AN ACT GENERALLY REVISING LAWS RELATED TO REGULATION BY THE STATE AUDITOR; MODIFYING DOCUMENTARY REQUIREMENTS FOR SECURITY REGISTRATION BY QUALIFICATION; CLARIFYING EMPLOYER ABILITY TO FUND EMPLOYEE INDIVIDUAL HEALTH INSURANCE POLICIES; CLARIFYING PROCESS FOR SHARING EXAMINATION REPORTS WITH GOVERNMENTAL ENTITIES; ALIGNING CONTESTED CASE TIMING WITH THE MONTANA ADMINISTRATIVE PROCEDURE ACT; MODIFYING RISK-BASED CAPITAL REQUIREMENTS; ESTABLISHING A FARM MUTUAL INSURER VOLUNTARY DISSOLUTION PROCESS; CLARIFYING DUTY OF GUARANTY ASSOCIATION FOR EXCESS WORKERS' COMPENSATION; CLARIFYING LIFE INSURANCE TIMELY SETTLEMENT DISCOUNT RATE; ADOPTING CERTIFICATION TERMINOLOGY FOR HEALTH SERVICE CORPORATIONS; PERMITTING MULTIPLE EMPLOYER WELFARE ARRANGEMENTS TO UTILIZE GENERALLY ACCEPTED ACCOUNTING PRINCIPLES FOR REPORTING PURPOSES; ELIMINATING THE REQUIREMENT FOR RETURN OF PAPER LICENSES BY CERTAIN LICENSEES; REVISING MONTANA COMPREHENSIVE HEALTH ASSOCIATION LAWS; AMENDING SECTIONS 15-30-2110, 17-6-606, 27-1-732, 30-10-205, 33-1-409, 33-1-701, 33-2-117, 33-2-708, 33-2-1902, 33-2-1904, 33-4-101, 33-7-117, 33-10-105, 33-17-1502, 33-20-114, 33-20-1603, 33-22-132, 33-22-138, 33-22-140, 33-22-142, 33-22-143, 33-22-706, 33-22-1501, 33-22-1502, 33-22-1504, 33-22-1513, 33-22-1804, 33-30-107, 33-30-108, 33-30-201, 33-30-204, 33-35-301, 53-2-215, AND 53-4-1007, MCA; REPEALING SECTIONS 33-2-1912, 33-17-1003, 33-18-214, 33-22-166, 33-22-245, 33-22-1501, 33-22-1502, 33-22-1503, 33-22-1504, 33-22-1505, 33-22-1511, 33-22-1512, 33-22-1513, 33-22-1514, 33-22-1515, 33-22-1516, 33-22-1517, 33-22-1518, 33-22-1521, 33-22-1523, 33-22-1524, AND 33-31-322, MCA; AND PROVIDING EFFECTIVE DATES.

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

Section 1. Section 15-30-2110, MCA, is amended to read:

"15-30-2110. Adjusted gross income. (1) Subject to subsection (13), adjusted gross income is the taxpayer's federal adjusted gross income as defined in section 62 of the Internal Revenue Code, 26 U.S.C. 62,

and in addition includes the following:

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

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

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

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

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

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

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

(g) except for exempt-interest dividends described in subsection (2)(a)(ii), for tax years commencing after December 31, 2002, the amount of any dividend to the extent that the dividend is not included in federal adjusted gross income.

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

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

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

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

(c) (i) except as provided in subsection (2)(c)(ii), the first $3,600 of all pension and annuity income

received as defined in 15-30-2101;

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

(A) each taxpayer filing singly, head of household, or married filing separately shall reduce the total amount of the exclusion provided in subsection (2)(c)(i) by $2 for every $1 of federal adjusted gross income in excess of $30,000 as shown on the taxpayer's return;

(B) in the case of married taxpayers filing jointly, if both taxpayers are receiving pension or annuity income or if only one taxpayer is receiving pension or annuity income, the exclusion claimed as provided in subsection (2)(c)(i) must be reduced by $2 for every $1 of federal adjusted gross income in excess of $30,000 as shown on their joint return;

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

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

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

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

(h) all health insurance premiums paid by an employer for an employee if attributed as income to the employee under federal law~~, including premiums paid by the employer for an employee pursuant to 33-22-166~~;

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

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

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

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

a designated beneficiary;

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

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

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

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

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

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

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

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

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

(5) Married taxpayers filing a joint federal return who are required to include part of their social security benefits or part of their tier 1 railroad retirement benefits in federal adjusted gross income may split the federal

base used in calculation of federal taxable social security benefits or federal taxable tier 1 railroad retirement benefits when they file separate Montana income tax returns. The federal base must be split equally on the Montana return.

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

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

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

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

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

(10) A taxpayer receiving retirement disability benefits who has not attained 65 years of age by the end of the tax year and who has retired as permanently and totally disabled may exclude from adjusted gross income

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

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

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

(12) (a) A taxpayer may exclude the amount of the loan payment received pursuant to subsection (12)(a)(iv), not to exceed $5,000, from the taxpayer's adjusted gross income if the taxpayer:

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

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

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

(iv) has received a loan payment during the tax year made on the taxpayer's behalf by a loan repayment

program described in subsection (12)(b) as an incentive to practice in Montana.

(b) For the purposes of subsection (12)(a), a loan repayment program includes a federal, state, or qualified private program. A qualified private loan repayment program includes a licensed health care facility, as defined in 50-5-101, that makes student loan payments on behalf of the person who is employed by the facility as a licensed health care professional.

(13) Notwithstanding the provisions of subsection (1), adjusted gross income does not include 40% of capital gains on the sale or exchange of capital assets before December 31, 1986, as capital gains are determined under subchapter P. of Chapter 1 of the Internal Revenue Code as it read on December 31, 1986.

(14) By November 1 of each year, the department shall multiply the amount of pension and annuity income contained in subsection (2)(c)(i) and the federal adjusted gross income amounts in subsection (2)(c)(ii) by the inflation factor for that tax year, but using the year 2009 consumer price index, and rounding the results to the nearest $10. The resulting amounts are effective for that tax year and must be used as the basis for the exemption determined under subsection (2)(c). (Subsection (2)(f) terminates on occurrence of contingency--sec. 3, Ch. 634, L. 1983; subsection (2)(o) terminates on occurrence of contingency--sec. 9, Ch. 262, L. 2001.)"

Section 2. Section 17-6-606, MCA, is amended to read:

"17-6-606. Tobacco settlement accounts -- purpose -- uses. (1) The purpose of this section is to dedicate a portion of the tobacco settlement proceeds to fund statewide programs for tobacco disease prevention designed to:

(a) discourage children from starting use of tobacco;

(b) assist adults in quitting use of tobacco; and

(c) provide funds for the children's health insurance program~~; and~~

~~(d) provide funds for the comprehensive health association programs~~.

(2) An amount equal to 32% of the total yearly tobacco settlement proceeds received after June 30, 2003, must be deposited in a state special revenue account. Subject to subsection (5), the funds referred to in this subsection may be used only for funding statewide programs for tobacco disease prevention designed to prevent children from starting tobacco use and to help adults who want to quit tobacco use. The department of public health and human services shall manage the tobacco disease prevention programs and shall adopt rules to implement the programs. In adopting rules, the department shall consider the standards contained in Best

Practices for Comprehensive Tobacco Control Programs--August 1999 or its successor document, published by the U.S. department of health and human services, centers for disease control and prevention.

(3) An amount equal to 17% of the total yearly tobacco settlement proceeds received after June 30, 2003, must be deposited in a state special revenue account. Subject to subsection (5), the funds referred to in this subsection may be used only for~~:~~

~~(a)~~ matching funds to secure the maximum amount of federal funds for the Children's Health Insurance Program Act provided for in Title 53, chapter 4, part 10~~; and~~

~~(b) programs of the comprehensive health association provided for in Title 33, chapter 22, part 15, with funding use subject to 33-22-1513~~.

(4) Funds deposited in a state special revenue account, as provided in subsection (2) or (3), that are not appropriated within 2 years after the date of deposit must be transferred to the trust fund.

(5) The legislature shall appropriate money from the state special revenue accounts provided for in this section for programs for tobacco disease prevention, for the programs referred to in the subsection establishing the account, and for funding the tobacco prevention advisory board.

(6) Programs funded under this section that are private in nature may be funded through contracted services."

Section 3. Section 27-1-732, MCA, is amended to read:

"27-1-732. Immunity of nonprofit corporation officers, directors, and volunteers. (1) An officer, director, or volunteer of a nonprofit corporation is not individually liable for any action or omission made in the course and scope of the officer's, director's, or volunteer's official capacity on behalf of the nonprofit corporation. This section does not apply to liability for willful or wanton misconduct. The immunity granted by this section does not apply to the liability of a nonprofit corporation.

(2) For purposes of this section, "nonprofit corporation" means:

(a) an organization exempt from taxation under section 501(c) of the Internal Revenue Code, 26 U.S.C. 501(c), as amended; or

(b) a corporation or organization that is eligible for or has been granted tax-exempt status by the department of revenue under the provisions of 15-31-102~~; or~~

~~(c) the comprehensive health association created by 33-22-1503~~."

Section 4. Section 30-10-205, MCA, is amended to read:

"30-10-205. Registration by qualification. (1) Any security may be registered by qualification. A registration statement under this section must contain the following information and be accompanied by the following documents, in addition to payment of the registration fee prescribed in 30-10-209:

(a) with respect to the issuer and any significant subsidiary: its name, address, form of organization, the state or foreign jurisdiction and date of its organization, the general character and location of its business, and a description of its physical properties and equipment;

(b) with respect to every director and officer of the issuer or person occupying a similar status or performing similar functions: the person's name, address, and principal occupation for the past 5 years, the amount of securities of the issuer held by the person as of a specified date within 90 days of the filing of the registration statement, the remuneration paid to all listed persons in the aggregate during the past 12 months and estimated to be paid during the next 12 months, directly or indirectly, by the issuer, together with all predecessors, parents, and subsidiaries;

(c) with respect to any person not named in subsection (1)(b) owning of record, or beneficially if known, 10% or more of the outstanding shares of any class of equity security of the issuer: the information specified in subsection (1)(b) other than the person's occupation;

(d) with respect to every promoter not named in subsection (1)(b), if the issuer was organized within the past 3 years: the information specified in subsection (1)(b), any amount paid to the promoter by the issuer within that period or intended to be paid to the promoter, and the consideration for any payment;

(e) the capitalization and long-term debt, on both a current and a pro forma basis, of the issuer and any significant subsidiary, including a description of each security outstanding or being registered or otherwise offered, and a statement of the amount and kind of consideration, whether in the form of cash, physical assets, services, patents, goodwill, or anything else, for which the issuer or any subsidiary has issued any of its securities within the past 2 years or is obligated to issue any of its securities;

(f) the kind and amount of securities to be offered; the amount to be offered in this state; the proposed offering price and any variation from the offering price at which any portion of the offering is to be made to any persons except as underwriting and selling discounts and commissions; the estimated aggregate underwriting and selling discounts, commissions, and other promotional fees, including separately cash, securities, or anything

else of value to accrue to the underwriters in connection with the offering; the estimated amounts of other selling expenses, and legal, engineering, and accounting expenses to be incurred by the issuer in connection with the offering; the name and address of every underwriter and every recipient of a promotional fee; a copy of any underwriting or selling group agreement pursuant to which the distribution is to be made, or the proposed form of any agreement whose terms have not yet been determined; and a description of the plan of distribution of any securities that are to be offered otherwise than through an underwriter;

(g) the estimated cash proceeds to be received by the issuer from the offering, the purposes for which the proceeds are to be used by the issuer, the amount to be used for each purpose, the amounts of any funds to be raised from other sources to achieve the purposes stated and the sources of the additional funds, and, if any part of the proceeds is to be used to acquire any property, including goodwill, otherwise than in the ordinary course of business, the names and addresses of the vendors and the purchase price;

(h) a description of any stock options or other security options outstanding or to be created in connection with the offering, together with the amount of any options held or to be held by every person required to be named in subsection (1)(b), (1)(c), (1)(d), (1)(e), or (1)(g) and by any person who holds or will hold 10% or more in the aggregate of any options;

(i) the states in which a registration statement or similar document in connection with the offering has been or is expected to be filed;

(j) any adverse order, judgment, or decree previously entered in connection with the offering by any court or the securities and exchange commission~~.~~;

(k) a description of any pending litigation or proceeding to which the issuer is a party and that materially affects its business or assets, including any litigation or proceeding known to be contemplated by governmental authorities;

~~(k)~~(l) a copy of any prospectus or circular intended as of the effective date to be used in connection with the offering;

~~(l)~~(m) if the issuer issues a document showing ownership of the security being registered, a specimen or copy of the ~~security being registered,~~ document;

(n) a copy of the issuer's articles of incorporation and bylaws as currently in effect~~, and~~;

(o) a copy of any indenture or other instrument covering the security to be registered;

~~(m)~~(p) a signed or conformed copy of an opinion of counsel, if available, as to the legality of the security

being registered;

~~(n)~~(q) a balance sheet of the issuer as of a date within 4 months prior to the filing of the registration statement, a profit and loss statement and analysis of surplus for each of the 3 fiscal years preceding the date of the balance sheet and for any period between the close of the last fiscal year and the date of the balance sheet or for the period of the issuer's and any predecessor's existence if less than 3 years, and, if any part of the proceeds of the offering is to be applied to the purchase of any business, the same financial statements that would be required if that business were the registrant;

~~(o)~~(r) a consent to service of process meeting the requirements of 30-10-208; and

~~(p)~~(s) other information that the commissioner may require.

(2) In the case of a nonissuer distribution, information may not be required under this section unless it is known to the person filing the registration statement or to the persons on whose behalf the distribution is to be made or can be furnished by them without unreasonable effort or expense.

(3) A registration statement by qualification under this section becomes effective when the commissioner so orders. The commissioner may require as a condition of registration under this section that a prospectus containing any designated part of the information specified in this section be sent or given to each person to whom an offer is made before or concurrently with:

(a) the first written offer made to the person, by means other than a public advertisement, by or for the account of the issuer or any other person on whose behalf the offering is being made or by any underwriter or broker-dealer who is offering part of an unsold allotment or subscription taken by the underwriter or broker-dealer as a participant in the distribution;

(b) the confirmation of any sale made by or for the account of any such person;

(c) payment pursuant to any such sale; or

(d) delivery of the security pursuant to any such sale, whichever first occurs, but the commissioner shall accept for use under the requirement a current prospectus or offering circular regarding the same securities filed under the Securities Act of 1933 or regulations implementing that act."

Section 5. Section 33-1-409, MCA, is amended to read:

"33-1-409. Examination reports -- hearings -- confidentiality -- publication. (1) All examination reports must be composed only of facts appearing upon the books, records, or other documents of the company,

its agents, or other persons examined or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs. The report must contain the conclusions and recommendations that the examiners find reasonably warranted from the facts.

(2) Not later than 60 days following completion of the examination, the examiner in charge shall file with the department a verified written report of examination under oath. Upon receipt of the verified report, the department shall transmit the report to the company examined, together with a notice that gives the company examined a reasonable opportunity, but not more than 30 days, to make a written submission or rebuttal with respect to any matters contained in the examination report.

(3) Within 30 days of the end of the period allowed for the receipt of written submissions or rebuttals, the commissioner shall fully consider and review the report, together with any written submissions or rebuttals and any relevant portions of the examiner's workpapers and enter an order:

(a) adopting the examination report as filed or with modification or corrections. If the examination report reveals that the company is operating in violation of any law, regulation, or prior order of the commissioner, the commissioner may order the company to take any action the commissioner considers necessary and appropriate to cure the violation.

(b) rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation, information, or testimony and of refiling pursuant to subsection (2); or

(c) calling for an investigatory hearing with no less than 20 days' notice to the company for purposes of obtaining additional data, documentation, information, and testimony.

(4) (a) All orders entered pursuant to subsection (3)(a) must be accompanied by findings and conclusions resulting from the commissioner's consideration and review of the examination report, relevant examiner workpapers, and any written submissions or rebuttals. An order must be considered a final administrative decision and may be appealed pursuant to Title 33, chapter 1, part 7, and must be served upon the company by certified mail, together with a copy of the adopted examination report. Within 30 days of the issuance of the adopted report, the company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related orders.

(b) (i) A hearing conducted under subsection (3)(c) by the commissioner or an authorized representative must be conducted as a nonadversarial, confidential, investigatory proceeding as necessary for the resolution

of any inconsistencies, discrepancies, or disputed issues apparent upon the face of the filed examination report or raised by or as a result of the commissioner's review of relevant workpapers or by the written submission or rebuttal of the company. Within 20 days of the conclusion of the hearing, the commissioner shall enter an order pursuant to subsection (3)(a).

(ii) The commissioner may not appoint an examiner as an authorized representative to conduct the hearing. The hearing must proceed expeditiously with discovery by the company limited to the examiner's workpapers that tend to substantiate any assertions set forth in any written submission or rebuttal. The commissioner or the commissioner's representative may issue subpoenas for the attendance of witnesses or the production of documents considered relevant to the investigation, whether under the control of the department, the company, or other persons. The documents produced must be included in the record, and testimony taken by the commissioner or the commissioner's representative must be under oath and preserved for the record. This section does not require the department to disclose any information or records that would indicate or show the existence or content of an investigation or activity of a criminal justice agency.

(iii) The hearing must proceed with the commissioner or the commissioner's representative posing questions to the persons subpoenaed. The company and the department may present testimony relevant to the investigation. Cross-examination may be conducted only by the commissioner or the commissioner's representative. The company and the department must be permitted to make closing statements and may be represented by counsel of their choice.

(5) (a) Upon the adoption of the examination report under subsection (3)(a), the commissioner shall continue to hold the content of the examination report as private and confidential information for a period of 30 days, except to the extent provided in subsection (2). After 30 days, the commissioner shall open the report for public inspection as long as a court of competent jurisdiction has not stayed its publication.

(b) This title does not prevent and may not be construed as prohibiting the commissioner from disclosing the content of an examination report or preliminary examination report, the results of an examination, or any matter relating to a report or results to the insurance department of this state or of any other state or country, to law enforcement officials of this state or of any other state, or to an agency of the federal government at any time as long as the agency or office receiving the report or matters relating to the report agrees ~~in writing~~ to hold it in a manner consistent with this part.

(c) If the commissioner determines that regulatory action is appropriate as a result of an examination,

the commissioner may initiate any proceedings or actions as provided by law.

(6) (a) Working papers must be given confidential treatment, are not subject to subpoena, are not discoverable or admissible as evidence in any private action, and may not be made public by the commissioner or any other person except to the extent provided in 33-1-311(5) and subsection (5) of this section. Persons given access to working papers shall agree ~~in writing~~, prior to receiving the information, to treat the information in the manner required by this section unless prior written consent has been obtained from the company to which the working papers pertain.

(b) For purposes of subsection (6)(a), "working papers" means:

(i) all papers and copies created, produced, obtained by, or disclosed to the commissioner or any other person in the course of an examination or analysis by the commissioner;

(ii) confidential criminal justice information, as defined in 44-5-103;

(iii) personal information protected by an individual privacy interest; and

(iv) specifically identified trade secrets, as defined in 30-14-402, that have been obtained by or disclosed to the commissioner or any other person in the course of an examination made under this part for which there are reasonable grounds of privilege that are asserted by the party claiming the privilege."

Section 6. Section 33-1-701, MCA, is amended to read:

"33-1-701. Hearings -- discretion -- written demand -- procedure. (1) The commissioner may hold hearings for any purpose within the scope of this code considered necessary. Hearing procedures contained in Title 33, chapter 1, apply only to Title 33, except as otherwise provided.

(2) A person may provide the commissioner with a written demand for a hearing. A written demand must specify the grounds relied upon as a basis for the relief sought at the hearing. If the commissioner does not issue an order granting a person's request for a hearing within 30 days of receiving a request, the hearing is considered refused.

(3) All hearings must be conducted pursuant to the Montana Administrative Procedure Act, as provided in Title 2, chapter 4, part 6. Any supplemental hearing procedures may be adopted by administrative rule. ~~The commissioner shall hold a hearing within 45 days of receipt of a request for a hearing unless postponed by mutual consent of the person requesting the hearing and the commissioner.~~"

Section 7. Section 33-2-117, MCA, is amended to read:

"33-2-117. Renewal, expiration, reinstatement, and amendment of certificate of authority. (1) A certificate of authority issued or renewed under this code must continue in force as long as the insurer is entitled under this code and until suspended, revoked, or otherwise terminated. A certificate is subject to renewal by the insurer each year by payment on or prior to March 1 of the fee provided for in 33-2-708.

(2) If not continued by the insurer, the certificate of authority expires at midnight on May 31 following failure of the insurer to continue it in force. The commissioner shall promptly notify the insurer of its failure to pay the fee that can result in the expiration of its certificate of authority.

(3) The commissioner may reinstate a certificate of authority that the insurer has inadvertently permitted to expire after the insurer cures any failures resulting in expiration and upon payment of a fee of $100 for reinstatement ~~in addition to the fee provided for in 33-2-708~~. Otherwise, the insurer may be granted another certificate of authority only after filing an application and meeting all other requirements for an original certificate of authority in this state.

(4) The commissioner may amend a certificate of authority at any time to accord with changes in the insurer's charter of insuring powers."

Section 8. Section 33-2-708, MCA, is amended to read:

"33-2-708. Fees and licenses. (1) (a) ~~Except as provided in 33-17-212(2), the~~ The commissioner shall collect a fee of $1,900 from each insurer applying for or annually renewing a certificate of authority to conduct the business of insurance in Montana.

(b) The commissioner shall collect certain additional fees as follows:

(i) nonresident insurance producer's license:

(A) application for original license, including issuance of license, if issued, $100;

(B) biennial renewal of license, $50;

(C) lapsed license reinstatement fee, $100;

(ii) resident insurance producer's license lapsed license reinstatement fee, $100;

(iii) surplus lines insurance producer's license:

(A) application for original license and for issuance of license, if issued, $50;

(B) biennial renewal of license, $100;

(C) lapsed license reinstatement fee, $200;

(iv) insurance adjuster's license:

(A) application for original license, including issuance of license, if issued, $50;

(B) biennial renewal of license, $100;

(C) lapsed license reinstatement fee, $200;

(v) insurance consultant's license:

(A) application for original license, including issuance of license, if issued, $50;

(B) biennial renewal of license, $100;

(C) lapsed license reinstatement fee, $200;

(vi) viatical settlement broker's license:

(A) application for original license, including issuance of license, if issued, $50;

(B) biennial renewal of license, $100;

(C) lapsed license reinstatement fee, $200;

(vii) resident and nonresident rental car entity producer's license:

(A) application for original license, including issuance of license, if issued, $100;

(B) quarterly filing fee, $25;

(viii) an original notification fee for a life insurance producer acting as a viatical settlement broker, in accordance with 33-20-1303(2)(b), $50;

(ix) navigator certification:

(A) application for original certification, including issuance of certificate if issued, $100;

(B) biennial renewal of certification, $50;

(C) lapsed certification reinstatement fee, $100;

(x) 50 cents for each page for copies of documents on file in the commissioner's office.

(c) The commissioner may adopt rules to determine the date by which a nonresident insurance producer, a surplus lines insurance producer, an insurance adjuster, or an insurance consultant is required to pay the fee for the biennial renewal of a license.

(2) (a) The commissioner shall charge a fee of $75 for each course or program submitted for review as required by 33-17-1204 and 33-17-1205, but may not charge more than $1,500 to a sponsoring organization submitting courses or programs for review in any biennium.

(b) Insurers and associations composed of members of the insurance industry are exempt from the charge in subsection (2)(a).

(3) (a) Except as provided in subsection (3)(b), the commissioner shall promptly deposit with the state treasurer to the credit of the general fund all fines and penalties and those amounts received pursuant to 33-2-311, 33-2-705, 33-28-201, and 50-3-109.

(b) The commissioner shall deposit 33% of the money collected under 33-2-705 in the special revenue account provided for in 53-4-1115.

(c) All other fees collected by the commissioner pursuant to Title 33 and the rules adopted under Title 33 must be deposited in the state special revenue fund to the credit of the state auditor's office.

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

Section 9. Section 33-2-1902, MCA, is amended to read:

"33-2-1902. Definitions. As used in this part, the following definitions apply:

(1) "Adjusted RBC report" means an RBC report that has been adjusted by the commissioner in accordance with 33-2-1903(5).

(2) "Corrective order" means an order issued by the commissioner specifying corrective actions that the commissioner has determined are required.

(3) "Domestic insurer" means any insurance company domiciled in this state.

(4) "Foreign insurer" means any insurance company licensed to do business in this state under 33-2-116 but not domiciled in this state.

(5) "Life or disability insurer" means:

(a) any insurance company licensed under 33-2-116 and engaged in the business of entering into contracts of disability insurance, as described in 33-1-207, or life insurance, as described in 33-1-208;

(b) a licensed property and casualty insurer writing only disability insurance; ~~or~~

(c) any insurer engaged solely in the business of reinsurance of life or disability contracts~~.~~;

(d) a fraternal benefit society formed under Title 33, chapter 7; or

(e) a health service corporation formed under Title 33, chapter 30.

(6) "NAIC" means the national association of insurance commissioners.

(7) "Negative trend" means, with respect to a life or health insurer, a negative trend over a period of time, as determined in accordance with the trend test calculation included in the RBC instructions.

(8) (a) "Property and casualty insurer" means:

(i) any insurance company licensed under 33-2-116 and engaged in the business of entering into contracts of property insurance, as described in 33-1-210, or casualty insurance, as described in 33-1-206;

(ii) any insurance company engaged solely in the business of reinsurance of property and casualty contracts; or

(iii) any insurance company engaged in the business of surety and marine insurance.

(b) The term does not include monoline mortgage guaranty insurers, financial guaranty insurers, and title insurers.

(9) "RBC instructions" means the RBC report, including risk-based capital instructions adopted by the NAIC, as the RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

(10) "RBC level" means an insurer's authorized control level RBC, company action level RBC, mandatory control level RBC, or regulatory action level RBC, where:

(a) "authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions;

(b) "company action level RBC" means, with respect to any insurer, the product of 2 and its authorized control level RBC;

(c) "mandatory control level RBC" means the product of 0.70 and the authorized control level RBC; and

(d) "regulatory action level RBC" means the product of 1.5 and its authorized control level RBC.

(11) "RBC plan" means a comprehensive financial plan containing the elements specified in 33-2-1904(2). If the commissioner rejects the RBC plan and it is revised by the insurer, with or without the commissioner's recommendation, the plan must be called a revised RBC plan.

(12) "RBC report" means the report required in 33-2-1903.

(13) "Total adjusted capital" means the sum of:

(a) an insurer's statutory capital and surplus; and

(b) other items, if any, as the RBC instructions may provide."

Section 10. Section 33-2-1904, MCA, is amended to read:

"33-2-1904. Company action level event. (1) "Company action level event" means any of the following events:

(a) the filing of an RBC report by an insurer indicating that:

(i) the insurer's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC;

(ii) for a life or disability insurer, the insurer has total adjusted capital that:

(A) is greater than or equal to its company action level RBC but less than its authorized control level RBC multiplied by ~~2.5~~ 3; and

(B) has a negative trend; or

(iii) for a property and casualty insurer, the insurer has total adjusted capital that:

(A) is greater than or equal to its company action level RBC but less than its authorized control level RBC multiplied by 3; and

(B) triggers the trend test determined in accordance with the trend test calculation included in the RBC instructions;

(b) the notification by the commissioner to the insurer of an adjusted RBC report that indicates an event in subsection (1)(a) if the insurer does not challenge the adjusted RBC report under 33-2-1908 or if the commissioner has rejected the insurer's challenge.

(2) In the event of a company action level event, the insurer shall prepare and submit to the commissioner an RBC plan that must:

(a) identify the conditions that contribute to the company action level event;

(b) contain proposals of corrective actions that the insurer intends to take and that would be expected to result in the elimination of the company action level event;

(c) provide projections of the insurer's financial results in the current year and at least the next 4 years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital, and surplus. The projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense, and benefit component.

(d) identify the key assumptions impacting the insurer's projections and the sensitivity of the projections

to the assumptions; and

(e) identify the quality of and problems associated with the insurer's business, including but not limited to its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance, if any, in each case.

(3) The RBC plan must be submitted:

(a) within 45 days of the company action level event; or

(b) if the insurer challenges an adjusted RBC report pursuant to 33-2-1908, within 45 days after notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(4) Within 60 days after an insurer submits an RBC plan to the commissioner, the commissioner shall notify the insurer as to whether the RBC plan may be implemented or is unsatisfactory in the judgment of the commissioner. If the commissioner determines that the RBC plan is unsatisfactory, the notification to the insurer must set forth the reasons for the determination and may propose revisions intended to render the RBC plan satisfactory in the judgment of the commissioner. Upon notification from the commissioner, the insurer shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by the commissioner, and shall submit the revised RBC plan to the commissioner:

(a) within 45 days after the notification from the commissioner; or

(b) if the insurer challenges the notification from the commissioner under 33-2-1908, within 45 days after a notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(5) If the commissioner notifies an insurer that the insurer's RBC plan or revised RBC plan is unsatisfactory, the commissioner may, at the commissioner's discretion, subject to the insurer's right to a hearing under 33-2-1908, specify in the notification that the notification constitutes a regulatory action level event.

(6) Each domestic insurer that files an RBC plan or revised RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in any state in which the insurer is authorized to do business if:

(a) the state has an RBC provision substantially similar to 33-2-1909(1); and

(b) the insurance commissioner of that state has notified the insurer in writing of its request for the filing, in which case the insurer shall file a copy of the RBC plan or revised RBC plan in that state by the later of:

(i) 15 days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with that state; or

(ii) the date on which the RBC plan or revised RBC plan is filed under subsections (3) and (4)."

Section 11. Section 33-4-101, MCA, is amended to read:

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

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

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

(c) all insurers formed under this chapter.

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

(3) The following chapters and sections of this title apply to farm mutual insurers to the extent applicable and not inconsistent with the express provisions of this chapter and the reasonable implications of the express provisions of this chapter: chapter 1, parts 1 through 4, 7, 12, and 13; 33-2-112; 33-2-501; 33-2-502; 33-2-708; 33-2-1212; chapter 2, parts 13 and 16; 33-2-1501; 33-2-1517(2); 33-3-218; 33-3-308; 33-3-309; 33-3-401; 33-3-402; 33-3-431; 33-3-436; chapter 3, part 6; and chapters 18 and 19."

Section 12. Section 33-7-117, MCA, is amended to read:

"33-7-117. Scope -- provisions applicable. (1) Except as provided in subsection (2), societies are governed by this chapter and are exempt from all other provisions of the insurance laws of this state, not only in governmental relations with the state but for every other purpose. The provisions of a law enacted after January 1, 1992, do not apply to fraternal benefit societies unless expressly made applicable by the provisions of the law.

(2) In addition to the provisions of this chapter, the provisions of chapter 1, parts 1 through 4 and 7; 33-2-104; 33-2-107; 33-2-112; chapter 2, ~~part~~ parts 13 and 19; 33-3-308; 33-3-701 through 33-3-704; 33-15-502; and chapters 17, 18, 20, and 22 apply to fraternal benefit societies to the extent applicable and to the extent not in conflict with the provisions of this chapter and the reasonable implications of this chapter."

Section 13. Section 33-10-105, MCA, is amended to read:

"33-10-105. General powers and duties. (1) Subject to subsection (2), the association:

(a) (i) is obligated to the extent of the covered claims existing prior to the determination of insolvency and arising within 30 days after the determination of insolvency or before the policy expiration date if less than 30 days after the determination or before the insured replaces the policy or causes its cancellation if the insured does so within 30 days of the determination;

(ii) is obligated under subsection (1)(a)(i) only for that amount of each covered claim that does not exceed $300,000, except that:

(A) the association shall pay an amount not exceeding $10,000 for each policy for a covered claim for the return of unearned premium; and

(B) the association shall pay the full amount of any covered claim arising out of a workers' compensation or excess workers' compensation policy; and

(iii) is not obligated to a policyholder or claimant in an amount in excess of the obligation of the insolvent insurer under the policy from which the claim arises;

(b) is considered the insurer to the extent of its obligation on the covered claims and to that extent has all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent;

(c) shall investigate claims brought against the association and adjust, compromise, settle, and pay covered claims to the extent of the association's obligation and deny all other claims and may review settlements, releases, and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which the settlements, releases, and judgments may be properly contested;

(d) shall notify persons as the commissioner directs under 33-10-109(2)(a), including the department of labor and industry for workers' compensation claims;

(e) shall handle claims through its employees or through one or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the commissioner, but the designation may be declined by a member insurer.

(f) shall reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and shall pay the other expenses of the association authorized by this part.

(2) (a) Except as provided in subsection (2)(b), a covered claim may not include a claim filed with the association or a liquidator for protection under the insured's policy for losses incurred but not reported and may

not include a claim filed with the association after the earlier of:

(i) 36 months after the date of the order of liquidation; or

(ii) the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.

(b) (i) If the claimant learns that the claimant's condition resulted from an occupational disease compensable under Title 39, chapter 71, within 36 months of the order of liquidation or the final date set by the court for the filing of claims against the liquidator, the claimant shall file a claim, which must be paid under the terms of subsection (1)(a). If the claimant does not learn of a compensable condition under Title 39, chapter 71, until after the time specified in either subsection (2)(a)(i) or (2)(a)(ii) has expired, the claimant shall file a claim with the association within 1 year from the date the claimant knew or should have known that the claimant's condition resulted from an occupational disease.

(ii) Notice by a claimant or insurer to the department of labor and industry of a workers' compensation claim or an occupational disease claim pursuant to Title 39, chapter 71, constitutes notice to the liquidator for the purposes of workers' compensation or occupational disease claims.

(3) The association may:

(a) employ or retain persons necessary to handle claims and perform other duties of the association;

(b) borrow funds necessary to effect the purposes of this part in accord with the plan of operation;

(c) sue or be sued;

(d) negotiate and become a party to contracts necessary to carry out the purpose of this part;

(e) perform other acts necessary or proper to effectuate the purpose of this part;

(f) refund to the member insurers in proportion to the contribution of each member insurer to the association that amount by which the assets of the association exceed the liabilities, if, at the end of any calendar year, the board of directors finds that the assets of the association exceed the liabilities of the association as estimated by the board of directors for the coming year."

Section 14. Section 33-17-1502, MCA, is amended to read:

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

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

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

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

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

(6) A rental vehicle entity shall submit to the commissioner an annual report listing each customer service representative presenting rental vehicle insurance information to the public."

Section 15. Section 33-20-114, MCA, is amended to read:

"33-20-114. Payment of claims -- interest. (1) There must be a provision, which may be made by endorsement, that when a claim is made upon the death of the insured, settlement must be made upon receipt of proof of death and, at the insurer's option, surrender of the policy or proof of the interest of the claimant, or both.

(2) There must be a provision, which may be made by endorsement, that settlement must be made within 60 days of receipt of proof of death and that if settlement is made after the first 30 days, the settlement must include interest from the 30th day until settlement. Interest must be paid at the monthly average discount rate on 90-day AA asset-backed commercial paper in effect at the federal reserve bank in the ninth federal reserve district at the time of proof of death or at the rate stated in the policy, whichever is greater. The settlement period and interest provisions of this subsection apply to all claims upon deaths filed with an insurer, regardless of whether those provisions are included in the policy."

Section 16. Section 33-20-1603, MCA, is amended to read:

"33-20-1603. Application of part. (1) This part applies to life insurance policies, annuity contracts, certificates under a life insurance policy or annuity contract, or certificates issued to a fraternal benefit society under which benefits are payable upon the death of the insured.

(2) This part may not be construed to limit any agreement by the commissioner with ~~a company~~ an insurer regarding unclaimed life insurance benefits.

(3) For the purposes of this part, the term "annuity contract" does not include an annuity used to fund an employment-based retirement plan or program when the insurer is not committed by terms of the annuity contract to pay death benefits to the beneficiaries of specific plan participants."

Section 17. Section 33-22-132, MCA, is amended to read:

"33-22-132. Coverage for mammography examinations. (1) Each group or individual medical expense~~, cancer,~~ and blanket disability policy, certificate of insurance, and membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide minimum mammography examination coverage.

(2) For the purpose of this section, "minimum mammography examination" means:

(a) one baseline mammogram for a woman who is 35 years of age or older and under 40 years of age;

(b) a mammogram every 2 years for any woman who is 40 years of age or older and under 50 years of age or more frequently if recommended by the woman's physician; and

(c) a mammogram each year for a woman who is 50 years of age or older.

(3) A minimum $70 payment or the actual charge if the charge is less than $70 must be made for each mammography examination performed before the application of the terms of the applicable group or individual disability policy, certificate of insurance, or membership contract that establish durational limits, deductibles, and copayment provisions as long as the terms are not less favorable than for physical illness generally.

(4) This section does not apply to disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, or specified disease policies."

Section 18. Section 33-22-138, MCA, is amended to read:

"33-22-138. Coverage for telemedicine services. (1) Each group or individual policy, certificate of disability insurance, subscriber contract, membership contract, or health care services agreement that provides coverage for health care services must provide coverage for health care services provided by a health care provider or health care facility by means of telemedicine if the services are otherwise covered by the policy, certificate, contract, or agreement.

(2) Coverage under this section must be equivalent to the coverage for services that are provided in person by a health care provider or health care facility.

(3) Nothing in this section may be construed to require:

(a) a health insurance issuer to provide coverage for services that are not medically necessary, subject to the terms and conditions of the insured's policy; or

(b) a health care provider to be physically present with a patient at the site where the patient is located unless the health care provider who is providing health care services by means of telemedicine determines that the presence of a health care provider is necessary.

(4) Coverage under this section may be subject to deductibles, coinsurance, and copayment provisions. Special deductible, coinsurance, copayment, or other limitations that are not generally applicable to other medical services covered under the plan may not be imposed on the coverage for services provided by means of telemedicine.

(5) This section does not apply to disability income, hospital indemnity, medicare supplement, specified disease, or long-term care policies.

(6) For the purposes of this section, the following definitions apply:

(a) "Health care facility" means a critical access hospital, hospice, hospital, long-term care facility, mental health center, outpatient center for primary care, or outpatient center for surgical services licensed pursuant to Title 50, chapter 5.

(b) "Health care provider" means an individual:

(i) licensed pursuant to Title 37, chapter 3, 6, 7, 10, 11, 15, 17, 20, 22, 23, 24, 25, or 35;

(ii) licensed pursuant to Title 37, chapter 8, to practice as a registered professional nurse or as an advanced practice registered nurse;

(iii) certified by the American board of genetic counseling as a genetic counselor; or

(iv) certified by the national certification board for diabetes educators as a diabetes educator.

(c) "Store-and-forward technology" means electronic information, imaging, and communication that is transferred, recorded, or otherwise stored in order to be reviewed at a later date by a health care provider or health care facility at a distant site without the patient present in real time. The term includes interactive audio, video, and data communication.

(d) (i) "Telemedicine" means the use of interactive audio, video, or other telecommunications technology

that is:

(A) used by a health care provider or health care facility to deliver health care services at a site other than the site where the patient is located; and

(B) delivered over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1320d, et seq.

(ii) The term includes the use of electronic media for consultation relating to the health care diagnosis or treatment of a patient in real time or through the use of store-and-forward technology.

(iii) The term does not include the use of audio-only telephone, e-mail, or facsimile transmissions."

Section 19. Section 33-22-140, MCA, is amended to read:

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

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

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

(3) "COBRA continuation provision" means:

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

(b) Title I, subtitle B, part 6, excluding section 609, of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001, et seq.; or

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

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

(i) a group health plan;

(ii) health insurance coverage;

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

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

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

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

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

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

~~(ix)~~(viii) a public health plan;

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

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

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

(5) "Dependent" means:

(a) a spouse;

(b) an unmarried child under 25 years of age:

(i) who is not an employee eligible for coverage under a group health plan offered by the child's employer for which the child's premium contribution amount is no greater than the premium amount for coverage as a dependent under a parent's individual or group health plan;

(ii) who is not a named subscriber, insured, enrollee, or covered individual under any other individual health insurance coverage, group health plan, government plan, church plan, or group health insurance;

(iii) who is not entitled to benefits under 42 U.S.C. 1395, et seq.; and

(iv) for whom the insured parent has requested coverage;

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

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

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

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

(8) "Excepted benefits" means:

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

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

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

(d) workers' compensation or similar insurance;

(e) automobile medical payment insurance;

(f) credit-only insurance;

(g) coverage for onsite medical clinics;

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

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

(i) limited-scope dental or vision benefits;

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

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

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

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

(ii) hospital indemnity or other fixed indemnity insurance;

(k) if offered as a separate insurance policy:

(i) medicare supplement coverage;

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

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

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

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

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

(c) who is not eligible for coverage under:

(i) a group health plan;

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

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

program;

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

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

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

(g) who has exhausted continuation coverage under the COBRA continuation provision or program described in subsection (9)(f) if the individual elected the continuation coverage described in subsection (9)(f).

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

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

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

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

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

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

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

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

(18) "Late enrollee" means an eligible employee or dependent, other than a special enrollee under

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

(19) "Medical care" means:

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

(b) transportation primarily for and essential to medical care referred to in subsection (19)(a); or

(c) insurance covering medical care referred to in subsections (19)(a) and (19)(b).

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

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

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

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

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

Section 20. Section 33-22-142, MCA, is amended to read:

"33-22-142. Certification of creditable coverage. (1) A group health plan and a health insurance issuer

offering group health insurance coverage shall issue the certification described in subsection (3):

(a) within 10 days after an individual ceases to be covered under the group health plan or otherwise becomes covered under a COBRA continuation provision;

(b) not later than 10 days after the expiration of the notice period for cancellation for nonpayment of premium pursuant to the provisions of 33-22-121 and 33-22-530 or after termination of coverage for any other reason;

(c) in the case of an individual becoming covered under a COBRA continuation provision, at the time that the individual ceases to be covered under a COBRA continuation provision; and

(d) at the request on behalf of an individual made not later than 24 months after the date of termination of the coverage described in subsection (1)(a) or (1)(c), whichever is later.

(2) The certification pursuant to subsection (1)(a) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

(3) Certification is the written:

(a) certification of the period of creditable coverage of the individual under a group health plan and the coverage under the COBRA continuation provision;

(b) certification of the waiting period, if any, and affiliation period, as defined in 33-31-102, if applicable, imposed with respect to the individual for any coverage under a group health plan;

(c) certification of the date of issuance of the certificate specified on the form; and

(d) notification to the individual of:

~~(i) the individual's option to apply to the Montana comprehensive health association, provided for in 33-22-1503, for an association portability plan, as defined in 33-22-1501, within 63 days of issuance of a certificate of creditable coverage;~~

~~(ii)~~(i) the individual's conversion rights;

~~(iii)~~(ii) the availability of COBRA continuation coverage; and

~~(iv) the telephone number and address of the Montana comprehensive health association; and~~

~~(v)~~(iii) other notification as determined necessary and in the form prescribed by rule by the commissioner.

(4) To the extent that medical care under a group health plan consists of group health insurance coverage, a group health plan satisfies the certification requirement of this section if the health insurance issuer offering the coverage provides the certification in accordance with this section.

(5) In the case of an election described in 33-22-141 by a group health plan or health insurance issuer, if the group health plan or health insurance issuer enrolls an individual for coverage under the group health plan and the individual provides a certification of coverage of the individual, the entity that issued the certification shall upon request of the group health plan or health insurance issuer promptly disclose information on coverage of classes and categories of health benefits available under the certified coverage. The entity may charge the requesting group health plan or health insurance issuer the reasonable cost of disclosing the information.

(6) This section applies to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as it applies to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the group market."

Section 21. Section 33-22-143, MCA, is amended to read:

"33-22-143. Rules. The commissioner may adopt rules to implement 33-22-140 through 33-22-142, 33-22-246, 33-22-247, 33-22-514, and 33-22-523 through 33-22-526~~, and 33-22-1523~~."

Section 22. Section 33-22-706, MCA, is amended to read:

"33-22-706. Coverage for severe mental illness -- definition. (1) A policy or certificate of health insurance or disability insurance that is delivered, issued for delivery, renewed, extended, or modified in this state must provide a level of benefits for the necessary care and treatment of severe mental illness, as defined in subsection (6), that is no less favorable than that level provided for other physical illness generally. Benefits for treatment of severe mental illness may be subject to managed care provisions contained in the policy or certificate.

(2) Benefits provided pursuant to subsection (1) include but are not limited to:

(a) inpatient hospital services;

(b) outpatient services;

(c) rehabilitative services;

(d) medication;

(e) services rendered by a licensed physician, licensed advanced practice registered nurse with a specialty in mental health, licensed social worker, licensed psychologist, or licensed professional counselor when those services are part of a treatment plan recommended and authorized by a licensed physician; and

(f) services rendered by a licensed advanced practice registered nurse with prescriptive authority and specializing in mental health.

(3) Benefits provided pursuant to this section must be included when determining maximum lifetime benefits, copayments, and deductibles.

(4) (a) This section applies to health service benefits provided by:

(i) individual and group health and disability insurance;

(ii) individual and group hospital or medical expense insurance;

(iii) medical subscriber contracts;

(iv) membership contracts of a health service corporation; and

(v) health maintenance organizations~~; and~~

~~(vi) the comprehensive health association created by 33-22-1503~~.

(b) This section does not apply to the following coverages:

(i) blanket;

(ii) short-term travel;

(iii) accident only;

(iv) limited or specific disease;

(v) Title XVIII of the Social Security Act (medicare); or

(vi) any other similar coverage under state or federal government plans.

(5) This section does not limit benefits for an illness or condition that does not constitute a severe mental illness, as defined in subsection (6), but that does constitute a mental illness, as defined in 33-22-702.

(6) As used in this section, "severe mental illness" means the following disorders as defined by the American psychiatric association:

(a) schizophrenia;

(b) schizoaffective disorder;

(c) bipolar disorder;

(d) major depression;

(e) panic disorder;

(f) obsessive-compulsive disorder; and

(g) autism.

(7) Coverage for a child with autism who is 18 years of age or younger must comply with 33-22-515(3) through (5) if the child is diagnosed with:

(a) autistic disorder;

(b) Asperger's disorder; or

(c) pervasive developmental disorder not otherwise specified."

Section 23. Section 33-22-1501, MCA, is amended to read:

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

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

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

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

~~(4)~~(3) "Association portability plan" means a policy of insurance coverage that is offered by the association to a federally defined eligible individual.

~~(5)~~(4) "Association portability plan premium" means the charge determined by the association and approved by the commissioner for an association portability plan.

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

~~(7)~~(5) (a) "Eligible person" means an individual who:

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

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

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

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

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

(A) has, within 6 months prior to the date of application, been rejected for disability insurance or health

service benefits by at least one insurer, society, or health service corporation, unless the association waives this requirement; or

(B) has had a restrictive rider or preexisting conditions limitation required by at least one insurer, society, or health service corporation that has the effect of substantially reducing coverage from that received by a person considered a standard risk.

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

~~(8)~~(6) "Federally defined eligible individual" means a person who is an individual enrolling in the association portability plan:

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

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

(c) who is not eligible for coverage under:

(i) a group health plan;

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

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

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

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

(f) who has exhausted continuation coverage under the COBRA continuation provision or program described in subsection ~~(8)(e)~~ (6)(e) if the individual elected the continuation coverage described in subsection ~~(8)(e)~~ (6)(e).

~~(9)~~(7) "Health service corporation" means a corporation operating pursuant to Title 33, chapter 30, and offering or selling contracts of disability insurance.

~~(10)~~(8) "Insurance arrangement" means any plan, program, contract, or other arrangement to the extent not exempt from inclusion by virtue of the provisions of the federal Employee Retirement Income Security Act of 1974 under which one or more employers, unions, or other organizations provide to their employees or members, either directly or indirectly through a trust of a third-party administrator, health care services or benefits other than through an insurer.

~~(11)~~(9) "Insurer" means a company operating pursuant to Title 33, chapter 2 or 3, and offering or selling policies or contracts of disability insurance, as provided in Title 33, chapter 22.

~~(12)~~(10) "Lead carrier" means the licensed administrator or insurer selected by the association to administer the association plan.

~~(13)~~(11) "Medicare" means coverage under both parts A and B of Title XVIII of the Social Security Act, 42 U.S.C. 1395, et seq., as amended.

~~(14)~~(12) "Preexisting condition" means any condition for which an applicant for coverage under the association plan has received medical attention during the 3 years immediately preceding the filing of an application.

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

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

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

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

~~(16)~~(13) "Resident" means an individual who has been legally domiciled in this state for a period of at least 30 days, except that for a federally defined eligible individual there is no 30-day requirement. The criteria for determining residency must be specified in the association's operating rules.

~~(17)~~(14) "Society" means a fraternal benefit society operating pursuant to Title 33, chapter 7, and offering or selling certificates of disability insurance.

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

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

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

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

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

~~(19)~~(15) "Termination plan" means a contingency plan developed by the association board of directors that provides conditions for cessation of the block of business in the association plan and the association portability plan."

Section 24. Section 33-22-1502, MCA, is amended to read:

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

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

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

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

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

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

~~(f)~~(1) review a termination plan and approve, in conjunction with the approval of the termination plan, the dissolution of the association board of directors and cessation of the association plan and the association portability plan in accordance with state and federal laws~~.~~; and

(2) ~~The commissioner may adopt rules that limit association plan eligibility under 33-22-1501(7)(a)(ii)(B) according to income level~~ supervise the windup of the businesses of the association."

Section 25. Section 33-22-1504, MCA, is amended to read:

"33-22-1504. Association board of directors -- organization -- duties. (1) There is a board of directors of the association, consisting of nine members as follows:

(a) one member from each of the five participating members of the association with the highest annual premium volume of disability insurance contracts, health maintenance organization health care services agreements, or health service corporation contracts, derived from or on behalf of residents in the previous calendar year, as determined by the commissioner;

(b) two members at large who must be participating members of the association, appointed by the commissioner; and

(c) two members at large, appointed by the commissioner to represent the public interest.

(2) The public interest board members provided for in subsection (1)(c) must be enrolled in a Montana comprehensive health association plan at the time of appointment.

(3) The public interest board members are entitled to one board vote each. Each of the seven board members representing the association members is entitled to a weighted average vote, in person or by proxy, based on the association member's annual Montana premium volume. However, a board member may not have more than 50% of the vote.

(4) Members of the board may be reimbursed from the money of the association for expenses incurred by them because of their service as board members but may not otherwise be compensated by the association for their services. The costs of conducting the meetings of the association and reimbursing its board of directors must be borne by participating members of the association in accordance with 33-22-1513.

(5) The commissioner may replace a board member if the commissioner determines that the board member is not actively participating in the affairs of the board or if the participating member does not appoint a board representative within a reasonable time period. A board member appointed under subsection (1)(a) must be replaced by a participating member of the association with the next highest annual Montana premium volume of disability insurance contracts, health maintenance organization health care service agreements, or health service corporation contracts, derived from or on behalf of residents in the previous calendar year, as determined by the commissioner.

(6) The commissioner shall include the applicable premium volume of all affiliates, as defined in 33-2-1101, in making the determination required by subsection (1)(a) or (5).

(7) (a) The board of directors of the association shall develop a termination plan that specifies a time

when the eligibility requirements for an eligible person and a federally defined eligible individual are no longer valid because of changes in the health insurance market. The commissioner shall review the termination plan, which is subject to the commissioner's approval.

(b) The termination plan must include:

(i) a proposed timeline to allow enrolled members of the association plan and the association portability plan to acquire other health insurance;

(ii) financial data showing the general plan for completing all financial transactions within the association plan and the association portability plan as provided in 33-22-1513 and the effect that the plan will have on funding sources, including tobacco settlement funds ~~allocated pursuant to 17-6-606~~;

(iii) documents and related educational materials designed to inform enrolled members of the association plan and the association portability plan of obligations and methods to transfer to other health insurance plans. The plan must include at least a 90-day notice of nonrenewal.

(iv) proposed language for the repeal of Title 33, chapter 22, part 15.

(8) The commissioner shall present the termination plan to the economic affairs interim committee.

(9) Since the termination of all association plans occurred on December 31, 2013, the board of directors of the association pursuant to this part shall wind up the business of the association, including paying claims and resolving all appeals resulting from those claims."

Section 26. Section 33-22-1513, MCA, is amended to read:

"33-22-1513. Operation of association plan and association portability plans. ~~(1) Upon acceptance by the lead carrier under 33-22-1516, an eligible person may enroll in the association plan by payment of the association plan premium to the lead carrier.~~

~~(2) Upon application by a federally defined eligible individual or a TAA-eligible individual to the lead carrier for an association portability plan, the association may not:~~

~~(a) decline to offer an association portability plan; or~~

~~(b) except as provided in subsection (3), impose a preexisting condition exclusion with respect to an individual's association portability plan coverage if application for association portability plan coverage is made within 63 days following termination of the applicant's most recent prior creditable coverage.~~

~~(3) The association may impose a preexisting condition exclusion as provided in 33-22-1516 with respect~~

~~to a TAA-eligible individual's association portability plan coverage if that individual does not meet the requirements defining a qualified TAA-eligible individual.~~

~~(4)~~(1) Not less than 88% of the association plan and the association portability plan premiums paid to the lead carrier may be used to pay claims and not more than 12% may be used for payment of the lead carrier's direct and indirect expenses as specified in 33-22-1514.

~~(5)~~(2) Any income in excess of the costs incurred by the association in providing reinsurance or administrative services must be held at interest and used by the association to offset past and future losses because of claims expenses of the association plan and the association portability plan ~~or be allocated to reduce association plan and association portability plan premiums~~.

~~(6)~~(3) (a) Each participating member of the association shall share the losses because of claims expenses of the association plan and the association portability plan for plans issued or approved for issuance by the association and shall share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs in the following manner:

(i) Each participating member of the association must be assessed by the association on an annual basis an amount not to exceed 1% of the association member's total disability insurance premium received from or on behalf of Montana residents as determined by the commissioner. Assessments made under this subsection ~~(6)(a)~~ (3)(a) or funds from any other source must be allocated to the association plan and the association portability plan in proportion to the needs of the two plans. If the needs of the association plan and the association portability plan exceed the funds generated by the 1% assessment, the association is then authorized to spend any funds appropriated by the legislature for the support of the plans. Any appropriation to the association may be expended for the operation of the association plan or the association portability plan.

(ii) (A) Payment of an assessment is due within 30 days of receipt by a member of a written notice of the annual assessment. After 30 days, the association shall charge a member:

(I) a late payment penalty of 1.5% a month or fraction of a month on the unpaid assessment, not to exceed 18% of the assessment due;

(II) interest at the rate of 12% a year on the unpaid assessment, to be accrued at 1% a month or fraction of a month; or

(III) both of the charges in subsections ~~(6)(a)(ii)(A)(I) and (6)(a)(ii)(A)(II)~~ (3)(a)(ii)(A)(I) and (3)(a)(ii)(A)(II).

(B) Failure by a contributing member to tender the association assessment within the 30-day period is

grounds for termination of membership. A member terminated for failure to tender the association assessment is ineligible to write health care benefit policies or contracts in this state under 33-22-1503(2).

(iii) An association member that ceases to do disability insurance business within the state remains liable for assessments through the calendar year in which the member ceased doing disability insurance business. The association may decline to levy an assessment against an association member if the assessment, as determined pursuant to this section, would not exceed $50.

(b) For purposes of this subsection ~~(6)~~ (3), "total disability insurance premium" does not include premiums received from disability income insurance, credit disability insurance, disability waiver insurance, life insurance, medicare risk or other similar medicare health maintenance organization payments, or medicaid health maintenance organization payments.

(c) Any income in excess of the incurred or estimated claims expenses of the association plan and the association portability plan and the operating and administrative expenses of the association must be held at interest and used by the association to offset past and future losses because of claims expenses of the association plan and the association portability plan or be allocated to reduce association plan and association portability plan premiums.

~~(7)~~(4) The proportion of the annual assessment allocated to the operation and expenses of the association plan, not to include any amount of late payment penalty or interest charged, may be offset by an association member against the premium tax payable by that association member pursuant to 33-2-705 for the year in which the annual assessment is levied. The commissioner shall report to the office of budget and program planning, as a part of the information required by 17-7-111, the total amount of premium tax offset claimed by association members during the preceding biennium. The proportion of the annual assessment allocated to the operation and expenses of the association portability plan and levied against an association member may not be offset against the premium tax payable by that association member.

~~(8)~~(5) The association may also accept funding from the federal government, private foundations, and other private funding sources."

Section 27. Section 33-22-1804, MCA, is amended to read:

"33-22-1804. Applicability and scope. (1) This part applies to a health benefit plan marketed through a small employer that provides coverage to the employees of a small employer in this state if any of the following

conditions are met:

(a) a portion of the premium or benefits is paid by or on behalf of the small employer;

(b) an eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium;

(c) the health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of section 106, 125, or 162 of the Internal Revenue Code, except a plan or program that is funded entirely by contributions from the employees; or

(d) all of the premium is paid by the employee who obtains coverage through the employer's group health benefit plan.

(2) This part does not apply to an individual health benefit plan for which the entire premium is paid by an employee through payroll deduction or other means.

(3) Unless prohibited by a written opinion from a federal agency, by final regulations implementing Public Law 104-191, or by a ruling by a court of competent jurisdiction, this part does not apply to an individual health benefit plan if the eligible employee or dependent is directly or indirectly reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium. However, this part does apply to an individual health benefit plan if the employer making the direct or indirect reimbursement for any portion of the premium has had in place an employer-sponsored group health benefit plan in the 12 months preceding the reimbursement.

~~(4) This part does not apply to an individual health benefit plan for which the premium is paid by a small employer pursuant to 33-22-166.~~"

Section 28. Section 33-30-107, MCA, is amended to read:

"33-30-107. Annual statement. (1) On or before March 1 of each year, each health service corporation shall file an annual statement for the preceding year on the national association of insurance commissioners' health blank form with the commissioner of insurance. This annual statement must be completed in accordance with the annual statement instructions and the Accounting Practices and Procedures Manual of the national association of insurance commissioners. The statement must be accompanied by an actuarial opinion attesting to the insurer's reserves.

(2) The health service corporation shall file a statement containing any other information concerning its

financial affairs that may be reasonably requested by the commissioner.

(3) (a) Each health service corporation shall file electronic versions of its annual and quarterly financial statements with the national association of insurance commissioners. The date for submission of the annual statement electronic filing is March 1. The dates for submission of the quarterly statement electronic filing are as follows:

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

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

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

(b) The commissioner may exempt health service corporations operating only in Montana from these filing requirements.

(c) The health service corporation shall pay all fees and costs associated with preparing the annual statement and other filings and submitting them to the national association of insurance commissioners.

(4) The commissioner may, after notice and hearing, suspend or revoke a health service corporation's ~~license~~ certificate of authority or impose a fine not to exceed $100 a day and not to exceed $1,000 upon a health service corporation that fails to file an annual statement as required by this part."

Section 29. Section 33-30-108, MCA, is amended to read:

"33-30-108. ~~License~~ Certificate required. (1) A person may not act as a health service corporation and a health service corporation may not conduct business in this state except as authorized by a ~~license~~ certificate of authority issued by the commissioner.

(2) The commissioner may issue a ~~license~~ certificate of authority after the person has complied with the applicable provisions of this title and has submitted an application on a form prescribed by the commissioner.

(3) A health service corporation is entitled to a continuation of its ~~license~~ certificate of authority upon payment of the annual continuation fee specified in 33-30-204 on or before March 1 of each year and upon continued compliance with the provisions of this title.

(4) The commissioner may revoke or suspend any ~~license~~ certificate of authority issued under this section for violations of this title."

Section 30. Section 33-30-201, MCA, is amended to read:

"33-30-201. Reserves -- requirements suspended. (1) The corporation shall maintain at all times unobligated funds adequate to:

(a) provide the hospital, medical-surgical, and other health services made available to its members and beneficiaries; and

(b) meet all costs and expenses.

(2) In addition, reserves of a health service corporation in cash, certificates of deposit, obligations issued or guaranteed by the government of the United States, or other assets approved by the commissioner must be maintained in an amount not less than:

(a) $500,000 or, if ~~licensed~~ authorized under this chapter after October 1, 1999, $750,000; or

(b) an amount equal to 1 month's average income from dues or fees paid to the corporation by its members or beneficiaries, based on an average of the preceding 12 months, whichever is less.

(3) The determination of minimum reserves is subject, as to amounts payable to participating providers of the health services, to any right of the corporation to prorate the amounts under the terms of its health service contracts with providers.

(4) The commissioner may decrease or suspend the requirements of this section if the commissioner finds that the action is in the best interest of the members of the corporation."

Section 31. Section 33-30-204, MCA, is amended to read:

"33-30-204. Fees. (1) Every health service corporation subject to the provisions of this chapter shall pay the following fees to the commissioner for enforcement of the provisions of this chapter:

(a) for a certified copy of any document or other paper filed in the office of the commissioner, per page, 50 cents;

(b) filing of a membership contract, $25;

(c) filing of a membership contract package, $100;

(d) filing annual statement, $25;

(e) issuance of health service corporation ~~license~~ certificate of authority, $300; and

(f) annual continuation of health service corporation ~~license~~ certificate of authority, $300.

(2) The commissioner shall promptly deposit with the state treasurer, to the credit of the state special revenue fund of the state auditor's office, all fees and ~~license~~ certificate of authority fees received under this

section."

Section 32. Section 33-35-301, MCA, is amended to read:

"33-35-301. Reporting. (1) A self-funded multiple employer welfare arrangement shall comply with the reporting requirements of this section.

(2) Within 3 months following the close of the arrangement's year of operations, the arrangement shall file with the commissioner, on forms prescribed by the commissioner:

(a) a statement of financial condition;

(b) a statement of change in financial conditions accompanied by an actuarial opinion that the unpaid claim liability of the arrangement satisfies the standards of 33-2-514. The commissioner may, in the commissioner's discretion, waive the requirement of an actuarial opinion and require a report prepared by an actuarial firm and, upon a showing of good cause, may extend by 30 days the filing date for the report.

(c) a statement of its contribution rates for the ensuing year;

(d) a statement of operations for the previous year;

(e) if the total payments to the arrangement for participation during the prior year of operations exceeded the sum of $2 million, an audit satisfying the requirements of the commissioner's rules governing annual audited reports, except that an arrangement audit may be prepared using generally accepted accounting principles. The audit must be certified by an independent certified public accountant. The filing date for the audit must be extended by the commissioner upon a showing of good cause.

(f) additional information as the commissioner reasonably determines to be necessary to determine the financial integrity of the management.

(3) An arrangement shall file with the commissioner a copy of the arrangement's internal revenue service form 5500 together with all attachments to the form, at the time required for filing the form."

Section 33. Section 53-2-215, MCA, is amended to read:

"53-2-215. Social Security Act section 1115 waiver. (1) The department may pursue approval from the U.S. department of health and human services for implementation in Montana of a health insurance flexibility and accountability demonstration initiative and other demonstration projects through section 1115 waivers.

(2) The department may implement a demonstration project upon approval of a section 1115 waiver by

the U.S. department of health and human services. The department may:

(a) coordinate a demonstration project with a program approved through a section 1915 waiver; or

(b) terminate and subsume in a new section 1115 waiver an existing managed care or access program approved through a section 1915(b) waiver, an optional state plan medicaid service authorized under 53-6-101, an optional state plan eligibility group authorized under 53-6-131, or an existing program approved by a section 1115 waiver, inclusive of the demonstration program authorized by 53-4-202 and Title 53, chapter 4, part 6, that is administered by the department.

(3) The department may amend the existing section 1115 demonstration project authorized in 53-4-601 and 53-6-101 to expand the demonstration project to implement the purposes of this section.

(4) The department may initiate and administer section 1115 waivers to more efficiently apply available state general fund money, other available state and local public and private funding, and federal money to the development and maintenance of medicaid-funded programs of health services and of other public assistance services and to structure those programs or services for more efficient and effective delivery to specific populations.

(5) (a) In establishing programs or services in a demonstration project approved through a section 1115 waiver, the department shall administer the expenditures under each demonstration project within the state spending authority that is available for that demonstration project. The department may limit enrollments in each program within a demonstration project, reduce the per capita expenditures available to enrollees, and modify and reduce the types and amounts of services available through each program when the department determines that expenditures can be reasonably expected to exceed the available state spending authority.

(b) The department shall develop a contingency plan if there is a spending cap as a condition of the waiver and the spending cap is exceeded. The contingency plan must address the effects on new programs, services, or eligibility groups.

(6) The department may coordinate the state children's health insurance program authorized under Title 53, chapter 4, part 10, with a section 1115 waiver for the purpose of increasing the state funding match available under the waiver and expanding the number of participants in the state children's health insurance program.

(7) The department, subject to the terms and conditions of the section 1115 waiver:

(a) shall establish the eligibility groups based upon the funding principles stated in 53-6-101(2);

(b) may provide medicaid coverage for one or more optional medicaid eligibility groups;

(c) may provide medicaid coverage for one or more specific populations of persons who are not within the federally authorized medicaid eligibility groups but who are within the requirements of subsection (8);

(d) may establish the service coverage, eligibility requirements, financial participation requirements, and other features for the administration and delivery of services to each section 1115 waiver eligibility group;

(e) shall set limits on the number of participants for each section 1115 waiver eligibility group;

(f) shall set limits on the total expenditures under each demonstration project; and

(g) shall set the limits on the total expenditures on the services to be provided to each section 1115 waiver eligibility group.

(8) The categories of persons that the department may consider for establishment as a section 1115 waiver eligibility group include but are not limited to:

(a) low-income parents of children who are eligible to participate in medicaid under 53-6-131 or in the state children's health insurance program authorized under Title 53, chapter 4, part 10;

~~(b) persons who because of low income and health-care needs are unable to procure health insurance coverage and are eligible to participate in a comprehensive health association plan authorized under Title 33, chapter 22, part 15;~~

~~(c)~~(b) children who because of limits on enrollment may not be covered through the state children's health insurance program authorized under Title 53, chapter 4, part 10;

~~(d)~~(c) children who are eligible to participate in the state children's health insurance program authorized under Title 53, chapter 4, part 10; and

~~(e)~~(d) other specific groups of persons who are participants in programs or services funded solely or primarily through state general funds or who the department determines are in need of specific types of health care and related services, such as prescription drugs, reproductive health care, and mental health services, and are without adequate financial means to procure health insurance coverage of those needs.

(9) Children participating in a section 1115 waiver eligibility group or children who would be eligible to participate in the state children's health insurance program are subject to the eligibility criteria applicable under 53-4-1004, except as provided in subsection (10) of this section, for participation in the state children's health insurance program and must receive benefits as provided through the state children's health insurance program under 53-4-1005.

(10) (a) Except as provided in this subsection (10), the eligibility for the section 1115 waiver eligibility

groups may not exceed 150% of the federal poverty level.

(b) The department may establish eligibility at greater than 150% but no more than 200% of the federal poverty level for any of the following groups established for purposes of a section 1115 waiver:

(i) participants in the state children's health insurance program;

(ii) participants in a group that may be covered under the state children's health insurance program;

(iii) participants in a family planning program;

(iv) participants in a group composed of persons previously served through a program funded with state general fund money and other nonmedicaid money; or

(v) participants in a group composed of persons with a significant need for particular services that are not readily available to that population through insurance products or because of personal financial limitations.

(c) In establishing the eligibility criteria based upon federal poverty levels, the department shall select levels to ensure that the resulting expenditures will remain within the available funding and will conform with the terms and conditions of approval by the U.S. department of health and human services.

(d) The department may adopt additional programmatic and financial eligibility criteria for a section 1115 waiver eligibility group in order to appropriately define the subject population, to limit use for fiscal and programmatic purposes, to prevent improper use, and to conform the administration of the program with the terms and conditions of the section 1115 waiver.

(e) Eligibility criteria applicable to a section 1115 waiver eligibility group need not conform to the criteria applicable to another section 1115 waiver eligibility group or to a medicaid eligibility group that is not encompassed within the demonstration project.

(11) (a) For each section 1115 waiver eligibility group, the department shall establish the program benefit or benefits to be available to the participants in the group.

(b) Program benefits may be in the form of:

(i) assistance in the payment of health insurance premiums for health care coverage through an employer or other existing group coverage available to the program enrollee;

(ii) assistance in the payment of health insurance premiums for health care coverage that meets a set of defined standards and limitations adopted by the department in consultation with the commissioner of insurance and obtained from participating private insurers or through self-insured pools;

(iii) premium purchase for insurance coverage on behalf of children who are 18 years of age or younger

for the defined set of health care and related services adopted by the department for the state children's health insurance program authorized in Title 53, chapter 4, part 10; or

(iv) coverage of a defined set of health care and related services administered directly by the department on a fee-for-service basis.

(c) The department may limit the types of program benefits available to enrollees in a program. For programs in which the department provides for more than one type of program benefit, the department may require that enrollees, either as a whole or on an individual basis based on certain circumstances, use certain types of program benefits in lieu of using other types of program benefits.

(d) The department shall, as necessary to maintain expenditures for a program within the available funding for that program, set monetary limitations on the total benefit amounts available on a periodic basis for an enrollee through that program, whether that benefit is in the form of premium assistance, premium purchase, or a set of covered services.

(12) The benefits for a section 1115 waiver eligibility group may be in the form of a defined set of covered services consisting of one or more of the mandatory and optional medicaid state plan services specified in 53-6-101 or other health-care related services. The department may select the types of services that constitute a defined set of covered services for a section 1115 waiver eligibility group. The department may provide coverage of a service not specified in 53-6-101 if the department determines the service to be appropriate for the particular section 1115 waiver eligibility group. The department may define the nature, components, scope, amount, and duration of each covered service to be made available to a section 1115 waiver eligibility group. The nature, components, scope, amount, and duration of a covered service made available to a section 1115 waiver eligibility group need not conform to those aspects of that service as defined by the department for delivery as a covered service to another section 1115 waiver eligibility group or to a medicaid eligibility group that is not encompassed within a section 1115 waiver.

(13) The department may adopt financial participation requirements for enrollees in a section 1115 eligibility group to foster appropriate use among enrollees and to maintain the fiscal accountability of the program. The department may adopt financial participation requirements, including but not limited to copayments, payment of monthly or yearly enrollment fees, or deductibles. The requirements may vary among the section 1115 waiver eligibility groups. In adopting financial participation requirements for enrollees selecting coverage as provided in subsection (11)(b)(iv), the department may not adopt cost-sharing amounts that exceed the nominal deductible,

coinsurance, copayment, or similar charges adopted by the department to apply to categorically or medically needy persons for a service pursuant to the state medicaid plan.

(14) The department shall adopt rules as necessary for the implementation of a section 1115 waiver. Rules may include but are not limited to:

(a) designation of programs and activities for implementation of a section 1115 waiver;

(b) features and benefit coverage of the programs;

(c) the nature, components, scope, amount, and duration of each program service;

(d) appropriate insurance products and coverage as benefits;

(e) required enrollee eligibility information;

(f) enrollee eligibility categories, criteria, requirements, and related measures;

(g) limits upon enrollment;

(h) requirements and limitations for service costs and expenditures;

(i) measures to ensure the appropriateness and quality of services to be delivered;

(j) provider requirements and reimbursement;

(k) financial participation requirements for enrollees;

(l) use measures; and

(m) other appropriate provisions necessary for administration of a demonstration project and for implementation of the conditions placed upon approval of a section 1115 waiver by the U.S. department of health and human services.

(15) The department shall administer the programs and activities that are subject to a section 1115 waiver in accordance with the terms and conditions of approval by the U.S. department of health and human services. The department may modify aspects of established programs and activities administered by the department as may be necessary to implement a section 1115 waiver as provided in this section.

(16) The department may seek an initial duration and durational extensions for a section 1115 waiver as the department determines appropriate for demonstration and fiscal considerations.

(17) The department shall provide a report to the legislature, as provided in 5-11-210, on the conditions of approval and the status of implementation for each section 1115 waiver approved by the U.S. department of health and human services. For any proposed section 1115 waiver not approved by the U.S. department of health and human services, the department shall provide to the next legislative session a report on the basis for

disapproval and an analysis of the fiscal costs and programmatic impacts of serving the persons within the proposed section 1115 waiver eligibility groups through eligibility under one of the optional medicaid eligibility categories established in federal law and authorized by 53-6-131.

(18) The department shall present a section 1115 waiver proposal to the appropriate medicaid advisory council, which must include consumer advocates, prior to the submission of the proposal to the federal government.

(19) The department shall present a section 1115 waiver proposal to the house appropriations committee or, during the interim, the children, families, health, and human services interim committee for review and comment at a public hearing prior to the submission of the proposal to the federal government for formal approval and shall also present the section 1115 waiver after final approval from the federal government.

(20) (a) The department shall provide for a public comment period on the proposed section 1115 waiver at least 60 days before the submission of the section 1115 waiver application to the federal government for formal approval.

(b) The department shall give notice of the proposal by announcing the pending submittal, stating its general purpose, and informing the public that information on the proposal is available on the department's website.

(c) The department shall provide for public comment through electronic means or mail and shall provide for a public forum in at least one location at which members of the public can submit views on the proposal. The department shall consider comments received and make any appropriate changes to the waiver request before submitting it to the federal government.

(d) The department shall post on its website the waiver concept paper, formal correspondence regarding a waiver proposal, and the final approved waiver, including documents received from the center for medicare and medicaid services."

Section 34. Section 53-4-1007, MCA, is amended to read:

"53-4-1007. (Temporary) Department may contract for services. (1) The department of public health and human services may administer the program directly or contract with insurance companies or other entities to provide services for a set monthly or yearly fee based on the number of participants in the program and the types of services provided or based on a fee for service as established by the department.

(2) The department of public health and human services may contract for a health care service based on a fee for service when the department does not contract for a health care service through an insurance plan, a health maintenance organization, or a managed care plan. A contract entered into or renewed on or after July 1, 2009, may not limit enrollee access to providers who are willing to provide services at the rates provided for under the program. In operating the program and providing health services, the department may:

(a) pay providers on a fee-for-service basis in a self-funded program and contract with an insurance company, third-party administrator, or other entity to provide administrative services, including but not limited to processing and payment of claims with program funds;

(b) purchase health coverage for eligible children from an insurance company or other entity through premiums, capitated payments, or other appropriate methods;

(c) purchase health coverage as provided in subsection (2)(b) for some types of health services and contract directly with providers for other types of health services on a fee-for-service basis; or

(d) pay providers on a fee-for-service basis and directly provide administrative services in a self-funded program.

(3) If the department of public health and human services contracts with an insurance company or other entity to administer the program as provided in subsection (2)(b) or (2)(c), not more than 12% of the contract payment may be used for administrative expenses, including:

~~(a) direct and indirect expenses as specified in 33-22-1514;~~

~~(b)~~(a) risk charges; and

~~(c)~~(b) any applicable assessments, fees, and taxes.

(4) If the department operates the program by providing administrative services under subsection (2)(a), (2)(c), or (2)(d), the department's administrative expense may not exceed the lesser of 10% of total program expenses or the applicable federal limitation, excluding costs for federally required audits.

(5) (a) An insurance company or other entity that contracts with the department for a fully insured contract as provided in subsection (2)(b) shall calculate the surplus account balance at the end of each contract year and may retain an amount equal to 50% of the risk charge allowed under the contract. The remainder of the surplus balance must be deposited in the state special revenue account provided for in 53-4-1012.

(b) For the purposes of this subsection (5):

(i) "risk charge" means the percentage of the administrative expense allowed in the contract for assuming

the risk; and

(ii) "surplus account balance" means funds that remain after all claims and all administrative expenses have been paid for a claim period. (Terminates on occurrence of contingency--sec. 15, Ch. 571, L. 1999; sec. 7, Ch. 565, L. 2005; sec. 5, Ch. 129, L. 2007.)"

Section 35. Repealer. (1) The following sections of the Montana Code Annotated are repealed:

33-2-1912. Applicability for 1995.

33-17-1003. Return of license.

33-18-214. Unfair referral as unfair trade practice.

33-22-166. Employer payment of employee individual disability coverage.

33-22-245. Uniform health benefit plan -- individual.

33-22-1511. Minimum benefits of association plan.

33-22-1512. Association plan and association portability plan premium.

33-22-1515. Solicitation of eligible persons.

33-22-1516. Enrollment by eligible person.

33-22-1517. Limitations on eligibility.

33-22-1518. Unfair referral to plan.

33-22-1521. Association plan -- minimum benefits.

33-22-1523. Association portability plans.

33-22-1524. Association authority for borrowing.

33-31-322. Uniform health benefit plan -- health maintenance organization.

(2) The following sections of the Montana Code Annotated are repealed:

33-22-1501. Definitions.

33-22-1502. Duties of commissioner -- rules.

33-22-1503. Comprehensive health association -- mandatory membership.

33-22-1504. Association board of directors -- organization -- duties.

33-22-1505. Liability of association membership.

33-22-1513. Operation of association plan and association portability plans.

33-22-1514. Administration of association plan -- rules.

Section 36. Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

Section 37. Effective dates. (1) Except as provided in subsection (2), [this act] is effective on passage and approval.

(2) [Sections 3, 19, 20, 22, 33, and 35(2)] are effective January 1, 2016.

- END -

I hereby certify that the within bill,

HB 0103, originated in the House.

Chief Clerk of the House

Speaker of the House

Signed this _____ day

of _____, 2015.

President of the Senate

Signed this _____ day

of _____, 2015.

HOUSE BILL NO. 103

INTRODUCED BY Z. BROWN

BY REQUEST OF THE STATE AUDITOR

AN ACT GENERALLY REVISING LAWS RELATED TO REGULATION BY THE STATE AUDITOR; MODIFYING DOCUMENTARY REQUIREMENTS FOR SECURITY REGISTRATION BY QUALIFICATION; CLARIFYING EMPLOYER ABILITY TO FUND EMPLOYEE INDIVIDUAL HEALTH INSURANCE POLICIES; CLARIFYING PROCESS FOR SHARING EXAMINATION REPORTS WITH GOVERNMENTAL ENTITIES; ALIGNING CONTESTED CASE TIMING WITH THE MONTANA ADMINISTRATIVE PROCEDURE ACT; MODIFYING RISK-BASED CAPITAL REQUIREMENTS; ESTABLISHING A FARM MUTUAL INSURER VOLUNTARY DISSOLUTION PROCESS; CLARIFYING DUTY OF GUARANTY ASSOCIATION FOR EXCESS WORKERS' COMPENSATION; CLARIFYING LIFE INSURANCE TIMELY SETTLEMENT DISCOUNT RATE; ADOPTING CERTIFICATION TERMINOLOGY FOR HEALTH SERVICE CORPORATIONS; PERMITTING MULTIPLE EMPLOYER WELFARE ARRANGEMENTS TO UTILIZE GENERALLY ACCEPTED ACCOUNTING PRINCIPLES FOR REPORTING PURPOSES; ELIMINATING THE REQUIREMENT FOR RETURN OF PAPER LICENSES BY CERTAIN LICENSEES; REVISING MONTANA COMPREHENSIVE HEALTH ASSOCIATION LAWS; AMENDING SECTIONS 15-30-2110, 17-6-606, 27-1-732, 30-10-205, 33-1-409, 33-1-701, 33-2-117, 33-2-708, 33-2-1902, 33-2-1904, 33-4-101, 33-7-117, 33-10-105, 33-17-1502, 33-20-114, 33-20-1603, 33-22-132, 33-22-138, 33-22-140, 33-22-142, 33-22-143, 33-22-706, 33-22-1501, 33-22-1502, 33-22-1504, 33-22-1513, 33-22-1804, 33-30-107, 33-30-108, 33-30-201, 33-30-204, 33-35-301, 53-2-215, AND 53-4-1007, MCA; REPEALING SECTIONS 33-2-1912, 33-17-1003, 33-18-214, 33-22-166, 33-22-245, 33-22-1501, 33-22-1502, 33-22-1503, 33-22-1504, 33-22-1505, 33-22-1511, 33-22-1512, 33-22-1513, 33-22-1514, 33-22-1515, 33-22-1516, 33-22-1517, 33-22-1518, 33-22-1521, 33-22-1523, 33-22-1524, AND 33-31-322, MCA; AND PROVIDING EFFECTIVE DATES.