is taken within 60 days of the member insurer's receipt of notice of the final action being appealed. A final action or order of the commissioner is subject to judicial review in a court of competent jurisdiction in accordance with the laws of this state that apply to the actions or orders of the commissioner.

~~(7)~~(4) The liquidator, ~~or~~ rehabilitator, or conservator of an impaired or insolvent insurer may notify all affected persons of the effect of this part."

Section 5. Section 33-10-216, MCA, is amended to read:

"33-10-216. Plan of operation -- delegation of powers provision. (1) (a) The association shall submit to the commissioner a plan of operation and any amendments to the plan that are necessary or suitable to ensure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments to the plan become effective upon the commissioner's written approval or 60 days after receipt by the commissioner's office if the commissioner does not disapprove the submitted plan of operation and any amendments within those 60 days.

(b) If the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate reasonable rules necessary or advisable to effectuate the provisions of this

part. The rules remain in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(2) All member insurers shall comply with the plan of operation.

(3) The plan of operation must, in addition to requirements enumerated elsewhere in this part:

(a) establish procedures for handling the assets of the association;

(b) establish the amount and method of reimbursing members of the board of directors under 33-10-204;

(c) establish regular places and times for meetings of the board of directors;

(d) establish procedures for keeping records of all financial transactions of the association, its agents, and the board of directors;

(e) establish procedures to select the board of directors and submit notice of the selections to the commissioner;

(f) establish any additional procedures for assessments under 33-10-227;

(g) establish procedures for the removal of a director for cause, including in a case in which a member insurer director becomes an impaired or insolvent insurer;

(h) require the board of directors to establish a policy and procedures for addressing conflicts of interests;

~~(g)~~(i) contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(4) The plan of operation may provide that any or all powers and duties of the association, except those under 33-10-205(9)(c) and 33-10-227, may be delegated to a corporation, association, or other organization that performs or will perform functions similar to those of this association or its equivalent in two or more states. A corporation, association, or organization to which these powers and duties are delegated must be reimbursed for any payments made on behalf of the association and must be paid for performing any function of the association. A delegation of authority under this subsection may take effect only with the approval of both the board of directors and the commissioner and may be made only to a corporation, association, or organization that extends protection not substantially less favorable or less effective than that provided by this part."

Section 6. Section 33-10-224, MCA, is amended to read:

"33-10-224. Coverage, limitations, and extent of liability. (1) (a) This part establishes coverage for the policies and contracts specified in subsection (2) to persons who, except as provided in subsections (1)(b)

through (1)(e), are:

(i) beneficiaries, assignees, or payees, including health care providers, of the persons covered under subsection (1)(a)(ii) regardless of where the beneficiaries, assignees, or payees reside, except for nonresident certificate holders under group policies or contracts;

(ii) owners of or certificate holders or enrollees under the policies and contracts specified in subsection (2), other than unallocated annuity contracts and structured settlement annuities that are provided for in subsections (1)(b) and (1)(c), if the persons are:

(A) residents; or

(B) nonresidents, but only under all of the following conditions:

(I) the member insurer that issued the policies is domiciled in this state;

(II) the state in which the person resides has an association similar to the association created under this part; and

(III) the person is not eligible for coverage by an association in any other state because the insurer, health service corporation, or health maintenance organization was not licensed in the state at the time specified in the state's guaranty association law.

(b) The provisions of subsection (1)(a) do not apply to unallocated annuity contracts specified in subsection (2). A person who is the owner of an unallocated annuity contract receives coverage under this part, except as provided in subsections (1)(d) and (1)(e), if:

(i) the contract is issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in this state; or

(ii) the unallocated annuity contract was issued to or in connection with a government lottery if the owner is a resident.

(c) The provisions of subsection (1)(a) do not apply to structured settlement annuities specified in subsection (2). A person who is a payee under a structured settlement annuity or the beneficiary of a payee if the payee is deceased receives coverage under this part, except as provided in subsections (1)(d) and (1)(e), if the payee:

(i) is a resident, regardless of where the contract owner resides; or

(ii) is not a resident and one of the following conditions applies:

(A) the contract owner of the structured settlement annuity is a resident and is not eligible for coverage by another state's association, and the payee or beneficiary is not eligible for coverage by the association of the

state in which the payee or beneficiary resides; or

(B) the contract owner of the structured settlement annuity is not a resident, the insurer that issued the structured settlement annuity is domiciled in this state, the state in which the contract owner resides has an association similar to the association created by this part, and the payee, beneficiary, and contract owner are not eligible for coverage by the association in the state in which the payee, beneficiary, or contract owner resides.

(d) This part does not provide coverage to:

(i) a person who is a payee or a beneficiary of a contract owner that is a resident of this state if the payee or beneficiary is afforded any coverage by the association of another state; ~~or~~

(ii) a person covered under subsection (1)(b) if any coverage is provided by the association of another state to the person; or

(iii) a person who acquires rights to receive payments through a structured settlement factoring transaction as defined in 26 U.S.C. 5891(c)(3)(A), regardless of whether the transaction occurred before or after 26 U.S.C. 5891(c)(3)(A) became effective.

(e) This part is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. To avoid duplicate coverage, a person may not receive coverage under this part if the person who would otherwise receive coverage under this part receives coverage under the laws of any other state. To determine the application of this subsection (1)(e) to a situation in which a person could be covered by the association of more than one state, whether as an owner, payee, beneficiary, or assignee, this part must be construed in conjunction with other state laws to result in coverage by only one association.

(2) (a) (i) Except as otherwise provided in this part, this part provides coverage to the persons specified in subsection (1) for:

(A) direct, nongroup life and health policies, direct, nongroup annuity contracts, and supplemental contracts to any of these;

(B) certificates under direct group policies and contracts and supplemental contracts to any of these; and

(C) unallocated annuity contracts issued by member insurers.

(ii) Annuity contracts and certificates under group annuity contracts include but are not limited to guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, annuities issued in connection with government lotteries, and any immediate or deferred annuity contracts.

(b) This part does not provide coverage for any of the following:

(i) a portion of a policy or contract not guaranteed by the member insurer or under which the risk is borne by the policy or contract owner;

(ii) a policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

(iii) except for the portion of the policy, including a rider, that provides long-term care or any other health insurance benefits, a portion of a policy or contract to the extent that the rate of interest on which the portion is based or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

(A) when averaged over the period of 4 years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this part exceeds the rate of interest determined by subtracting 2 percentage points from Moody's corporate bond yield average that is averaged for that same period or for a lesser period if the policy or contract was issued less than 4 years before the member insurer became an impaired or insolvent insurer under this part; and

(B) when the returns or changes in value exceed the rate of interest determined by subtracting 3 percentage points from the Moody's corporate bond yield average most recently available on or after the date on which the member insurer becomes an impaired or insolvent insurer under this part.

(iv) a portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life, health, or annuity benefits to its employees, members, or others to the extent that the plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association, or other person under:

(A) a multiple employer welfare arrangement as defined in 29 U.S.C. 1002;

(B) a minimum premium group insurance plan;

(C) a stop-loss group insurance plan; or

(D) an administrative services-only contract;

(v) a portion of a policy or contract to the extent that it contains provisions for dividends, experience rating credits, or voting rights or for payment of any fees or allowances to any person, including the policyowner or contract owner, in connection with the service to or administration of the policy or contract;

(vi) a policy or contract issued in this state by a member insurer at any time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state;

(vii) any unallocated annuity contract issued to or in connection with a benefit plan that is protected under

the federal pension benefit guaranty corporation, regardless of whether the federal pension benefit guaranty corporation has yet become liable to make any payments with respect to the benefit plan;

(viii) a portion of any unallocated annuity contract that is not issued to or in connection with a specific employee, union, or association of natural persons' benefit plan or a government lottery;

(ix) a portion of a policy or contract to the extent that federal or state law preempts or otherwise does not permit the assessments required by 33-10-227 with respect to the policy or contract;

(x) an obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policyowner, including without limitation:

(A) claims based on marketing materials;

(B) claims based on side letters, riders, or other documents that were issued by the insurer without meeting applicable requirements for filing policy forms or for policy approval;

(C) misrepresentation of or regarding policy benefits;

(D) extracontractual claims; or

(E) a claim for penalties or consequential or incidental damages;

(xi) a contractual agreement that establishes the member insurer's obligation to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case may not be an affiliate of the member insurer;

(xii) a portion of a policy or contract to the extent that it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policyowner's or contract owner's rights are subject to forfeiture as of the date the member insurer becomes an impaired or insolvent insurer under this part. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this section, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of the impairment or insolvency of the member insurer and the interest or changes in value are not subject to forfeiture.

(xiii) a policy or contract providing any hospital, medical, prescription drug, or other health care benefits pursuant to either 42 U.S.C. 1395w-21 through 1395w-152, commonly known as medicare parts C and D, or 42 U.S.C. 1396 to 1396w-5, commonly known as medicaid, or any regulations issued pursuant to ~~medicare parts C and D.~~ those federal statutes; or

(xiv) structured settlement annuity benefits to which a payee or beneficiary has transferred his or her rights in a structured settlement factoring transaction as defined in 26 U.S.C. 5891(c)(3)(A), regardless of whether the transaction occurred before or after 26 U.S.C. 5891(c)(3)(A) became effective.

(3) The benefits for which the association may become liable may not exceed the lesser of:

(a) the contractual obligations for which the insurer is liable or would have become liable if it were not an impaired or insolvent insurer; or

(b) (i) with respect to any one life, regardless of the number of policies or contracts:

(A) $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;

(B) in health insurance benefits:

(I) $500,000 for health insurance coverage ~~basic hospital, medical, and surgical insurance or major medical insurance as defined in the covered policy or contract~~;

(II) $300,000 for disability income insurance;

(III) $300,000 for long-term care insurance;

(IV) $100,000, including any net cash surrender and net cash withdrawal values, for coverages not included in subsections (3)(b)(i)(B)(I) through (3)(b)(i)(B)(III);

(C) $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;

(ii) with respect to each individual participating in a governmental retirement plan established under section 401, 403(b), or 457 of the Internal Revenue Code and covered by an unallocated annuity contract or with respect to the beneficiaries of each individual, if deceased, in the aggregate, $250,000 in present value annuity benefits, including net cash surrender and net cash withdrawal values;

(iii) with respect to each payee of a structured settlement annuity or beneficiary of the payee if the payee is deceased, $250,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any;

(iv) with respect to either one contract owner provided coverage under subsection (1)(b) or one plan sponsor whose plan owns directly or in trust one or more unallocated annuity contracts not included in subsection (3)(b)(ii), $5 million in benefits, irrespective of the number of contracts held by the contract owner or plan sponsor. If one or more unallocated annuity contracts are covered contracts under this part and are owned by a trust or other entity for the benefit of two or more plan sponsors, coverage must be afforded by the association if the

largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in this state. In no event is the association obligated to cover more than $5 million in benefits with respect to all these unallocated contracts.

(4) In no event is the association obligated to cover more than:

(a) an aggregate of $300,000 in benefits with respect to any one life under subsections (3)(b)(i) through (3)(b)(iii), except with respect to benefits for ~~basic hospital, medical, and surgical insurance and major medical insurance~~ health insurance coverage under subsection (3)(b)(i), in which case the aggregate liability of the association may not exceed $500,000 with respect to any one individual; and

(b) with respect to one owner of multiple nongroup policies of life insurance, whether the policyowner is an individual, firm, corporation, or other person and whether the persons insured are officers, managers, employees, or other persons, $5 million in benefits, regardless of the number of policies and contracts held by the owner.

(5) The limitations set forth in this section are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under this part may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights.

(6) In performing its obligations to provide coverage under this part, the association is not required to guarantee, assume, reinsure, or perform or cause to be guaranteed, assumed, reinsured, or performed the contractual obligations of the impaired or insolvent insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

(7) For purposes of this part, benefits provided by a long-term care rider to a life insurance policy or annuity contract must be considered the same type of benefits as the basic life insurance policy or annuity contract to which it relates."

Section 7. Section 33-10-227, MCA, is amended to read:

"33-10-227. Assessments -- abatement -- basis for ratesetting. (1) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at the times and for the amounts as the board finds necessary.

(2) Assessments are due not less than 30 days after prior written notice to the member insurers. An

unpaid assessment accrues interest at 10% a year on and after the due date. The association may also impose any charges on a late-paid assessment if the plan of operation provides for late-paid assessments.

(3) There are two classes of assessments:

(a) Class A assessments must be authorized and called for the purpose of meeting administrative and legal costs and other expenses. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer.

(b) Class B assessments must be authorized and called to the extent necessary to carry out the powers and duties of the association under 33-10-205 with regard to an impaired or insolvent insurer.

(4) (a) The amount of any Class A assessment for each account must be determined by the board and may be authorized and called on a pro rata or non-pro rata basis. If pro rata, the board may provide that the amount be credited against future Class B assessments. ~~The total of all non-pro rata assessments may not exceed $300 for each member insurer in any 1 calendar year.~~

(b) The amount of any Class B assessment, except for assessments related to long-term care insurance, must be allocated for assessment purposes among the accounts pursuant to an allocation formula that may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard determined by the board in its sole discretion as being fair and reasonable under the circumstances.

(c) The amount of the Class B assessment for long-term care insurance written by the impaired or insolvent insurer must be allocated according to a methodology included in the plan of operation and approved by the commissioner. The methodology must provide for 50% of the assessment to be allocated to accident and health member insurers and 50% to life and annuity member insurers.

~~(b)~~(d) Class B assessments against member insurers for each account and subaccount must be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account or subaccount bear to the premiums received on business in this state by all assessed member insurers. This ratio must be calculated from information that is available for the 3 most recent calendar years preceding the year in which the insurer became insolvent or, in the case of an assessment with respect to an impaired insurer, the 3 most recent calendar years for which information is available preceding the year in which the insurer became impaired.

~~(c)~~(e) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer may not be authorized and called until necessary to implement the purposes of this part. Classification of assessments under subsection (3) and computation of assessments under this subsection (4)

must be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within 180 days after the assessment is authorized.

(5) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated or deferred, in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

(6) (a) (i) Subject to the provisions of subsection (6)(a)(ii), the total of all assessments authorized by the association with respect to a member insurer for each subaccount of the life insurance and annuity account and for the health account may not in 1 calendar year exceed 2% of that member insurer's average annual premiums received in this state on the policies and contracts covered by the subaccount or account during the 3 calendar years preceding the year in which the insurer became an impaired or insolvent insurer.

(ii) If two or more assessments are authorized in 1 calendar year with respect to insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in subsection (6)(a)(i) must be equal and limited to the higher of the 3-year average annual premiums for the applicable account or subaccount as calculated pursuant to this section.

(iii) If the maximum assessment, together with the other assets of the association in an account, does not provide in 1 year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds must be assessed as soon as permitted by this part.

(b) The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, for use when the board determines that the maximum assessment is insufficient to cover anticipated claims.

(c) If the maximum assessment for a subaccount of the life insurance and annuity account in 1 year does not provide an amount sufficient to carry out the responsibilities of the association, then pursuant to subsection ~~(4)(b)~~ (4)(d), the board shall assess the other subaccounts of the life insurance and annuity account for the necessary additional amount, subject to the maximum assessment stated in subsection (6)(a).

(7) The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, and net realized gains and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses.

(8) It is proper for any member insurer, in determining its premium rates and policyowner dividends as to any kind of insurance within the scope of this part, to consider the amount reasonably necessary to meet its assessment obligations under this part.

(9) The association shall issue to each insurer paying an assessment under this part a certificate of contribution, in a form prescribed by the commissioner, for the amount paid. All outstanding certificates must be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in that form and for the amount, if any, and period of time that the commissioner may approve.

(10) (a) A member insurer that wishes to protest all or a part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment must be available to meet association obligations during the pendency of the protest or any subsequent appeal. A written statement must accompany the payment and must indicate that the payment is made under protest and include a brief description of the grounds for the protest.

(b) Within 60 days after the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issue raised by the protest.

(c) Within 30 days after a final decision has been made, the association shall notify the protesting member insurer in writing of that final decision. Within 60 days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the commissioner.

(d) Instead of rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the commissioner for a final decision, with or without a recommendation from the association.

(e) If the protest or appeal of the assessment is upheld, the amount paid in error or excess must be returned to the member insurer. Interest on a refund due to a protesting member insurer must be paid at the rate

actually earned by the association.

(11) The association may request information of member insurers to aid in the exercise of its powers and duties under this section. Member insurers shall promptly comply with a request from the association."

Section 8. Section 33-30-102, MCA, is amended to read:

"33-30-102. Application of 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, parts 13, 19, and 23; Title 33, chapter 3, part 6; Title 33, chapter 17, parts 2 and 10 through 12; and Title 33, chapters 1, 10, 12, 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 9. 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, parts 7 and 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, 33-2-1114, 33-2-1211, 33-2-1212, Title 33, chapter 2, parts 13, 19, and 23, 33-3-401, 33-3-422, 33-3-431, Title 33, chapter 3, part 6, Title 33, chapter 10, Title 33, chapter 12, 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, and Title 33, chapter 32, apply to health maintenance organizations."

NEW SECTION. **Section 10. Saving clause.** [This act] does not affect rights and duties that matured, penalties that were incurred, or proceedings that were begun before [the effective date of this act].

NEW SECTION. **Section 11. Effective date.** [This act] is effective January 1, 2020.

NEW SECTION. **Section 12. Applicability.** [This act] applies to insolvencies that occur on or after January 1, 2020. In addition, health service corporations and health maintenance organizations that become part of the life and health insurance guaranty association because of [this act] are not subject to assessment for insolvencies that occurred prior to January 1, 2020.

- END -