AN ACT GENERALLY REVISING LAWS REGULATED BY THE COMMISSIONER OF SECURITIES AND INSURANCE, MONTANA STATE AUDITOR; REVISING DEFINITIONS; CLARIFYING LAWS RELATING TO STATE SCHOOL HEALTH TRUSTS THAT ARE APPROVED BY THE COMMISSIONER; REVISING LAWS RELATING TO REPLACEMENT VALUE AND BOOK VALUE; REMOVING A FEE PAID BY SECURITIES ISSUERS TO THE COMMISSIONER; REVISING SECURITIES LAWS RELATED TO STOCK EXCHANGES; REVISING SECURITIES REGISTRATION REQUIREMENTS; REVISING LAWS RELATING TO SECURITIES ACTIONS TO ALLOW AN ACTION TO BE FILED WITHIN 1 YEAR AFTER DISCOVERY; REVISING SECURITIES RESTITUTION FUND ELIGIBILITY; REVISING REGULATORY FILING LAWS; REVISING LAWS RELATING TO DOMESTIC SURPLUS LINES INSURERS; REVISING LAWS RELATING TO INTEREST OF NAMED INSURANCE LAWS AND TRANSFER; REVISING INSURANCE PRODUCER EXCHANGE TRAINING LAWS; REVISING LAWS RELATING TO INSURANCE INFORMATION AND PRIVACY PROTECTION; REVISING LAWS RELATING TO MEDICALLY NECESSARY AND CLINICALLY APPROPRIATE EXAMINATIONS; REVISING LAWS RELATING TO TELEHEALTH; REVISING LAWS RELATING TO RECIPROCAL LIMITATIONS; REVISING LAWS RELATING TO GRACE PERIODS AND NOTICE OF CLAIMS; REVISING LAWS RELATING TO DISCLOSURES BY AN INSURER; REVISING LAWS RELATING TO PAYMENT OF INTEREST BY A HEALTH INSURANCE ISSUER; REVISING LAWS APPLICABLE TO MULTIPLE EMPLOYER WELFARE ARRANGEMENTS; EXTENDING THE TERMINATION DATE OF THE PROHIBITION AGAINST A PHARMACY BENEFIT MANAGER OR HEALTH CARRIER REQUIRING FEDERALLY CERTIFIED HEALTH ENTITIES TO IDENTIFY 340B DRUGS; AMENDING SECTION 26, CHAPTER 501, LAWS OF 2021, AND SECTION 1, CHAPTER 259, LAWS OF 2023; AMENDING SECTIONS 2-18-101, 20-3-369, 27-1-306, 30-10-104, 30-10-201, 30-10-307, 30-10-1005, 33-1-501, 33-2-301, 33-2-306, 33-3-201, 33-17-237, 33-17-243, 33-17-1402, 33-19-105, 33-20-1302, 33-22-132, 33-22-138, 33-22-150, 33-22-206, 33-22-208, 33-22-244, 33-22-521, 33-22-906, 33-22-907, 33-22-921, 33-22-922, 33-22-923, 33-22-924, 33-32-211, AND 33-35-306, MCA; AND PROVIDING EFFECTIVE DATES.

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

Section 1. Section 2-18-101, MCA, is amended to read:

"**2-18-101. Definitions.** As used in parts 1 through 3 and part 10 of this chapter, the following definitions apply:

(1) "Agency" means a department, board, commission, office, bureau, institution, or unit of state government recognized in the state budget.

(2) "Base salary" means the base hourly pay rate annualized paid to an employee, excluding overtime and longevity.

(3) "Benchmark" means a representative position in a specific occupation that is used to illustrate the application of the job evaluation factor used to classify the occupation.

(4) "Blue-collar pay plan" means a strictly negotiated classification and pay plan consisting of unskilled or skilled labor, trades, and crafts occupations.

(5) "Board" means the board of personnel appeals established in 2-15-1705.

(6) "Broadband classification plan" means a job evaluation method that measures the difficulty of the work and the knowledge or skills required to perform the work.

(7) "Broadband pay plan" means a pay plan using a pay hierarchy of broad pay bands based on a classification plan, including market midpoint and occupational wage ranges.

(8) "Compensation" means the annual or hourly wage or salary and includes the longevity allowance provided in 2-18-304 and leave and holiday benefits provided in part 6 of this chapter.

(9) "Competencies" means sets of measurable and observable knowledge, skills, and behaviors that contribute to success in a position.

(10) "Department" means the department of administration created in 2-15-1001.

(11) (a) Except in 2-18-306, "employee" means any state employee other than an employee excepted under 2-18-103 or 2-18-104.

(b) The term does not include a student intern.

(12) "Job evaluation factor" means a measure of the complexities of the predominant duties of a

position.

(13) "Job sharing" means the sharing by two or more persons of a position.

(14) "Market midpoint" means the median base salary that other employers pay to employees in comparable occupations as determined by the department's salary survey of the relevant labor market.

(15) "Occupation" means a generalized family of positions having substantially similar duties and requiring similar qualifications, education, and experience.

(16) "Occupational wage range" means a range of pay, including a minimum, market midpoint, and maximum salary, for a specific occupation that is most consistent with the pay being offered by competing employers for fully competent employees within that occupation. The salary for an employee may be less than the minimum salary.

(17) "Pay band" means a wide salary range covering a number of different occupations. Pay bands are used for reporting and analysis purposes only.

(18) "Pay progression" means a process by which an employee's compensation may be increased, based on documented factors determined by the department, to bring the employee's compensation to a higher rate within the occupational wage range of the employee.

(19) "Permanent employee" means an employee who is designated by an agency as permanent, who was hired through a competitive selection process unless excepted from the competitive process by law, and who has attained or is eligible to attain permanent status.

(20) "Permanent status" means the state an employee attains after satisfactorily completing an appropriate probationary period.

(21) "Personal staff" means those positions occupied by employees appointed by the elected officials enumerated in Article VI, section 1, of the Montana constitution or by the public service commission as a whole, by each director appointed by the governor as provided in 2-15-111(1), or by each division administrator, or equivalent, appointed by the elected officials enumerated in Article VI, section 1, of the Montana constitution.

(22) "Position" means a collection of duties and responsibilities currently assigned or delegated by competent authority, requiring the full-time, part-time, or intermittent employment of one person.

(23) "Program" means a combination of planned efforts to provide a service.

(24) "Seasonal employee" means a permanent employee who is designated by an agency as seasonal, who performs duties interrupted by the seasons, and who may be recalled without the loss of rights or benefits accrued during the preceding season.

(25) "Short-term worker" means a person who:

(a) may be hired by an agency without using a competitive hiring process for an hourly wage established by the agency;

(b) may not work for the agency for more than 90 days in a continuous 12-month period;

(c) is not eligible for permanent status;

(d) may not be hired into a permanent position by the agency without a competitive selection process;

(e) is not eligible to earn the leave and holiday benefits provided in part 6 of this chapter; and

(f) may be discharged without cause.

(26) "Student intern" means a person who:

(a) has been accepted in or is currently enrolled in an accredited school, college, or university and may be hired by an agency in a student intern position without using a competitive selection process;

(b) is not eligible for permanent status;

(c) is not eligible to become a permanent employee without a competitive selection process;

(d) must be covered by the hiring agency's workers' compensation insurance;

(e) is not eligible to earn the leave and holiday benefits provided for in part 6 of this chapter; and

(f) may be discharged without cause.

(27) (a) "Telework" means a flexible work arrangement in which a designated employee may work from:

(i) home within the state of Montana or an alternative worksite within the state of Montana 1 or more days a week instead of physically traveling to a central workplace; or

(ii) an alternative worksite outside the state of Montana limited to:

(A) employees who are mental health professionals as defined in 27-1-1101 involved in psychological or psychiatric evaluations and treatment;

(B) employees engaged in providing services related to information technology resources as

defined in 2-17-506;

(C) employees who are medical professionals involved in medical evaluations and treatment; ~~or~~

(D) employees who are engaged in providing services related to economic development outside the state and whose work duties require the employees to reside out of state; or

(E) employees who are associates or fellows of the casualty actuarial society or society of actuaries.

(b) The office of budget and program planning must approve a designated employee's alternative worksite outside the state of Montana before the employee begins work.

(28) "Temporary employee" means an employee who:

(a) is designated as temporary by an agency for a definite period of time not to exceed 12 months;

(b) performs duties on a temporary basis;

(c) is not eligible for permanent status;

(d) is terminated at the end of the employment period; and

(e) is not eligible to become a permanent employee without a competitive selection process."

Section 2. Section 20-3-369, MCA, is amended to read:

"**20-3-369. State school health trust operating reserve account -- distribution and uses.** (1) There is a state school health trust operating reserve account in the state special revenue fund provided for in 17-2-102. The purpose of the account is to provide a one-time-only distribution of incentive funding to the first self-funded district health insurance trust that is qualified by the state auditor pursuant to 20-3-366.

(2) The state school health trust operating reserve account is statutorily appropriated, as provided in 17-7-502, to the office of public instruction for distribution as provided in this section.

(3) If a trust has been qualified by the state auditor on or before June 30, 2026, for initial operation beginning July 1, 2026, the superintendent shall, on July 1, 2026, or on qualification by the state auditor, distribute $40 million to the district health insurance trust. The qualifying district health insurance trust shall use the funds to stabilize health insurance costs through capitalization of an operating reserve for the district members of the trust.

(4) If a trust has not been qualified by June 30, 2026, the account balance must be transferred to

the capital developments long-range building program account for uses consistent with 17-7-209."

Section 3. Section 27-1-306, MCA, is amended to read:

"**27-1-306. When replacement value to be allowed.** The measure of damages in a case in which the cost of repairing a motor vehicle exceeds its value is the actual replacement value of the motor vehicle rather than its "book" value unless, after the damages arise, the parties agree to use the "book" value. "Book" value must be determined by referring to the most recent ~~volume of the Mountain States Edition of the National Automobile Dealers Association (N.A.D.A.) Official Used Car Guide or the National Edition of N.A.D.A. Appraisal Guides Official Older Used Car Guide~~ used car value and pricing information published by an organization nationally recognized for providing information related to used car value and pricing. Actual replacement value is the actual cash value of the motor vehicle immediately prior to the damage. "Book" value may be used to assist in determining the actual replacement value of the motor vehicle."

Section 4. Section 30-10-104, MCA, is amended to read:

"**30-10-104. Exempt securities.** Sections 30-10-202 through 30-10-207 and 30-10-211 do not apply to any of the following securities:

(1) any security, including a revenue obligation, issued or guaranteed by the United States, any state, any political subdivision of a state, or any agency or corporate or other instrumentality of one or more of those entities. However, 30-10-202 through 30-10-207 and 30-10-211 apply to a security issued by any of those entities that is payable solely from payments to be received in respect to property or money used under a lease, sale, or loan arrangement by or for a nongovernmental industrial or commercial enterprise unless the enterprise or any security of which it is the issuer is within any of the exemptions listed in subsections (2) through (15).

(2) any security issued or guaranteed by Canada, a Canadian province, a political subdivision of a province, or an agency or corporate or other instrumentality of one or more of those entities or any other foreign government with which the United States currently maintains diplomatic relations if the security is recognized as a valid obligation by the issuer or guarantor;

(3) any security issued by and representing an interest in or a debt of or guaranteed by a bank organized under the laws of the United States or a bank, savings institution, or trust company organized and

supervised under the laws of any state;

(4) any security issued by and representing an interest in, or a debt of, or guaranteed by a federal savings and loan association or a building and loan or similar association organized under the laws of any state and authorized to do business in this state;

(5) any security issued or guaranteed by a federal credit union or a credit union, industrial loan association, or similar association organized and supervised under the laws of this state;

(6) any security issued or guaranteed by a railroad, other common carrier, public utility, or holding company that is:

(a) subject to the jurisdiction of the federal surface transportation board;

(b) a registered holding company under the Energy Policy Act of 2005 or a subsidiary of a registered holding company within the meaning of that act;

(c) regulated in respect of its rates and charges by a governmental authority of the United States or any state or municipality; or

(d) regulated in respect to the issuance or guarantee of the security by a governmental authority of the United States, any state, Canada, or any Canadian province. A security referred to under this subsection (6)(d) includes equipment trust certificates in respect to equipment conditionally sold or leased to a railroad or public utility if other securities issued by the railroad or public utility would be exempt under this subsection (6)(d).

(7) any security that meets all of the following conditions:

(a) if the issuer is not organized under the laws of the United States or a state, it has appointed an authorized agent in the United States for service of process and has set forth the name and address of the agent in its prospectus;

(b) a class of the issuer's securities is required to be and is registered under section 12 of the Securities Exchange Act of 1934 and has been registered for the 3 years immediately preceding the offering date;

(c) the issuer or a significant subsidiary has not had a material default during the last 7 years, or during the issuer's existence if that period is less than 7 years, in the payment of:

(i) principal, interest, dividend, or sinking fund installment on preferred stock or indebtedness for

borrowed money; or

(ii) rentals under leases with terms of 3 years or more;

(d) the issuer has had consolidated net income, before extraordinary items and the cumulative effect of accounting changes, of at least $1 million in 4 of its last 5 fiscal years, including its last fiscal year, and if the offering is of interest-bearing securities, has had for its last fiscal year consolidated net income, before deduction for income taxes and depreciation, of at least 1 1/2 times the issuer's annual interest expense, giving effect to the proposed offering and the intended use of the proceeds. "Last fiscal year", as used in this subsection (7)(d), means the most recent year for which audited financial statements are available provided that the statements cover a fiscal period that ended not more than 15 months from the commencement of the offering.

(e) if the offering is of stock or shares, other than preferred stock or shares, the securities have voting rights and rights including the right to have at least as many votes per share and the right to vote on at least as many general corporate decisions as each of the issuer's outstanding classes of stock or shares except as otherwise required by law;

(f) if the offering is of stock or shares, other than preferred stock or shares, the securities are owned beneficially or of record on any date within 6 months prior to the commencement of the offering by at least 1,200 persons and on that date there are at least 750,000 of the shares outstanding with an aggregate market value, based on the average bid price for that day, of at least $3,750,000. In connection with the determination of the number of persons who are beneficial owners of the stock or shares of an issuer, the issuer or broker-dealer may rely in good faith for the purposes of this section upon written information furnished by the record owners.

(8) any security issued by a person organized and operated not for private profit but exclusively for religious, educational, benevolent, charitable, fraternal, social, athletic, or reformatory purposes ~~if the issuer pays a fee of $50 and files with the commissioner 20 days prior to the offering a written notice specifying the terms of the offer and the commissioner does not disallow the exemption in writing within the 20-day period~~;

(9) any commercial paper that arises out of a current transaction or the proceeds of which have been or are to be used for the current transaction and that evidences an obligation to pay cash within 9 months of the date of issuance, exclusive of days of grace, or any renewal of the paper that is likewise limited or any

guarantee of the paper or of any renewal when the commercial paper is sold to banks or insurance companies;

(10) any investment contract issued in connection with an employee's stock purchase, savings, pension, profit-sharing, or similar benefit plan;

(11) any security for which the commissioner determines by order that an exemption would better serve the purposes of 30-10-102 than would registration. The fee for this exemption must be as prescribed in 30-10-209(4).

(12) any security listed or approved for listing ~~upon notice of issuance on the New York stock exchange, the American stock exchange, the Pacific stock exchange, the Midwest stock exchange, the Chicago board of options exchange, the Philadelphia stock exchange, the Boston stock exchange, or any other~~ on a stock exchange registered with the federal securities and exchange commission ~~and approved by the commissioner~~, any other security of the same issuer that is of senior or substantially equal rank, any security called for by subscription rights or warrants listed or approved for listing as provided in this subsection, or any warrant or right to purchase or subscribe to any of the securities listed in this subsection. The commissioner may by rule or order limit, restrict, or otherwise condition the terms under which any security may be exempt under this subsection.

(13) any national market system security listed or approved for listing upon notice of issuance on the national association of securities dealers automated quotation system or any other national quotation system approved by the commissioner, any other security of the same issuer that is of senior or substantially equal rank, any security called for by subscription rights or warrants listed or approved for listing as provided in this subsection, or any warrant or right to purchase or subscribe to any of the securities listed in this subsection. The commissioner may by rule or order limit, restrict, or otherwise condition the terms under which any security may be exempt under this subsection.

(14) any security issued by and representing an interest in, or a debt of, or any security guaranteed by any insurer organized and authorized to transact business under the laws of any state;

(15) any security for which an offer or sale is not directed to or received by a person in this state when the issuer does not maintain a place of business in the state."

Section 5. Section 30-10-201, MCA, is amended to read:

"**30-10-201. Registration and notice filing requirements of broker-dealers, salespersons, investment advisers, and investment adviser representatives.** (1) It is unlawful for a person to transact business in this state as a broker-dealer or salesperson, except as provided in 30-10-105, unless the person is registered under parts 1 through 3 of this chapter.

(2) It is unlawful for a broker-dealer or issuer to employ a salesperson to represent the broker-dealer or issuer in this state, except in transactions exempt under 30-10-105, unless the salesperson is registered under parts 1 through 3 of this chapter.

(3) It is unlawful for a person to transact business in this state as an investment adviser or as an investment adviser representative unless:

(a) the person is registered under parts 1 through 3 of this chapter;

(b) the person does not have a place of business in the state and the person's only clients in this state are:

(i) investment companies, as defined in the Investment Company Act of 1940, or insurance companies;

(ii) other investment advisers;

(iii) federal covered advisers;

(iv) broker-dealers;

(v) banks;

(vi) trust companies;

(vii) savings and loan associations;

(viii) employee benefit plans with assets of not less than $1 million;

(ix) governmental agencies or instrumentalities, whether acting for themselves or as trustees with investment control; or

(x) other institutional investors as designated by rule or order of the commissioner; or

(c) the person does not have a place of business in this state and, during the preceding 12-month period, the person has not had more than five clients who are residents of this state, other than those clients specified in subsection (3)(b). This subsection (3)(c) also applies to broker-dealers and investment advisers.

(4) Except for federal covered advisers whose only clients are clients listed in subsection (3)(b) or

who meet the requirements of subsection (3)(c), it is unlawful for a federal covered adviser to conduct advisory business in this state unless the federal covered adviser complies with the provisions of subsection (6)(b).

(5) (a) It is unlawful for a person required to be registered as an investment adviser under Title 30, chapter 10, parts 1 through 3, to employ an investment adviser representative unless the investment adviser representative is registered or exempt from registration under Title 30, chapter 10, parts 1 through 3.

(b) It is unlawful for a federal covered adviser to employ, supervise, or associate with an investment adviser representative who maintains a place of business in this state unless the investment adviser representative is registered or exempt from registration under Title 30, chapter 10, parts 1 through 3.

(6) (a) A broker-dealer or a salesperson, acting as an agent for an issuer or as an agent for a broker-dealer in the offer or sale of securities for an issuer, or an investment adviser or investment adviser representative may apply for registration by filing an application in the form that the commissioner prescribes and payment of the fee prescribed in 30-10-209.

(b) Except for a federal covered adviser whose only clients are those listed in subsection (3)(b) or who meet the requirements of subsection (3)(c), a federal covered adviser shall, prior to acting as a federal covered adviser in this state, submit a notice filing to the commissioner consisting of the fee prescribed in 30-10-209 and copies of any documents filed with the securities and exchange commission that the commissioner requires by rule or order. A notice filing is effective upon its receipt by the commissioner.

(7) The application must contain whatever information the commissioner requires. A registration application of a broker-dealer, salesperson, investment adviser, or investment adviser representative may not be withdrawn before the commissioner approves or denies the registration, without the express written consent of the commissioner.

(8) When the registration requirements are met, the commissioner shall make the registration effective. An effective registration of a broker-dealer, salesperson, investment adviser, or investment adviser representative may not be withdrawn or terminated without the express written consent of the commissioner.

(9) Registration of a broker-dealer, salesperson, investment adviser, or investment adviser representative or a notice filing by a federal covered adviser:

(a) is effective until December 31 following the registration or notice filing or any other time as the commissioner may by rule adopt; and

(b) may be renewed pursuant to subsection (11).

(10) (a) The registration of a salesperson is not effective during any period when the salesperson is not associated with an issuer or a registered broker-dealer specified in the application. When a salesperson begins or terminates a connection with an issuer or registered broker-dealer, the salesperson and the issuer or broker-dealer shall promptly notify the commissioner.

(b) The registration of an investment adviser representative is not effective during any period when the person is not associated with either an investment adviser registered under this act or a federal covered adviser with an effective notice filing who is specified in the application. When an investment adviser representative begins or terminates a connection with an investment adviser, the investment adviser shall promptly notify the commissioner. When an investment adviser representative begins or terminates a connection with a federal covered adviser, the investment adviser representative shall promptly notify the commissioner.

(11) Registration of a broker-dealer, salesperson, investment adviser, or investment adviser representative or notice filing for a federal covered adviser may be renewed by filing, prior to the expiration of the registration or notice filing, an application containing information as the commissioner may require to indicate any material change in the information contained in the original application or any renewal application for registration or notice filing, and payment of the fee prescribed by 30-10-209. A broker-dealer who is not a member of the national association of securities dealers, inc., is required to file a financial statement of the broker-dealer within 90 days of the end of the broker-dealer's fiscal year, except as provided in section 15 of the Securities Exchange Act of 1934. A registered broker-dealer or investment adviser may file an application for registration of a successor, to become effective upon approval of the commissioner.

(12) (a) Except as provided in section 15 of the Securities Exchange Act of 1934 in the case of a broker-dealer and section 222 of the Investment Advisers Act of 1940 in the case of an investment adviser, every registered broker-dealer and investment adviser shall make and keep accounts and other records, except with respect to securities exempt under 30-10-104(1), as may be prescribed by the commissioner by rule or order. All required records of an investment adviser must be preserved for the period the commissioner prescribes by rule or order. All the records of a registered broker-dealer or investment adviser are subject at any time or from time to time to reasonable periodic, special, or other examinations, within or outside this state,

by representatives of the commissioner, as the commissioner considers necessary or appropriate in the public interest or for the protection of investors.

(b) The commissioner may require investment advisers who are registered or required to be registered to furnish or disseminate certain information as necessary or appropriate in the public interest or for the protection of investors and advisory clients.

(c) If information contained in any document filed with the commissioner is, or becomes, inaccurate or incomplete in any material respect, the registrant or federal covered adviser shall promptly file a correcting amendment.

(13) The commissioner may by order deny, suspend, or revoke registration of any broker-dealer, salesperson, investment adviser, or investment adviser representative if the commissioner finds that the order is in the public interest and that the applicant or registrant or, in the case of a broker-dealer or investment adviser, any partner, officer, director, person occupying a similar status or performing similar functions, or person directly or indirectly controlling the broker-dealer or investment adviser:

(a) has filed an application for registration under this section that, as of its effective date or as of any date after filing in the case of an order denying effectiveness, was incomplete in any material respect or contained any statement that was, in light of the circumstances under which it was made, false or misleading with respect to any material fact;

(b) has willfully violated or willfully failed to comply with any provision of parts 1 through 3 of this chapter or a predecessor law or any rule or order under parts 1 through 3 of this chapter or a predecessor law;

(c) has been convicted of any misdemeanor involving a security or any aspect of the securities business or any felony;

(d) is permanently or temporarily enjoined by any court of competent jurisdiction from engaging in or continuing any conduct or practice involving any aspect of the securities business;

(e) is the subject of an order of the commissioner denying, suspending, or revoking registration as a broker-dealer, salesperson, investment adviser, or investment adviser representative;

(f) is the subject of an adjudication or determination, within the past 5 years, by a securities or commodities agency or administrator of another state or a court of competent jurisdiction, that the person has violated the Securities Act of 1933, the Securities Exchange Act of 1934, the Investment Advisors Act of 1940,

the Investment Company Act of 1940, or the Commodity Exchange Act or the securities or commodities law of any other state;

(g) has engaged in dishonest or unethical practices in the securities business;

(h) is insolvent, either in the sense that the person's liabilities exceed the person's assets or in the sense that the person cannot meet obligations as they mature, but the commissioner may not enter an order against a broker-dealer or investment adviser under this subsection (13) without a finding of insolvency as to the broker-dealer or investment adviser;

(i) has not complied with a condition imposed by the commissioner under this section or is not qualified on the basis of such factors as training, experience, or knowledge of the securities business;

(j) has failed to pay the proper filing fee, but the commissioner may enter only a denial order under this subsection (13), and the commissioner shall vacate any order when the deficiency has been corrected; or

(k) has failed to reasonably supervise the person's salespersons or employees or investment adviser representatives or employees to ensure their compliance with this act.

(14) The commissioner may not institute a suspension or revocation proceeding on the basis of a fact or transaction known to the commissioner when registration became effective unless the proceeding is instituted within ~~30~~ 90 days after the date on which the registration became effective.

(15) The commissioner may by order summarily postpone or suspend registration pending final determination of any proceeding under this section.

(16) Upon the entry of the order under subsection (13), the commissioner shall promptly notify the applicant or registrant, as well as the employer or prospective employer if the applicant or registrant is a salesperson or investment adviser representative, that it has been entered and of the reasons for the order and that if requested by the applicant or registrant within 15 days after the receipt of the commissioner's notification, the matter will be promptly set for hearing. If a hearing is not requested within 15 days and none is ordered by the commissioner, the order will remain in effect until it is modified or vacated by the commissioner. If a hearing is requested or ordered, the commissioner, after notice of and opportunity for hearing, may modify or vacate the order or extend it until final determination.

(17) If the commissioner finds that a registrant or applicant for registration is no longer in existence

or has ceased to do business as a broker-dealer, salesperson, investment adviser, or investment adviser representative or is subject to an adjudication of mental incompetence or to the control of a committee, conservator, or guardian or cannot be located after reasonable search, the commissioner may by order cancel the registration or application.

(18) The commissioner may, after suspending or revoking registration of any broker-dealer, salesperson, investment adviser, or investment adviser representative, impose a fine not to exceed $5,000 upon the broker-dealer, salesperson, investment adviser, or investment adviser representative. The fine is in addition to all other penalties imposed by the laws of this state and must be collected by the commissioner in the name of the state of Montana and deposited in the general fund. Imposition of any fine under this subsection is an order from which an appeal may be taken pursuant to 30-10-308. If any broker-dealer, salesperson, investment adviser, or investment adviser representative fails to pay a fine referred to in this subsection, the amount of the fine is a lien upon all of the assets and property of the broker-dealer, salesperson, investment adviser, or investment adviser representative in this state and may be recovered by suit by the commissioner and deposited in the general fund. Failure of a broker-dealer, salesperson, investment adviser, or investment adviser representative to pay a fine also constitutes a forfeiture of the right to do business in this state under parts 1 through 3 of this chapter.

(19) A sole proprietor registered as a broker-dealer or investment adviser who does not employ other salespersons or investment adviser representatives, other than the sole proprietor, is not required to register as both a broker-dealer and a salesperson or as an investment adviser and an investment adviser representative if the sole proprietor meets the examination requirements established by the commissioner by rule.

(20) A person who is subject to the provisions of this section and who has passed the general securities principal's examination is not required to also pass the uniform investment adviser law examination. The commissioner shall by rule provide for a form that a person who passes the general securities principal's examination shall file with the commissioner as a verification of having passed the examination unless the commissioner can verify electronically that the person has passed the exam."

Section 6. Section 30-10-307, MCA, is amended to read:

"**30-10-307. Civil liabilities -- limitations on actions.** (1) Any person who offers or sells a security in violation of 30-10-202 or offers or sells a security by means of fraud or misrepresentation is liable to the person buying the security from the offeror or seller, who may sue either at law or in equity to recover the consideration paid for the security, together with interest at 10% a year from the date of payment, costs, and reasonable attorneys' fees, less the amount of any income received on the security, upon the tender of the security, or for damages if the buyer no longer owns the security. Damages are the amount that would be recoverable upon a tender less:

(a) the value of the security when the buyer disposed of it; and

(b) interest at 10% a year from the date of disposition.

(2) Every person who directly or indirectly controls a seller liable under subsection (1), every partner, officer, or director (or person occupying a similar status or performing similar functions) or employee of the seller, and every broker-dealer or salesperson who participates or materially aids in the sale is liable jointly and severally with and to the same extent as the seller if the nonseller knew, or in the exercise of reasonable care could have known, of the existence of the facts by reason of which the liability is alleged to exist. There must be contribution among the several liable persons.

(3) Any tender specified in this section may be made at any time before entry of judgment. A cause of action under this statute survives the death of any person who might have been a plaintiff or a defendant. A person may not sue under this section if:

(a) the buyer has received a written offer, at a time when the buyer owned the security, to refund the consideration paid, together with interest at 10% a year from the date of payment, less the amount of any income received on the security and the buyer failed to accept the offer within 30 days of its receipt; or

(b) the buyer has received a written offer at a time when the buyer did not own the security in the amount that would be recoverable under subsection (1) upon a tender less:

(i) the value of the security when the buyer disposed of it; and

(ii) interest at 10% a year from the date of disposition.

(4) A person who has made or engaged in the performance of any contract in violation of any provision of parts 1 through 3 of this chapter or any rule or order under parts 1 through 3 of this chapter or who has acquired any purported right under the contract with knowledge of the facts by reason of which its making

or performance was in violation may not base any suit on the contract. Any condition, stipulation, or provision binding any person acquiring any security to waive compliance with any provision of parts 1 through 3 of this chapter or any rule or order adopted under parts 1 through 3 of this chapter is void as against public policy and in the public interest.

(5) (a) An action may not be maintained under this section to enforce any liability founded on a violation of 30-10-202 unless it is brought within ~~2 years after the violation occurs~~ 1 year after discovery of the violation or after the discovery should have been made by exercise of reasonable diligence.

(b) An action may not be maintained under this section to enforce any liability founded on fraud or misrepresentation unless it is brought within 2 years after discovery of the fraud or misrepresentation on which the liability is founded or after the discovery should have been made by the exercise of reasonable diligence.

(c) An action may not be maintained under this section to enforce any liability founded on fraud or misrepresentation unless it is brought within 5 years after the transaction on which the action is based."

Section 7. Section 30-10-1005, MCA, is amended to read:

"**30-10-1005. (Temporary) Eligibility.** (1) The following victims are eligible for restitution assistance:

(a) a natural person who is a resident of Montana at the time the offense is committed; or

(b) a person, other than a natural person, domiciled in Montana at the time the offense is committed.

(2) The commissioner may not award securities restitution assistance under this part:

(a) to more than one claimant per victim;

(b) unless the person ordered to pay restitution has not paid the full amount of restitution owed to the victim before the application for restitution assistance from the fund is due; or

(c) if there was no award of restitution in the final order.

(3) If an award of restitution in a final order is overturned on appeal, the commissioner may not award restitution assistance under this part.

(4) If, after the commissioner has made a securities restitution assistance award from the fund under this part, the restitution award in the final order is overturned on appeal and all legal remedies have been exhausted, the claimant shall forfeit the restitution assistance awarded under this part. (Terminates June 30,

2027--secs. 3, 4, Ch. 404, L. 2021.)"

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

"**33-1-501. Filing of forms -- approval -- review of disapproval or withdrawal of approval -- application.** (1) (a) An insurance policy or annuity contract form, certificate, enrollment form, application form, printed rider or endorsement form, or form of renewal certificate may not be delivered or issued for delivery in Montana unless the form and, for the purposes of disability insurance, an outline of coverage as required by 33-22-244 and 33-22-521 have been filed with and approved by the commissioner and, if required, the regulatory official of the state of domicile of the insurer or the interstate insurance product regulation commission provided for in 33-39-101. This provision does not apply to surety bonds or policies, riders, endorsements, or forms of unique character designed for and used with relation to insurance upon a particular subject or that relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or disability insurance policies and are used at the request of the individual policyholder, contract holder, or certificate holder. Forms for use in property, marine, other than ocean marine and foreign trade coverages, casualty, and surety insurance coverages may be filed by a rating organization on behalf of its members and subscribers or by a member or subscriber on its own behalf.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) reinsurance;

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

(c) ocean marine and foreign trade insurances.

(10) Except as provided in chapter 21, group certificates that are delivered or issued for delivery in Montana for group insurance policies effectuated and delivered outside Montana but covering persons resident in Montana must be filed with the commissioner ~~upon request~~. The certificates must meet the minimum provisions mandated by Montana if Montana law prevails over conflicting provisions of other state law."

Section 9. Designation as a domestic surplus lines insurer -- requirements -- scope of business activity permitted. (1) A domestic insurer possessing minimum capital and surplus of at least $15 million, pursuant to a resolution by its board of directors and on the written approval of the commissioner, may be designated as a domestic surplus lines insurer. A domestic surplus lines insurer must be considered an unauthorized insurer only for the purposes of writing surplus lines insurance coverage pursuant to the requirements of this section.

(2) A domestic surplus lines insurer shall only write surplus lines insurance in this state procured pursuant to the requirements of this 33-2-324 title. A domestic surplus lines insurer may write surplus lines insurance in any other jurisdiction in which the insurer is eligible to write surplus lines insurance if the domestic

surplus lines insurer complies with any requirements of that jurisdiction.

(3) Insurance written by a domestic surplus lines insurer is subject to the tax on premiums required by 33-2-311 and is exempt from the tax on premiums required by 33-2-705.

(4) A domestic surplus lines insurer must be considered a nonadmitted insurer as referenced in 15 U.S.C. 8206 with respect to surplus lines insurance issued in this state.

(5) Surplus lines insurance policies issued in this state by a domestic surplus lines insurer are not subject to the protection or other provisions of the Montana Insurance Guaranty Association Act, Title 33, chapter 10, part 1.

(6) Surplus lines insurance policies issued in this state by a domestic surplus lines insurer are not subject to and are exempt from all statutory requirements relating to insurance rating and rating plans, policy forms, and policy cancellation and nonrenewal in the same manner and to the same extent as a surplus lines insurer domiciled in another state.

Section 10. Section 33-2-301, MCA, is amended to read:

"**33-2-301. Short title -- purpose -- definitions.** (1) This part constitutes and may be referred to as "The Surplus Lines Insurance Law".

(2) The purpose of this part is to:

(a) protect persons seeking insurance in this state;

(b) permit surplus lines insurance to be placed with reputable and financially sound unauthorized insurers and, except with a domestic surplus lines insurer, to be exported from this state pursuant to this part;

(c) establish a system of regulation that will permit orderly access to surplus lines insurance in this state and encourage unauthorized insurers to provide new and innovative types of insurance to consumers in this state; and

(d) protect revenues of this state.

(3) As used in this part, the following definitions apply:

(a) "Affiliated" means that a person directly or indirectly controls, is controlled by, or is under common control with the insured.

(b) "Affiliated group" means any group of persons that are affiliated.

(c) "Approved risk list" means the list approved by the commissioner of the kinds of insurance presumed unobtainable from authorized insurers when Montana is the home state of the insured.

(d) "Authorized insurer" means an insurer authorized pursuant to 33-2-101 to transact insurance in this state.

(e) (i) "Business entity" means a corporation, a limited liability company, an association, a partnership, a limited liability partnership, or other legal entity.

(ii) The term does not include an individual.

(f) "Control", including the terms "controlled by" and "under common control with", means that:

(i) the person directly or indirectly or acting through one or more other persons owns, controls, or has the power to vote 25% or more of any class of voting securities of a business entity; or

(ii) the person controls in any manner the election of a majority of the directors or trustees of a business entity.

(g) (i) "Disability income insurance" has the meaning provided in 33-1-235 for:

(A) individuals employed in professional sports or the entertainment industry; or

(B) a business entity insuring a principal to cover liability or provide assurance for the business entity's loans or contracts.

(ii) Disability income insurance sold on the surplus lines market must be unavailable from or limited by an authorized insurer.

(h) "Eligible surplus lines insurer" means an unauthorized insurer that is eligible to issue surplus lines insurance under 33-2-307.

(i) "Exempt commercial purchaser" has the meaning provided in 33-2-318.

(j) "Export" means to place surplus lines insurance with an unauthorized insurer.

(k) "Home state" means, with respect to an insured:

(i) the state in which the insured maintains its principal place of business or, in the case of an individual, the individual's principal residence;

(ii) if 100% of the insured risk is located outside the state referred to in subsection (3)(k)(i), the state with the greatest allocated percentage of the insured's taxable premium for that surplus lines insurance contract;

(iii) if more than one insured from an affiliated group are named insureds on a single surplus lines insurance contract, the home state as determined under subsection (3)(k)(i) or (3)(k)(ii) for the member of the affiliated group that has the largest percentage of premium attributed to it under the surplus lines insurance contract; or

(iv) if a group policyholder pays 100% of the premium from its own funds, the home state of the group policyholder as determined under subsection (3)(k)(i) or, if a group policyholder does not pay 100% of the premiums from its own funds, the home state of the group member as determined under subsection (3)(k)(i).

(l) "Independently procured insurance" means surplus lines insurance procured directly by an insured from an eligible surplus lines insurer.

(m) "Multistate risk" means a risk covered by an unauthorized insurer with insured exposures in more than one state.

(n) "Natural disaster multiperil insurance" means any combination of flood, earthquake, and landslide insurance that may be sold as surplus lines insurance.

(o) "Principal place of business" means the state where the insured business maintains its headquarters and where the insured's high-level officers direct, control, and coordinate the business activities of the insured.

(p) "Principal residence" means the state where an individual insured resides for the greatest number of days during a calendar year or, if the insured's principal residence is located outside of any state, the state to which the greatest percentage of the insured's taxable premium for that insurance contract is located.

(q) "Producing insurance producer" means a Montana-licensed property and casualty insurance producer dealing directly with a person seeking insurance.

(r) "Qualified risk manager" has the meaning provided in 33-2-319.

(s) "Single-state risk" means a risk covered by an unauthorized insurer with exposures in only one state.

(t) "State" means any state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Northern Mariana Islands, the Virgin Islands, and American Samoa.

(u) (i) "Surplus lines insurance" means any property, casualty, or inland marine insurance permitted in a state to be placed directly or through a surplus lines insurance producer with an unauthorized

insurer eligible to accept the insurance. The term includes independently procured insurance.

(ii) The term does not include the kinds of insurance exempted under 33-2-317.

(v) "Surplus lines insurance producer" means an individual or business entity licensed under 33-2-305 to place surplus lines insurance on risks resident, located, or to be performed in this state with unauthorized insurers eligible to accept the insurance.

(w) "Unauthorized insurer" means, with respect to a state, an insurer not authorized to transact the business of insurance in the state. The term includes an insurance exchange authorized under the laws of another state. The term does not include a risk retention group, as that term is defined in the Liability Risk Retention Act of 1986, 15 U.S.C. 3901(a)(4)."

Section 11. Section 33-2-306, MCA, is amended to read:

"**33-2-306. Surplus lines insurance producer's authority under license -- acceptance of business from other insurance producers.** (1) Under a surplus lines insurance producer's license, the licensee may place surplus lines insurance, in compliance with this part, with a domestic surplus lines insurer or a foreign or alien insurer not authorized to transact insurance in this state and may act as a surplus lines insurance producer in this state for the insurer.

(2) The surplus lines insurance producer may accept surplus lines insurance from a licensed insurance producer of an authorized insurer or, if the commissioner agrees in advance, through an individual or business entity that has not been appointed as an insurance producer in this state and may provide compensation for the service, notwithstanding 33-17-1103.

(3) A surplus lines insurance producer who places or renews surplus lines insurance in accordance with subsection (1) may collect an inspection fee for the actual costs of inspecting the risk to be covered."

Section 12. Section 33-3-201, MCA, is amended to read:

"**33-3-201. Incorporation.** (1) This section applies to stock and mutual insurers incorporated in this state.

(2) Five or more individuals, none of whom are less than 18 years of age, may incorporate a stock

insurer. Ten or more individuals, none of whom are less than 18 years of age, may incorporate a mutual insurer. At least a majority of the incorporators must be citizens of the United States. At least a majority of the incorporators must be residents of this state.

(3) The incorporators shall execute articles of incorporation ~~and acknowledge their execution in the same manner as provided by law for the acknowledgment of deeds~~. The articles of incorporation must state the purpose for which the corporation is formed and must show:

(a) the name of the corporation. If a mutual corporation, the word "mutual" must be a part of the name. An alternative name or names may be specified for use in jurisdictions where a conflict of name with that of another insurer or organization might otherwise prevent the corporation from being authorized to transact insurance in that jurisdiction.

(b) the duration of its existence, which may be perpetual;

(c) the kinds of insurance, as defined in this code, which the corporation is formed to transact;

(d) if a stock corporation, its authorized capital stock, the number of shares of common stock, and the par value of each share. The par value must be at least $1. Shares without par value or other than one class of voting common stock are not authorized. The articles of incorporation may limit or deny present or future stockholders preemptive or preferential rights to acquire additional issues of the stock, bonds, debentures, or other obligations convertible into stock, of the corporation, subject to the laws of Montana fixing the required representation and proportion of outstanding capital stock required to be represented and voted, for specified action, at any and all corporate meetings, elections, votes, or consent proceedings.

(e) if a stock corporation, the extent, if any, to which shares of its stock are subject to assessment;

(f) if a stock corporation, the number of shares subscribed, if any, by each incorporator;

(g) if a mutual corporation, the maximum contingent liability of its members, other than as to nonassessable policies, for payment of losses and expenses incurred. Any liability must be stated in the articles of incorporation but may not be less than one or more than six times the premium for the member's policy at the annual premium rate for a term of 1 year.

(h) the minimum, not less than 5, and the maximum, not more than 21, number of directors who constitute the board of directors and conduct the affairs of the corporation, and the names, addresses, and terms of the members of the initial board of directors. The term of office of initial directors may not be for more

than 1 year after the date of incorporation.

(i) the name of the county, and the city, town, or place within the county, in which its principal office or principal place of business is to be located in this state;

(j) any other provisions, not inconsistent with law, considered appropriate by the incorporators;

(k) the name and residence address of each incorporator and the citizenship of each incorporator who is not a citizen of the United States."

Section 13. Section 33-17-237, MCA, is amended to read:

"**33-17-237. Notification of violation or appointment termination.** (1) ~~Upon~~ On the termination of an appointed insurance producer by an insurer, the insurer shall notify the ~~insurance department~~ commissioner within 30 days in the manner prescribed by the ~~insurance department~~ commissioner, which may include electronic filing.

(2) If the reason for the termination is any of the causes listed in 33-17-1001 or 33-25-301, the insurer shall immediately notify the ~~insurance department~~ commissioner of the reason.

(3) Whenever an insurance company or an employee or representative of the company has reasonable cause to believe that a person has violated 33-17-1001 or 33-25-301, it is the duty of that entity, upon acquiring the knowledge, to notify the ~~insurance department~~ commissioner and provide the ~~insurance department~~ commissioner with a complete statement of all relevant facts and circumstances.

(4) The insurer, employee, or representative shall, ~~upon~~ on request of the ~~insurance department~~ commissioner, provide information, documents and records, or other data pertaining to the alleged violation or termination that may be used by the ~~insurance department~~ commissioner in any action taken pursuant to Title 33, chapter 17, part 10.

(5) Any information, documents, records, or other data provided pursuant to this section is privileged, and there is no liability on the part of nor may a cause of action of any nature arise against the ~~insurance department~~ commissioner, the insurance company, or an authorized representative of either so long as the privileged information is furnished in good faith."

Section 14. Section 33-17-243, MCA, is amended to read:

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

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

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

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

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

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

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

Section 15. Section 33-17-1402, MCA, is amended to read:

"**33-17-1402. Requirements to offer and disseminate travel insurance -- types of policies -- rulemaking.** (1) The commissioner may issue a limited lines travel insurance producer license to an individual or business entity that has filed with the commissioner an application for a limited lines travel insurance producer license in a form and manner prescribed by the commissioner. The limited lines travel insurance producer must be licensed to sell, solicit, or negotiate travel insurance through a licensed insurer. A person may not act as a limited lines travel insurance producer or travel retailer unless properly licensed or registered, respectively.

(2) A travel retailer may offer and disseminate travel insurance under a limited lines travel insurance producer business entity license only if the following conditions are met:

(a) the limited lines travel insurance producer or travel retailer provides purchasers of travel insurance with:

(i) a description of the material terms or the actual material terms of the insurance coverage;

(ii) a description of the process for filing a claim;

(iii) a description of the review or cancellation process for the travel insurance policy; and

(iv) the identity and contact information of the insurer and the limited lines travel insurance producer;

(b) the limited lines travel insurance producer designates an employee who is an individual licensed producer as the designated responsible producer responsible for the limited lines travel insurance producer's compliance with the applicable insurance laws and rules of this state;

(c) the designated responsible producer, president, secretary, treasurer, and any other officer or person who directs or controls the limited lines travel insurance producer's insurance operations have complied with the fingerprinting requirements in the resident state of the limited lines travel insurance producer;

(d) the limited lines travel insurance producer has paid all applicable insurance producer licensing fees required pursuant to 33-2-708 or other applicable state law; and

(e) the limited lines travel insurance producer requires each employee and authorized representative of the travel retailer whose duties include offering and disseminating travel insurance to receive a program of instruction or training, which may be subject to review by the commissioner. The training material must, at a minimum, contain instructions on the types of insurance offered, ethical sales practices, and required disclosures to prospective customers.

(3) A travel retailer offering or disseminating travel insurance shall make available to prospective purchasers brochures or other written materials that:

(a) provide the identity and contact information of the insurer and the limited lines travel insurance producer;

(b) explain that the purchase of travel insurance is not required in order to purchase any other product or service from the travel retailer; and

(c) explain that a travel retailer employee or authorized representative who is not licensed as an insurance producer is permitted to provide general information about the insurance offered by the travel retailer, including a description of the coverage and price, but is not qualified or authorized to answer technical questions about the terms and conditions of the insurance offered by the travel retailer or to evaluate the adequacy of the customer's existing insurance coverage.

(4) A travel retailer's employees or authorized representatives who are not licensed as insurance

producers may not:

(a) evaluate or interpret the technical terms, benefits, and conditions of the offered travel insurance coverage;

(b) evaluate or provide advice concerning a prospective purchaser's existing insurance coverage; or

(c) hold themselves out as licensed insurers, licensed producers, or insurance experts.

(5) Travel insurance may be provided under an individual policy or under a group or master policy.

(6) A person licensed in property and casualty as an insurance producer is authorized to sell, solicit, and negotiate travel insurance. A property and casualty insurance producer is not required to become appointed by an insurer in order to sell, solicit, or negotiate travel insurance."

Section 16. Section 33-19-105, MCA, is amended to read:

"**33-19-105. Exemption based on federal standards for privacy of individually identifiable health information -- notice to commissioner required -- rules.** (1) ~~The~~ Except as provided in subsection (5), the obligations imposed under this chapter do not apply to a licensee that is a covered entity under the provisions of federal regulations that are part of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, parts 160 and 164, standards for privacy of individually identifiable health information or security standards for the protection of electronic health information as to any use or disclosure of personal information that is covered under the HIPAA privacy and security regulations, except for the following provisions:

(a) A notice of insurance information practices described as a notice of privacy practices for protected health information under HIPAA privacy regulations must be delivered as provided for in 33-19-202(1).

(b) To the extent that an insurer collects, discloses, or uses personal information that is not covered under the HIPAA notice of privacy practices, a separate Montana specific notice must be delivered pursuant to the provisions of 33-19-202.

(c) A disclosure authorization remains valid for a period that does not exceed 24 months, as provided for in 33-19-206(2).

(d) The reasons for an adverse underwriting decision must be specified, as provided for in 33-19-303.

(e) Disclosure of underwriting information is required, as provided for in 33-19-308.

(2) The commissioner may adopt rules regarding the exceptions from the exemption provisions described in subsection (1), including additional exceptions that embody substantive provisions of this chapter but would not be preempted by HIPAA privacy regulations.

(3) If a licensee considers itself exempt from a provision of this chapter for the reason provided in subsection (1), the licensee shall give written notice to the commissioner of that exemption and a brief statement describing why the licensee is a HIPAA-covered entity.

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

(5) A licensee exempt under subsection (1) shall comply with 33-19-321.

~~(5)~~(6) ~~A~~ Except as provided in subsection (7), a business associate, as defined in the HIPAA privacy regulations, 45 CFR 160.103, that is a party to a valid business associate agreement required by HIPAA privacy regulations is exempt from the provisions of this chapter, but only as to the scope of that particular agreement. Any activity of the business associate that falls outside of the scope of that agreement is subject to the provisions of this chapter.

(7) A business associate party to an agreement with a licensee exempt under subsection (1) shall comply with 33-19-321.

~~(6)~~(8) The commissioner retains the authority to conduct complete market conduct examinations of the licensee as to the privacy policies and practices that are subject to state privacy laws.

~~(7)~~(9) Beginning July 1, 2011:

(a) if a licensee is subject to and in compliance with a federal regulation that is part of the federal health insurance portability and accountability privacy and security regulations, 45 CFR, parts 160 and 164, and the federal regulation with which the licensee complies is inconsistent with a provision of this chapter and not less protective of consumer privacy, the licensee is exempt from compliance with the inconsistent provision of this chapter;

(b) if a licensee considers itself exempt from a provision of this chapter for the reason provided in

subsection ~~(7)(a)~~ (9)(a), the licensee shall give written notice to the commissioner of that exemption unless the requirements of this subsection ~~(7)~~ (9) are preempted by HIPAA privacy regulations. The notice must include a statement of the reason for the claimed exemption."

Section 17. Section 33-20-1302, MCA, is amended to read:

"**33-20-1302. Definitions.** As used in this part, unless the context requires otherwise, the following definitions apply:

(1) "Financing entity" means an underwriter, placement agent, lender, or any entity, other than a nonaccredited investor, that has a direct ownership in a policy or certificate that is the subject of a viatical settlement contract, whose sole activity related to the transaction is the provision of funds to effect the viatical settlement contract, and who has an agreement in writing with one or more licensed viatical settlement providers.

(2) "Related provider trust" means a trust established by a licensed viatical settlement provider or a financing entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction. The trust must have a written agreement with the viatical settlement provider under which the licensed viatical settlement provider is responsible for ensuring compliance with all statutory and regulatory requirements and under which the trust agrees to make all records and files related to viatical settlement transactions available to the commissioner.

(3) "Special purpose entity" means a corporation, partnership, trust, limited liability company, or other similar entity formed solely to provide, either directly or indirectly, access to institutional capital markets for a financing entity or licensed viatical settlement provider.

(4) (a) "Viatical settlement broker" means an individual who, for a fee, commission, or other consideration:

(i) offers or advertises the availability of viatical settlement contracts;

(ii) introduces holders of life insurance policies or certificates insuring the lives of individuals with a terminal illness or condition to viatical settlement providers; or

(iii) offers or attempts to negotiate viatical settlement contracts between the policyholders or certificate holders and one or more viatical settlement providers.

(b) Viatical settlement broker does not mean an attorney, accountant, or financial planner retained to represent the policyholder or certificate holder unless compensation paid to the attorney, accountant, or consultant is paid by the viatical settlement provider.

(5) (a) "Viatical settlement contract" means a written agreement establishing the terms under which compensation or anything of value will be paid, when the compensation or value is less than the expected death benefit of the insurance policy or certificate, in return for the viator's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of any portion of the insurance policy or certificate of insurance.

(b) The term includes:

(i) a contract for a loan or other financing transaction with a viator secured primarily by an individual or group life insurance policy, other than a loan by a life insurance company pursuant to the terms of the life insurance contract, or a loan secured by the cash value of a policy; or

(ii) an agreement with a viator to transfer ownership or change the beneficiary designation at a later date regardless of the date that compensation is paid to the viator.

(c) The term does not mean a written agreement entered into between a viator and a person having an insurable interest in the viator's life.

(6) (a) "Viatical settlement provider" means a person who solicits, enters into, or negotiates viatical settlement contracts or offers to enter into or negotiate viatical settlement contracts.

(b) Viatical settlement provider does not mean:

(i) a bank, savings bank, savings and loan association, credit union, or other licensed lending institution that takes an assignment of a life insurance policy only as collateral for a loan;

(ii) an insurer issuing a life insurance policy providing accelerated benefits pursuant to 33-20-127 or pursuant to the laws of the state to which the policy was subject when issued;

(iii) an individual who enters into a single agreement in a calendar year for the transfer of life insurance policies for any value less than the expected death benefit; or

(iv) any corporation, partnership, or partner that purchases a life insurance contract of an employee or retiree of the corporation or of a partner. The settlement made on any contract exempt under this section must be reasonable and subject to the standards imposed on licensees under 33-20-1304.

(7) (a) "Viatical settlement purchase agreement" means a contract or agreement entered into by a viatical settlement purchaser with a viatical settlement provider to purchase a life insurance policy or an interest in a life insurance policy for the purpose of deriving an economic benefit.

(b) A viatical settlement purchase agreement does not include a viatical settlement contract.

(8) (a) "Viatical settlement purchaser" means a person who, for the purpose of deriving an economic benefit:

(i) gives consideration for a life insurance policy or an interest in the death benefits of a life insurance policy; or

(ii) owns, acquires, or is entitled to a beneficial interest in a trust that owns a viatical settlement contract or that is the beneficiary of a life insurance policy that has been or will be the subject of a viatical settlement contract.

(b) A viatical settlement purchaser does not include a licensed viatical settlement provider, a licensed viatical settlement broker, a qualified institutional buyer as defined in 17 CFR 230.144A, a financing entity, a special purpose entity, or a related provider trust.

(9) (a) "Viator" means the owner of a life insurance policy or the certificate holder under a group policy who enters or seeks to enter into a viatical settlement contract. For the purposes of this part, a viator may not be limited to an owner of a life insurance policy or a certificate holder under a group policy insuring the life of an individual with a terminal or chronic illness or condition except where specifically addressed.

(b) The term does not include a licensed viatical settlement provider, a licensed viatical settlement broker, a qualified institutional buyer as defined in 17 CFR 230.144A, a financing entity, a special purpose entity, or a related provider trust."

Section 18. Section 33-22-132, MCA, is amended to read:

"**33-22-132. Coverage for minimum mammography and other breast examinations.** (1) Each group or individual medical expense 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 coverage of minimum mammography and other breast examinations as provided in this section.

(2) For the purpose of this section, the following definitions apply:

(a) "Cost-sharing requirement" means a deductible, coinsurance, copayment, and any maximum limitation on the application of a deductible, coinsurance, copayment, or similar out-of-pocket expense.

(b) (i) "Diagnostic breast examination" means a medically necessary and clinically appropriate examination of the breast that is used to evaluate an abnormality seen or suspected from a screening examination for breast cancer or detected by another means of examination.

(ii) The term includes examinations using diagnostic mammography, breast magnetic resonance imaging, or breast ultrasound.

(c) "Minimum mammography examination" means:

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

(ii) 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

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

(d) (i) "Supplemental breast examination" means a medically necessary and clinically appropriate examination of the breast that is used to screen for breast cancer when there is no abnormality seen or suspected and is based on personal or family medical history or other factors that may increase a person's risk of breast cancer.

(ii) The term includes examination using breast magnetic resonance imaging or breast ultrasound.

(3) A minimum $70 payment or the actual charge if the charge is less than $70 must be made for each minimum 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) (a) Except as provided in subsection (4)(b), a group health plan or a health insurance issuer offering group or individual health insurance coverage may not impose any cost-sharing requirements for a diagnostic breast examination or supplemental breast examination rendered by a preferred provider as defined in 33-22-1703 when the plan or coverage provides screening benefits, supplemental breast examinations, and diagnostic breast examinations furnished to an individual enrolled under the plan or coverage.

(b) If, under federal law, application of subsection (4)(a) would result in health savings account ineligibility under section 223 of the federal Internal Revenue Code, this requirement may apply only, for health savings account-qualified high deductible health plans with respect to the deductible of the plan after the ~~enrollee~~ individual has satisfied the plan's minimum deductible ~~under~~ as required by section 223, except for with respect to items or services that are preventive care pursuant to section 223(c)(2)(C) of the federal Internal Revenue Code, in which case the requirements of subsection (4)(a) apply regardless of whether the plan's minimum deductible ~~under section 223~~ has been satisfied.

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

Section 19. Section 33-22-138, MCA, is amended to read:

"**33-22-138. Coverage for telehealth services -- rulemaking.** (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 telehealth if the services are otherwise covered by the policy, certificate, contract, or agreement.

(2) A policy, certificate, contract, or agreement may not:

(a) impose restrictions involving:

(i) the site at which the patient is physically located and receiving health care services by means of telehealth; or

(ii) the site at which the health care provider is physically located and providing the services by means of telehealth; or

(b) distinguish between telehealth services provided to patients in rural locations and telehealth services provided to patients in urban locations.

(3) 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.

(4) 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;

(b) coverage of an otherwise noncovered benefit;

(c) 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 telehealth determines that the presence of a health care provider is necessary; or

(d) except as provided in 16-12-509 or as provided in Title 37 and related administrative rules, a patient to have a previously established patient-provider relationship with a specific health care provider in order to receive health care services by means of telehealth.

(5) Coverage under this section may be subject to deductibles, coinsurance, and copayment provisions. ~~Special deductible~~ Deductibles, 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 telehealth may not be more than deductibles, coinsurance, copayment, or other limitations that are applicable to other medical services covered under the plan.

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

(7) The commissioner may adopt rules necessary to implement the provisions of this section.

(8) 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, 4, 6, 7, 10, 11, 15, 17, 20, 22, 23, 24, 25, 26, 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) (i) "Telehealth" means the use of audio, video, or other telecommunications technology or media, including audio-only communication, that is:

(A) used by a health care provider or health care facility to deliver health care services; and

(B) delivered over a secure connection that complies with state and federal privacy laws.

(ii) The term does not include delivery of health care services by means of facsimile machines or electronic messaging alone. The use of facsimile and electronic message is not precluded if used in conjunction with other audio, video, or telecommunications technology or media.

(iii) For physicians providing written certification of a debilitating medical condition pursuant to 16-12-509, the term does not include audio-only communication unless the physician has previously established a physician-patient relationship through an in-person encounter."

Section 20. Section 33-22-150, MCA, is amended to read:

"**33-22-150. Reciprocal limitations on claim filing and claim audits -- time limit for reimbursements or offsets -- exceptions.** (1) Except as provided in subsection (3), (4), or (5), if a health insurance issuer limits the time in which a health care provider or other person is required to submit a claim for payment, the health insurance issuer has the same time limit following payment of the claim to perform any review or audit ~~for reconsidering~~ to reconsider the validity of the claim and ~~requesting~~ to request reimbursement ~~for~~ or offset another claim payment for reimbursement of an invalid claim or overpayment of a claim.

(2) Except as provided in subsection (3), (4), or (5), if a health insurance issuer does not limit the time in which a health care provider or other person is required to submit a claim for payment, ~~a~~ the health insurance issuer may not request reimbursement or offset another claim payment for reimbursement of an invalid claim or overpayment of a claim more than 12 months after the payment of an invalid or overpaid claim.

(3) Regardless of the period allowed by a health insurance issuer for submission of claims for payment, ~~a~~ the health insurance issuer may perform a review or audit to reconsider the validity of a claim and may request reimbursement or offset another claim payment for reimbursement of an invalid or overpaid claim within 12 months from the date upon which the health insurance issuer received notice of a determination, adjustment, or agreement regarding the amount payable with respect to a claim by:

(a) medicare;

(b) a workers' compensation insurer;

(c) another health insurance issuer or group health plan;

(d) a liable or potentially liable third party; or

(e) a foreign health insurance issuer under an agreement among plans operating in different states when the agreement provides for payment by the Montana health insurance issuer as host plan to Montana providers for services provided to an individual under a plan issued outside of the state of Montana.

(4) (a) The time limitations on the health insurance issuer in subsections (1) and (2) do not commence running until the time specified in subsection (4)(b) if ~~a~~ the health insurance issuer pays a claim in which the health insurance issuer:

(i) suspects the health care provider or claimant of insurance fraud related to the claim; and

(ii) has reported evidence of fraud related to the claim to the commissioner pursuant to 33-1-1205.

(b) The time limitation commences running on the date that the commissioner determines that insufficient evidence of fraud exists.

(5) The time limitations on the health insurance issuer in subsections (1) and (2) do not commence running until the health insurance issuer has actual knowledge of an invalid claim, claim overpayment, or other incorrect payment if the health insurance issuer has paid a claim incorrectly because of an error, misstatement, misrepresentation, omission, or concealment, other than insurance fraud, by the health care provider or other person. Regardless of the date upon which the health insurance issuer obtains actual knowledge of an invalid claim, claim overpayment, or other incorrect payment, this subsection does not permit the health insurance issuer to request reimbursement or to offset another claim payment for reimbursement of the claim more than 24 months after payment of the claim."

Section 21. Section 33-22-206, MCA, is amended to read:

"**33-22-206. Grace period.** (1) There must be a provision as follows:

"Grace Period: A grace period of.... (insert a number not less than 7 for weekly premium policies, 10 for monthly premium policies, and 31 for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy must continue in force."

(2) A policy in which the insurer reserves the right to refuse renewal must ~~have,~~ include the following language at the beginning of the provision contained in subsection (1):

"~~Unless not less than 30 days prior to the premium due date~~ If the insurer ~~has delivered~~ does not

deliver to the insured or ~~has mailed~~ mail to the insured's last address as shown by the records of the insurer a written notice at least 30 days prior to the premium due date of its intention not to renew this policy beyond the period for which the premium has been accepted.""

Section 22. Section 33-22-208, MCA, is amended to read:

"**33-22-208. Notice of claim.** (1) A policy must contain a provision as follows:

"Notice of Claim: Written notice of claim must be given to the insurer within 6 months after the occurrence or commencement of any loss covered by the policy or as soon after that date as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at.... (insert the location of the office that the insurer may designate for the purpose) or to any authorized insurance producer of the insurer, with information sufficient to identify the insured, is considered notice to the insurer."

(2) A policy may allow written notice of a claim to be given to the insurer more than 6 months after the occurrence or commencement of any loss covered by the policy or as soon after that date as is reasonably possible.

~~(2)~~(3) In a policy providing a loss-of-time benefit that may be payable for at least 2 years, an insurer may at its option insert the following between the first and second sentences of the provision in subsection (1):

"Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least 2 years, the insured shall, at least once in every 6 months after having given notice of the claim, give to the insurer notice of continuance of the disability, except in the event of legal incapacity. The period of 6 months following any filing of proof by the insured or any payment by the insurer on account of the claim or any denial of liability in whole or in part by the insurer must be excluded in applying this provision. Delay in giving the notice may not impair the insured's right to any indemnity that would otherwise have accrued during the period of 6 months preceding the date on which the notice is actually given.""

Section 23. Section 33-22-244, MCA, is amended to read:

"**33-22-244. Disclosure standards -- individual policy.** (1) In order to provide for full and fair disclosure in the sale of disability insurance, an individual disability insurance policy may not be delivered or

issued for delivery in this state unless an outline of coverage is filed with and approved by the insurance commissioner in accordance with 33-1-501 and is delivered to the applicant at the time the application is made.

(2) The outline of coverage must include:

(a) a general description of the principal benefits and coverages provided by the policy;

(b) a general description of the insured's financial responsibility under the policy, including, if applicable, the amount of the deductible, the amount or percentage of copayment, and the maximum annual out-of-pocket expenses to be paid by the insured;

(c) a statement of the maximum lifetime benefit available under the policy;

(d) a statement of the estimated periodic premium to be paid by the insured;

(e) a general description of the factors or case characteristics that the insurer may consider in establishing or changing the premiums and, if applicable, in determining the insurability of the applicant;

(f) a description of any preauthorization or other preapproval requirements for medical care; and

(g) a prominently displayed statement of the insured's responsibility for payment of billed charges beyond those charges reimbursed by the insurer when the insured uses health care services from a health care provider who is outside a network of health care providers used by the insurer~~; and~~

~~(h) a general description of the trend of premium increases or decreases for comparable policies issued by the insurer during the preceding 5 years, if the trend data is available~~.

(3) The outline of coverage may include any other information that the insurer considers relevant to the applicant's selection of an appropriate individual disability policy.

(4) An insurer or producer shall provide to an individual, upon request, an outline of coverage for any health benefit product marketed to the general public. The outline of coverage provided under this subsection may exclude the statement of the estimated periodic premium to be paid by the insured.

(5) Prior to issuance of an individual disability insurance policy, written informational materials describing the policy's cancer screening coverages must be provided to a potential applicant. The informational materials are not subject to filing with and approval of the insurance commissioner."

Section 24. Section 33-22-521, MCA, is amended to read:

"**33-22-521. Disclosure standards -- group policy.** (1) In order to provide for full and fair disclosure

in the sale of disability insurance, a group disability insurance policy may not be delivered or issued for delivery in this state unless an outline of coverage is filed with and approved by the insurance commissioner in accordance with 33-1-501 and is delivered to the applicant at the time the application is made.

(2) The outline of coverage must include:

(a) a general description of the principal benefits and coverages provided by the policy;

(b) a general description of the insured's financial responsibility under the policy, including, if applicable, the amount of the deductible, the amount or percentage of copayment, and the maximum annual out-of-pocket expenses to be paid by the insured;

(c) a statement of the maximum lifetime benefit available under the policy;

(d) a statement of the estimated periodic premium to be paid by the insured;

(e) a general description of the factors or case characteristics that the insurer may consider in establishing or changing the premiums and, if applicable, in determining the insurability of the applicant;

(f) a description of any preauthorization or other preapproval requirements for medical care; and

(g) a prominently displayed statement of the insured's responsibility for payment of billed charges beyond those charges reimbursed by the insurer when the insured uses health care services from a health care provider who is outside a network of health care providers used by the insurer~~; and~~

~~(h) a general description of the trend of premium increases or decreases for comparable policies issued by the insurer during the preceding 5 years, if the trend data is available~~.

(3) If applicable, the outline of coverage must disclose that the policy does not contain coverage for mental illness or chemical dependency.

(4) The outline of coverage may include any other information that the insurer considers relevant to the applicant's selection of an appropriate group disability policy.

(5) An insurer or producer shall provide to an individual, upon request, an outline of coverage for any health benefit product marketed to the general public. The outline of coverage provided under this subsection may exclude the statement of the estimated periodic premium to be paid by the insured.

(6) An outline of coverage must also be sent to an employee when an employee is sent a certificate of insurance.

(7) Prior to issuance of a group disability insurance policy, written informational materials

describing the policy's cancer screening coverages must be provided to a prospective applicant. The informational materials are not subject to filing with and approval of the insurance commissioner."

Section 25. Section 33-22-906, MCA, is amended to read:

"**33-22-906. Loss ratio standards and filing requirements -- limits on compensation.** (1) Medicare supplement policies and certificates must return to policyholders or certificate holders benefits that are reasonable in relation to the premium charged. The commissioner shall adopt reasonable rules to establish minimum standards for loss ratios of medicare supplement policies and certificates on the basis of incurred claims experience or incurred health care expenses, where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and earned premiums for the entire period for which rates are computed to provide coverage and in accordance with accepted actuarial principles and practices. Every ~~entity~~ issuer providing medicare supplement insurance benefits to a resident of this state shall make premium adjustments:

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

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

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

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

(a) the existing policy or certificate were replaced by another policy or certificate with the same

~~insurer~~ issuer and the new benefits are substantially similar to the benefits under the old policy or certificate; and

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

Section 26. Section 33-22-907, MCA, is amended to read:

"**33-22-907. Disclosure standards -- informational brochure -- rules.** (1) In order to provide for full and fair disclosure in the sale of medicare supplement policies and certificates, a medicare supplement policy may not be delivered or issued for delivery in this state and a certificate may not be delivered pursuant to a group medicare supplement policy delivered or issued for delivery in this state unless an outline of coverage is delivered to the applicant at the time that application is made. The outline of coverage must be filed with the commissioner as required by 33-1-501. The filing must be made at least 60 days in advance of the date that the outline of coverage is delivered to any resident of this state.

(2) (a) The commissioner shall prescribe the format and content of the outline of coverage required by subsection (1).

(b) For purposes of this section, "format" means style, arrangements, and overall appearance, including such items as the size, color, and prominence of type and the arrangement of text and captions.

(c) The outline of coverage must include:

(i) a description of the principal benefits and coverage provided in the policy or certificate;

(ii) a statement of the exceptions, reductions, and limitations contained in the policy or certificate;

(iii) a statement of the renewal provisions, including any reservation by the issuer of a right to change premiums and disclosure of the existence of any automatic renewal premium increases based on the policyholder's or certificate holder's age;

(iv) a statement that the outline of coverage is a summary of the policy or certificate issued or applied for and that the policy or certificate should be consulted to determine governing contractual provisions.

(3) The commissioner may prescribe by rule a standard form and the contents of an informational brochure for persons eligible for medicare, which is intended to improve the buyer's ability to select the most appropriate coverage and to improve the buyer's understanding of medicare. Except in the case of direct response insurance policies, the commissioner may require by rule that the information brochure be provided to

any prospective insureds eligible for medicare at the same time that the outline of coverage is delivered. With respect to direct response insurance policies, the commissioner may require by rule that the prescribed brochure be provided upon request, but not later than the time of policy delivery, to any prospective insureds eligible for medicare.

(4) The commissioner may adopt reasonable rules for captions or notice requirements, determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not medicare supplement coverages, for all accident and sickness insurance policies sold to persons eligible for medicare, other than:

(a) medicare supplement policies or certificates; or

(b) disability income policies.

(5) The commissioner may further adopt reasonable rules to govern the full and fair disclosure of the information in connection with the replacement of accident and sickness policies or certificates by persons eligible for medicare.

(6) As soon as practicable, but no later than 30 days before the annual effective date of a medicare benefit change, every ~~entity~~ issuer providing medicare supplement insurance or benefits to a resident of this state shall notify its policyholders and certificate holders, in a format that the commissioner prescribes by rule, of the changes that it has made to the medicare supplement policy or certificate."

Section 27. Section 33-22-921, MCA, is amended to read:

"**33-22-921. Discontinuance or nonrenewal -- alternate policy or certificate -- same ~~insurer~~ issuer.** (1) If ~~a disability insurer~~ an issuer discontinues or does not renew a medicare supplement policy product or certificate and offers an alternate medicare supplement policy or certificate to its insureds within this state, it may not deny benefits under the replacing policy or certificate to an insured who receives treatment for a condition that was a covered expense under the replaced policy or certificate and is a covered expense under the replacing policy or certificate if the insured enrolls in and pays the premium for the replacing policy or certificate within 31 days after the termination of the replaced policy or certificate.

(2) ~~A disability insurer~~ An issuer who discontinues or does not renew a medicare supplement policy product or certificate and offers an alternate medicare supplement policy or certificate shall base its

premium for the alternate policy or certificate on the rates currently in place for that policy or certificate.

(3) If the insured has not satisfied the preexisting condition limitation under the replaced medicare supplement policy or certificate, any period of time that was covered by that policy or certificate must be credited toward the preexisting condition limitation period of the replacing policy or certificate."

Section 28. Section 33-22-922, MCA, is amended to read:

"**33-22-922. Discontinuance or nonrenewal -- alternate policy -- unauthorized bulk reinsurance.** (1) Alternate medicare supplement coverage as provided in 33-22-921 must be offered to its insureds by ~~a disability insurer~~ an issuer that:

(a) bulk cedes its medicare supplement policy business to an insurer that does not meet the requirements of chapter 2;

(b) authorizes the bulk reinsurer to administer the medicare supplement policies on its behalf; and

(c) discontinues or does not renew a medicare supplement policy product.

(2) The premium for the alternate policy referred to in subsection (1) must be based on actuarially justified rates."

Section 29. Section 33-22-923, MCA, is amended to read:

"**33-22-923. Replacement policy or certificate -- different ~~insurer~~ issuer.** (1) If ~~a disability insurer~~ an issuer replaces a medicare supplement policy or certificate, it may not deny benefits under the replacing policy or certificate to an insured who receives treatment for a condition that was a covered expense under the replaced policy or certificate and is a covered expense under the replacing policy or certificate if the insured pays the premium for the replacing policy or certificate when due or within 31 days after the termination of the replaced policy or certificate.

(2) An ~~insurer~~ issuer who replaces a medicare supplement policy or certificate shall base its premium for the replacement policy or certificate on the rates currently in place for that policy or certificate.

(3) If the insured has not satisfied the preexisting condition limitation under the replaced medicare supplement policy or certificate, any period of time that was covered by that policy or certificate must be credited toward the preexisting condition limitation period of the replacing policy or certificate.

(4) To receive the benefits of subsections (1) through (3), a person shall submit to the replacing ~~insurer~~ issuer proof of prior coverage, evidence of benefits provided under the previous policy or certificate, and the effective date and the date of termination of coverage under the previous policy or certificate."

Section 30. Section 33-22-924, MCA, is amended to read:

"**33-22-924. Renewal requirement.** (1) If a person pays a renewal premium on the date it is due or within 31 days after it is due, an ~~insurer~~ issuer may not refuse to renew a medicare supplement policy or certificate unless the ~~insurer~~ issuer:

(a) refuses to renew all policies or certificates in this state that are of the same form and issued to persons of the same class; and

(b) offers a replacement policy or certificate at actuarially justified rates.

(2) If an ~~insurer~~ issuer refuses to renew all policies or certificates in this state that are of the same form and issued to persons of the same class, the policies or certificates will remain in force during the grace period stated in the replaced policy or certificate. An ~~insurer's~~ issuer's refusal to renew a policy or certificate may not affect a claim that arose under the discontinued policy or certificate during the period in which an insured was confined without interruption to a medical care facility for treatment."

Section 31. Section 33-32-211, MCA, is amended to read:

"**33-32-211. Procedures for standard utilization review and benefit determinations -- notices.** (1) A health insurance issuer shall establish written procedures and clinical review criteria for conducting standard utilization reviews and making benefit determinations on requests for benefits submitted to the health insurance issuer by covered persons or their authorized representatives. The written procedures must also include provisions for notifying covered persons or, if applicable, their authorized representatives of the health insurance issuer's determinations with respect to these requests within the timeframes specified in this section.

(2) (a) Subject to subsection (2)(c), for prospective review determinations, a health insurance issuer shall make the determination and notify the covered person or, if applicable, the covered person's authorized representative of the determination, whether the health insurance issuer certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person's medical condition. The

notification must be made not later than 7 business days after the date the health insurance issuer receives the request or not later than 7 business days after the health insurance issuer receives all information under subsection (2)(d) necessary to make a determination.

(b) If the determination is an adverse determination, the health insurance issuer shall provide notification of the adverse determination in writing in accordance with subsection (8).

(c) The time period for making a determination and notifying the covered person or, if applicable, the covered person's authorized representative of the determination pursuant to subsection (2)(a) may be extended one time by the health insurance issuer for up to 7 business days if the health insurance issuer:

(i) determines that an extension is necessary due to matters beyond the health insurance issuer's control; and

(ii) notifies the covered person or, if applicable, the covered person's authorized representative, prior to the expiration of the initial 7-business-day period, of the circumstances requiring the extension of time and of the date by which the health insurance issuer expects to make a determination.

(d) If the extension under subsection (2)(c) is necessary because of the failure of the covered person or, if applicable, the covered person's authorized representative to submit information necessary to reach a determination on the request, the notice of extension must:

(i) describe specifically the required information necessary to complete the request; and

(ii) give the covered person or, if applicable, the covered person's authorized representative at least 45 days after the date of receipt of the notice to provide the specified information.

(3) (a) If the health insurance issuer receives from a covered person or, if applicable, the covered person's authorized representative a prospective review request that fails to meet the health insurance issuer's filing procedures, the health insurance issuer shall notify the covered person or, if applicable, the covered person's authorized representative of this failure and provide in the notice any information regarding the proper procedures to be followed for filing a request.

(b) The notice required under subsection (3)(a) must be provided as soon as possible but not later than 3 days after the date of the failure. The health insurance issuer may provide the notice orally or, if requested by the covered person or the covered person's authorized representative, in writing or electronically.

(c) To qualify for the provisions of this subsection (3) related to a failed filing procedure, the

communication must:

(i) have been sent by a covered person or, if applicable, the covered person's authorized representative and received by a person or an organizational unit of the health insurance issuer responsible for handling benefit matters; and

(ii) refer to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment, or health care provider for which certification is being requested.

(4) For concurrent review determinations, if a health insurance issuer has certified an ongoing course of treatment to be provided over a period of time or a specified number of treatments:

(a) any reduction or termination by the health insurance issuer during the course of treatment before the end of the period or the specified number of treatments, other than by health plan amendment or termination of the health plan, constitutes an adverse determination; and

(b) the health insurance issuer shall notify the covered person or, if applicable, the covered person's authorized representative of the adverse determination in accordance with subsection (8) at a time sufficiently in advance of the reduction or termination to allow the covered person or, if applicable, the covered person's authorized representative to:

(i) file a grievance requesting a review of the adverse determination pursuant to Title 33, chapter 32, parts 3 and 4; and

(ii) obtain a determination with respect to the review of the adverse determination before the benefit is reduced or terminated.

(5) The health care service or treatment that is the subject of the adverse determination must be continued without liability to the covered person pending a determination under the internal review request made pursuant to Title 33, chapter 32, part 3.

(6) (a) For retrospective review determinations, a health insurance issuer shall make the determination no later than 30 days after the date of receiving the benefit request.

(b) If the determination is an adverse determination, the health insurance issuer shall provide notice of the adverse determination to the covered person or, if applicable, the covered person's authorized representative in accordance with subsection (8).

(c) The time period for making a determination and notifying the covered person or, if applicable,

the covered person's authorized representative of the determination pursuant to subsection (6)(a) may be extended one time by the health insurance issuer for up to 15 days if the health insurance issuer:

(i) determines that an extension is necessary due to matters beyond the health insurance issuer's control; and

(ii) notifies the covered person or, if applicable, the covered person's authorized representative, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and of the date by which the health insurance issuer expects to make a determination.

(d) If the extension under subsection (6)(c) is necessary because of the failure of the covered person or, if applicable, the covered person's authorized representative to submit information necessary to reach a determination on the request, the notice of extension must:

(i) describe specifically the information required to complete the request; and

(ii) give the covered person or, if applicable, the covered person's authorized representative at least 45 days after the date of receipt of the notice to provide the specified information.

(e) A health insurance issuer is not liable for the payment of interest under 33-18-232(2) when the health insurance issuer timely complies with the requirements of this subsection (6).

(7) (a) For purposes of this section, the period within which a determination must be made begins on the date the request is received by the health insurance issuer in accordance with the health insurance issuer's procedures, established pursuant to 33-32-207, for filing a request. The date the request is received by the health insurance issuer must be counted without regard to whether all of the information necessary to make the determination accompanies the filing of the request.

(b) If the period for making the determination under this section is extended due to the failure of the covered person or, if applicable, the covered person's authorized representative to submit the information necessary to make the determination, the period for making the determination is counted from the date on which the health insurance issuer sends the notification of the extension to the covered person or, if applicable, the covered person's authorized representative until the earlier of:

(i) the date on which the covered person or, if applicable, the covered person's authorized representative responds to the request for additional information; or

(ii) the date on which the specified information was to have been submitted.

(c) If the covered person or, if applicable, the covered person's authorized representative fails to submit the information before the end of the extension period, as specified in this section, the health insurance issuer may deny the certification of the requested benefit.

(8) A notification of an adverse determination under this section must, in a manner calculated to be understood by the covered person or, if applicable, the covered person's authorized representative, set forth:

(a) information sufficient to identify the benefit request or claim involved and, if applicable, the date of service, the health care provider, and the claim amount;

(b) a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning. On receiving a request for a diagnosis or treatment code, the health insurance issuer shall provide the information to the covered person or, if applicable, the covered person's authorized representative as soon as practicable. A health insurance issuer may not consider a request for the diagnosis code and treatment information, in itself, to be a request to file a grievance for review of an adverse determination pursuant to Title 33, chapter 32, part 3, or a request for external review as outlined in Title 33, chapter 32, part 4.

(c) the specific rationale behind the adverse determination, including the denial code and its corresponding meaning, as well as a description of the health insurance issuer's standard, if any, that was used in denying the benefit request or claim;

(d) a reference to the specific plan provision on which the determination is based;

(e) a description of any additional material or information necessary for the covered person or, if applicable, the covered person's authorized representative to complete the benefit request, including an explanation of why the material or information is necessary to complete the request;

(f) a description of the health insurance issuer's grievance procedures established pursuant to Title 33, chapter 32, part 3, including any time limits applicable to those procedures;

(g) a copy of any internal rule, guideline, protocol, or other similar criteria that the health insurance issuer may have relied on to make the adverse determination. Alternatively, the health insurance issuer may provide a statement that a specific rule, guideline, protocol, or other similar criteria was relied on to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criteria will be provided free of charge to the covered person on request.

(h) an explanation of the scientific or clinical judgment for making the adverse determination if the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit. Alternatively, the health insurance issuer may provide a statement that an explanation will be provided to the covered person free of charge on request. The explanation under this subsection (8)(h) must apply the terms of the health plan to the covered person's medical circumstances.

(i) a statement explaining the availability of further assistance from the commissioner's office and the right of the covered person or, if applicable, the covered person's authorized representative to contact the commissioner's office at any time for assistance or, on completion of the health insurance issuer's grievance procedure and the external review process as provided under Title 33, chapter 32, parts 3 and 4, to file a civil suit in a court of competent jurisdiction. The statement must include contact information for the commissioner's office.

(9) (a) A health insurance issuer shall provide the notice required under this section in a culturally and linguistically appropriate manner as required in accordance with federal regulations, including 45 CFR 147.136(e), and rules adopted pursuant to Title 33, chapter 32, part 3.

(b) To satisfy the provisions of subsection (9)(a), the health insurance issuer shall, at a minimum:

(i) provide oral language services, such as a telephone assistance hotline, that include answering questions in any applicable non-English language and providing assistance with filing benefit requests, claims, and appeals in any applicable non-English language;

(ii) provide, upon request, a notice in any applicable non-English language; and

(iii) include in the English version of the notice a prominently displayed statement in any applicable non-English language clearly indicating how to access the language services provided by the health insurance issuer.

(c) For purposes of this subsection (9), with respect to any United States county to which a notice is sent, a non-English language is an applicable non-English language if 10% or more of the population residing in the county is literate only in the same non-English language, as determined in federal guidance.

(10) If the adverse determination is a recission, the health insurance issuer shall provide, in addition to any applicable disclosures required under this section, in a notice sent at least 30 days in advance of implementing the rescission decision:

(a) clear identification of the alleged fraudulent act, practice, or omission or the intentional misrepresentation of material fact;

(b) an explanation of why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact;

(c) the date when the advance notice period ends and the date to which the coverage is to be retroactively rescinded;

(d) notice that the covered person or, if applicable, the covered person's authorized representative may immediately file a grievance with the health insurance issuer requesting a review of the rescission; and

(e) a description of the health insurance issuer's grievance procedures, including any time limits applicable to these procedures.

(11) A health insurance issuer may provide the notices required under this section in writing or electronically."

Section 32. Section 33-35-306, MCA, is amended to read:

"**33-35-306. Application of insurance code to arrangements.** (1) In addition to this chapter, self-funded multiple employer welfare arrangements are subject to the following provisions:

(a) 33-1-111;

(b) Title 33, chapter 1, part 4, but the examination of a self-funded multiple employer welfare arrangement is limited to those matters to which the arrangement is subject to regulation under this chapter;

(c) Title 33, chapter 1, part 7;

(d) Title 33, chapter 2, parts 23 and 24;

(e) 33-3-308;

(f) Title 33, chapter 7;

(g) Title 33, chapter 18, except 33-18-242;

(h) Title 33, chapter 19;

(i) 33-22-107, 33-22-114, 33-22-128, 33-22-129, 33-22-131, 33-22-134, 33-22-135, 33-22-138, 33-22-139, 33-22-141, 33-22-142, and 33-22-152 through 33-22-155;

~~(j) 33-22-316 ;~~

~~(k)~~(j) 33-22-512, 33-22-515, 33-22-525, and 33-22-526;

~~(l)~~(k) Title 33, chapter 22, parts 7 and 21; and

~~(m)~~(l) 33-22-707.

(2) Except as provided in this chapter, other provisions of Title 33 do not apply to a self-funded multiple employer welfare arrangement that has been issued a certificate of authority that has not been revoked."

Section 33. Directions to code commissioner. [Section 33-22-2104] is intended to be renumbered and codified as a new part in Title 53, chapter 6.

Section 34. Section 26, Chapter 501, Laws of 2021, is amended to read:

"**Section 26. Termination.** [Section 10(3)] terminates June 1, ~~2023~~ 2029."

Section 35. Codification instruction. [Section 9] is intended to be codified as an integral part of Title 33, chapter 2, part 3, and the provisions of Title 33, chapter 2, part 3, apply to [section 9].

Section 36. Section 1, Chapter 259, Laws of 2023, is amended to read:

"**Section 26. Termination.** [Section 10(3)] terminates June 1, ~~2023~~ ~~2025~~ 2029."

Section 37. Effective dates. (1) Except as provided in subsection (2), this act is effective October 1, 2025.

(2) [Sections 34 and 36] and this section are effective on passage and approval.

- END -

I hereby certify that the within bill,

HB 60, originated in the House.

_____

Chief Clerk of the House

_____

Speaker of the House

Signed this _____day

of_____, 2025.

_____

President of the Senate

Signed this _____day
of_____, 2025.

HOUSE BILL NO. 60

INTRODUCED BY E. BUTTREY

BY REQUEST OF THE STATE AUDITOR

AN ACT GENERALLY REVISING LAWS REGULATED BY THE COMMISSIONER OF SECURITIES AND INSURANCE, MONTANA STATE AUDITOR; REVISING DEFINITIONS; CLARIFYING LAWS RELATING TO STATE SCHOOL HEALTH TRUSTS THAT ARE APPROVED BY THE COMMISSIONER; REVISING LAWS RELATING TO REPLACEMENT VALUE AND BOOK VALUE; REMOVING A FEE PAID BY SECURITIES ISSUERS TO THE COMMISSIONER; REVISING SECURITIES LAWS RELATED TO STOCK EXCHANGES; REVISING SECURITIES REGISTRATION REQUIREMENTS; REVISING LAWS RELATING TO SECURITIES ACTIONS TO ALLOW AN ACTION TO BE FILED WITHIN 1 YEAR AFTER DISCOVERY; REVISING SECURITIES RESTITUTION FUND ELIGIBILITY; REVISING REGULATORY FILING LAWS; REVISING LAWS RELATING TO DOMESTIC SURPLUS LINES INSURERS; REVISING LAWS RELATING TO INTEREST OF NAMED INSURANCE LAWS AND TRANSFER; REVISING INSURANCE PRODUCER EXCHANGE TRAINING LAWS; REVISING SURETY BAIL BOND INSURANCE TRAINING REQUIREMENTS; REVISING LAWS RELATING TO INSURANCE INFORMATION AND PRIVACY PROTECTION; REVISING LAWS RELATING TO MEDICALLY NECESSARY AND CLINICALLY APPROPRIATE EXAMINATIONS; REVISING LAWS RELATING TO TELEHEALTH; REVISING LAWS RELATING TO RECIPROCAL LIMITATIONS; REVISING LAWS RELATING TO GRACE PERIODS AND NOTICE OF CLAIMS; REVISING LAWS RELATING TO DISCLOSURES BY AN INSURER; REVISING LAWS RELATING TO PAYMENT OF INTEREST BY A HEALTH INSURANCE ISSUER; REVISING LAWS APPLICABLE TO MULTIPLE EMPLOYER WELFARE ARRANGEMENTS; EXTENDING THE TERMINATION DATE OF THE PROHIBITION AGAINST A PHARMACY BENEFIT MANAGER OR HEALTH CARRIER REQUIRING FEDERALLY CERTIFIED HEALTH ENTITIES TO IDENTIFY 340B DRUGS; AMENDING SECTION 26, CHAPTER 501, LAWS OF 2021, AND SECTION 1, CHAPTER 259, LAWS OF 2023; AND AMENDING SECTIONS 2-18-101, 20-3-369, 27-1-306, 30-10-104, 30-10-201, 30-10-307, 30-10-1005, 33-1-501, 33-2-301, 33-2-306, 33-3-201, 33-17-237, 33-17-243, 33-17-1402, 33-17-1602, 33-19-105, 33-20-1302, 33-22-132, 33-22-138, 33-22-150, 33-22-206, 33-22-208, 33-22-244, 33-

22-521, 33-22-906, 33-22-907, 33-22-921, 33-22-922, 33-22-923, 33-22-924, 33-32-211, AND 33-35-306, MCA; AND PROVIDING EFFECTIVE DATES.