HOUSE BILL NO. 92

INTRODUCED BY J. DOOLING

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING INSURANCE LAWS; AMENDING LAWS RELATING TO CONFLICTS OF INTEREST AND CERTAIN COMPENSATION; REVISING SERVICE OF PROCESS FEES PAID TO THE COMMISSIONER; PROVIDING RULEMAKING AUTHORITY; REVISING INSURANCE CODE PENALTY INTEREST CALCULATION; REVISING UNAUTHORIZED INSURER LAWS; REVISING LAWS RELATED TO THE COMMISSIONER'S REQUEST OF BIOGRAPHICAL INFORMATION FOR CERTAIN INSURERS; REQUIRING ELECTRONIC COPIES FOR PROPOSED ARTICLES OF INCORPORATION; REVISING VOLUNTARY DISSOLUTION FOR FOR-PROFIT DOMESTIC MUTUAL INSURERS; REVISING LAWS ON MIDTERM PREMIUM INCREASES; ~~REVISING LAWS RELATING TO SPECIAL RISK CLASSIFICATIONS AND CLAIMS HISTORY;~~ CLARIFYING GRIEVANCE REPORTING REQUIREMENTS; AND AMENDING SECTIONS 33-1-305, 33-1-603, 33-1-1302, 33-2-104, 33-2-1106, 33-2-1113, 33-3-105, 33-3-202, 33-3-601, 33-15-1108, ~~33-16-201,~~ AND ~~33-18-210~~ 33-32-306, MCA."

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

Section 1. Section 33-1-305, MCA, is amended to read:

"33-1-305. Conflicts of interest ~~and certain compensation~~ prohibited. ~~(1)~~ The commissioner or any deputy, examiner, assistant, or employee of the commissioner:

(1) ~~shall~~ MAY not be financially interested, directly or indirectly, in any insurer, insurance agency, or insurance transaction except as a policyholder or claimant under a policy; AND

(2) IS SUBJECT TO THE ETHICS PROVISIONS IN TITLE 2, CHAPTER 2.

~~(2) The commissioner or any deputy, examiner, or employee of the commissioner shall not be given or receive any fee, compensation, loan, gift, or other thing of value in addition to the compensation and expense allowance provided by law for any service rendered or to be rendered as such commissioner, deputy, examiner, or employee or in connection therewith.~~"

Section 2. Section 33-1-603, MCA, is amended to read:

"33-1-603. Serving process -- time to plead -- rulemaking. (1) Duplicate copies of legal process against an insurer for whom the commissioner is the attorney, pursuant to 33-1-601, must be served upon the commissioner or upon the commissioner's deputy or other person in charge of the office during the commissioner's absence. At the time of service, the plaintiff shall pay to the commissioner ~~$10~~ fees as established by the commissioner through rule, taxable as costs in the action. Upon receiving the service, the commissioner shall promptly forward a copy by certified mail to the person last designated by the insurer to receive the service.

(2) When process is served upon the commissioner as an insurer's attorney, the insurer has 30 days within which to appear, answer, or plead after the date of mailing of the copy by the commissioner, exclusive of the date of mailing, as provided by subsection (1).

(3) Process served upon the commissioner and a copy of the process forwarded as provided in this section constitutes service of the process upon the insurer."

Section 3. Section 33-1-1302, MCA, is amended to read:

"33-1-1302. Insurance, viatical settlement, medical care discount card, and pharmacy discount card administrative or civil fraud -- insurer. (1) A person commits the act of insurance, viatical settlement, medical care discount card, or pharmacy discount card fraud when:

(a) in the course of offering or selling insurance, a medical care discount card, or a pharmacy discount card, the person misrepresents a material fact, known to the person to be untrue or made with reckless indifference as to whether it is true, with the intention of causing another person to rely upon the misrepresentation to that relying person's detriment; or

(b) with respect to a viatical settlement, the person violates the provisions of 33-1-1304.

(2) A person commits the act of insurance fraud or viatical settlement fraud by engaging in any transaction, act, practice, course of business, or course of dealing that involves a violation of insurable interest laws.

(3) The commissioner may, after having conducted a hearing pursuant to 33-1-701, impose the penalties provided for in 33-1-317 for a violation of 33-1-1304 or this section. Failure to pay a fine under this section results in a lien upon the assets and property of the person as provided in 33-1-318(3).

(4) In addition to any penalty provided for in 33-1-317, the commissioner may require a person regulated under this title who commits insurance, viatical settlement, medical care discount card, or pharmacy discount card

fraud to make full restitution to the victim for all financial losses sustained as a result of the fraud with interest of 10% a year from the date of the fraud plus any costs and reasonable attorney fees, less the amount of any income, refund, or other benefit received by the victim from the insurance, viatical settlement, medical care discount card, or pharmacy discount card.

(5) The commissioner may require a person who commits a violation of this part to make full restitution to any person who may have sustained any losses as a result of the fraud with interest ~~of 10% a year~~ from the date of the loss plus any costs and reasonable attorney fees. The interest rate must be calculated as of the date of the order pursuant to 25-9-205.

(6) An insurer, insurance producer, or other person who sustained any losses and who was awarded restitution may bring suit to recover those sums, including any attorney fees, interest at ~~10% a year~~ the rate provided in 25-9-205, and costs incurred in obtaining a judgment.

(7) Failure of a person to pay any amount ordered under this section constitutes a forfeiture of the right to do business in this state."

Section 4. Section 33-2-104, MCA, is amended to read:

"33-2-104. Representing or aiding unauthorized insurer prohibited. (1) A person ~~in this state~~ may not directly or indirectly act as insurance producer in this state for, or otherwise represent or aid on behalf of another, any insurer not authorized to transact insurance in this state in the solicitation, negotiation, or effectuation of insurance or of annuity contracts, inspection of risks, fixing of rates, investigation or adjustment of losses, collection of premiums, or any other transaction of insurance with respect to subjects of insurance resident, located or to be performed in this state.

(2) This section does not apply to:

(a) acceptance of service of process by the commissioner under 33-1-613; or

(b) surplus lines insurance and other transactions for which a certificate of authority is not required of an insurer as stated in 33-2-102."

Section 5. Section 33-2-1106, MCA, is amended to read:

"33-2-1106. Exemptions -- violations -- jurisdiction. (1) The provisions of 33-2-1104~~,~~ and 33-2-1105~~, and this section~~ do not apply to an offer, request, invitation, agreement, or acquisition that the commissioner by order exempts from those sections as:

(a) not having been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic insurer; or

(b) otherwise not comprehended within the purposes of 33-2-1104 and 33-2-1105.

(2) The following are violations of 33-2-1104~~,~~ or 33-2-1105~~, and this section~~:

(a) the failure to file any statement, amendment, or other material required to be filed pursuant to 33-2-1104(1) through (5);

(b) the effectuation or any attempt to effectuate an acquisition of control of, divestiture of, or merger with a domestic insurer unless the commissioner has given approval.

(3) The courts of this state are vested with jurisdiction over every person not resident, domiciled, or authorized to do business in this state who files a statement with the commissioner under 33-2-1104 and over all actions involving the person arising out of violations of 33-2-1104~~,~~ or 33-2-1105~~, and this section~~. Each person is considered to have performed acts equivalent to and constituting an appointment of the commissioner to be the person's attorney upon whom may be served all lawful process in any action, suit, or proceeding arising out of violations of this section. Copies of all lawful process must be served on the commissioner and transmitted by certified mail by the commissioner to the person at the person's last-known address."

Section 6. Section 33-2-1113, MCA, is amended to read:

"33-2-1113. Transactions with affiliates -- standards. (1) Material transactions by registered insurers with their affiliates are subject to the following standards:

(a) The terms must be fair and reasonable.

(b) Charges or fees for services performed must be reasonable.

(c) Expenses incurred and payments received must be allocated to the insurer in conformity with customary insurance accounting practices consistently applied.

(d) The books, accounts, and records of each party must clearly and accurately disclose the precise nature and details of the transactions, including any accounting information necessary to support the reasonableness of the charges or fees to the respective parties.

(e) The insurer's surplus as regards policyholders following any dividends or distributions to shareholder affiliates must be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

(2) (a) The following transactions involving a domestic insurer and a person in its holding company system, including amendments or modifications to affiliate agreements previously filed under this section, may

not be entered into unless the insurer has notified the commissioner in writing of its intention to enter into a transaction within at least 30 days prior to the transaction, or a shorter period as the commissioner may permit, and the commissioner does not disapprove the transaction:

(i) sales, purchases, exchanges, loans or extensions of credit, guaranties, or investments if, as of the prior December 31, the transactions are equal to or exceed:

(A) with respect to insurers other than life insurers, the lesser of 3% of the insurer's admitted assets or 25% of its surplus as regards policyholders; and

(B) with respect to life insurers, 3% of the insurer's admitted assets;

(ii) loans or extensions of credit to a person who is not an affiliate if the insurer makes the loans or extensions of credit with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in an affiliate of the insurer making the loans or extensions of credit if the transactions, as of the prior December 31, are equal to or exceed:

(A) with respect to insurers other than life insurers, the lesser of 3% of the insurer's admitted assets or 25% of its surplus as regards policyholders;

(B) with respect to life insurers, 3% of the insurer's admitted assets;

(iii) reinsurance agreements or modifications to reinsurance agreements, including:

(A) reinsurance pooling agreements;

(B) agreements in which the reinsurance premium or a change in the insurer's liabilities, or the projected reinsurance premium or a change in the insurer's liabilities in any of the next 3 years, equals or exceeds 5% of the insurer's surplus regarding policyholders as of the prior December 31; and

(C) those agreements that may require as consideration the transfer of assets from an insurer to a nonaffiliate if an agreement or understanding exists between the insurer and nonaffiliate that a portion of the assets will be transferred to one or more affiliates of the insurer;

(iv) all management agreements, service contracts, tax allocation agreements, guarantees, and cost-sharing arrangements;

(v) direct or indirect acquisitions or investments in a person that controls the insurer or in an affiliate of the insurer in an amount that, together with its present holdings in such investments, exceeds 2.5% of the insurer's surplus to policyholders; and

(vi) any material transactions, specified by rule, that the commissioner determines may adversely affect

the interests of the insurer's policyholders.

(b) Nothing in this subsection (2) is considered to authorize or permit a transaction that, in the case of an insurer that is not a member of the same holding company system, would otherwise be contrary to law.

(3) A domestic insurer may not enter into a transaction that is part of a plan or series of like transactions with a person within the holding company system if the purpose of those separate transactions is to avoid the statutory threshold amount review. If the commissioner determines that the separate transactions were entered into over a 12-month period for the purpose of evading review, the commissioner may exercise authority under 33-2-1120.

(4) The commissioner, in reviewing a transaction pursuant to subsection (2), shall consider whether the transaction complies with the standards set forth in subsection (1) and whether the transaction may adversely affect the interests of a policyholder.

(5) The commissioner must be notified within 30 days of an investment by a domestic insurer in a corporation if the total investment in the corporation by the insurance holding company system exceeds 10% of the corporation's voting securities.

(6) For purposes of this section, in determining whether an insurer's surplus as regards policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to the insurer's financial needs, the following factors, among others, must be considered:

(a) the size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria;

(b) the extent to which the insurer's business is diversified among the several lines of insurance;

(c) the number and size of risks insured in each line of business;

(d) the extent of the geographical dispersion of the insurer's insured risks;

(e) the nature and extent of the insurer's reinsurance program;

(f) the quality, diversification, and liquidity of the insurer's investment portfolio;

(g) the recent past and projected future trend in the size of the insurer's surplus as regards policyholders;

(h) the surplus as regards policyholders maintained by other comparable insurers;

(i) the adequacy of the insurer's reserves;

(j) the quality and liquidity of investments in affiliates made pursuant to 33-2-1104 and 33-2-1105 ~~through 33-2-1106~~. The commissioner may treat any investment as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever in the commissioner's judgment the investment so

warrants."

Section 7. Section 33-3-105, MCA, is amended to read:

"33-3-105. Commissioner's request of biographical information. (1) The commissioner may request from domestic insurers biographical information from officers, directors, and persons in a position to control the activity of the following entities:

(a) insurers provided for in Title 33, chapter 3;

(b) farm mutual insurers provided for in Title 33, chapter 4;

(c) reciprocal insurers provided for in Title 33, chapter 5;

(d) health service corporations provided for in Title 33, chapter 30; ~~and~~

(e) health maintenance organizations provided for in Title 33, chapter 31; and

(f) the state fund provided for in Title 39, chapter 71, part 23.

(2) Officers, directors, or other persons in a position to control the activity of the entities listed in subsection (1) shall submit biographical information on a form prescribed by the commissioner."

Section 8. Section 33-3-202, MCA, is amended to read:

"33-3-202. Articles of incorporation -- filing and approval. (1) The incorporators of a proposed domestic insurer shall deliver ~~the triplicate originals~~ an electronic copy of the proposed articles of incorporation to the commissioner. The commissioner shall examine the proposed articles of incorporation. If the commissioner finds that the articles comply with this chapter and are not in conflict with the constitution and laws of the United States or of this state, the commissioner shall approve ~~in writing each set of~~ the articles. However, if the commissioner finds that the proposed insurer would not be eligible for a certificate of authority under 33-2-112, the commissioner shall refuse to approve the articles of incorporation and shall ~~return them to the proposed incorporators, together with~~ provide a written statement of the reasons for the refusal. ~~The commissioner shall forward the approved articles of incorporation to the incorporators. The~~ If approved by the commissioner, the incorporators shall subsequently file ~~one set of~~ the articles of incorporation with the secretary of state and ~~one set~~ provide a copy of the articles certified by the secretary of state ~~with~~ to the commissioner. ~~The remaining set of articles must be made a part of the corporation's record.~~

(2) If the commissioner finds that the proposed articles of incorporation do not comply with law, the commissioner shall refuse to approve the proposed articles of incorporation and shall return ~~all sets of~~ the

~~proposed~~ articles of incorporation to the proposed incorporators, together with a written statement of the reasons for the refusal.

(3) The corporation has legal existence as a corporation upon the issuance of the certificate of incorporation by the secretary of state and completion of the filing with the commissioner required in subsection (1), but the corporation may not transact business as an insurer until it has qualified for and received from the commissioner a certificate of authority as provided in this title.

(4) A copy of the certificate of incorporation, certified by the secretary of state, is admissible in all the courts of this state as prima facie evidence of proper incorporation."

Section 9. 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 a domestic stock insurer or a for-profit domestic mutual 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 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.

(2) At least 60 days before a nonprofit 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 10. Section 33-15-1108, MCA, is amended to read:

"33-15-1108. Limitation on midterm premium increases. (1) In any case involving property or casualty insurance that is subject to this part, ~~if the insured has prepaid the premium for the insurance policy for a specified period,~~ the insurer may not unilaterally increase the rate charged or decrease the coverage provided for the contract period ~~for which the premium has been paid~~ unless:

(a) there is a change in risk during that period because of the addition or removal of persons or property that was included in the rate at last renewal;

(b) the risk was misrepresented by the insured; or

(c) the insured requests a policy change that increases the rate because of that specific request.

(2) This section does not prohibit the cancellation of a policy for any other reason permitted by the policy or by law during an initial policy period not to exceed 60 days."

~~**Section 11.** Section 33-16-201, MCA, is amended to read:~~

~~**"33-16-201. Standards applicable to rates.** The following standards apply to the making and use of rates pertaining to all classes of insurance to which the provisions of this chapter are applicable:~~

~~(1) (a) Rates may not be excessive or inadequate, and they may not be unfairly discriminatory.~~

~~(b) A rate may not be held to be excessive unless the rate is unreasonably high for the insurance provided and a reasonable degree of competition does not exist in the area with respect to the classification to which the rate is applicable.~~

~~(c) A rate may not be held to be inadequate unless the rate is unreasonably low for the insurance provided and the continued use of the rate endangers the solvency of the insurer using the rate or unless the rate is unreasonably low for the insurance provided and the use of the rate by the insurer has, or if continued will have,~~

~~the effect of destroying competition or creating a monopoly.~~

~~(2) (a) Consideration must be given, when applicable, to past and prospective loss experience within and outside this state, to revenue and profits from reserves, to conflagration and catastrophe hazards, if any, to a reasonable margin for underwriting profit and contingencies, to past and prospective expenses, both countrywide and those specially applicable to this state, and to all other factors, including judgment factors, considered relevant within and outside this state. In the case of fire insurance rates, consideration may be given to the experience of the fire insurance business during the most recent 5-year period for which experience is available.~~

~~(b) Consideration may also be given in the making and use of rates to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers.~~

~~(3) The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the operating methods of the insurer or group with respect to any kind of insurance or with respect to any subdivision or combination of insurance.~~

~~(4) (a) Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for separate risks in accordance with rating plans that establish standards for measuring variations in hazards or expense provisions, or both. The standards may measure any difference among risks that have a probable effect upon losses or expenses. Classifications or modifications of classifications of risks may be established, based upon size, expense, management, individual experience, location or dispersion of hazard, or any other reasonable considerations.~~

~~(b) Special risk classifications may be established for private passenger automobile policies. Special risk classifications may be based upon favorable aspects of an insured individual's claims history that is 3 years old or older. Special risk classifications may not be established based on adverse information contained in an insured individual's driving record that is 3 years old or older.~~

~~(c) Special risk classifications may be established for commercial automobile policies. Special risk classifications for commercial automobile policies may be based upon favorable aspects of an insured's claims history that is 5 years old or older. Special risk classifications for commercial automobile policies~~ may not be ~~established~~ based on adverse information contained in an insured's claim history or applicable driving records ~~that is 5 years old or older for an insured's adverse loss experience may not use more than the most recent 5 years of claims history that is available.~~

~~(d) Classifications and modifications apply to all risks under the same or substantially the same~~

~~circumstances or conditions.~~

~~(e) As used in subsection (4)(b), "private passenger automobile policy" means an automobile insurance policy issued to individuals or families but does not include policies known as commercial automobile policies."~~

~~**Section 12.** Section 33-18-210, MCA, is amended to read:~~

~~**"33-18-210. Unfair discrimination and rebates prohibited for title, property, casualty, or surety insurance -- exceptions -- limitations.** (1) Except as provided in subsections (3), (4), and (11)(a), a title, property, casualty, or surety insurer or an employee, representative, or insurance producer of an insurer may not, as an inducement to purchase insurance or after insurance has been effected, pay, allow, or give or offer to pay, allow, or give, directly or indirectly, a:~~

~~(a) rebate, discount, abatement, credit, or reduction of the premium named in the insurance policy;~~

~~(b) special favor or advantage in the dividends or other benefits to accrue on the policy; or~~

~~(c) valuable consideration or inducement not specified in the policy, except to the extent provided for in an applicable filing with the commissioner as provided by law.~~

~~(2) Except as provided in subsections (3), (4), and (11)(a), an insured named in a policy or an employee of the insured may not knowingly receive or accept, directly or indirectly, a:~~

~~(a) rebate, discount, abatement, credit, or reduction of premium;~~

~~(b) special favor or advantage; or~~

~~(c) valuable consideration or inducement.~~

~~(3) The prohibitions in subsections (1) and (2) do not apply to a benefit provided for by a telematics agreement as provided in 33-23-221 through 33-23-226.~~

~~(4) The prohibitions under subsections (1) and (2) do not apply to an active, retired, or honorably separated member of the United States armed forces as described in 33-18-217(1)(a) or to a spouse, surviving spouse, dependent, or heir of a United States armed forces member as provided in 33-18-217.~~

~~(5) An insurer may not make or permit unfair discrimination in the premium or rates charged for insurance, in the dividends or other benefits payable on insurance, or in any other of the terms and conditions of the insurance either between insureds or property having like insuring or risk characteristics or between insureds because of race, color, creed, religion, or national origin.~~

~~(6) This section may not be construed as prohibiting the payment of commissions or other compensation to licensed insurance producers or as prohibiting an insurer from allowing or returning lawful dividends, savings,~~

~~or unabsorbed premium deposits to its participating policyholders, members, or subscribers.~~

~~(7) An insurer may not make or permit unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, canceling, or limiting the amount of insurance coverage on a property or casualty risk because of the geographic location of the risk, unless:~~

~~(a) the refusal, cancellation, or limitation is for a business purpose that is not a mere pretext for unfair discrimination; or~~

~~(b) the refusal, cancellation, or limitation is required by law or regulatory mandate.~~

~~(8) An insurer may not make or permit unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, canceling, or limiting the amount of insurance coverage on a residential property risk or on the personal property contained in the residential property, because of the age of the residential property, unless:~~

~~(a) the refusal, cancellation, or limitation is for a business purpose that is not a mere pretext for unfair discrimination; or~~

~~(b) the refusal, cancellation, or limitation is required by law or regulatory mandate.~~

~~(9) An insurer may not refuse to insure, refuse to continue to insure, or limit the amount of coverage available to an individual because of the sex or marital status of the individual. However, an insurer may take marital status into account for the purpose of defining persons eligible for dependents' benefits.~~

~~(10) An insurer may not terminate or modify coverage or refuse to issue or refuse to renew a property or casualty policy or contract of insurance solely because the applicant or insured or any employee of either is mentally or physically impaired. However, this subsection does not apply to accident and health insurance sold by a casualty insurer, and this subsection may not be interpreted to modify any other provision of law relating to the termination, modification, issuance, or renewal of any insurance policy or contract.~~

~~(11) (a) An insurer may not refuse to insure, refuse to continue to insure, charge higher rates, or limit the amount of coverage available to an individual under a private passenger automobile policy based solely on adverse information contained in an individual's driving record that is 3 years old or older. An insurer may provide discounts to an insured under a private passenger automobile policy based on favorable aspects of an insured's claims history that is 3 years old or older.~~

~~(b) An insurer may not use more than the most recent 5 years of loss experience that is available when determining whether to refuse to insure, refuse to continue to insure, charge higher rates, or limit the amount of~~

~~coverage available under a commercial automobile policy~~ based solely on adverse information contained in the ~~loss experience or applicable driving records that is 5 years old or older~~. ~~An insurer may provide discounts to an insured under a commercial automobile policy based on favorable aspects of an insured's claims history that is 5 years old or older.~~

~~(c) As used in subsection (11)(a), "private passenger automobile policy" means an automobile insurance policy issued to individuals or families but does not include policies known as commercial automobile policies.~~

~~(12) An insurer may not charge points or surcharge a private passenger motor vehicle policy because of a claim submitted under the insured's policy if the insured was not at fault.~~

~~(13) (a) An insurer that provides personal lines insurance for an insured may not consider the insured's inquiries or claims made to any insurer that did not result in a payment by any insurer in considering an application for, renewal of, or change in an insurance policy as defined in 33-15-102.~~

~~(b) This subsection (13) does not apply to an insurer's consideration of a claim that was the basis for a criminal or civil insurance fraud action by a state or regulatory enforcement entity.~~

~~(c) (i) For the purposes of this subsection (13), the term "personal lines insurance" means vehicle insurance under 33-1-206(1)(a) and property insurance under 33-1-210 that is sold by an insurer for personal, family, or household purposes.~~

~~(ii) The term does not include disability insurance or insurance for commercial, business, or professional services, products, or activities."~~

SECTION 11. SECTION 33-32-306, MCA, IS AMENDED TO READ:

"33-32-306. Grievance reporting and recordkeeping requirements -- definition. (1) (a) A health insurance issuer shall maintain within a register all written records that document grievances received during a calendar year, including the notices and claims associated with the grievances.

(b) For the purposes of this section, "register" means the written record of grievances received by a health insurance issuer that includes the notices and claims associated with the grievances as required by this section.

(2) Retention of the records in the register must be as provided in subsection (6), except that a health insurance issuer shall maintain for at least 6 years those records specified by the commissioner by rule.

(3) A health insurance issuer shall:

(a) maintain the records in a manner that is reasonably clear and accessible to the commissioner; and

(b) make the records available for examination, on request, by covered persons, the commissioner, and any appropriate federal oversight agency.

(4) A request for a review of a grievance involving an adverse determination must be processed in compliance with 33-32-308 and must be included in the register.

(5) For each grievance, the register must contain, at a minimum, the following information:

(a) a general description of the reason for the grievance;

(b) the date received;

(c) the date of each review or, if applicable, review meeting;

(d) a report on the resolution of the grievance, if applicable;

(e) the date of the resolution, if applicable; and

(f) the name of the covered person for whom the grievance was filed.

(6) Subject to the provisions of subsection (2), a health insurance issuer shall retain the register compiled in a calendar year for 3 years or until the commissioner has adopted a final report of an examination that contains a review of the register for that calendar year, whichever is longer.

(7) (a) At least annually, a health insurance issuer shall submit to the commissioner a report in the format specified by the commissioner.

(b) The report must include for each type of health plan offered by the health insurance issuer:

(i) the certificate of compliance required by 33-32-307(4)(b);

(ii) the number of covered persons;

(iii) the total number of grievances;

(iv) the number of grievances resolved, if applicable, and their resolution;

~~(v) the number of grievances of which the health insurance issuer has been informed that were appealed to the commissioner;~~

~~(vi)~~(v) the number of grievances referred to an alternative dispute resolution procedure or resulting in litigation; and

~~(vii)~~(vi) a synopsis of actions taken or being taken to correct problems that have been identified."

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