AN ACT GENERALLY REVISING INSURANCE LAWS; IMPLEMENTING ACCREDITATION STANDARDS AND MODEL ACTS DEVELOPED BY THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, INCLUDING STANDARDS FOR RISK MANAGEMENT AND RETENTION, VALUATION, ENTERPRISE RISK STANDARDS FOR HOLDING COMPANY SYSTEMS, AND CERTAIN NONFORFEITURE PROVISIONS; CREATING GUIDELINES AND RELATED REQUIREMENTS FOR AN INSURER'S SELF-ASSESSMENT OF RISK AND SOLVENCY; ADOPTING PRINCIPLE-BASED VALUATION; ADOPTING A VALUATION MANUAL FOR RESERVES; APPLYING ACTUARIAL STANDARDS TO RESERVE REPORTING; APPLYING THE VALUATION MANUAL TO ACCIDENT AND HEALTH PLANS; PROVIDING FOR ENTERPRISE RISK REPORTING; GRANTING THE COMMISSIONER OF INSURANCE APPROVAL AUTHORITY OVER DIVESTITURES; ALLOWING FOR DISCLAIMERS OF AFFILIATION; EXTENDING CONFIDENTIALITY FOR VARIOUS REPORTS FILED WITH THE COMMISSIONER; EXPANDING PENALTIES FOR WITHHOLDING OF CERTAIN INFORMATION; CLARIFYING CREDIT FOR CEDING INSURERS OR REINSURERS; REVISING TERMS FOR RISK RETENTION GROUPS, INCLUDING CLARIFICATION OF INDEPENDENT DIRECTORS AND MATERIAL RELATIONSHIPS; EXPANDING NONFORFEITURE VALUATION OPTIONS; EXTENDING RULEMAKING AUTHORITY; AMENDING SECTIONS 33-2-521, 33-2-523, 33-2-525, 33-2-526, 33-2-527, 33-2-537, 33-2-1101, 33-2-1104, 33-2-1105, 33-2-1106, 33-2-1111, 33-2-1112, 33-2-1113, 33-2-1115, 33-2-1116, 33-2-1120, 33-2-1216, 33-2-1217, 33-2-1501, 33-11-103, 33-20-203, 33-20-208, AND 33-31-204, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE AND A RETROACTIVE APPLICABILITY DATE.

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

Section 1. Short title. [Sections 1 through 9] may be cited as the "Own Risk and Solvency Assessment Act".

Section 2. Purpose. The purpose of [sections 1 through 9] is to provide:

(1) requirements for maintaining a risk management framework and completing an own risk and solvency

assessment; and

(2) guidance and instructions for filing an ORSA summary report with the commissioner.

Section 3. Definitions. For the purposes of [sections 1 through 9], the following definitions apply:

(1) "Insurance group" means those insurers and affiliates included within an insurance holding company system as defined in 33-2-1101.

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

(3) "ORSA guidance manual" means the current version of the own risk and solvency assessment guidance manual developed and adopted by the NAIC as of [the effective date of this act] or as subsequently adopted by rule by the commissioner. A change to the ORSA guidance manual is effective on January 1 following the calendar year in which the commissioner adopts the changed manual by rule.

(4) "ORSA summary report" means a confidential, high-level summary of an insurer's or insurance group's ORSA.

(5) "Own risk and solvency assessment" or "ORSA" means a confidential, internal assessment, appropriate to the nature, scale, and complexity of an insurer or insurance group, conducted by an insurer or insurance group of the material and relevant risks associated with the insurer or the insurance group's current business plan and of the sufficiency of the insurer's or insurance group's capital resources to support those risks.

(6) "Risk management framework" means a study of the elements used to assist an insurer or insurance group to identify, assess, monitor, manage, and report on material and relevant risk of the insurer or the insurance group.

Section 4. Risk management framework required. All Montana insurers and insurance groups shall maintain a risk management framework. This requirement is satisfied if the insurance group of which the insurer is a member maintains a risk management framework applicable to the operations of the insurer.

Section 5. Own risk and solvency assessment required. Subject to the exemptions in [section 7], an insurer or an insurance group of which the insurer is a member shall conduct an own risk and solvency assessment consistent with a process comparable to the ORSA guidance manual. The own risk and solvency assessment must be conducted no less than annually and at any time when there are significant changes to the

risk profile of the insurer or the insurance group of which the insurer is a member.

Section 6. ORSA summary report. (1) No more than once a year, the commissioner may request and an insurer or its insurance group shall provide to the commissioner, as provided in subsection (2), an ORSA summary report or any combination of reports that together contain the information described in the ORSA guidance manual as applicable to the insurer and the insurance group of which the insurer is a member.

(2) (a) If the insurer is a member of an insurance group, the insurer shall submit any report required under this section to the commissioner when the commissioner is the lead state regulator for that insurance group.

(b) If the insurer is not a member of an insurance group, the insurer shall submit any report required under this section to the commissioner.

(c) An insurer that is a member of an insurance group may voluntarily submit the report to a requesting insurance regulator who is not the lead state regulator for the insurer's insurance group.

(3) (a) The report must be prepared consistent with the ORSA guidance manual and subsection (3)(b). Documentation and supporting information must be maintained and made available for an examination or on request of the commissioner.

(b) The review of the ORSA summary report and any additional requests for information must be made using similar procedures currently used in the analysis and examination of multistate or global insurers and insurance groups.

(4) (a) The report must include the signature of the chief risk officer of the insurer or insurance group or of another executive charged with overseeing the enterprise risk management process for the insurer or the insurance group.

(b) The signature of the chief risk officer or other executive charged with overseeing the enterprise risk management is an attestation that to the best of the officer's or executive's knowledge the insurer or insurance group applies the enterprise risk management process described in the ORSA summary report and that a copy of the report has been provided to the board of directors of the insurer or the insurance group or to the appropriate committee of the board of directors.

(5) An insurer may comply with this section by providing the most recent and substantially similar report provided by the insurer or another member of an insurance group of which the insurer is a member to the

insurance regulator of another state or to a supervisor or regulator of a foreign jurisdiction, if that report provides information that is comparable to the information described in the ORSA guidance manual. A report in a language other than English must be accompanied by a translation of the report into English.

Section 7. ORSA exemptions -- conditions -- waiver -- override. (1) Except as provided in subsection (5), an insurer is exempt from the requirements of [sections 1 through 9] if:

(a) (i) the insurer has an annual direct written and unaffiliated assumed premium of less than $500 million. This total includes international direct and assumed premiums. The total excludes premiums reinsured through the federal crop insurance corporation and the federal flood program.

(ii) the insurer's insurance group has annual direct written and unaffiliated assumed premiums of less than $1 billion. This total includes international direct and assumed premiums. The total excludes premiums reinsured through the federal crop insurance corporation and the federal flood program.

(b) the insurer provides the most recent and similar report provided by the insurer or another group member of an insurance group of which the insurer is a member to the insurance regulator of another state or to an insurance supervisor or insurance regulator of a foreign jurisdiction.

(2) If an insurer qualifies for exemption pursuant to subsection (1)(a)(i) but the insurance group of which the insurer is a member does not qualify for exemption pursuant to subsection (1)(a)(ii), the ORSA summary report must include every insurer within the insurance group. This requirement may be satisfied by the submission of more than one ORSA summary report for any combination of insurers as long as each combination of reports includes every insurer within the insurance group.

(3) If an insurer does not qualify for exemption pursuant to (1)(a)(i) but the insurance group of which the insurer is a member qualifies for exemption pursuant to subsection (1)(a)(ii), the only required ORSA summary report is the report applicable to that insurer.

(4) (a) An insurer that does not qualify for exemption under this section may apply to the commissioner for a waiver from the requirements of [sections 1 through 9] based on unique circumstances.

(b) In deciding whether to grant an insurer's request for a waiver, the commissioner may consider the type and volume of business written, ownership, organizational structure, and any other factor the commissioner considers relevant to the insurer or to the insurance group of which the insurer is a member.

(c) If the insurer is part of an insurance group with insurers domiciled in more than one state, the

commissioner may coordinate with the lead state regulator and with the other domiciliary insurance regulators in considering whether to grant the insurer's request for a waiver.

(5) (a) The commissioner may override the exemptions provided under this section:

(i) based on unique circumstances, which may include the type and volume of business written, ownership, organizational structure, federal agency requests, or international supervisor requests;

(ii) if the insurer has risk-based capital that meets a company action level event as provided in 33-2-1904;

(iii) if the insurer is in hazardous financial condition as described in 33-2-1321; or

(iv) if the insurer exhibits the qualities of a troubled insurer as determined by the commissioner.

(b) If the commissioner determines that an override of the exemptions as provided in subsection (5)(a) is necessary, the commissioner may require an insurer to maintain a risk management framework, conduct an own risk and solvency assessment, and file an ORSA summary report.

(6) If an insurer qualifies for an exemption pursuant to subsection (1) but subsequently no longer qualifies for that exemption because of changes in premium as reflected in the insurer's most recent annual statement or in the most recent annual statements of the insurers within the insurance group of which the insurer is a member, the insurer has 1 year following the year in which the threshold was exceeded to comply with the requirements of [sections 1 through 9].

Section 8. Confidentiality. (1) Information provided or developed under [sections 1 through 9] for an own risk and solvency assessment or ORSA summary report and in the possession of or control of the commissioner or any other person under [sections 1 through 9] is recognized as proprietary and containing trade secrets. The information is confidential by law and privileged, not admissible as evidence in any civil action, and not subject to subpoena, discovery, the provisions of 2-6-102, or the Freedom of Information Act, 5 U.S.C. 552.

(2) The commissioner may use information in an ORSA summary report in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties.

(3) The commissioner and any person who receives ORSA-related information while operating under the authority of the commissioner or with whom information is shared pursuant to an own risk and solvency assessment may not testify in any private civil action concerning the ORSA-developed information.

(4) To assist in the commissioner's regulatory duties, the commissioner:

(a) may, on request, share ORSA-related information, including proprietary and trade secret documents

and materials, with other state, federal, and international financial regulatory agencies, including with members of any supervisory college, the NAIC, or third-party consultants designated by the commissioner. A person with whom the ORSA-related information is shared shall agree in writing to maintain the confidentiality and privileged status of the ORSA-related information and shall verify in writing that the recipient has legal authority to maintain confidentiality.

(b) may receive ORSA-related information, including otherwise confidential and privileged documents, materials, or other information that may include proprietary and trade secret information or documents, from regulatory officials of other foreign or domestic jurisdictions, supervisory college members, and the NAIC. Received information is confidential as provided in this section.

(c) shall enter into a written agreement with the NAIC or a third-party consultant governing sharing and use of the information provided pursuant to an ORSA, consistent with this subsection (4).

(5) The written agreement required under subsection (4)(c) must:

(a) specify procedures and protocols regarding the confidentiality of the information, including procedures and protocols for sharing by the NAIC with other state regulators from states in which the insurance group has domiciled insurers;

(b) provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the information and that the recipient has verified the legal authority to maintain confidentiality;

(c) specify that ownership of shared information remains with the commissioner. Use of the information by the NAIC or a third-party consultant is subject to the direction of the commissioner.

(d) prohibit the recipient from storing the shared information in a permanent database after any underlying analysis is completed;

(e) require prompt notice to be given to an insurer whose information in the possession of the recipient is subject to a request or subpoena to the recipient for disclosure or production;

(f) require the recipient to consent to intervention by an insurer in any judicial or administrative action in which the recipient may be required to disclose confidential information about the insurer that is received under an ORSA; and

(g) require the insurer's consent when entering into an agreement with a third-party consultant.

(6) The sharing of information pursuant to [sections 1 through 9] does not constitute a delegation of regulatory authority or rulemaking, and the commissioner remains solely responsible for the administration,

execution, and enforcement of the provisions of [sections 1 through 9].

(7) Disclosure of information under this section to or from the commissioner does not constitute a waiver of any applicable privilege or claim of confidentiality related to the information obtained under [sections 1 through 9].

(8) Information in the possession of or control of the NAIC or a third-party consultant pursuant to [sections 1 through 9] is confidential by law and privileged, is not admissible in evidence in any private civil action, and is not subject to 2-6-102, subpoena, or discovery.

(9) For the purposes of this section, "information" means documents, materials, or other ORSA-related information, including the ORSA summary report, that is in the possession of or control of the commissioner or any other person under [sections 1 through 9].

Section 9. Sanctions. (1) Any insurer failing to timely file the ORSA summary report shall be fined no more than $500 for each day's delay, up to a maximum penalty of $25,000.

(2) The commissioner shall collect the fine and deposit the money in the state general fund.

Section 10. Short title. [Sections 10 through 16], 33-2-521 through 33-2-529, 33-2-531, and 33-2-537 may be cited as the "Standard Valuation Act".

Section 11. Definitions. As used in [this part], the following definitions apply unless the context clearly indicates otherwise:

(1) "Accident and health insurance" means contracts that incorporate morbidity risk and provide protection against economic loss resulting from accident, sickness, or medical conditions.

(2) "Appointed actuary" means a qualified actuary who is appointed in accordance with the valuation manual to prepare an actuarial opinion required by [this part].

(3) "Deposit-type contract" means a contract that does not incorporate mortality or morbidity risks.

(4) "Insurer" means an entity that:

(a) has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in Montana and has at least one of the named contracts in force or on claim; or

(b) has written, issued, or reinsured life insurance contracts, accident and health insurance contracts,

or deposit-type contracts in any state and is required to hold a certificate of authority to write life insurance, accident and health insurance, or deposit-type contracts in Montana.

(5) "Life insurance" means contracts that incorporate mortality risk, including annuity and pure endowment contracts.

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

(7) (a) "Policyholder behavior" means any action taken by a policyholder, a contract holder, or any other person with the right to elect options, such as the action that a certificate holder may take under a policy or a contract subject to [this part]. The actions include but are not limited to allowing a policy or contract to lapse, making a premium payment or loan, or making benefit elections prescribed by the policy or contract. Other actions may be identified by rule.

(b) The term does not include events of mortality or morbidity that result in benefits prescribed in their essential aspects by the terms of the policy or contract.

(8) "Principle-based valuation" means a reserve valuation that uses one or more methods or one or more assumptions determined by the insurer. A principle-based valuation must comply with the provisions of [section 13].

(9) "Qualified actuary" means an individual who is qualified to sign the applicable statement of actuarial opinion in accordance with the American academy of actuaries qualification standards and meets the requirements specified in the valuation manual.

(10) "Tail risk" means a risk that occurs either when the frequency of low-probability events is higher than expected under a normal probability distribution or when there are observed events of very significant size or magnitude.

(11) "Valuation manual" means the valuation manual adopted by the NAIC in accordance with its model law regarding standard valuation and adopted by the commissioner by rule.

Section 12. Valuation for policies. (1) For policies issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under 33-2-521, except as provided in subsection (6) or (8) of this section.

(2) The operative date of the valuation manual is January 1 of the first calendar year following the first July 1 as of which all of the following have occurred:

(a) the valuation manual has been adopted by the NAIC by an affirmative vote of at least 42 members or three-fourths of the members voting, whichever is greater;

(b) the standard valuation law as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by states representing greater than 75% of the direct premiums written as reported in the following annual statements submitted for 2008: life, accident and health, health, and fraternal annual statements;

(c) the standard valuation law as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least 42 of the following 55 jurisdictions: the 50 states of the United States, American Samoa, the American Virgin Islands, the District of Columbia, Guam, and Puerto Rico; and

(d) the commissioner has adopted by rule the valuation manual.

(3) Unless a change in the valuation manual specifies a later effective date, changes to the valuation manual are effective on January 1 following the date when all of the following have occurred:

(a) the change in the valuation manual has been adopted by an affirmative vote representing:

(i) at least three-fourths of the members of the NAIC voting but not less than a majority of the total membership; and

(ii) members of the NAIC representing jurisdictions totaling more than 75% of the direct premiums written as reported in the following annual statements most recently available prior to the vote in subsection (3)(a)(i): life, accident and health, health, and fraternal annual statements; and

(b) the change to the valuation manual is adopted by the commissioner by rule.

(4) The valuation manual adopted by the commissioner must specify all of the following:

(a) minimum valuation standards for and definitions of the policies or contracts subject to 33-2-521(2). The minimum valuation standards include:

(i) the commissioner's reserve valuation method for life insurance contracts, other than annuity contracts, subject to [section 13];

(ii) the commissioner's annuity reserve valuation method for annuity contracts subject to 33-2-521(2); and

(iii) minimum reserves for all other policies or contracts subject to [section 13(2)].

(b) a description of which policies or contracts or types of policies or contracts that are subject to the requirements of a principle-based valuation in [section 13(1)] and the minimum valuation standards consistent

with those requirements;

(c) for policies and contracts subject to a principle-based valuation:

(i) requirements for the format of reports to the commissioner under [section 13(3)(c)], which must include information necessary to determine if the valuation is appropriate and in compliance with [this part];

(ii) prescribed assumptions for risks over which the company does not have significant control or influence; and

(iii) procedures for corporate governance and oversight of the actuarial function as well as a process for appropriate waiver or modification of the corporate governance procedures.

(d) for policies not subject to a principle-based valuation under [section 13], the minimum valuation standard must either:

(i) be consistent with the minimum standard of valuation prior to the operative date of the valuation manual as determined in subsections (1) and (2) or as amended as provided in subsection (3); or

(ii) develop reserves that quantify the benefits and guarantees as well as the funding associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring; and

(e) other components in the valuation manual that the commissioner considers necessary for the smooth operation of policies or contracts under [this part]. These may include but are not limited to reserve methodologies, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company experience, risk measurement, disclosure, certifications, reports, actuarial opinions and memoranda, transition rules, and internal controls.

(5) The commissioner shall specify by rule the data and form of the data required under [section 14] and to whom the data must be submitted as well as any other requirements including data analysis and reporting of analysis.

(6) In the absence of a specific valuation requirement or if a specific valuation requirement in the valuation manual is not, in the opinion of the commissioner, in compliance with [this part], the company shall, with respect to the requirements named as out of compliance with [this part], comply with minimum standard valuations prescribed by the commissioner by rule.

(7) The commissioner may engage a qualified actuary, at the expense of the company, to perform an actuarial examination of the company and comment on the appropriateness of any reserve assumption or method

used by the company or to review and comment on a company's compliance with any requirement in [this part]. The commissioner may rely on the opinion, regarding provisions contained in [this part], of a qualified actuary engaged by the insurance regulator of another state, district, or territory of the United States. As used in this subsection, the term "engage" includes employment and contracting.

(8) The commissioner may require a company to change any assumption or method that in the opinion of the commissioner is necessary in order to comply with the requirements of the valuation manual or of [this part].

(9) A company shall adjust its reserves as required by the commissioner.

(10) The commissioner may take disciplinary action for violations of this section as provided in 33-1-317.

Section 13. Principle-based valuation. (1) A company domiciled in Montana shall establish reserves using a principle-based valuation that meets the conditions for policies or contracts in this section and as specified in the valuation manual.

(2) The principle-based valuation at a minimum must:

(a) quantify the benefits and guarantees as well as the funding associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring during the lifetime of the contracts. The principle-based valuation method must reflect conditions appropriately adverse to quantify the tail risk for policies and contracts with significant tail risk.

(b) incorporate assumptions, risk analysis methods, and financial models and management techniques that are consistent with but not necessarily identical to those used within the company's overall risk assessment process. This process must recognize potential differences in financial reporting structures and any prescribed assumptions or methods.

(c) incorporate assumptions derived:

(i) as prescribed in the valuation manual; or

(ii) if not prescribed in the valuation manual, using:

(A) the company's available experience to the extent the experience is relevant and statistically credible; or

(B) other relevant and statistically credible experience whenever the company's own data is not available, relevant, or statistically credible; and

(d) provide margins for uncertainty, including adverse deviation and estimation error to the extent that

the greater the uncertainty, the larger the margin and resulting reserve.

(3) A company using principle-based valuation for one or more policies or contracts subject to this section and as specified in the valuation manual shall:

(a) establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual;

(b) provide to the commissioner and its board of directors an annual certification of the effectiveness of the internal controls with respect to the principle-based valuation. These internal controls must be designed to assure that all material risks inherent in the liabilities and associated assets subject to the principle-based valuation are included in the valuation and are performed in accordance with the valuation manual. The certification must be based on controls in place as of the end of the preceding calendar year.

(c) develop a principle-based valuation report that complies with standards prescribed in the valuation manual. This report must be filed with the commissioner upon the commissioner's request. A report under this subsection (3)(c) is required after the commissioner has adopted rules as provided in [section 16].

(4) A principle-based valuation may include a prescribed formulaic reserve component.

Section 14. Experience reporting. A company shall submit mortality, morbidity, policyholder behavior, expense experience, and other data as prescribed by the commissioner and in accordance with the valuation manual.

Section 15. Confidentiality -- definitions. (1) Except as provided in subsection (9), a company's confidential information is confidential and privileged and is not subject to subpoena, discovery, or public information requests under 2-6-102 or admissible in evidence in any private civil action.

(2) The commissioner may use the confidential information to further any regulatory or legal action brought against the company as a part of the commissioner's official duties.

(3) Neither the commissioner nor any person who receives confidential information while acting under the authority of the commissioner may be required or permitted to testify in any private civil action concerning a company's confidential information.

(4) Subject to the conditions in subsection (4)(c), the commissioner may, to assist in the performance of the commissioner's duties, share:

(a) confidential information with other state, federal, and international regulatory agencies and with the NAIC and its affiliates and subsidiaries upon agreement that the confidential information will be kept confidential; and

(b) only confidential information as defined in subsections (10)(a)(i)(A) and (10)(a)(i)(D) with:

(i) the actuarial board for counseling and discipline or its successor upon a request that states the confidential information is required for use in professional disciplinary proceedings; and

(ii) state, federal, and international law enforcement officials; and

(c) the information under this subsection (4) only if the recipient of the information has the legal authority to agree, and the recipient has agreed, to maintain the confidentiality and privileged status of the documents, materials, data, and other information in the same manner and to the same extent as required for the commissioner.

(5) (a) The commissioner may receive documents, materials, data, and other information, including otherwise confidential and privileged documents, materials, data, and other information, from:

(i) the NAIC and its affiliates and subsidiaries;

(ii) regulatory or law enforcement officials of other foreign or domestic jurisdictions; and

(iii) the actuarial board for counseling and discipline or its successor.

(b) The commissioner shall maintain as confidential or privileged any documents, materials, data, or other information received from the entities listed in subsection (5)(a) with notice or the understanding that the documents, materials, data, or other information is confidential or privileged under the laws of the jurisdiction that is the source of the documents, materials, data, or other information.

(6) The commissioner may enter into agreements governing the sharing and use of confidential information consistent with this section.

(7) A disclosure to the commissioner under this section or a sharing of confidential information authorized in this section does not constitute a waiver of any applicable privilege or claim of confidentiality for the confidential information.

(8) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this section must be recognized and enforced in any proceeding in this state, including any court proceedings.

(9) The confidential information defined in subsections (10)(a)(i)(A) and (10)(a)(i)(D) may:

(a) be subject to subpoena for the purpose of defending an action seeking damages from the appointed actuary submitting the related memorandum in support of an opinion submitted under 33-2-521 or a principle-based valuation report developed pursuant to [section 13(3)(c)] by reason of an action required by [sections 10 through 16];

(b) be otherwise released by the commissioner with the written consent of the company; or

(c) no longer be confidential for all portions after any portion of a memorandum in support of an opinion submitted under 33-2-521 or a principle-based valuation report developed under [section 13(3)(c)] is cited by the company in its marketing or is publicly volunteered to or before a governmental agency other than a state insurance department or is released by the company to the news media.

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

(a) (i) "Confidential information" means:

(A) a memorandum in support of an opinion submitted under 33-2-521 and any other documents, materials, and other information, including but not limited to all working papers or copies of the working papers that were created, produced, or obtained by the commissioner or by any other person in connection with the memorandum or disclosed to the commissioner or to any other person in connection with the memorandum;

(B) subject to the provisions of subsection (10)(a)(ii)(A), all documents, materials, and other information in the course of an examination made under [section 12(7)], including but not limited to all working papers and copies of the working papers that were created, produced, or obtained by the commissioner or by any other person in connection with the examination or disclosed to the commissioner or to any other person in connection with the examination;

(C) any reports, documents, materials, or other information developed by a company in support of or in connection with an annual certification by the company under [section 13(3)(b)] evaluating the effectiveness of the company's internal controls with respect to a principle-based valuation and any other documents, materials, and other information, including but not limited to working papers and copies of the working papers created, produced, or obtained by the commissioner or by any other person in connection with the reports, documents, materials, and other information disclosed to the commissioner or to any other person in connection with those reports, documents, materials, and other information;

(D) any principle-based valuation report developed under [section 13(3)(c)] and any other documents, materials, and other information, including but not limited to all working papers and copies of working papers

created, produced, or obtained by the commissioner or any other person in connection with the principle-based valuation report or disclosed to the commissioner or to any other person in connection with the report; and

(E) any experience data and any other documents, materials, data, and other information, including but not limited to all working papers and copies of working papers created or produced in connection with the experience data. The information under this subsection (10)(a)(i)(E) includes any potential company-identifying or personally identifiable information that is provided to or obtained by the commissioner or any other person in connection with the documents, materials, data, and other information described in this subsection (10)(a)(i)(E), including but not limited to working papers and copies of working papers created, produced, or obtained by the commissioner or any other person or disclosed to the commissioner or to any other person.

(ii) The term does not include:

(A) an examination report or other material prepared in connection with an examination made under [section 12(7)] to the extent that the examination report or other material prepared in connection with the examination would not have been held private and confidential if prepared under 33-1-401; or

(B) any portion of confidential information that has been cited by the insurer in its marketing, provided to any governmental agency other than a state insurance department, released by the insurer to the news media, or otherwise made public by the insurer in any way.

(b) "Experience data" means any documents, materials, data, and other information submitted by a company under [section 14].

(c) "NAIC" means the national association of insurance commissioners and its employees, agents, consultants, and contractors.

(d) "Regulatory agency" includes the agency's employees, agents, consultants, and contractors.

Section 16. Rulemaking. The commissioner shall adopt rules necessary to implement the provisions of [this part], including but not limited to adopting the valuation manual.

Section 17. Section 33-2-521, MCA, is amended to read:

"33-2-521. Standard valuation of reserve liabilities law ~~-- life insurance~~. (1) The commissioner shall annually value or cause to be valued the reserve liabilities (reserves) for all outstanding life insurance policies and annuity and pure endowment contracts of every life insurer doing business in this state ~~and may certify the~~

~~amount of any reserves, specifying the mortality table or tables, rate or rates of interest, and methods (net level premium method or other) used in the calculation of reserves~~ issued on or before the operative date of the valuation manual. In calculating the reserves under this subsection, the commissioner may use group methods and approximate averages for fractions of a year or otherwise.

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

~~(2)~~(3) In lieu of the valuation of the reserves required in this section of any foreign or alien insurer, the commissioner may accept any valuation made or caused to be made by the insurance supervisory official of any state or other jurisdiction when the valuation complies with the minimum standard provided in ~~this section and if the official of the other state or jurisdiction accepts as sufficient and valid for all legal purposes the certificate of valuation of the commissioner when the certificate states the valuation to have been made in a specified manner according to which the aggregate reserves would be at least as large as if they had been computed in the manner prescribed by the law of that state or jurisdiction~~ [this part].

~~(3)~~(4) Any insurer that has adopted any standard of valuation producing greater aggregate reserves than those calculated according to the minimum ~~standard~~ standards provided in ~~this section~~ [this part] may, with the approval of the commissioner, adopt any lower standard of valuation but not lower than the minimum in this section. For the purposes of this section, the holding of additional reserves previously determined by ~~a qualified~~ an appointed actuary to be necessary to render the opinion required in ~~subsection (4)~~ subsections (5) and (6) may not be considered to be the adoption of a higher standard of valuation.

~~(4)~~(5) (a) Each life insurer doing business in this state prior to the operative date of the valuation manual shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by rule are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this state. The commissioner by rule shall define the specifics of this opinion and add any other items considered necessary to its scope.

(b) Each life insurer, except as exempted by or pursuant to regulation, shall also annually include in the opinion required by subsection ~~(4)(a)~~ (5)(a) an opinion of the same qualified actuary as to whether the reserves

and related actuarial items held in support of the policies and contracts specified by the commissioner by rule~~, when considered in light of the assets held by the insurer with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts,~~ make adequate provision for the insurer's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts. In developing the opinion, the qualified actuary shall consider the assets held by the insurer with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts.

(c) The commissioner may provide by rule for a transition period for establishing any higher reserves that the qualified actuary may consider necessary in order to render the opinion required by this subsection ~~(4)~~ (5).

(d) Each opinion required by this subsection ~~(4)~~ (5) must be governed by the following provisions:

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

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

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

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

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

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

(vii) Except in cases of fraud or willful misconduct, the qualified actuary is not liable for damages to any person, other than the insurer and the commissioner, for any act, error, omission, decision, or conduct with respect to the actuary's opinion.

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

~~(ix) Any memorandum in support of the opinion and any other material provided by the insurer to the commissioner in connection with those items must be kept confidential by the commissioner, may not be made public, and is not subject to subpoena, other than for the purpose of defending an action seeking damages from any person by reason of any action required by this subsection (4) or by rules promulgated under this subsection (4). However, the memorandum or other material may otherwise be released by the commissioner:~~

~~(A) with the written consent of the insurer; or~~

~~(B) to the American academy of actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the commissioner for preserving the confidentiality of the memorandum or other material. Once any portion of the confidential memorandum is cited by the insurer in its marketing, is cited before any governmental agency other than a state insurance department, or is released by the insurer to the news media, all portions of the confidential memorandum are no longer confidential.~~

~~(5) For purposes of this section, "qualified actuary" means a member in good standing of the American academy of actuaries who meets the requirements set forth in the academy's rules.~~

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

(i) computed appropriately;

(ii) based on assumptions that satisfy contractual provisions;

(iii) consistent with prior reported amounts; and

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

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

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

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

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

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

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

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

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

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

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

Section 18. Section 33-2-523, MCA, is amended to read:

"33-2-523. Contracts on or after operative date of 33-20-213 and prior to operative date of valuation manual -- valuation. (1) This section applies to only those policies and contracts issued prior to the date of adoption of the valuation manual, which is the operative date for the valuation manual, and on or after the operative date of 33-20-213, except as otherwise provided in 33-2-524 for group annuity and pure endowment contracts issued prior to that date.

(2) Except as otherwise provided in 33-2-524, 33-2-525, and 33-2-537(2), the minimum standard for the valuation of all the policies and contracts issued prior to October 1, 1995, is the standard provided by the laws in effect prior to October 1, 1995. Except as otherwise provided in 33-2-524, 33-2-525, and 33-2-537(2), the minimum standard for the valuation of all policies and contracts issued prior to the operative date of the valuation manual, as provided in subsection (1), is the commissioner's reserve valuation methods defined in 33-2-525, 33-2-526(3) and (4), and 33-2-537, 5% interest for group annuity and pure endowment contracts, and 3 1/2% interest for all other policies and contracts or, in the case of life insurance policies and contracts other than annuity and pure endowment contracts issued on or after March 17, 1973, 4% interest for all other policies issued prior to July 1, 1979, 5 1/2% interest for single-premium life insurance policies, and 4 1/2% interest for all other policies issued on or after July 1, 1979, and the following tables:

(a) for all ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in the policies:

(i) the 1941 commissioners standard ordinary mortality table for policies issued prior to the operative date of 33-20-206, as amended, and the 1958 commissioners standard ordinary mortality table for policies issued on or after that operative date but prior to January 1, 1989, except that for any category of the policies issued on female risks, modified net premiums and present values, referred to in 33-2-525 and 33-2-526, may be calculated, at the option of the insurer, with the approval of the commissioner, according to an age younger than the actual age of the insured;

(ii) for policies issued prior to the operative date of the valuation manual but on or after January 1, 1989:

(A) the 1980 commissioners standard ordinary mortality table;

(B) at the election of the insurer for any one or more specified policies of life insurance, the 1980 commissioners standard ordinary mortality table with 10-year select mortality factors; or

(C) any ordinary mortality table adopted after 2001 by the national association of insurance commissioners that is approved by the commissioner by rule for use in determining the minimum standard of valuation for policies;

(iii) for policies issued on or after January 1, 2005, and before January 1, 2009, at the election of the insurer for any one or more specified policies of life insurance, the 2001 commissioners standard ordinary mortality table; or

(iv) for policies issued prior to the operative date of the valuation manual but on or after January 1, 2009,

the 2001 commissioners standard ordinary mortality table;

(b) for all industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in the policies, the 1941 standard industrial mortality table for policies issued prior to the operative date of 33-20-207 and, for policies issued on or after that operative date, the 1961 commissioners standard industrial mortality table or any industrial mortality table adopted after 1980 by the national association of insurance commissioners that is approved by the commissioner by rule for use in determining the minimum standard of valuation for the policies;

(c) for individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in the policies, the 1937 standard annuity mortality table or, at the option of the insurer, the annuity mortality table for 1949, ultimate, or any modification of either of these tables approved by the commissioner;

(d) for group annuity and pure endowment contracts, excluding any disability and accidental death benefits in the policies, the group annuity mortality table for 1951, any modification of the table approved by the commissioner, or, at the option of the insurer, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts;

(e) (i) for total and permanent disability benefits in or supplementary to ordinary policies or contracts:

(A) for policies or contracts issued on or after January 1, 1966, the tables of period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 disability study of the society of actuaries, with due regard to the type of benefit, or any tables of disablement rates and termination rates adopted after 1980 by the national association of insurance commissioners that are approved by the commissioner by rule for use in determining the minimum standard of valuation for the policies;

(B) for policies or contracts issued on or after January 1, 1961, and prior to January 1, 1966, either the tables or, at the option of the insurer, the class 3 disability table (1926); and

(C) for policies issued prior to January 1, 1961, the class 3 disability table (1926);

(ii) any table must, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies;

(f) (i) for accidental death benefits in or supplementary to policies:

(A) for policies issued on or after January 1, 1966, the 1959 accidental death benefits table or any accidental death benefits table adopted after 1980 by the national association of insurance commissioners that is approved by the commissioner by rule for use in determining the minimum standard of valuation for the policies;

(B) for policies issued on or after January 1, 1961, and prior to January 1, 1966, a table referenced in subsection (2)(f)(i)(A) or, at the option of the insurer, the intercompany double indemnity mortality table; and

(C) for policies issued prior to January 1, 1961, the intercompany double indemnity mortality table;

(ii) either table must be combined with a mortality table permitted for calculating the reserves for life insurance policies;

(g) for group life insurance, life insurance issued on the substandard basis, and other special benefits, the tables approved by the commissioner."

Section 19. Section 33-2-525, MCA, is amended to read:

"33-2-525. Commissioner's reserve valuation method. (1) Except as otherwise provided in subsection (4) of this section, 33-2-526(3) and (4), and 33-2-537(2), reserves according to the commissioner's reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums, must be the excess, if any, of the present value, at the date of valuation, of future guaranteed benefits provided for by the policies, over the then present value of any future modified net premiums. The modified net premiums for any policy must be the uniform percentage of the respective contract premiums for the benefits that the present value, at the date of issue of the policy, of all modified net premiums must be equal to the sum of the then present value of the benefits provided for by the policy and the excess of subsection (1)(a) over subsection (1)(b), as follows:

(a) a net level annual premium equal to the present value, at the date of issue, of benefits provided for after the first policy year, divided by the present value, at the date of issue of an annuity of one per annum payable on the first and each subsequent anniversary of the policy on which a premium falls due. However, the net level annual premium may not exceed the net level annual premium on the 19-year premium whole life plan for insurance of the same amount at an age 1 year higher than the age at issue of the policy.

(b) a net 1-year term premium for benefits provided for in the first policy year.

(2) (a) For each life insurance policy issued on or after January 1, 1987, for which the contract premium in the first policy year exceeds that of the second year, for which a comparable additional benefit is not provided in the first year for the excess, and that provides an endowment benefit, a cash surrender value, or a combination of both in an amount greater than the excess premium, the reserve according to the commissioner's reserve valuation method, as of any policy anniversary occurring on or before the assumed ending date as the first policy

anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than the excess premium, is, except as otherwise provided in 33-2-526, the greater of the reserve as of the policy anniversary calculated as described in subsection (1) or the reserve as of the policy anniversary calculated as described in subsection (1) with the following exceptions:

(i) the value defined in subsection (1)(a) is reduced by 15% of the amount of the excess first-year premium;

(ii) all present values of benefits and premiums are determined without reference to premiums or benefits provided for in the policy after the assumed ending date;

(iii) the policy is assumed to mature on the assumed ending date as an endowment; and

(iv) the cash surrender value provided on the assumed ending date is considered an endowment benefit.

(b) In making the comparisons in subsection (2)(a), the mortality and interest bases stated in 33-2-523 and 33-2-527 must be used.

(3) Reserves according to the commissioner's reserve valuation method for the following must be calculated by a method consistent with the principles of this section, except that any extra premiums charged because of impairments or special hazards must be disregarded in the determination of modified net premiums:

(a) life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums;

(b) group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the Internal Revenue Code, as amended;

(c) disability and accidental death benefits in all policies and contracts; and

(d) all other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts.

(4) (a) Subsection (4)(b) applies to any annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the Internal Revenue Code, as amended.

(b) Reserves according to the commissioner's annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in the contracts, must be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by the contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations required by the terms of the contract that become payable prior to the end of the respective contract year. The future guaranteed benefits must be determined by using the mortality table, if any, and the interest rate or rates specified in the contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of the contracts to determine nonforfeiture values.

(c) The commissioner's reserve valuation method provided by this section is subject to the provisions of the valuation manual as adopted by the commissioner."

Section 20. Section 33-2-526, MCA, is amended to read:

"33-2-526. Limits -- options -- minimum reserves. (1) (a) An insurer's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits issued on or after October 1, 1995, and prior to adoption of the valuation manual by the commissioner by rule may not be less than the aggregate reserves calculated in accordance with the methods set forth in 33-2-525, 33-2-537(2), subsection (3) of this section, and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for the policies.

(b) After the operative date of the valuation manual, the reserve valuation methods determined by the commissioner under 33-2-525(4)(c) must be used in conjunction with the provisions of this section.

(2) Reserves for all policies and contracts issued prior to October 1, 1995, may be calculated, at the option of the insurer, according to standards that produce greater aggregate reserves for those policies and contracts than the minimum reserves required by the laws in effect immediately prior to October 1, 1995. Reserves for any category of policies, contracts, or benefits as established by the commissioner, issued on or after October 1, 1995, may be calculated at the option of the insurer according to any standards which produce greater aggregate reserves for a category than those calculated according to the minimum standard provided in this section, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, may not be higher than the corresponding rate or rates of interest used in calculating any

nonforfeiture benefits provided for a category.

(3) If in any contract year the gross premium charged by any life insurer on any policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve on the policy or contract but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for the policy or contract must be the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for the policy or contract or the reserve calculated by the method actually used for the policy or contract but using the minimum standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this section are those standards stated in 33-2-524 and 33-2-527.

(4) For every life insurance policy issued after December 30, 1986, for which the gross premium in the first policy year exceeds that of the second year, for which a comparable additional benefit is not provided in the first year for an excess, and that provides an endowment benefit, a cash surrender value, or a combination of both in an amount greater than the excess premium, subsections (1) through (3) of this section must be applied as if the method actually used in calculating the reserve for the policy were the method described in 33-2-525(1). The minimum reserve at each policy anniversary of the policy must be the greater of the minimum reserve calculated in accordance with 33-2-525 and the minimum reserve calculated in accordance with this section."

Section 21. Section 33-2-527, MCA, is amended to read:

"33-2-527. Interest rates -- determination of minimum standard valuation. (1) ~~The~~ For policies issued prior to the operative date of the valuation manual, the calendar year statutory valuation interest rates as established in this section must be used in determining the minimum standard for the valuation of:

(a) all life insurance policies issued in a particular calendar year on or after January 1, 1989;

(b) all individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 1984;

(c) all annuities and pure endowments purchased in a particular calendar year on or after January 1, 1984, under group annuity and pure endowment contracts; and

(d) the net increase, if any, in a particular calendar year after January 1, 1984, in amounts held under guaranteed interest contracts.

(2) Except as provided in subsection (3), the calendar year statutory valuation interest rates are determined as follows and the results rounded to the nearer 1/4 of 1%, when R1 is the lesser of R and .09, R2 is the greater of R and .09, R is the reference interest rate established in 33-2-529, and W is the weighting factor established in 33-2-528:

(a) for life insurance:

Interest rate = .03 + W(R1 - .03) + (W/2)(R2 - .09);

(b) for single-premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options:

Interest rate = .03 + W(R - .03);

(c) for other annuities with:

(i) cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in subsection (2)(b), the formula for life insurance stated in subsection (2)(a) applies to annuities and guaranteed interest contracts with guarantee durations in excess of 10 years and the formula for single-premium immediate annuities stated in subsection (2)(b) applies to annuities and guaranteed interest contracts with guarantee durations of 10 years or less;

(ii) no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single-premium immediate annuities stated in subsection (2)(b) applies; and

(iii) cash settlement options and guaranteed interest contracts with cash settlement options valued on a change-in-fund basis, the formula for single-premium immediate annuities stated in subsection (2)(b) applies.

(3) If the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than 1/2 of 1%, the calendar year statutory valuation interest rate for such life insurance policies is equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of this subsection, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year must be determined for 1980 (using the reference interest rate defined for 1979) and must be determined for each subsequent calendar year regardless of when 33-20-208 becomes operative."

Section 22. Section 33-2-537, MCA, is amended to read:

"33-2-537. Reserve calculation -- indeterminate premium plans -- minimum standards for disability plans and accident and health plans. (1) In the case of a plan of life insurance that provides for future premium determination, the amounts of which are to be determined by the insurer based on then estimates of future experience, or in the case of a plan of life insurance or annuity that is of a nature that the minimum reserves cannot be determined by the methods described in 33-2-525 and 33-2-526(3), the reserves that are held under the plan must:

(a) be appropriate in relation to the benefits and the pattern of premiums for that plan; and

(b) be computed by a method that is consistent with the principles of 33-2-521 through 33-2-529.

(2) The commissioner may promulgate a rule containing the minimum standards applicable to the valuation of disability plans issued prior to the operative date of the valuation manual. For accident and health insurance contracts issued on or after the operative date of the valuation manual and after the applicable effective date provided in [section 12], the minimum standard of valuation prescribed by the valuation manual must be used."

Section 23. Section 33-2-1101, MCA, is amended to read:

"33-2-1101. Definitions. As used in this part, the following terms shall have the respective meanings hereinafter set forth definitions apply, unless the context shall requires otherwise require:

(1) An "affiliate" of or person "affiliated" with a specific person is a person that directly, or indirectly through one or more intermediaries, controls or is controlled by or is under common control with the person specified.

(2) The term "control" "Control" (, including the terms "controlling", "controlled by", and "under common control with"), means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether. This power may be evidenced through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be is presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 10% or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by 33-2-1112 that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific

findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(3) "Enterprise risk" means any activity, circumstance, event, or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect on the financial condition or liquidity of the insurer or its insurance holding company system as a whole. The term includes but is not limited to anything that would cause the insurer's risk-based capital to fall into a company action level, as provided in 33-2-1904, or that would cause the insurer to be in hazardous financial condition as determined by the commissioner pursuant to 33-2-1321.

~~(3)~~(4) ~~An "insurance~~ "Insurance holding company system" ~~consists of~~ means two or more affiliated persons, one or more of which is an insurer.

~~(4)~~(5) ~~The term "insurer" shall have~~ "Insurer" has the ~~same~~ meaning ~~as set forth~~ provided in 33-1-201, except that ~~it shall~~ the term does not include agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

~~(5)~~(6) (a) ~~A "person" is~~ "Person" means an individual, a corporation, a partnership, an association, a joint-stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing acting in concert ~~but shall~~.

(b) The term does not include any securities broker performing no more than the usual and customary broker's function.

~~(6)~~(7) A "securityholder" of a specified person is one who owns any security of ~~such~~ that person, including common stock, preferred stock, debt obligations, and any other security convertible into or evidencing the right to acquire any of the foregoing.

~~(7)~~(8) A "subsidiary" of a specified person is an affiliate controlled by ~~such~~ that person directly or indirectly through one or more intermediaries.

~~(8)~~(9) ~~The term "voting~~ "Voting security" ~~shall include~~ means any security convertible into or evidencing a right to acquire a voting security."

Section 24. Section 33-2-1104, MCA, is amended to read:

"33-2-1104. Acquisition or divestiture of control of or merger with domestic insurer -- filing

requisites. (1) (a) A person other than the issuer may not make a tender offer for or a request or invitation for tenders of or enter into any agreement to exchange securities for, seek to acquire, or acquire, in the open market or otherwise, any voting security of a domestic insurer if, after the consummation of the transaction, the person would, directly or indirectly or by conversion or by exercise of any right to acquire, be in control of the insurer.

(b) A person may not enter into an agreement to merge with or otherwise to acquire control of a domestic insurer unless, at the time any offer, request, or invitation is made or any agreement is entered into or prior to the acquisition of the securities if an offer or agreement is not involved, the person has filed with the commissioner and has sent to the insurer, and the insurer has sent to its shareholders, a statement as provided in subsection (3) containing the information required by this section and the offer, request, invitation, agreement, or acquisition has been approved by the commissioner in the manner prescribed in this section. ~~For purposes of this section, a domestic insurer includes any other person controlling a domestic insurer unless the other person is either directly or through its affiliates primarily engaged in business other than the business of insurance.~~

(2) (a) A controlling person of a domestic insurer seeking to divest its controlling interest in the domestic insurer in any manner shall file for approval a confidential notice of its proposed divestiture at least 30 days prior to the cessation of control.

(b) The information in the notice must remain confidential until the conclusion of the transaction unless the commissioner, at the commissioner's discretion, determines confidential treatment will interfere with enforcement of this section.

(c) Subsections (2)(a) and (2)(b) do not apply to persons filing a statement under subsection (1).

~~(2)~~(3) The statement to be filed with the commissioner must be made under oath or affirmation and must contain the following ~~information~~:

(a) the name and address of each person by whom or on whose behalf the merger or other acquisition of control referred to in subsection (1) is to be effected, who is called the "acquiring party":

(i) if the person is an individual, the principal occupation and all offices and positions held during the past 5 years and any conviction of crimes other than minor traffic violations during the past 10 years;

(ii) if the person is not an individual:

(A) a report of the nature of its business operations during the past 5 years or for a lesser period that the person and any predecessors have been in existence;

(B) an informative description of the business intended to be done by the person and the person's

subsidiaries; and

(C) a list of all individuals who are or who have been selected to become directors or executive officers of the person or who perform or will perform functions appropriate to the positions. The list must include for each individual the information required by subsection ~~(2)(a)(i)~~ (3)(a)(i).

(b) the source, nature, and amount of the consideration used or to be used in effecting the merger or other acquisition of control, a description of any transaction in which funds were or are to be obtained for any purpose, and the identity of persons furnishing the consideration, provided that when a source of consideration is a loan made in the lender's ordinary course of business, the identity of the lender must remain confidential if the person filing the statement requests;

(c) fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding 5 fiscal years of each acquiring party, or for a lesser period that the acquiring party and any predecessors have been in existence, and similar unaudited information as of a date not earlier than 90 days prior to the filing of the statement;

(d) any plans or proposals that each acquiring party may have to liquidate the insurer, to sell its assets or merge or consolidate it with any person, or to make any other material change in its business or corporate structure or management;

(e) the number of shares of any security referred to in subsection (1) that each acquiring party proposes to acquire and the terms of the offer, request, invitation, agreement, or acquisition referred to in subsection (1) and a statement as to the method by which the fairness of the proposal was arrived at;

(f) the amount of each class of any security referred to in subsection (1) that is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party;

(g) a full description of any contracts, arrangements, or understandings with respect to any security referred to in subsection (1) in which any acquiring party is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. The description must identify the persons with whom the contracts, arrangements, or understandings have been entered into.

(h) a description of the purchase of any security referred to in subsection (1) by an acquiring party during the 12 calendar months preceding the filing of the statement, including the dates of purchase, names of the

purchasers, and consideration paid or agreed to be paid for the security;

(i) a description of any recommendations to purchase any security referred to in subsection (1) during the 12 calendar months preceding the filing of the statement made by any acquiring party or by anyone based upon interviews or at the suggestion of the acquiring party;

(j) copies of all tender offers for, requests or invitations for tenders of, exchange offers for, and agreements to acquire or exchange any securities referred to in subsection (1) and, if distributed, of additional soliciting material relating to the offers or agreements;

(k) the terms of any agreement, contract, or understanding made with any broker-dealer as to solicitation of securities referred to in subsection (1) for tender and the amount of any fees, commissions, or other compensation to be paid to broker-dealers with regard to the solicitation;

(l) an agreement by which the person required to file the statement referred to in subsection (1) agrees to provide the annual enterprise risk report for as long as control exists;

(m) an acknowledgment by the person required to file the statement referred to in subsection (1) that the person and all affiliates within its control in the insurance holding company system agree to provide information to the commissioner upon request if the commissioner determines the information is necessary to evaluate enterprise risk to the insurer; and

~~(l)~~(n) additional information that the commissioner may by rule prescribe as necessary or appropriate for the protection of policyholders and securityholders of the insurer or in the public interest.

~~(3)~~(4) If the person required to file the statement referred to in subsection (1) is a partnership, limited partnership, syndicate, or other group, the commissioner may require that the information called for by subsection ~~(2)~~ (3) must be given with respect to each partner of the partnership or limited partnership, each member of the syndicate or group, and each person who controls the partner or member. If any partner, member, or person is a corporation or the person required to file the statement referred to in subsection (1) is a corporation, the commissioner may require that the information required by subsection ~~(2)~~ (3) be given with respect to the corporation, each officer and director of the corporation, and each person who is directly or indirectly the beneficial owner of more than 10% of the outstanding voting securities of the corporation.

~~(4)~~(5) If any material change occurs in the facts set forth in the statement filed with the commissioner and sent to the insurer pursuant to this section, an amendment ~~setting forth~~ describing the change, together with copies of all documents and other material relevant to the change, must be filed with the commissioner and sent

to the insurer within 2 business days after the person learns of the change. The insurer shall send the amendment to its shareholders.

~~(5)~~(6) If any offer, request, invitation, agreement, or acquisition referred to in subsection (1) is proposed to be made by means of a registration statement under the Securities Act of 1933 or in circumstances requiring the disclosure of similar information under the Securities Exchange Act of 1934 or under a state law requiring similar registration or disclosure, the person required to file the statement referred to in subsection (1) may use the documents in furnishing the information called for by that statement.

(7) As used in this section:

(a) "domestic insurer" includes any person controlling a domestic insurer unless the person, as determined by the commissioner, is either directly or through its affiliates primarily engaged in a business other than the business of insurance;

(b) "person" does not include a securities broker holding, in the usual and customary broker's function, less than 20% of the voting securities of an insurance company or of any person who controls an insurance company."

Section 25. Section 33-2-1105, MCA, is amended to read:

"33-2-1105. Approval by commissioner -- hearings -- notice. (1) The commissioner shall approve any merger or other acquisition or divestiture of control referred to in ~~33-2-1104(1)~~ 33-2-1104 unless, after a public hearing, the commissioner finds that:

(a) after the change of control, the domestic insurer referred to in ~~33-2-1104(1)~~ 33-2-1104 would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which ~~it~~ the domestic insurer is presently licensed;

(b) the effect of the merger or other acquisition of control would be substantially to lessen competition in insurance in this state or tend to create a monopoly;

(c) the financial condition of any acquiring party might jeopardize the financial stability of the insurer or prejudice the interest of ~~its~~ the insurer's policyholders or the interests of any remaining securityholders who are unaffiliated with the acquiring party;

(d) the terms of the offer, request, invitation, agreement, or acquisition referred to in ~~33-2-1104(1)~~ 33-2-1104 are unfair and unreasonable to the securityholders of the insurer;

(e) the plans or proposals that the acquiring party has to liquidate the insurer, to sell its assets or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management are unfair and unreasonable to policyholders of the insurer and not in the public interest;

(f) the competence, experience, and integrity of those persons who would control the operation of the insurer are of the nature that ~~it~~ the change in control would not be in the interest of policyholders of the insurer and of the public ~~to permit the merger or other acquisition of control~~.

(2) The public hearing referred to in subsection (1) must be held within 30 days after the statement required by 33-2-1104(1) is filed, and at least 20 days' notice of the hearing must be given by the commissioner to the person filing the statement. Not less than 7 days' notice of the public hearing must be given by the person filing the statement to the insurer and to other persons as may be designated by the commissioner. The insurer shall give notice to its securityholders. The commissioner shall make a determination within 30 days after the conclusion of the hearing. At the hearing, the person filing the statement, the insurer, any person to whom notice of hearing was sent, and any other person whose interests may be affected has the right to present evidence, examine and cross-examine witnesses, and offer oral and written arguments and to conduct discovery proceedings in the same manner that is presently allowed in the district court of this state. All discovery proceedings must be concluded not later than 3 days prior to the commencement of the public hearing.

(3) All statements, amendments, or other material filed pursuant to 33-2-1104(1) through ~~(4)~~ (5) and all notices of public hearings held pursuant to subsection (1) of this section must be mailed by the insurer to its shareholders within 5 business days after the insurer has received the statements, amendments, other material, or notices. The expenses of mailing must be borne by the person making the filing. As security for the payment of the expenses, the person shall file with the commissioner an acceptable bond or other deposit in an amount to be determined by the commissioner.

(4) The commissioner may retain at the expense of the acquiring ~~party's expense~~ or divesting party any attorneys, actuaries, accountants, and other experts not otherwise a part of the commissioner's staff as may be reasonably necessary to assist the commissioner in reviewing the proposed acquisition of control."

Section 26. Section 33-2-1106, MCA, is amended to read:

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

exempts from those sections as:

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

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

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

(a) the failure to file any statement, amendment, or other material required to be filed pursuant to 33-2-1104(1) through ~~(4)~~ (5);

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

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

Section 27. Section 33-2-1111, MCA, is amended to read:

"33-2-1111. Registration of insurers -- requisites -- termination. (1) (a) An insurer authorized to do business in this state that is a member of an insurance holding company system shall register with the commissioner, except that a foreign insurer subject to disclosure requirements and standards adopted by statute or regulation in the jurisdiction of its domicile that are substantially similar to those contained in this section is not required to register.

(b) Any insurer subject to registration under this section shall register within 15 days after becoming subject to registration, unless the commissioner for good cause extends the time for registration.

(c) The commissioner may require any authorized insurer that is a member of a holding company system that is not subject to registration under this section to furnish a copy of the registration statement or other information filed by the insurance company with the insurance regulatory authority in the jurisdiction where the

company is domiciled.

(2) An insurer subject to registration shall file with the commissioner, on or before April 30 each year, a registration statement on a form provided by the commissioner that must contain current information about:

(a) the capital structure, general financial condition, ownership, and management of the insurer and any person controlling the insurer;

(b) the identity of every member of the insurance holding company system;

(c) existing relationships, transactions currently outstanding between the insurer and its affiliates, and the following agreements that are in force:

(i) loans, other investments, or purchases, sales, or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates;

(ii) purchases, sales, or exchanges of assets;

(iii) transactions not in the ordinary course of business;

(iv) guaranties or undertakings for the benefit of an affiliate that result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business;

(v) management and service contracts and cost-sharing arrangements;

(vi) reinsurance agreements covering all or substantially all of one or more lines of insurance of the ceding company;

(vii) dividends and other distributions to shareholders; and

(viii) consolidated tax allocation agreements;

(d) a pledge of the insurer's stock, including stock of a subsidiary or controlling affiliate for a loan made to a member of the insurance holding company system;

(e) all matters concerning transactions between registered insurers and any affiliates as may be included from time to time in registration forms adopted or approved by the commissioner.

(3) A registration statement must contain a summary outlining each item in the current registration statement that represents a change from the prior registration statement.

(4) Information need not be disclosed on the registration statement filed pursuant to subsection (2) if the information is not material for the purposes of this section. Unless the commissioner by rule or order provides otherwise, sales, purchases, exchanges, loans or extensions of credit, or investments involving 1/2 of 1% or less

of an insurer's admitted assets as of the prior December 31 are not material for purposes of this section.

(5) A person within an insurance holding company system subject to registration shall provide complete and accurate information to an insurer if the information is reasonably necessary to enable the insurer to comply with Title 33, chapter 2, part 11.

(6) Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions on amendment forms provided by the commissioner within 15 days after the end of the month in which ~~it~~ the registered insurer learns of each change or addition.

(7) The ultimate controlling person of every insurer subject to registration under this section shall also file an annual enterprise risk report. The report must identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer to the best of the controlling person's knowledge and belief. The report must be filed with the insurance regulator in the state in which the insurance holding company system is domiciled, as determined by the procedures within the financial analysis handbook adopted by the NAIC.

~~(7)~~(8) The commissioner shall terminate the registration of any insurer that demonstrates that ~~it~~ the insurer no longer is a member of an insurance holding company system.

~~(8)~~(9) The commissioner may require or allow two or more affiliated insurers subject to registration under this section to file a consolidated registration statement or consolidated reports amending their consolidated registration statement or their individual registration statements.

~~(9)~~(10) The commissioner may allow an insurer that is authorized to do business in this state and that is part of an insurance holding company system to register on behalf of any affiliated insurer which is required to register under subsection (1) and to file all information and material required to be filed under this section."

Section 28. Section 33-2-1112, MCA, is amended to read:

"33-2-1112. Exemptions -- disclaimer -- violations. (1) The provisions of 33-2-1111 and this section ~~shall~~ do not apply to any insurer, information, or transaction ~~if and~~ to the extent that the commissioner by rule or order ~~shall exempt the same~~ has exempted that insurer, information, or transaction from the provisions of 33-2-1111 and this section.

(2) (a) Any person may file with the commissioner a disclaimer of affiliation with any authorized insurer, or ~~such~~ a disclaimer may be filed by ~~such~~ an insurer or any member of an insurance holding company system.

The disclaimer ~~shall~~ must fully disclose all material relationships and bases for affiliation between ~~such~~ the person and ~~such~~ the insurer that is the object of the disclaimer as well as the basis for disclaiming ~~such~~ the affiliation. ~~After a disclaimer has been filed, the insurer shall be relieved of any duty to register or report under 33-2-1111 and this section which may arise out of the insurer's relationship with such person unless and until the commissioner disallows such a disclaimer. The commissioner shall disallow such a disclaimer only after furnishing all parties in interest with notice and opportunity to be heard and after making specific findings of fact to support such disallowance.~~

(b) The commissioner shall approve or deny a disclaimer within 30 days of filing. If the commissioner denies a disclaimer under this section, the disclaiming party may request a hearing, which must be granted. The disclaiming party is not required to register under this section if the commissioner approves the disclaimer.

(3) The failure to file a registration statement, any summary of the registration statement, an enterprise risk report, or any amendment ~~thereto~~ to the registration statement or enterprise risk request, as required by 33-2-1111 and this section, within the time specified for ~~such~~ filing ~~shall be~~ is a violation of 33-2-1111 and this section."

Section 29. Section 33-2-1113, MCA, is amended to read:

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

(a) The terms must be fair and reasonable.

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

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

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

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

(2) (a) The following transactions involving a domestic insurer and a person in its holding company system may not be entered into unless the insurer has notified the commissioner in writing of its intention to enter

into a transaction and the commissioner has not disapproved ~~it~~ the transaction within at least 30 days prior to the transaction, or a shorter period as the commissioner may permit:

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

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

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

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

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

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

(iii) any of the following arrangements ~~reinsurance agreements or modifications to reinsurance agreements~~ in which the projected reinsurance premium or a change in any of the next 3 years in the insurer's liabilities equals or exceeds 5% of the insurer's surplus as regards policyholders, as of the prior December 31~~, including~~:

(A) reinsurance pooling agreements;

(B) reinsurance agreements;

(C) reinsurance modification to reinsurance agreements; or

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

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

(v) any material transactions, specified by rule, that the commissioner determines may adversely affect the interests of the insurer's policyholders.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

warrants."

Section 30. Section 33-2-1115, MCA, is amended to read:

"33-2-1115. Examination. (1) (a) In addition to the powers ~~which the commissioner has~~ under Title 33, chapter 1, part 4, relating to the examination of insurers, the commissioner also has the power to order any insurer registered under 33-2-1111 to produce the records, books, or other information papers in the possession of the insurer or its affiliates ~~as~~ that the commissioner determines are necessary to ascertain the financial condition or legality of conduct of the insurer.

(b) The information that the commissioner may request under subsection (1)(a) includes information necessary to ascertain the enterprise risk to the insurer by the ultimate controlling party or by any entity or combination of entities within the insurance holding company system or by the insurance holding company system on a consolidated basis.

(c) If the insurer fails to comply with the order, the commissioner may examine the affiliates to obtain the information.

(2) The commissioner may retain at the registered insurer's expense attorneys, actuaries, accountants, and other experts not otherwise a part of the commissioner's staff ~~as are~~ that may be reasonably necessary to assist in the conduct of the examination under subsection (1). Any persons retained are under the direction and control of the commissioner and ~~shall~~ are retained to act in a purely advisory capacity.

(3) Each registered insurer producing for examination records, books, and papers pursuant to subsection (1) is liable for and shall pay the expense of the examination."

Section 31. Section 33-2-1116, MCA, is amended to read:

"33-2-1116. Confidentiality of information. ~~All confidential criminal justice information, as defined in 44-5-103, personal information protected by an individual privacy interest, and trade secrets, as defined in 30-14-402, specifically identified and for which there are reasonable grounds of privilege asserted by the party claiming the privilege obtained by or disclosed to the commissioner or any other person in the course of an examination or investigation made pursuant to 33-2-1115 and all information reported pursuant to 33-2-1111 and 33-2-1112 containing confidential criminal justice information, trade secrets, or personal information must be given confidential treatment, may not be subject to subpoena, and may not be made public by the commissioner~~

~~or any other person, except to insurance departments of other states, without the prior written consent of the insurer to which it pertains unless the commissioner, after giving the insurer and its affiliates who would be affected notice and opportunity to be heard, determines that the interests of policyholders, shareholders, or the public will be served by the publication of the trade secrets or personal information, in which event the commissioner may publish all or any part of the trade secrets or personal information in a manner that the commissioner considers appropriate.~~

~~———~~(1) Documents, materials, and other information in the possession or control of the commissioner that are obtained by or disclosed to the commissioner or any other person in the course of an examination or investigation made pursuant to 33-2-1115 and all information reported pursuant to 33-2-1104(3)(l), 33-2-1104(3)(m), 33-2-1111, and 33-2-1113 must be confidential by law and privileged, are not subject to 2-6-102, subpoena, or discovery, and are not admissible in evidence in any private civil action. The commissioner is authorized to use the documents, materials, and other information to further any regulatory or legal action brought as a part of the commissioner's official duties. The commissioner may not otherwise make the documents, materials, or other information public without the prior written consent of the insurer to which the documents, materials, or other information pertains unless the commissioner, after giving notice and an opportunity to be heard to the insurer and the insurer's affiliates who would be affected, determines that the interest of policyholders, shareholders, or the public would be served by the publication. On a determination that the interest of policyholders, shareholders, or the public would be served, the commissioner may publish all or any part of the documents, materials, or other information in a manner that the commissioner considers appropriate.

(2) Neither the commissioner nor any person who receives documents, materials, or other information while acting under the authority of the commissioner, or with whom the documents, materials, or other information is shared under [sections 10 through 16], 33-2-521 through 33-2-529, 33-2-531, 33-2-537, and this section, may be required or permitted to testify in a private civil action concerning any confidential documents, materials, or information subject to subsection (1).

(3) To assist in the performance of the commissioner's duties, the commissioner:

(a) may, subject to subsection (3)(b), share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subsection (1), with other state, federal, and international regulatory agencies, with the NAIC and its affiliates and subsidiaries, and with state, federal,

and international law enforcement authorities, including members of a supervisory college. To receive the shared documents, materials, or other information, the recipient shall verify in writing that the recipient has the legal authority to maintain confidentiality and agree in writing to maintain the confidentiality and privileged status of the documents, materials, or other information.

(b) may share confidential and privileged documents, materials, or other information reported pursuant to 33-2-1111(7) only with insurance regulators of states having statutes or regulations substantially similar to subsection (1) and only if the respective insurance regulators have agreed in writing not to disclose the documents, materials, or other information;

(c) may receive documents, materials, or other information, including otherwise confidential and privileged documents, materials, or other information from the NAIC and its affiliates and subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions; and

(d) shall maintain as confidential or privileged any document, materials, or other information received under subsection (3)(c) with notice or the understanding that the document, materials, or other information is confidential or privileged under the laws of the jurisdiction that is the source of the document, materials, or information.

(4) (a) The commissioner shall enter into written agreements with the NAIC governing the sharing and use of information provided pursuant to [sections 10 through 16], 33-2-521 through 33-2-529, 33-2-531, 33-2-537, and this section.

(b) An agreement with the NAIC under this subsection (4) must:

(i) specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC and its affiliates and subsidiaries pursuant to [sections 10 through 16], 33-2-521 through 33-2-529, 33-2-531, 33-2-537, and this section, including procedures and protocols for sharing by the NAIC with other state, federal, or international regulators;

(ii) specify that ownership information shared with the NAIC and its affiliates and subsidiaries pursuant to [sections 10 through 16], 33-2-521 through 33-2-529, 33-2-531, 33-2-537, and this section remains with the commissioner and that the NAIC's use of the information is subject to the direction of the commissioner;

(iii) require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC pursuant to [sections 10 through 16], 33-2-521 through 33-2-529, 33-2-531, 33-2-537, and this section is subject to a request or a subpoena to the NAIC for disclosure or production; and

(iv) require the NAIC and its affiliates and subsidiaries to consent to intervention by an insurer in any judicial or administrative action in which the NAIC and its affiliates and subsidiaries may be required to disclose confidential information about the insurer that has been shared with the NAIC and its affiliates and subsidiaries pursuant to [sections 10 through 16], 33-2-521 through 33-2-529, 33-2-531, 33-2-537, and this section.

(5) The sharing of information by the commissioner pursuant to [sections 10 through 16], 33-2-521 through 33-2-529, 33-2-531, 33-2-537, and this section does not constitute a delegation of regulatory authority or rulemaking. The commissioner is solely responsible for the administration, execution, and enforcement of the provisions of [sections 10 through 16], 33-2-521 through 33-2-529, 33-2-531, 33-2-537, and this section.

(6) Disclosure to the commissioner of information under this section or as a result of sharing of confidential information authorized under subsections (3) and (4) does not constitute a waiver of any applicable privilege or claim of confidentiality related to the information obtained under [sections 10 through 16], 33-2-521 through 33-2-529, 33-2-531, 33-2-537, and this section.

(7) Documents, materials, and other information in the possession or control of the NAIC pursuant to [sections 10 through 16], 33-2-521 through 33-2-529, 33-2-531, 33-2-537, and this section are confidential by law and privileged, are not admissible in evidence in a private civil action, and are not subject to 2-6-102, subpoena, or discovery."

Section 32. Section 33-2-1120, MCA, is amended to read:

"33-2-1120. Criminal or civil proceedings -- penalties. (1) An insurer failing without just cause to file a registration statement as required in 33-2-1111 shall, after notice and hearing, pay a penalty of $100 for each day of delinquency. The maximum penalty under this subsection is $25,000. The commissioner may reduce the penalty if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

(2) A director or an officer of an insurance holding company system who knowingly violates, participates in, or assents to a transaction or who knowingly permits an officer or insurance producer of the insurer to engage in a transaction or make an investment that has not been properly reported or submitted pursuant to 33-2-1111 or 33-2-1113 or that violates any other provision of Title 33, chapter 2, part 11, shall, after notice and hearing, pay, in the director's or officer's individual capacity, a fine of not more than $5,000 for each violation. To determine the amount of the fine, the commissioner shall consider the appropriateness of the fine with respect to the gravity of

the violation, the history of previous violations, and other matters that justice may require.

(3) If the commissioner determines that an insurer subject to Title 33, chapter 2, part 11, or a director, officer, employee, or insurance producer of the insurer has engaged in a transaction or entered into a contract that is subject to 33-2-1113 and that would not have been approved had approval been requested, the commissioner may order the insurer to cease and desist immediately any further activity under that transaction or contract. After notice and hearing, the commissioner may also order the insurer to void the contract and restore the status quo if that action is in the best interest of policyholders, creditors, or the public.

(4) Whenever ~~it appears to~~ the commissioner determines that ~~any~~ an insurer or ~~any~~ a director, officer, employee, or insurance producer of the insurer ~~has~~ may have committed a willful violation of this part, the commissioner may cause criminal proceedings to be instituted by the district court for the county in which the principal office of the insurer is located or if the insurer does not have an office in the state, then by the district court for Lewis and Clark County against the insurer or the responsible director, officer, employee, or insurance producer of the insurer.

(5) Withholding of information required under 33-2-1104, if lack of that information prevents a full understanding of the enterprise risk to the insurer by affiliates or by the insurance holding company system, is a violation of 33-2-1104 and may serve as an independent basis for:

(a) disapproving dividends or distributions; or

(b) placing the insurer under supervision as provided in 33-2-1321.

~~(5)~~(6) Any insurer that willfully violates this part may be fined not more than $25,000.

~~(6)~~(7) Any individual who willfully violates this part may be fined not more than $5,000 or, if the willful violation involves the deliberate perpetration of a fraud upon the commissioner, imprisoned for not more than 2 years, or both."

Section 33. Section 33-2-1216, MCA, is amended to read:

"33-2-1216. Credit allowed domestic ceding insurer. (1) Credit for reinsurance is allowed to a domestic ceding insurer as either an asset or a ~~deduction~~ reduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of subsection (2), (3), (4), (5), or (6). Credit must be allowed under subsections (2), (3), or (4) only in respect to cessions of those kinds or classes of business that the assuming insurer is licensed or otherwise permitted to write or assume in its state of domicile or, in the case of

a U.S. branch of an alien assuming insurer, in the state through which the branch of the alien assuming insurer entered and is licensed to transact insurance or reinsurance. If the requirements of subsection (4) or (5) are met, the requirements of subsection (7) must also be met.

(2) Credit must be allowed when the reinsurance is ceded to an assuming insurer that is licensed to transact insurance or reinsurance in this state.

(3) Credit must be allowed when the reinsurance is ceded to an assuming insurer that is accredited by the commissioner as a reinsurer in this state. Credit may not be allowed a domestic ceding insurer if the assuming insurer's accreditation has been revoked by the commissioner after notice and hearing. An accredited reinsurer is one that:

(a) files with the commissioner evidence of its submission to this state's jurisdiction;

(b) submits to this state's authority to examine its books and records;

(c) is licensed to transact insurance or reinsurance in at least one state or, in the case of a United States branch of an alien assuming insurer, is entered through and licensed to transact insurance or reinsurance in at least one state;

(d) files annually with the commissioner a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement; and ~~either:~~

~~(i) maintains a surplus with regard to policyholders in an amount that is not less than $20 million and whose accreditation has not been denied by the commissioner within 90 days of its submission; or~~

~~(ii) maintains a surplus with regard to policyholders in an amount less than $20 million and whose accreditation has been approved by the commissioner.~~

(e) demonstrates to the satisfaction of the commissioner that the accredited reinsurer has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers. An assuming insurer meets this requirement as of the time of its application if:

(i) the assuming accredited reinsurer maintains a surplus as regards policyholders in an amount not less than $20 million; and

(ii) the commissioner approves its accreditation within 90 days after the date that the accredited reinsurer submits its application.

(4) (a) Subject to subsection (4)(b), credit must be allowed when:

(i) the reinsurance is ceded to an assuming insurer that is domiciled and licensed in or, in the case of

a United States branch of an alien assuming insurer, is entered through a state that employs standards regarding credit for reinsurance substantially similar to those applicable under this statute; and

(ii) the assuming insurer or the United States branch of an alien assuming insurer:

(A) maintains a surplus with regard to policyholders in an amount not less than $20 million; and

(B) submits to the authority of this state to examine its books and records.

(b) The requirement of subsection (4)(a)(i) does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

(5) (a) Credit must be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund in a qualified United States financial institution for the payment of the valid claims of its United States policyholders and ceding insurers and their assigns and successors in interest. The assuming insurer shall report annually to the commissioner information substantially the same as that required to be reported on the NAIC annual statement form by licensed insurers to enable the commissioner to determine the sufficiency of the trust fund. The assuming insurer shall submit to examination of its books and records by the commissioner and shall bear the expense of examination.

(b) (i) In the case of a single assuming insurer, the trust must consist of a trusteed account representing the assuming insurer's liabilities attributable to business written in the United States, and in addition, the assuming insurer shall maintain a surplus with the trustee of not less than $20 million, except as provided in subsection (5)(b)(ii).

(ii) At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least 3 full years, the insurance regulator with principal regulatory oversight of the trust may authorize a reduction in the required trusteed surplus after a finding that the new required surplus level is adequate for the protection of United States ceding insurers, policyholders, and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows. The risk assessment must consider all material risk factors, including, when applicable, the lines of business involved, the stability of the incurred loss estimates, and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trusteed surplus may not be reduced to an amount less than 30% of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers covered by the trust.

~~(ii)~~(iii) In the case of a group, including incorporated and individual unincorporated underwriters, the trust

must consist of a trusteed account representing the ~~group's~~ respective underwriters' liabilities attributable to business written in the United States~~, and in addition,~~ to any underwriter of the group. Additionally, the group shall maintain a surplus with the trustee of which $100 million must be held jointly for the benefit of United States ceding insurers of any member of the group.

~~(iii)~~ The incorporated members of the group, as group members, may not be engaged in a business other than underwriting as members of the group and are subject to the same level of solvency regulation and control by the insurance regulator as the unincorporated members. The group shall make available to the commissioner an annual certification of the solvency of each underwriter by the insurance regulator and the independent public accountants in the jurisdiction where the underwriter is domiciled.

(iv) In the case of a group of incorporated insurers under common administration:

(A) the provisions of subsection (5)(b)(iv)(B) apply to the group that:

(I) complies with the reporting requirements contained in subsection (5)(a);

(II) has continuously transacted an insurance business outside the United States for at least 3 years immediately prior to making application for accreditation;

(III) submits to this state's authority to examine its books and records and bears the expense of the examination; and

(IV) has aggregate policyholders' surplus of $10 billion;

(B) (I) the trust must be in an amount equal to the group's several liabilities attributable to business ceded by United States ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of the group;

(II) the group shall maintain a joint surplus with a trustee of which $100 million is held jointly for the benefit of United States ceding insurers of any member of the group as additional security for any liabilities; and

(III) each member of the group shall make available to the commissioner an annual certification of the member's solvency by the insurance regulator and the independent public accountants in the jurisdiction where the underwriter is domiciled.

(c) The trust must be established in a form approved by the commissioner. The trust instrument must provide that contested claims are valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust must vest legal title to its assets in the trustees of the trust for its United States policyholders and ceding insurers and their assigns and successors in interest. The trust and the assuming

insurer are subject to examination as determined by the commissioner. The trust described in this subsection (5)(c) must remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust.

(d) No later than February 28 of each year, the trustees of the trust shall report to the commissioner in writing setting forth the balance of the trust and listing the trust's investments at the end of the preceding year. The trustees shall certify the date of termination of the trust, if planned, or certify that the trust may not expire prior to the following December 31.

(e) (i) The commissioner shall allow credit when the reinsurance is ceded to an assuming insurer that the commissioner has certified as a reinsurer in this state and secures its obligation in accordance with the requirements of subsection (5)(e)(ii) or (5)(e)(iii).

(ii) To be eligible for certification under this subsection (5)(e)(ii), an assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction as determined by the commissioner pursuant to subsection (5)(e)(iv) and shall:

(A) maintain minimum capital and surplus or its equivalent as promulgated by the commissioner by rule;

(B) maintain financial strength ratings from two or more rating agencies, as determined by the commissioner;

(C) agree to the jurisdiction of this state;

(D) appoint the commissioner as its agent for service of process in this state;

(E) agree to provide security for 100% of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if the assuming insurer resists enforcement of a final judgment from within the United States;

(F) agree to meet applicable information filing requirements as determined by the commissioner; and

(G) satisfy any other requirements for certification considered relevant by the commissioner.

(iii) An association, including incorporated and individual unincorporated underwriters, may be a certified reinsurer. The incorporated members of the association may not engage in any business other than underwriting as a member of the association. The incorporated members are subject to the same level of regulation and solvency control by the association's domiciliary regulator as are the unincorporated members. In order to be eligible for certification under this subsection (5)(e)(iii), the association shall satisfy the requirements of (5)(e)(ii) and shall:

(A) satisfy its minimum capital and surplus requirements through the capital and surplus equivalents as a net of liabilities of the association and its members. This provision must include use of a joint central fund that may be applied to any unsatisfied obligation of the association or any of its members in an amount that provides adequate protection as determined by the commissioner.

(B) provide to the commissioner, within 90 days of the date its financial statements are due to be filed with the association's domiciliary regulator, an annual certification by the association's domiciliary regulator of the solvency of each underwriter member. If a certification is unavailable, the association may provide a financial statement prepared by independent public accountants of each underwriter member.

(iv) The commissioner shall create, maintain, and publish a list of qualified jurisdictions under which an assuming insurer licensed and domiciled in a qualified jurisdiction is eligible to be considered for certification as a certified reinsurer. The commissioner shall certify all United States jurisdictions as long as those jurisdictions are accredited under the NAIC financial standards and accreditation program. For jurisdictions not in the United States, the commissioner may defer to a list of qualified jurisdictions published by the NAIC or, if the commissioner does not defer to the NAIC list, shall develop a list of qualified jurisdictions by considering:

(A) the reinsurance supervisory system of the jurisdiction;

(B) the rights, benefits, and extent of reciprocal recognition afforded by the jurisdiction to reinsurers licensed and domiciled within the United States;

(C) whether an NAIC-accredited jurisdiction has certified the reinsurer; and

(D) any additional factors the commissioner considers relevant.

(v) Qualified jurisdictions under subsection (5)(e)(iv) shall agree to share information and cooperate with the commissioner with respect to all certified reinsurers domiciled within that jurisdiction.

(vi) The commissioner may not approve a jurisdiction not in the United States if the commissioner determines that the jurisdiction does not adequately and promptly enforce final United States judgments and arbitration awards.

(vii) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, the commissioner may either suspend the reinsurer's certification indefinitely or revoke the certification entirely.

(viii) The commissioner shall assign a rating to each certified insurer. In assigning a rating, the commissioner shall consider the financial strength ratings assigned by agencies approved by the commissioner. The commissioner shall publish a list of all certified reinsurers and their ratings. The commissioner may defer to

a rating assigned by a jurisdiction accredited by the NAIC.

(ix) A certified reinsurer shall secure obligations assumed from United States ceding insurers under this subsection (5)(e)(ix) at a level consistent with the certified reinsurer's rating. A domestic ceding insurer qualifies for full financial statement credit for reinsurance ceded to a certified reinsurer if the domestic ceding insurer:

(A) maintains security in a form acceptable to the commissioner and in accord with the provisions of this section; or

(B) forms a multibeneficiary trust in accord with subsections (5)(a) through (5)(d), except that minimum trusteed surplus requirements as provided in subsection (5)(b) do not apply with respect to a multibeneficiary trust account maintained by a certified reinsurer for the purpose of securing obligations incurred under this subsection (5)(e)(ix). A multibeneficiary trust under this subsection (5)(e)(ix)(B) must be maintained with a minimum trusteed surplus of $10 million.

(x) A certified reinsurer operating under subsection (5)(e)(ix)(B) shall maintain separate trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer with reduced security as permitted by this subsection (5)(e) or comparable laws of other United States jurisdictions.

(xi) If obligations incurred by a certified reinsurer under this subsection (5)(e) lack sufficient security, the commissioner shall reduce the allowable credit by an amount proportionate to the deficiency. The commissioner may impose further reductions in allowable credit upon finding that there is a material risk that the certified reinsurer's obligations will not be paid in full when due.

(xii) For the purposes of this subsection (5)(e), a certified reinsurer whose certification has been terminated for any reason must be treated as a certified reinsurer required to secure 100% of its obligations. If the commissioner assigns a higher rating to a certified reinsurer on inactive status pursuant to this subsection (5)(e)(xii), this subsection (5)(e)(xii) does not apply. As used in this subsection (5)(e)(xii), "terminated" refers to a reinsurer whose certificate of authority has been revoked, suspended, voluntarily surrendered, or put on inactive status.

(xiii) A certified reinsurer that ceases to assume new business in this state may request to maintain its certification in inactive status in order to continue to qualify for a reduction in security for its in-force business. An inactive certified reinsurer shall continue to comply with all applicable requirements of this subsection (5)(e), and the commissioner shall assign a rating that takes into account, if relevant, the reasons the reinsurer is not assuming new business.

(6) Credit must be allowed when the reinsurance is ceded to an assuming insurer that does not meet the requirements of subsection (2), (3), (4), or (5), but only with respect to the insurance of risks located in a jurisdiction in which the reinsurance is required by applicable law or regulation of that jurisdiction.

(7) (a) If the assuming insurer is not licensed, ~~or~~ accredited, or certified to transact insurance or reinsurance in this state, the credit permitted by subsections (4) and (5) may not be allowed unless the assuming insurer agrees in the reinsurance agreements to the following provisions:

(i) ~~that in the event of~~ upon the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, ~~will~~ shall:

(A) submit to the jurisdiction of any court of competent jurisdiction in any state of the United States;

(B) comply with all requirements necessary to give the court jurisdiction; and

(C) abide by the final decision of the court or of any appellate court in the event of an appeal; and

(ii) ~~to~~ the assuming insurer shall designate the commissioner or a designated attorney as its attorney upon whom may be served any lawful process in any action, suit, or proceeding instituted by or on behalf of the ceding ~~company~~ insurer.

(b) Subsection (7)(a)(i) is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes if an obligation is created in the agreement.

(8) (a) If the assuming insurer does not meet the requirements of subsection (1), (2), or (3), the credit permitted by subsection (4) or (5) may not be allowed unless the assuming insurer agrees in the trust agreements to the conditions under subsections (8)(b) through (8)(d).

(b) Regardless of any other provisions in the trust instrument, the trustee shall comply with an order of the commissioner or with an order of a court of competent jurisdiction directing the trustee to transfer to the commissioner all assets of the trust fund if:

(i) the trust fund is inadequate because the trust fund contains an amount less than the required amount; or

(ii) the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation, or similar proceedings.

(c) The assets transferred under subsection (8)(a) must be distributed by the commissioner. Claims must be filed with and valued by the commissioner in accordance with the laws of the state in which the trust is domiciled and that apply to the liquidation of domestic insurers.

(d) The commissioner may determine that the assets of the trust fund or any part of the trust fund assets are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust. If the commissioner makes this determination, the commissioner shall return the assets or part of the assets to the trustee for distribution in accordance with the trust agreement.

(9) (a) The commissioner may suspend or revoke a reinsurer's accreditation or certification if the reinsurer ceases to meet the requirements of this section. The commissioner shall give the reinsurer notice and opportunity for a hearing. The suspension or revocation may not take effect until after the commissioner's order on hearing unless:

(i) the reinsurer waives its right to a hearing;

(ii) the commissioner's order is based on:

(A) regulatory action by the reinsurer's domiciliary jurisdiction; or

(B) the voluntary surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance business in its domiciliary jurisdiction; or

(iii) the commissioner finds that an emergency requires immediate action.

(b) While a reinsurer's accreditation or certification is suspended, no reinsurance contract issued or renewed after the effective date of the suspension qualifies for credit under this section except to the extent that the reinsurer's obligations under the contract are secured in accordance with this section. If a reinsurer's accreditation or certification is revoked, no credit for reinsurance may be granted after the effective date of the revocation except to the extent that the reinsurer's obligations under the contract are secured in accordance with 33-2-1217 and subsection (5)(e)(ix) of this section.

(10) A ceding insurer shall take steps:

(a) to manage the reinsurance recoverables proportionate to the ceding insurer's own book of business. A domestic ceding insurer shall provide notice to the commissioner within 30 days after:

(i) the reinsurance recoverables from any single assuming insurer or group of affiliated assuming insurers exceeds 50% of the domestic ceding insurer's last reported surplus to policyholders; or

(ii) a determination that the reinsurance recoverables from any single assuming insurer or group of affiliated assuming insurers is likely to exceed the limit in subsection (10)(a)(i).

(b) to diversify its reinsurance program. A domestic ceding insurer shall notify the commissioner within 30 days after ceding to any single assuming insurer or group of affiliated assuming insurers more than 20% of

the ceding insurer's gross written premium in the prior calendar year or after the domestic ceding insurer has determined that the reinsurance ceded to any single assuming insurer or group of affiliated assuming insurers is likely to exceed the 20% limit.

(c) The notifications made pursuant to this subsection (10) must demonstrate that the exposure is safely managed by the domestic ceding insurer.

(11) A reinsurance contract issued or renewed after the effective date of a suspension or revocation does not qualify for credit except to the extent that the reinsurer's obligations under the contract are secured in accordance with this section."

Section 34. Section 33-2-1217, MCA, is amended to read:

"33-2-1217. Reduction of liability for reinsurance ceded by domestic insurer to assuming insurer -- definition. A reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of 33-2-1216 must be allowed in an amount not exceeding the liabilities carried by the ceding insurer. The reduction must be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer:

(1) under a reinsurance contract with the assuming insurer as security for the payment of obligations under the contract if the security is held in the United States subject to withdrawal solely by and under the exclusive control of the ceding insurer; or

(2) in the case of a trust, in a qualified United States financial institution. This security may be in the form of:

(a) cash;

(b) securities listed by the securities valuation office of the NAIC, including those exempt from filing as defined in the purposes and procedures manual of the securities valuation office, and qualifying as admitted assets;

(c) clean, irrevocable, unconditional letters of credit that are issued or confirmed by a qualified United States financial institution no later than December 31 of the year for which filing is being made and that are in the possession of the ceding ~~company~~ insurer on or before the filing date of ~~its~~ the insurer's annual statement. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation must, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of

issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification, or amendment, whichever occurs first.

(d) any other form of security acceptable to the commissioner.

(3) For the purposes of subsection (2)(c), a "qualified United States financial institution" means an institution that:

(a) is organized or, in the case of a United States office of a foreign banking organization, licensed under the laws of the United States or any of its states;

(b) is regulated, supervised, and examined by United States federal or state authorities with regulatory authority over banks and trust companies; and

(c) has been determined by either the commissioner or the securities valuation office of the national association of insurance commissioners to meet the standards of financial condition and standing that are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner.

(4) For the purposes of this part, except for subsection (2)(c), "qualified United States financial institution" means, with respect to institutions eligible to act as a fiduciary of a trust, an institution that:

(a) is organized or, in the case of a United States branch or agency office of a foreign banking corporation, licensed under the laws of the United States or any of its states and that has been granted authority to operate with fiduciary powers; and

(b) is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies.

(5) The commissioner may adopt rules implementing the provisions of 33-2-307, 33-2-708, and chapter 12."

Section 35. Section 33-2-1501, MCA, is amended to read:

"33-2-1501. Definitions. As used in parts 15 through 17 of this chapter, the following definitions apply:

(1) "Accredited state" means a state in which the department of insurance or regulatory agency has qualified as meeting the minimum financial regulatory standards promulgated and established from time to time by the national association of insurance commissioners.

(2) "Actuary" means a person who is a member in good standing of the American academy of actuaries.

(3) "Captive insurer" means:

(a) an insurer that is owned by another entity and whose exclusive purpose is to insure risks of the parent entity and its affiliates; or

(b) in the case of a group or association, an insurer that is owned by the member insureds and whose exclusive purpose is to insure risks to member insureds and their affiliates.

(4) "Control" or "controlled" has the meaning defined in 33-2-1101.

(5) "Controlled insurer" means an authorized insurer that is controlled, directly or indirectly, by a producer.

(6) "Controlling person" means a person, firm, association, or corporation that has the power to direct or cause to be directed the management, control, or activities of a reinsurance intermediary.

(7) "Controlling producer" means a producer who, directly or indirectly, controls an insurer.

(8) (a) "Insurer" means any person, firm, association, or corporation authorized, under Title 33, chapter 2, part 1, to transact insurance business in this state.

(b) ~~With regard to part 15 only, the following are not insurers~~ The term does not mean:

~~(i) risk retention groups as defined in:~~

~~(A) the Superfund Amendments and Reauthorization Act of 1986, Pub. L. No. 99-499, 100 Stat. 1613 (1986);~~

~~(B) the Liability Risk Retention Act of 1986, 15 U.S.C. 3901, et seq.; or~~

~~(C) Title 33, chapter 11, part 1;~~

~~(ii)~~(i) residual market pools and joint underwriting authorities or associations; or

~~(iii)~~(ii) captive insurers, other than captive risk retention groups as defined in 33-28-101.

~~(c) With regard to parts 16 and 17, captive insurers are not insurers but captive risk retention groups are insurers.~~

(9) "Licensed producer" means a producer or reinsurance intermediary licensed pursuant to this title.

(10) (a) "Managing general agent" means a person who:

(i) manages all or part of the insurance business of an insurer and acts as an agent for the insurer;

(ii) either separately or together with affiliates, produces, directly or indirectly, and underwrites an amount of gross written premiums equal to or more than 5% of the policyholder surplus in any quarter or year; and

(iii) engages in one or more of the following activities on the business produced:

(A) adjustment or payment of claims in excess of an amount determined by the commissioner; or

(B) negotiation of reinsurance on behalf of the insurer.

(b) ~~Notwithstanding the provisions of subsection (10)(a), the following persons are not considered managing general agents~~ The term does not include:

(i) an employee of the insurer;

(ii) a manager of the United States branch of an alien insurer;

(iii) an underwriting manager who, pursuant to contract, manages all or part of the insurance operations of the insurer, is under common control with the insurer, is subject to Title 33, chapter 2, part 11, and whose compensation is not based solely on the value of premiums written;

(iv) the attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer or an interinsurance exchange under powers of attorney;

(v) a person managing the property and liability business of a resident domestic farm mutual insurer who has been granted a managing general agent waiver under 33-4-320; or

(vi) a director of a resident domestic farm mutual insurer who adjusts claims and participates in the underwriting process.

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

(12) "Producer" means an insurance producer or reinsurance intermediary authorized or licensed pursuant to this title.

(13) (a) "Qualified United States financial institution" means a financial institution that:

(i) is organized or licensed under the laws of the United States or any state;

(ii) is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies and that either:

(A) is determined by the commissioner to meet the standards of financial condition and standing considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit are acceptable to the commissioner; or

(B) is eligible to act as a fiduciary of a trust or has been granted authority to operate with fiduciary powers.

(b) For purposes of this definition, the commissioner may by rule adopt standards of financial condition and standing that may be developed from time to time by the securities valuation office of the NAIC.

(14) "Reinsurance intermediary" means a reinsurance intermediary-broker or a reinsurance intermediary-manager.

(15) "Reinsurance intermediary-broker" means a person, other than an officer or employee of the ceding insurer, who solicits, negotiates, or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of the insurer.

(16) (a) "Reinsurance intermediary-manager" means a person who:

(i) has authority to bind or who manages all or part of the assumed reinsurance business of a reinsurer, including the management of a separate division, department, or underwriting office; and

(ii) acts as an agent for the reinsurer, whether known as a reinsurance intermediary-manager, manager, or other similar term.

(b) The following persons are not considered reinsurance intermediary-managers with respect to the reinsurer:

(i) an employee of the reinsurer;

(ii) a manager of the United States branch of an alien reinsurer;

(iii) an underwriting manager who, pursuant to contract, manages all of the reinsurance operations of the reinsurer, is under common control with the reinsurer, is subject to Title 33, chapter 2, part 11, and whose compensation is not based on the volume of premiums written; or

(iv) a person who manages groups, associations, pools, or organizations of insurers that engage in joint underwriting or joint reinsurance and that are subject to examination by the insurance commissioner of the state in which the manager's principal business office is located.

(17) "Reinsurer" means a person, firm, association, or corporation licensed in this state under this title as an insurer with authority to assume reinsurance.

(18) "Underwrite" means the authority to accept or reject risk on behalf of the insurer."

Section 36. Section 33-11-103, MCA, is amended to read:

"33-11-103. Chartering -- licensing -- plan of operation. (1) A risk retention group seeking to be chartered in this state must be chartered and licensed to write only casualty insurance pursuant to the insurance laws of this state and, except as provided in this part, shall comply with all of the laws, rules, regulations, and requirements applicable to the insurers chartered and authorized in this state, including 33-11-104, to the extent

that the requirements are not a limitation on laws, rules, regulations, or requirements of this state. Before ~~it may offer~~ offering insurance in any state, the risk retention group shall also submit for approval to the commissioner a plan of operation or a feasibility study and revisions of the plan or study if the group intends to offer any additional lines of liability insurance.

(2) At the time of filing its application for charter, the risk retention group shall provide to the commissioner in summary form the following information:

(a) the identity of the initial members of the risk retention group;

(b) the identity of those individuals who organized the risk retention group or who will provide administrative services or otherwise influence or control the activities of the risk retention group;

(c) the amount and nature of initial capitalization;

(d) the coverages to be afforded; and

(e) the states in which the risk retention group intends to operate.

(3) Upon receipt of the information required under subsection (2), the commissioner shall forward the information to the national association of insurance commissioners. Providing this information to the national association of insurance commissioners does not satisfy the requirements of 33-11-104 or any other section of this chapter.

(4) All risk retention groups chartered in this state shall file with the department and the national association of insurance commissioners an annual statement in a form prescribed by the national association of insurance commissioners ~~and in diskette form~~, including electronically if required by the commissioner, and completed in accordance with ~~its~~ instructions provided by the national association of insurance commissioners and the national association of insurance commissioners' accounting practices and procedures manual.

(5) All risk retention groups must be in compliance with the governance standards contained within this section within 1 year of [the effective date of this act]. New risk retention groups must be in compliance with the standards at the time of licensure.

(6) (a) The board of directors of the risk retention group must consist of a majority of independent directors. If the risk retention group is reciprocal, the attorney-in-fact shall adhere to the same standards regarding independence of operation and governance as are imposed on the risk retention group's board of directors under these standards. The board of directors shall affirmatively determine that a director has no material relationship with the risk retention group for that director to be considered independent.

(b) Each risk retention group shall disclose the determinations of independence to the commissioner annually.

(c) (i) For the purpose of determining independence under this subsection (6), any person that is a direct or indirect owner of or a subscriber in the risk retention group or is an officer, director, or employee of the owner and insured, unless meeting the material relationship provisions under subsection (6)(c)(ii), is considered to be independent.

(ii) A person described in subsection (6)(c)(i) is not considered independent and has a material relationship of its members, as described in 15 U.S.C. 3901(a)(4)(E)(ii), if the person, a member of the person's immediate family, or any business with which the person is affiliated:

(A) has received in any 12-month period from the risk retention group, including a consultant or a service provider to the risk retention group, compensation or payment of any item of value that accounts for either 5% of the risk retention group's gross written premium for that 12-month period or 2% of the risk retention group's surplus, whichever is greater;

(B) has a relationship of employment or affiliation in a professional capacity or has had a relationship of employment or affiliation within 1 year with a present or former internal or external auditor of the risk retention group; or

(C) has a relationship or has had a relationship within 1 year with a related entity by which a director or an immediate family member of the director is employed as an executive officer. This condition includes any of the risk retention group's present executives serving on the related company's board of directors.

(7) (a) A material service provider contract with a risk retention group or its renewal:

(i) may not exceed 5 years;

(ii) requires the approval of a majority of the risk retention group's independent directors; and

(iii) is considered material if the amount to be paid for the contract is greater than or equal to 5% of the risk retention group's annual gross written premium or 2% of the risk retention group's surplus, whichever is greater.

(b) The entire board of directors may terminate any service provider contract at any time for cause after providing adequate notice as defined in the contract.

(c) The board may not enter a service provider contract with a person who has a material relationship with the risk retention group as provided in subsection (6)(c)(ii) unless the board has notified the commissioner

at least 30 days prior to entering the contract and the commissioner has not disapproved the contract.

(8) The risk retention group's board of directors shall adopt in the plan of operation a written policy that requires the board to:

(a) ensure that all owners or insureds of the risk retention group receive evidence of ownership interest;

(b) develop a set of governance standards applicable to the risk retention group;

(c) oversee the evaluation of the risk retention group's management, including but not limited to the performance of the captive manager, managing general underwriter, or any other party that is responsible for underwriting, determination of rates, collection of premium, adjusting or settling claims, or the preparation of financial statements;

(d) review and approve the amount to be paid for all material service providers; and

(e) review and approve at least annually:

(i) the risk retention group's goals and objectives relevant to the compensation of officers and service providers;

(ii) the officers' and service providers' performance in light of those goals and objectives; and

(iii) the continued engagement of the officers and material service providers.

(9) (a) Except as provided in subsection (9)(b), the risk retention group shall name an audit committee composed of at least three independent board members as defined in subsection (6)(c)(i). A nonindependent board member may participate in the activities of the audit committee but may not be a member of the audit committee.

(b) The entire board of directors shall serve as the audit committee if the board chooses not to designate a separate audit committee.

(10) An audit committee shall approve a written charter that defines the committee's purpose, which at a minimum must be to:

(a) assist board oversight of:

(i) the integrity of the financial statements;

(ii) the board's compliance with legal and regulatory requirements; and

(iii) the qualifications, independence, and performance of the independent auditor and actuary;

(b) discuss the annual audited financial statements and quarterly financial statements with management;

(c) discuss the annual audited financial statement with its independent auditor and, if advisable, discuss

its quarterly financial statements with its independent auditor;

(d) discuss policies with respect to risk assessment and risk management;

(e) meet separately and periodically, either directly or through a designated representative of the committee, with management and independent auditors;

(f) review with the independent auditor any audit problems or difficulties and management's response;

(g) set clear hiring policies of the risk retention group as to the hiring of employees or former employees of the independent auditor;

(h) require the external auditor to rotate the lead or coordinating audit partner having primary responsibility for the risk retention group's audit as well as the audit partner responsible for reviewing the audit so that neither individual performs audit services for more than 5 consecutive fiscal years; and

(i) report regularly to the board of directors.

(11) (a) The board of directors shall adopt and disclose standards that make information available through electronic or other means and shall provide that information upon request.

(b) For the purposes of this subsection (11), the information must include:

(i) the process by which the directors are elected by the owner or the insureds;

(ii) qualification standards, responsibilities, and compensation for directors;

(iii) director access to management and, as necessary and appropriate, to independent advisors;

(iv) director orientation and continuing education;

(v) management succession policies and procedures; and

(vi) annual board performance evaluation policies and procedures.

(12) (a) The board of directors shall adopt and disclose a code of business conduct and ethics for directors, officers, and employees. Any waivers of this code as the code applies to directors and officers must be voted on by a majority of the independent directors.

(b) The code must address:

(i) conflicts of interest, including conflicts provided for in 35-1-461(1)(b)(i);

(ii) confidentiality;

(iii) fair dealing;

(iv) protection and proper use of risk retention group assets;

(v) compliance with all applicable laws, rules, and regulations; and

(vi) requirements for the reporting of any illegal or unethical behavior that affects the operation of the risk retention group.

(13) The captive manager, president, or chief executive officer of the risk retention group shall promptly notify the commissioners in writing as soon as that person is aware of any material noncompliance with any standard provided for in this section."

Section 37. Section 33-20-203, MCA, is amended to read:

"33-20-203. Cash surrender value -- paid-up nonforfeiture benefit -- life. (1) Except as provided in subsection (2), any cash surrender value available under the policy in the event of default in the premium payment due on any policy anniversary, whether or not required by 33-20-202, ~~shall be~~ is an amount not less than the excess, if any, of the present value on ~~such~~ the anniversary of the future guaranteed benefits ~~which~~ that would have been provided for by the policy, including any existing paid-up additions, if there had been no default, over the sum of:

(a) the then present value of the adjusted premiums as defined in 33-20-204 through 33-20-208 corresponding to premiums ~~which~~ that would have fallen due on and after ~~such~~ the anniversary; and

(b) the amount of any indebtedness to the insurer on account of or secured by the policy.

(2) For any policy issued on or after the relevant operative date of 33-20-208 that provides supplemental life insurance or annuity benefits at the option of the insured and for an identifiable additional premium by rider or supplemental policy provision, the cash surrender value referred to in subsection (1) is an amount not less than the sum of the cash surrender value as defined in subsection (1) for an otherwise similar policy issued at the same age without ~~such~~ a rider or a supplemental policy provision and the cash surrender value as defined in subsection (1) for a policy that provides only the benefits otherwise provided by ~~such~~ the rider or the supplemental policy provision.

(3) Any cash surrender value available within 30 days after any policy anniversary under any policy paid up by completion of all premium payments or any policy continued under any paid-up nonforfeiture benefits, whether or not required by 33-20-202, ~~shall be~~ is an amount not less than the present value, on ~~such~~ the anniversary, of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by any indebtedness to the insurer on account of or secured by the policy.

(4) Any paid-up nonforfeiture benefit available under the policy in the event of default in the premium

payment due on any policy anniversary ~~shall be such that~~ is its present value as of ~~such~~ the anniversary ~~shall be~~ to the extent that the nonforfeiture benefit is at least equal to the cash surrender value then provided for by the policy or, if none is provided for, that cash surrender value ~~which~~ that would have been required by this part in the absence of the conditions that premiums ~~shall~~ must have been paid for at least a specified period.

(5) For any family policy issued on or after the relevant operative date of 33-20-208 that defines a primary insured and provides term insurance on the life of the spouse of the primary insured expiring before the spouse reaches 71 years of age, the cash surrender value referred to in subsection (1) is an amount not less than the sum of the cash surrender value as defined in subsection (1) for an otherwise similar policy issued at the same age without ~~such~~ the term insurance on the life of the spouse and the cash surrender value as defined in subsection (1) for a policy that provides only the benefits otherwise provided by ~~such~~ the term insurance on the life of the spouse."

Section 38. Section 33-20-208, MCA, is amended to read:

"33-20-208. Mortality tables -- interest rate adjusted premiums. (1) (a) This section applies to all policies issued on or after the operative date of this section. Except as provided in subsection (7), the adjusted premiums for any policy are calculated on an annual basis and must be ~~such~~ a uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments, special hazards, and any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits~~, that~~. The uniform percentage must represent the present value, at the date of issue of the policy, of all adjusted premiums that is equal to the sum of:

(i) the then present value of the future guaranteed benefits provided for by the policy;

(ii) 1% of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first 10 policy years; and

(iii) 125% of the nonforfeiture net level premium as provided in subsection (2). ~~No~~ A nonforfeiture net level premium is considered not to exceed 4% of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first 10 policy years.

(b) The date of issue of a policy for the purpose of this subsection is the date as of which the rated age of the insured is determined.

(2) The nonforfeiture net level premium is equal to the present value, at the date of issue of the policy, of the guaranteed benefits provided for by the policy divided by the present value, at the date of issue of the policy, of an annuity of one per annum payable on the date of issue of the policy and on each anniversary of ~~such~~ that policy on which a premium falls due.

(3) For policies that have on a basis guaranteed in the policy unscheduled changes in benefits or premiums or that provide an option for changes in benefits or premiums other than a change to a new policy, the adjusted premiums and present values are initially calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any ~~such~~ change in the benefits or premiums, the future adjusted premiums, nonforfeiture net level premiums, and present values must be recalculated on the assumption that future benefits and premiums do not change from those stipulated by the policy immediately after the change.

(4) Except as otherwise provided in subsection (7), the recalculated future adjusted premiums for any ~~such~~ policy ~~shall be such~~ are a uniform percentage of the respective future premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments, special hazards, and any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits~~, that~~. The uniform percentage must be the present value, at the time of change to the newly defined benefits or premiums, of all ~~such~~ future adjusted premiums ~~shall be~~ that is equal to the excess of:

(a) the sum of:

(i) the then present value of the then future guaranteed benefits provided for by the policy; and

(ii) the additional expense allowance, if any; over

(b) the then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy.

(5) The additional expense allowance, at the time of the change to the newly defined benefits or premiums, is the sum of:

(a) 1% of the excess, if positive, of the average amount of insurance at the beginning of each of the first 10 policy years subsequent to the change, over the average amount of insurance prior to the change at the beginning of each of the first 10 policy years subsequent to the time of the most recent previous change or, if there has been no previous change, the date of issue of the policy; and

(b) 125% of the increase, if positive, in the nonforfeiture net level premium.

(6) The recalculated nonforfeiture net level premium is equal to the result obtained by dividing the product of subsection (a) by the product of subsection (b):

(a) (i) the nonforfeiture net level premium applicable prior to the change multiplied by the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of the change on which a premium would have fallen due had the change not occurred; and

(ii) the present value of the increase in future guaranteed benefits provided for by the policy;

(b) the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium falls due.

(7) ~~Notwithstanding any other~~ Adjusted premiums and present values for a substandard policy may be calculated as if the substandard policy were issued to provide higher uniform amounts of insurance on the standard basis, regardless of other provisions of this section for a policy issued on a substandard basis that provides reduced graded amounts of insurance so that, in each policy year, ~~such~~ the policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis that provides higher uniform amounts of insurance~~, adjusted premiums and present values for such substandard policy may be calculated as if it were issued to provide such higher uniform amounts of insurance on the standard basis~~.

(8) Except as provided below, all adjusted premiums and present values referred to in this part are for policies of ordinary insurance calculated on the basis of the commissioner's 1980 standard ordinary mortality table or, at the election of the insurer for any one or more specified plans of life insurance, the commissioner's 1980 standard ordinary mortality table with 10-year select mortality factors. All adjusted premiums and present values for policies of industrial insurance are calculated on the basis of the commissioner's 1961 standard industrial mortality table. All adjusted premiums and present values for all policies issued in a particular calendar year are calculated on the basis of a rate of interest not exceeding the nonforfeiture interest rate as provided in this subsection for policies issued in that calendar year; with the following exceptions and conditions:

(a) At the option of the insurer, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as provided in this subsection for policies issued in the immediately preceding calendar year.

(b) Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, whether or not required by 33-20-202, is calculated on the basis of the mortality table and rate

of interest used in determining the amount of ~~such~~ the paid-up nonforfeiture benefit and paid-up dividend additions, if any.

(c) An insurer may calculate the amount of any guaranteed paid-up nonforfeiture benefit, including any paid-up additions under the policy, on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values.

(d) In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the commissioner's 1980 extended term insurance table for policies of ordinary insurance and not more than the commissioner's 1961 industrial extended term insurance table for policies of industrial insurance.

(e) For insurance issued on a substandard basis, the calculation of any ~~such~~ adjusted premiums and present values may be based on appropriate modifications of the tables set forth in this subsection (8).

(f) (i) ~~Any~~ For policies issued prior to the operative date of the valuation manual as provided in 33-2-523, any commissioner's standard ordinary mortality tables adopted after 1980 by the national association of insurance commissioners that are approved by the commissioner by rule for use in determining the minimum nonforfeiture standard may be substituted for the commissioner's 1980 standard ordinary mortality table with or without 10-year select mortality factors or for the commissioner's 1980 extended term insurance table.

(ii) For policies issued on or after the operative date of the valuation manual as provided in 33-2-523, the commissioner may use the standard mortality table provided in the valuation manual for use in determining the minimum nonforfeiture standard instead of using either the commissioner's 1980 standard ordinary mortality table with or without 10-year select mortality factors or the commissioner's 1980 extended term insurance table.

(iii) A minimum nonforfeiture standard, if adopted by the commissioner by rule for the commissioner's standard mortality table adopted by the national association of insurance commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, supersedes the valuation manual's nonforfeiture standard.

(g) (i) ~~Any~~ For policies issued prior to the operative date of the valuation manual, any industrial mortality tables adopted after 1980 by the national association of insurance commissioners that are approved by the commissioner by rule for use in determining the minimum nonforfeiture standard may be substituted for the commissioner's 1961 standard industrial mortality table or the commissioner's 1961 industrial extended term insurance table.

(ii) For policies issued on or after the operative date of the valuation manual, the valuation manual must provide the commissioner's standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the commissioner's 1961 standard industrial mortality table or the commissioner's 1961 industrial extended term insurance table.

(iii) A minimum nonforfeiture standard, if adopted by the commissioner by rule for the commissioner's standard industrial mortality table adopted by the national association of insurance commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, supersedes the valuation manual's nonforfeiture standard.

(9) (a) ~~The~~ For policies issued prior to the operative date of the valuation manual, the annual nonforfeiture interest rate ~~per annum~~ for any policy issued in a particular calendar year must be equal to 125% of the calendar year statutory valuation interest rate for such policy as defined in the standard valuation law, Title 33, chapter 2, part 5, rounded to the nearer 1/4 of 1%. However, the nonforfeiture interest rate provided for in this subsection (9)(a) may not be less than 4.00%.

(b) For policies issued on or after the operative date of the valuation manual, the annual nonforfeiture interest rate for any policy issued in a particular calendar year must be as provided in the valuation manual.

(10) ~~Notwithstanding any other provision in this code to the contrary, any~~ Any refiling of nonforfeiture values or their methods of computation for any previously approved policy form that involves only a change in the interest rate or mortality table used to compute nonforfeiture values does not require refiling of any other provisions of that policy form.

(11) After October 1, 1983, any insurer may file with the commissioner a written notice of its election to comply with the provisions of this section after a specified date, before January 1, 1989, which is the operative date of this section for ~~such~~ that insurer. If an insurer makes no ~~such~~ election, the operative date of this section for ~~such~~ the insurer is January 1, 1989."

Section 39. Section 33-31-204, MCA, is amended to read:

"33-31-204. Acquisition, control, or merger of a health maintenance organization. (1) Except as provided in 33-2-1106 and subsection (2) of this section, ~~no~~ a person may not tender for, request, or invite tenders of, or enter into an agreement to exchange securities for or acquire in the open market or otherwise, any voting security of a health maintenance organization or enter into any other agreement if, after the consummation

~~thereof~~ of the agreement, that person would, directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of the health maintenance organization.

(2) ~~No~~ A person may not enter into an agreement to merge or consolidate with or otherwise to acquire control of a health maintenance organization, unless, at the time any offer, request, or invitation is made or any agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the acquiring person has filed with the commissioner and has sent to the health maintenance organization information required by ~~33-2-1104(2)~~ 33-2-1104 and the commissioner has approved the offer, request, invitation, agreement, or acquisition pursuant to 33-2-1105."

Section 40. Codification instruction -- directions to code commissioner. (1) [Sections 1 through 9] are intended to be codified as an integral part of Title 33, chapter 2, part 11, and the provisions of Title 33, chapter 2, part 11, apply to [sections 1 through 9].

(2) [Sections 10 through 16] are intended to be codified as an integral part of Title 33, chapter 2, and the provisions of Title 33, chapter 2, apply to [sections 10 through 16].

(3) Sections 33-2-521 through 33-2-529, 33-2-531, and 33-2-537 are intended to be renumbered and codified as a new part of Title 33, chapter 2.

(4) [Sections 10 through 16] are intended to be codified into the same part in Title 33, chapter 2, as the sections enumerated in subsection (3).

(5) The code commissioner is instructed to change internal references within and to the renumbered sections, including sections enacted or amended by the 64th legislature, to reflect the new section numbers assigned to sections pursuant to this section.

Section 41. Saving clause. [This act] does not affect rights and duties that matured, penalties that were incurred, or proceedings that were begun before [the effective date of this act].

Section 42. Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

Section 43. Effective date. [This act] is effective on passage and approval.

Section 44. Retroactive applicability. [This act], except for the provisions of [sections 12 and 13], applies retroactively, within the meaning of 1-2-109, to all policies and contracts subject to 33-2-521 that were issued prior to the operative date of the valuation manual as provided in 33-2-523.

- END -

I hereby certify that the within bill,

HB 0119, originated in the House.

Chief Clerk of the House

Speaker of the House

Signed this _____ day

of _____, 2015.

President of the Senate

Signed this _____ day

of _____, 2015.

HOUSE BILL NO. 119

INTRODUCED BY T. BERRY

BY REQUEST OF THE STATE AUDITOR

AN ACT GENERALLY REVISING INSURANCE LAWS; IMPLEMENTING ACCREDITATION STANDARDS AND MODEL ACTS DEVELOPED BY THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, INCLUDING STANDARDS FOR RISK MANAGEMENT AND RETENTION, VALUATION, ENTERPRISE RISK STANDARDS FOR HOLDING COMPANY SYSTEMS, AND CERTAIN NONFORFEITURE PROVISIONS; CREATING GUIDELINES AND RELATED REQUIREMENTS FOR AN INSURER'S SELF-ASSESSMENT OF RISK AND SOLVENCY; ADOPTING PRINCIPLE-BASED VALUATION; ADOPTING A VALUATION MANUAL FOR RESERVES; APPLYING ACTUARIAL STANDARDS TO RESERVE REPORTING; APPLYING THE VALUATION MANUAL TO ACCIDENT AND HEALTH PLANS; PROVIDING FOR ENTERPRISE RISK REPORTING; GRANTING THE COMMISSIONER OF INSURANCE APPROVAL AUTHORITY OVER DIVESTITURES; ALLOWING FOR DISCLAIMERS OF AFFILIATION; EXTENDING CONFIDENTIALITY FOR VARIOUS REPORTS FILED WITH THE COMMISSIONER; EXPANDING PENALTIES FOR WITHHOLDING OF CERTAIN INFORMATION; CLARIFYING CREDIT FOR CEDING INSURERS OR REINSURERS; REVISING TERMS FOR RISK RETENTION GROUPS, INCLUDING CLARIFICATION OF INDEPENDENT DIRECTORS AND MATERIAL RELATIONSHIPS; EXPANDING NONFORFEITURE VALUATION OPTIONS; EXTENDING RULEMAKING AUTHORITY; AMENDING SECTIONS 33-2-521, 33-2-523, 33-2-525, 33-2-526, 33-2-527, 33-2-537, 33-2-1101, 33-2-1104, 33-2-1105, 33-2-1106, 33-2-1111, 33-2-1112, 33-2-1113, 33-2-1115, 33-2-1116, 33-2-1120, 33-2-1216, 33-2-1217, 33-2-1501, 33-11-103, 33-20-203, 33-20-208, AND 33-31-204, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE AND A RETROACTIVE APPLICABILITY DATE.