AN ACT GENERALLY REVISING INSURANCE REGULATORY LAWS; UPDATING REFERENCES TO FEDERAL REGULATIONS AND QUARTERLY LISTINGS OF ALIEN INSURERS; REQUIRING LIFE INSURERS TO ANNUALLY PROVIDE AN OPINION RELATING TO RESERVES; AMENDING SECTIONS 15-31-552, 33-2-307, 33-2-407, 33-20-505, 33-22-211, 33-22-1313, 33-22-1316, AND 33-32-102, MCA; AND PROVIDING AN EFFECTIVE DATE.

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

Section 1. Section 15-31-552, MCA, is amended to read:

"**15-31-552. Corporation dissolution or withdrawal certificates and tax clearance certificates furnished.** (1) For purposes of voluntary withdrawal or dissolution as set forth in Title 35, upon request of a corporation, the department of revenue may furnish to it a dissolution or withdrawal certificate verifying that the corporation has filed all applicable returns and has paid all taxes owing the state up to the date of the request for dissolution or withdrawal.

(2) Upon final withdrawal or dissolution, the department may furnish to a corporation a tax clearance certificate verifying that the corporation has filed all applicable returns and that all taxes have been paid through and including the corporation's final year of existence in Montana.

~~(3) For an authorized insurance company regulated under Title 33, the commissioner of insurance may furnish the certificate verifying that the corporation has filed all applicable returns and that taxes have been paid through and including the corporation's final year of existence in Montana.~~"

Section 2. Section 33-2-307, MCA, is amended to read:

"**33-2-307. Requirements for eligible surplus lines insurers -- list of eligible surplus lines insurers.** (1) If an unauthorized insurer is domiciled in any state, a surplus lines insurance producer may not

place insurance with that unauthorized insurer unless, at the time of placement, the unauthorized insurer:

(a) is authorized to issue the same kind of property or casualty insurance in its domiciliary jurisdiction; and

(b) maintains capital and surplus or its equivalent under the laws of its state of domicile, which equals the greater of:

(i) the minimum capital and surplus requirements of 33-2-109 and 33-2-110; or

(ii) $15 million. An insurer possessing less than $15 million capital and surplus may satisfy the requirements of this subsection upon an affirmative finding of acceptability by the commissioner. The commissioner's finding must be based on factors that include:

(A) the quality of management, capital, and surplus of a parent company;

(B) company underwriting profit and investment income trends;

(C) market availability; and

(D) company record and reputation within the industry.

(2) The commissioner may not make an affirmative finding of acceptability when the surplus lines insurer's capital and surplus is less than $4.5 million.

(3) If an unauthorized insurer is an alien insurer, a surplus lines insurance producer may not place insurance with that unauthorized insurer unless, at the time of placement, the unauthorized insurer appears on the national association of insurance commissioners' ~~Non-Admitted Insurers Quarterly Listing~~ Quarterly Listing of Alien Insurers.

(4) A list of eligible surplus lines insurers must be published at least semiannually by the commissioner for a range of risks, including disability income insurance. This subsection does not require the commissioner to place or maintain the name of any unauthorized insurer on the list of eligible surplus lines insurers. An action may not lie against the commissioner or an employee of the commissioner for anything said in issuing the list of eligible surplus lines insurers referred to in this subsection.

(5) As used in this section, the following definitions apply:

(a) "Capital", as used in the financial requirements of this section, means funds invested in for stocks or other evidences of ownership.

(b) "Surplus", as used in the financial requirements of this section, means funds over and above

liabilities and capital of the insurer for the protection of policyholders."

Section 3. Section 33-2-407, MCA, is amended to read:

"**33-2-407. Standard valuation of reserve liabilities law.** (1) The commissioner shall annually value or cause to be valued the reserve liabilities (reserves) for all outstanding life insurance policies and annuity and pure endowment contracts of every life insurer doing business in this state issued on or before the operative date of the valuation manual. In calculating the reserves under this subsection, the commissioner may use group methods and approximate averages for fractions of a year or otherwise.

(2) The commissioner shall annually value or cause to be valued the reserve liabilities for all outstanding life insurance contracts, annuities, and pure endowment contracts, accident and health contracts, and deposit-type contracts of every company issued after the operative date of the valuation manual in accordance with the valuation manual.

(3) In lieu of the valuation of the reserves required in this section of any foreign or alien insurer, the commissioner may accept any valuation made or caused to be made by the insurance supervisory official of any state or other jurisdiction when the valuation complies with the minimum standard provided in this part.

(4) Any insurer that has adopted any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standards provided in this part may, with the approval of the commissioner, adopt any lower standard of valuation but not lower than the minimum in this section. For the purposes of this section, the holding of additional reserves previously determined by an appointed actuary to be necessary to render the opinion required in subsections (5) and (6) may not be considered to be the adoption of a higher standard of valuation.

(5) (a) Each life insurer doing business in this state prior to the operative date of the valuation manual shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by rule are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this state. The commissioner by rule shall define the specifics of this opinion and add any other items considered necessary to its scope.

(b) Each life insurer, except as exempted by or pursuant to regulation, shall also annually include in

the opinion required by subsection (5)(a) an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by rule make adequate provision for the insurer's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts. In developing the opinion, the qualified actuary shall consider the assets held by the insurer with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts.

(c) The commissioner may provide by rule for a transition period for establishing any higher reserves that the qualified actuary may consider necessary in order to render the opinion required by this subsection (5).

(d) Each opinion required by this subsection (5) must be governed by the following provisions:

(i) A memorandum, in form and substance acceptable to the commissioner as specified by rule, must be prepared to support each actuarial opinion.

(ii) If the insurer fails to provide a supporting memorandum at the request of the commissioner within a period specified by rule or if the commissioner determines that the supporting memorandum provided by the insurer fails to meet the standards prescribed by the rules or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the insurer to review the opinion and the basis for the opinion and to prepare any supporting memorandum as is required by the commissioner.

(iii) The opinion must be submitted with the annual statement reflecting the valuation of the reserve liabilities for each year ending on or after December 31, 1996.

(iv) The opinion must apply to all business in force, including individual and group health insurance plans, in form and substance acceptable to the commissioner as specified by rule.

(v) The opinion must be based on standards adopted from time to time by the actuarial standards board and on additional standards as the commissioner may prescribe by rule.

(vi) In the case of an opinion required to be submitted by a foreign or alien insurer, the commissioner may accept the opinion filed by that insurer with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.

(vii) Except in cases of fraud or willful misconduct, the qualified actuary is not liable for damages to any

person, other than the insurer and the commissioner, for any act, error, omission, decision, or conduct with respect to the actuary's opinion.

(viii) Disciplinary action by the commissioner against the insurer or the qualified actuary must be defined in rules by the commissioner.

(6) (a) After the operative date of the valuation manual, each life insurer doing business in this state shall annually submit the opinion of a qualified actuary regarding whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by rule are:

(i) computed appropriately;

(ii) based on assumptions that satisfy contractual provisions;

(iii) consistent with prior reported amounts; and

(iv) in compliance with the applicable laws of this state.

(b) After the operative date of the valuation manual, each life insurer doing business in this state shall also annually include in the opinion required in subsection (6)(a) an opinion by the same qualified actuary on whether the reserves and related actuarial items held in support of the policies and contracts specified in the valuation manual make adequate provision for the company's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts. The opinion required in this subsection (6)(b) must consider the reserves and related actuarial items in light of the assets held by the company with respect to those reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts.

(c) A qualified actuary shall prepare a memorandum in support of each actuarial opinion under this subsection (6). The memorandum must be in the form and substance specified in the valuation manual and as provided by the commissioner.

~~(c)~~(d) The opinion under this subsection (6):

(i) must be submitted with the annual statement reflecting the valuation of the reserve liabilities for each year ending on or after the operative date of the valuation manual;

(ii) must apply to all policies and contracts subject to this subsection (6) and to other actuarial liabilities identified in the valuation manual; and

(iii) must be based on the actuarial standards board's standards and any additional standards prescribed in the valuation manual.

~~(d)~~(e) If the insurer fails to provide a supporting memorandum at the request of the commissioner within a period specified in the valuation manual or if the commissioner determines that the supporting memorandum provided by the insurer fails to meet the standards prescribed by the valuation manual or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the insurer to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the commissioner.

~~(e)~~(f) For an opinion required to be submitted by a foreign or alien insurer, the commissioner may accept the opinion filed by that insurer with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to an insurer domiciled in this state.

~~(f)~~(g) (i) Except as provided in subsection ~~(6)(f)(ii)~~ (6)(g)(iii), the appointed actuary is not liable for damages to any person other than the insurer and the commissioner for any act, error, omission, decision, or conduct with respect to the appointed actuary's opinion.

(ii) The provisions of subsection ~~(6)(f)(i)~~ (6)(g)(i) do not apply in cases of fraud or willful misconduct.

~~(g)~~(h) The commissioner shall define by rule any disciplinary action that may be taken by the commissioner against the insurer or the appointed actuary."

Section 4. Section 33-20-505, MCA, is amended to read:

"**33-20-505. Minimum nonforfeiture amounts.** (1) The minimum values as specified in 33-20-506 through 33-20-509 and 33-20-511 of any paid-up annuity, cash surrender, or death benefits available under an annuity contract must be based upon minimum nonforfeiture amounts, as defined in this section.

(2) (a) The minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments must be equal to an accumulation up to that time at rates of interest as indicated in subsection (3)(a) of the net considerations, as described in subsection (2)(b), paid prior to that time, decreased by the sum of:

(i) any prior withdrawals from or partial surrenders of the contract accumulated at rates of interest as

indicated in subsection (3)(a);

(ii) an annual contract charge of $50 accumulated at rates of interest as indicated in subsection (3)(a);

(iii) any premium tax paid by the company for the contract accumulated at rates of interest as indicated in subsection (3)(a); and

(iv) the amount of any indebtedness to the company on the contract, including interest due and accrued.

(b) The net consideration for a given contract year used to define the minimum nonforfeiture amount must be an amount equal to 87.5% of the corresponding gross considerations credited to the contract during that contract year.

(3) (a) (i) The interest rate used in determining minimum nonforfeiture amounts must be an annual rate of interest determined as the lesser of 3% a year or the amount calculated under subsection (3)(a)(ii), which must be specified in the contract if the interest rate will be reset.

(ii) The interest rate may be the 5-year constant maturity treasury rate reported by the federal reserve board as of a date or an average over a period, rounded to the nearest 1/20th of 1%, specified in the contract no longer than 15 months prior to the contract issue date or redetermination date under subsection (3)(a)(iii) and reduced by 125 basis points whenever the resulting interest rate is not less than ~~1%~~ 0.15%.

(iii) The interest rate under subsection (3)(a)(ii) must apply for an initial period and may be redetermined for additional periods. The redetermination date, basis, and period, if any, must be stated in the contract. The basis is the date or the average over a specified period that produces the value of the 5-year constant maturity treasury rate to be used at each redetermination date.

(b) During the period or term that a contract provides substantive participation in an equity indexed benefit, the contract may increase the reduction described in subsection (3)(a)(ii) by up to an additional 100 basis points to reflect the value of the equity index benefit. The present value at the contract issue date, and at each redetermination date, of the additional reduction may not exceed the market value of the benefit. The commissioner may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit. The commissioner may disallow or limit the additional reduction if the commissioner considers the demonstration unacceptable.

(4) The commissioner may adopt rules to implement the provisions of subsection (3)(b) and to provide

for further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity index benefit and for other contracts for which the commissioner determines that adjustments are justified."

Section 5. Section 33-22-211, MCA, is amended to read:

"**33-22-211. Time of payment of claims.** There shall be a provision as follows:

"Time of Payment of Claims: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid ~~immediately~~ pursuant to 33-18-232 upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid.... (insert period for payment which must not be less frequently than monthly), and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.""

Section 6. Section 33-22-1313, MCA, is amended to read:

"**33-22-1313. Association member assessments.** (1) (a) (i) For 2020 and each year thereafter, the commissioner shall assess each member insurer 1.2% of its total premium volume covering Montana residents, from the prior calendar year, regardless of type of license.

(ii) For purposes of subsection (1)(a)(i), total premium volume may not include premiums that member insurers collect on any coverage issued for excepted benefits as defined in 33-22-140.

(b) The board shall determine the timing of the assessment.

(c) The commissioner shall consider the board's recommendation when determining the assessment amounts.

(d) The commissioner shall verify the amount of each insurer's assessment based on annual financial statements and other reports determined to be necessary.

(2) The association shall determine and report to the commissioner the association's reinsurance payments and other expenses for the previous calendar year, including administrative expenses and any incurred but not reported claims for the previous calendar year.

(a) The report must consider investment income and other appropriate gains.

(b) The report must include an estimate of the assessments needed to cover the expected reinsurance claims for the following calendar year.

(3) If assessments and other funds collected by the association exceed the actual losses and administrative expenses of the association, the board shall use the excess funds to offset future claims or to reduce future assessments.

(4) The commissioner may, after notice and hearing:

(a) suspend or revoke the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment;

(b) impose a penalty on any insurer that fails to pay an assessment when due; or

(c) use any power granted to the commissioner to collect any unpaid assessment.

(5) An eligible health insurer may not submit claims for reinsurance payments unless the insurer has a medical loss ratio of 80% or greater, as defined in ~~45 CFR 158.221~~ 45 CFR 158.232(f)."

Section 7. Section 33-22-1316, MCA, is amended to read:

"**33-22-1316. Administration of reinsurance payments.** (1) Claims that are incurred during a benefit year and are submitted for reimbursement in the following benefit year by the date established by the board in the plan of operation will be allocated to the benefit year in which they are incurred. Claims submitted after the date established by the board following the benefit year in which they were incurred will be allocated to the next benefit year in accordance with the board's operating rules, policies, and procedures.

(2) If funds accumulated in the reinsurance program account in the state special revenue fund with respect to a benefit year are expected to be insufficient to pay all program expenses, claims for reimbursement, and other disbursements allocable to that benefit year, all claims for reimbursement allocable to that benefit year must be reduced proportionately to the extent necessary to prevent a deficiency in the funds for that benefit year. Any reduction in claims for reimbursement with respect to a benefit year must apply to all claims that are allocated to that benefit year without regard to when those claims were submitted for reimbursement, and any reduction must be applied to each claim in the same proportion.

(3) If funds accumulated in the reinsurance program account in the state special revenue fund exceed the actual claims for reimbursement and program expenses of the association in a given benefit year, the board

shall use such excess funds to pay reinsurance claims in successive benefit years and may recommend to the commissioner a reduction in the assessment amount for the following year.

(4) For each applicable benefit year, the board shall notify eligible health insurers of reinsurance payments to be made for the applicable benefit year by the date established by the board in the plan of operation in the year following the applicable benefit year.

(5) By ~~August 15~~ December 31 of the year following the applicable benefit year, the board shall disburse all applicable reinsurance payments payable to an eligible health insurer."

Section 8. Section 33-32-102, MCA, is amended to read:

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

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

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

(b) a denial, reduction, termination, or failure to provide or make payment in whole or in part for a requested benefit based on a determination by a health insurance issuer or its designated utilization review organization of a person's eligibility to participate in the health insurance issuer's health plan;

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

(d) a rescission of coverage determination.

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

(3) "Authorized representative" means:

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

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

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

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

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

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

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

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

(7) "Clinical review criteria" means the written policies, written screening procedures, decision abstracts, determination rules, clinical and medical protocols, practice guidelines, or any other criteria or rationale used by a health insurance issuer or its designated utilization review organization to determine the medical necessity of health care services.

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

(9) "Cost sharing" means the share of costs that a covered member pays under the health insurance issuer's health plan, including maximum out-of-pocket, deductibles, coinsurance, copayments, or similar charges, but does not include premiums, balance billing amounts for out-of-network providers, or the cost of noncovered services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(19) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease, including the provision of pharmaceutical products or services or durable medical equipment.

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

(21) "Medical necessity" means health care services that a health care provider exercising prudent

clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing, treating, curing, or relieving a health condition, illness, injury, or disease or its symptoms and that are:

(a) in accordance with generally accepted standards of practice;

(b) clinically appropriate in terms of type, frequency, extent, site, and duration and are considered effective for the patient's illness, injury, or disease; and

(c) not primarily for the convenience of the patient or health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's illness, injury, or disease.

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

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

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

(25) "Preservice claim" means a request for benefits or payment from a health insurance issuer for health care services that, under the terms of the health insurance issuer's contract of coverage, requires authorization from the health insurance issuer or from the health insurance issuer's designated utilization review organization prior to receiving the services.

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

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

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

(i) has only a prospective effect; or

(ii) is effective retroactively to the extent that the cancellation or discontinuance is attributable to a

failure to timely pay required premiums or contributions toward the cost of coverage.

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

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

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

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

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

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

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

(b) Except as provided in subsection (31)(c), in determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the health insurance issuer shall apply the judgment of a prudent lay person who possesses an average knowledge of health and medicine.

(c) Any request that a health care provider with knowledge of the covered person's medical condition determines is an urgent care request within the meaning of subsection (31)(a) must be treated as an urgent care request.

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

(33) "Utilization review organization" means an entity that conducts utilization review for one or more of the following:

(a) an employer with employees who are covered under a health benefit plan or health insurance policy;

(b) a health insurance issuer providing review for its own health plans or for the health plans of another health insurance issuer;

(c) a preferred provider organization or health maintenance organization; and

(d) any other individual or entity that provides, offers to provide, or administers hospital, outpatient, medical, or other health benefits to a person treated by a health care provider under a policy, plan, or contract."

Section 9. Effective date. [This act] is effective July 1, 2021.

- END -

I hereby certify that the within bill,

HB 63, originated in the House.

_____

Chief Clerk of the House

_____

Speaker of the House

Signed this _____day

of_____, 2021.

_____

President of the Senate

Signed this _____day

of_____, 2021.

HOUSE BILL NO. 63

INTRODUCED BY J. DOOLING

BY REQUEST OF THE STATE AUDITOR

AN ACT GENERALLY REVISING INSURANCE REGULATORY LAWS; UPDATING REFERENCES TO FEDERAL REGULATIONS AND QUARTERLY LISTINGS OF ALIEN INSURERS; REQUIRING LIFE INSURERS TO ANNUALLY PROVIDE AN OPINION RELATING TO RESERVES; AMENDING SECTIONS 15-31-552, 33-2-307, 33-2-407, 33-20-505, 33-22-211, 33-22-1313, 33-22-1316, AND 33-32-102, MCA; AND PROVIDING AN EFFECTIVE DATE.