AN ACT REVISING LAWS PERTAINING TO THE INSURANCE COMMISSIONER'S REGULATION OF INSURERS; CREATING THE CORPORATE GOVERNANCE ANNUAL DISCLOSURE ACT; PROVIDING FOR A LATE FILING PENALTY; ADDING RISK-BASED CAPITAL LAWS FOR HEALTH MAINTENANCE ORGANIZATIONS; PROVIDING RULEMAKING AUTHORITY; AMENDING SECTIONS 33-1-409, 33-2-1104, 33-2-1105, 33-2-1111, 33-2-1113, 33-2-1115, 33-2-1216, 33-2-1902, 33-2-1903, 33-2-1904, 33-2-1907, AND 33-2-1910, MCA; AND PROVIDING EFFECTIVE DATES.

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

Section 1. Short title. [Sections 1 through 9] may be cited as the "Corporate Governance Annual Disclosure Act."

Section 2. Purpose -- scope. (1) The purpose of [sections 1 through 9] is to:

(a) provide the insurance commissioner a summary of an insurer or insurance group's corporate governance structure, policies, and practices to permit the commissioner to gain and maintain an understanding of the insurer's corporate governance framework;

(b) outline the requirements for completing a corporate governance annual disclosure with the insurance commissioner; and

(c) provide for the confidential treatment of the corporate governance annual disclosure and related information that will contain confidential and sensitive information related to an insurer or insurance group's internal operations and proprietary and trade secret information which, if made public, could potentially cause the insurer or insurance group competitive harm or disadvantage.

(2) (a) Nothing in [sections 1 through 9] may be construed to prescribe or impose corporate governance standards and internal procedures beyond that which is required under applicable state corporate law.

(b) Notwithstanding subsection (2)(a), nothing in [sections 1 through 9] may be construed to limit the commissioner's authority, or the rights or obligations of third parties, under Title 33.

(3) The requirements of [sections 1 through 9] apply to all insurers domiciled in the state.

Section 3. Definitions. As used in [sections 1 through 9], the following definitions apply:

(1) "Commissioner" means the insurance commissioner of the state of Montana.

(2) "CGAD" means a corporate governance annual disclosure, a confidential report filed by the insurer or insurance group made in accordance with the requirements of [sections 1 through 9].

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

(4) "Insurer" has the meaning provided in 33-1-201, except that it may 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) "NAIC" means the national association of insurance commissioners.

Section 4. Disclosure requirement. (1) An insurer, or the insurance group of which the insurer is a member, shall, no later than June 1 of each calendar year, submit to the commissioner a CGAD that contains the information described in [section 6]. Notwithstanding any request from the commissioner made pursuant to subsection (3), if the insurer is a member of an insurance group, the insurer shall submit the report required by this section to the commissioner of the lead state for the insurance group, in accordance with the laws of the lead state, as determined by the procedures outlined in the financial analysis handbook adopted by rule by the commissioner.

(2) The CGAD must include a signature of the insurer or insurance group's chief executive officer or corporate secretary attesting to the best of that individual's belief and knowledge that the insurer has implemented the corporate governance practices and that a copy of the disclosure has been provided to the insurer's board of directors or the appropriate committee of the board of directors.

(3) An insurer not required to submit a CGAD under this section must do so upon the commissioner's request.

(4) For purposes of completing the CGAD, the insurer or insurance group may provide information regarding corporate governance at the ultimate controlling parent level, an intermediate holding company level, or the individual legal entity level, depending on how the insurer or insurance group has structured its system of

corporate governance. The insurer or insurance group is encouraged to make the CGAD disclosures at the level at which the insurer's or insurance group's risk appetite is determined, or at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors are coordinated and exercised, or the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on these criteria, it shall indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in the level of reporting.

(5) The review of the CGAD and any additional requests for information shall be made through the lead state as determined by the procedures within the financial analysis handbook referenced in subsection (1).

(6) Insurers providing information substantially similar to the information required by [sections 1 through 9] in other documents provided to the commissioner, including a proxy statement filed in conjunction with form B requirements, or other state or federal filings provided to the commissioner may not be required to duplicate that information in the CGAD, but must only be required to cross-reference the document in which the information is included.

Section 5. Rulemaking authority. The commissioner may, upon notice and opportunity for all interested persons to be heard, issue such rules and orders necessary to carry out the provisions of [sections 1 through 9].

Section 6. Contents of corporate governance annual disclosure. (1) The insurer or insurance group has discretion over the responses to the CGAD inquiries, provided the CGAD must contain the material information necessary to permit the commissioner to gain an understanding of the insurer's or group's corporate governance structure, policies, and practices. The commissioner may request additional information that the commissioner deems material and necessary to provide a clear understanding of the corporate governance policies, the reporting or information system, or controls implementing those policies.

(2) Notwithstanding subsection (1), the CGAD must be prepared consistent with any rules adopted by the commissioner. Documentation and supporting information must be maintained and made available upon examination or upon request of the commissioner.

Section 7. Confidentiality. (1) Documents, materials, or other information including the CGAD, in the

possession or control of the department of insurance that are obtained by, created by, or disclosed to the commissioner or any other person under [sections 1 through 9], are recognized by the state as being proprietary and to contain trade secrets. All such documents, materials, or other information is confidential by law and privileged, may not be subject to Title 2, chapter 6, part 10, may not be subject to subpoena, and may not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials, or other information in the furtherance of 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. Nothing in this section may be construed to require written consent of the insurer before the commissioner may share or receive confidential documents, materials, or other CGAD-related information pursuant to subsection (3) to assist in the performance of the commissioner's regular duties.

(2) Neither the commissioner nor any person who receives documents, materials, or other CGAD-related information, through examination or otherwise, while acting under the authority of the commissioner, or with whom such documents, materials, or other information are shared pursuant to [sections 1 through 9] may be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (1).

(3) In order to assist in the performance of the commissioner's regular duties, the commissioner may:

(a) upon request, share documents, materials, or other CGAD-related information including the confidential and privileged documents, materials, or information subject to subsection (1), including proprietary and trade secret documents and materials with other state, federal, and international financial regulatory agencies, including members of any supervisory college as provided in Title 33, chapter 2, part 11, with the NAIC and with third-party consultants pursuant to [section 8], provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, material, or other information and has verified in writing the legal authority to maintain confidentiality; and

(b) receive documents, materials, or other CGAD-related information, including otherwise confidential and privileged documents, materials, or information, including proprietary and trade-secret information or documents, from regulatory officials of other state, federal, and international financial regulatory agencies, including members of any supervisory college as provided in Title 33, chapter 2, part 11, and from the NAIC, and shall maintain as confidential or privileged any documents, materials, or information received with notice or the

understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

(4) The sharing of information and documents by the commissioner pursuant to [sections 1 through 9] may not constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely responsible for the administration, execution, and enforcement of the provisions of [sections 1 through 9].

(5) A waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade-secret materials, or other CGAD-related information may not occur as a result of disclosure of such CGAD-related information or documents to the commissioner under this section or as a result of sharing as authorized in [sections 1 through 9].

Section 8. NAIC and third-party consultants. (1) The commissioner may retain, at the insurer's expense, third-party consultants, including 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 CGAD and related information or the insurer's compliance with [sections 1 through 9].

(2) Any persons retained under subsection (1) must be under the direction and control of the commissioner and must act in a purely advisory capacity.

(3) The NAIC and third-party consultants must be subject to the same confidentiality standards and requirements of the commissioner.

(4) As part of the retention process, a third-party consultant shall verify to the commissioner, with notice to the insurer, that it is free of a conflict of interest and that it has internal procedures in place to monitor compliance with the conflict and to comply with the confidentiality standards and requirements of [sections 1 through 9].

(5) A written agreement with the NAIC or a third-party consultant governing sharing and use of information provided pursuant to [sections 1 through 9] must contain the following provisions and expressly require the written consent of the insurer prior to making public information provided under [sections 1 through 9]:

(a) specific procedures and protocols for maintaining the confidentiality and security of CGAD-related information shared with the NAIC or a third-party consultant pursuant to [sections 1 through 9];

(b) procedures and protocols for sharing by the NAIC only with other state regulators from states in which

the insurance group has domiciled insurers. The agreement must provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality;

(c) a provision specifying that ownership of the CGAD-related information shared with the NAIC or a third-party consultant remains with the department of insurance and the NAIC's or third-party consultant's use of the information is subject to the direction of the commissioner;

(d) a provision that prohibits the NAIC or third-party consultant from storing the information shared pursuant to [sections 1 through 9] in a permanent database after the underlying analysis is completed;

(e) a provision requiring the NAIC or third-party consultant to provide prompt notice to the commissioner and to the insurer or insurance group regarding any subpoena, request for disclosure, or request for production of the insurer's CGAD-related information; and

(f) a requirement that the NAIC or a third-party consultant consent to intervention by an insurer in any judicial or administrative action in which the NAIC or a third-party consultant may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant pursuant to [sections 1 through 9].

Section 9. Sanctions -- penalties. Any insurer failing, without just cause, to timely file the CGAD as required in [sections 1 through 9] must, after notice and hearing, pay a penalty of $100 for each day's delay to the commissioner. The penalty must be collected by the commissioner in the name of the state of Montana and deposited in the general fund. The maximum penalty under this section is $1,000,000. 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.

Section 10. Section 33-1-409, MCA, is amended to read:

"33-1-409. Examination reports -- hearings -- confidentiality -- publication. (1) All examination reports must be composed only of facts appearing upon the books, records, or other documents of the company, its agents, or other persons examined or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs. The report must contain the conclusions and recommendations that the examiners find reasonably warranted from the facts.

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

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

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

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

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

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

(b) (i) A hearing conducted under subsection (3)(c) by the commissioner or an authorized representative must be conducted as a nonadversarial, confidential, investigatory proceeding as necessary for the resolution of any inconsistencies, discrepancies, or disputed issues apparent upon the face of the filed examination report or raised by or as a result of the commissioner's review of relevant workpapers or by the written submission or rebuttal of the company. Within 20 days of the conclusion of the hearing, the commissioner shall enter an order

pursuant to subsection (3)(a).

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

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

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

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

(c) If the commissioner determines that regulatory action is appropriate as a result of an examination, the commissioner may initiate any proceedings or actions as provided by law.

(6) (a) Working papers must be given confidential treatment, are not subject to subpoena, are not discoverable or admissible as evidence in any private action, and may not be made public by the commissioner

or any other person except to the extent provided in 33-1-311(5) and subsection (5) of this section. Persons given access to working papers shall agree, prior to receiving the information, to treat the information in the manner required by this section unless prior written consent has been obtained from the company to which the working papers pertain.

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

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

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

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

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

Section 11. 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.

(2) (a) A controlling person of a domestic insurer seeking to divest its controlling interest in the domestic insurer in any manner shall file a statement as provided in subsection (3) with the commissioner 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).~~

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

(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 (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

(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.

(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 (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 (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.

(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 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.

(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 12. 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 unless, after a public hearing, the commissioner finds that:

(a) after the change of control, the domestic insurer referred to in 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 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 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 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 the change in control would not be in the interest of policyholders of the insurer and of the public~~.~~; or

(g) the acquisition is likely to be hazardous or prejudicial to the insurance-buying public.

(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 (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 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 13. 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 and relationship of every member of the insurance holding company system;

(c) ~~existing relationships,~~ transactions currently outstanding or which occurred during the last calendar

year 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) if requested by the commissioner, financial statements of or within an insurance holding company system, including all affiliates, which may include annual audited financial statements filed with the U.S. securities and exchange commission pursuant to the Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended, or the most recently filed parent corporation financial statements filed with the U.S. securities and exchange commission;

(f) statements that the insurer's board of directors is responsible for and oversees corporate governance and internal controls and that the insurer's officers or senior management have approved, implemented, and continue to maintain and monitor corporate governance and internal control procedures;

~~(e)~~(g) 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~~.~~; and

(h) any other information required by the commissioner by rule.

(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 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,~~ lead state commissioner of the insurance holding company system, as determined by the procedures within the financial analysis handbook ~~adopted by the NAIC~~ adopted by rule of the commissioner.

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

(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.

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

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

(a) The terms must be fair and reasonable.

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

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

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

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

(2) (a) The following transactions involving a domestic insurer and a person in its holding company system, including amendments or modifications to affiliate agreements previously filed under this section, may not be entered into unless the insurer has notified the commissioner in writing of its intention to enter into a transaction ~~and the commissioner has not disapproved the transaction~~ within at least 30 days prior to the transaction, or a shorter period as the commissioner may permit, and the commissioner does not disapprove the transaction:

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

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

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

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

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

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

(iii) reinsurance agreements or modifications to reinsurance agreements, including ~~any of the following arrangements 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~~:

(A) reinsurance pooling agreements;

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

~~(C) reinsurance modification to reinsurance agreements; or~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(j) the quality and liquidity of investments in affiliates made pursuant to 33-2-1104 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 15. Section 33-2-1115, MCA, is amended to read:

"33-2-1115. Examination. (1) (a) In addition to the powers 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 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 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 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.

(4) In the event the insurer fails to comply with an order, the commissioner shall have the power to examine the affiliates to obtain the information.

(5) Nothing in this section limits the authority of the commissioner under sections 33-1-315 through 33-1-318 to issue subpoenas, administer oaths, examine under oath any person, compel testimony, issue penalties, or seek injunctions or other remedies to determine and ensure compliance with this section."

Section 16. 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 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 subsection (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

(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.

(iii) In the case of a group, including incorporated and individual unincorporated underwriters, the trust must consist of a trusteed account representing the respective underwriters' liabilities attributable to business written in the United States 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. 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 this 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 subsection (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) if the commissioner approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions published by the NAIC, the commissioner shall provide thoroughly documented justification in accordance with the criteria listed under subsection (5)(e)(iv).

~~(v)~~(vi) 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)~~(vii) 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)~~(viii) 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)~~(ix) The commissioner shall assign a rating to each certified ~~insurer~~ reinsurer. 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)~~(x) 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~~ the certified reinsurer:

(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)~~ (5)(e)(x). A multibeneficiary trust under this subsection ~~(5)(e)(ix)(B)~~ (5)(e)(x)(B) must be maintained with a minimum trusteed surplus of $10 million.

~~(x)~~(xi) A certified reinsurer operating under subsection ~~(5)(e)(ix)(B)~~ (5)(e)(x)(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)~~(xii) 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)~~(xiii) 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)~~ (5)(e)(xiii), this subsection ~~(5)(e)(xii)~~ (5)(e)(xiii) does not apply. As used in this subsection ~~(5)(e)(xii)~~ (5)(e)(xiii), "terminated" refers to a reinsurer whose certificate of authority has been revoked, suspended, voluntarily surrendered, or put on inactive status.

~~(xiii)~~(xiv) 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, 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) 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, 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) 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 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)~~ (5)(e)(x) of this section.

(10) (a) A ceding insurer shall take steps:

(i) 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:

(A) 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

(B) 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)(A).

(ii) 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.

(b) 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 17. Section 33-2-1902, MCA, is amended to read:

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

(1) "Adjusted RBC report" means an RBC report that has been adjusted by the commissioner in accordance with ~~33-2-1903(5)~~ 33-2-1903(6).

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

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

(4) "Foreign insurer" means any insurance company licensed to do business in this state under 33-2-116 but not domiciled in this state, or a health organization licensed to do business in this state under Title 33, chapter 31, but not domiciled in this state.

(5) "Health organization" means a health maintenance organization or other managed care organization licensed under Title 33, chapter 31. This definition does not include an organization licensed as either a life or disability insurer or a property and casualty insurer, or that is otherwise subject to either the life and health or the property and casualty RBC requirements.

(6) "Insurer" includes life or other disability insurers, property and casualty insurers, and health organizations.

~~(5)~~(7) "Life or disability insurer" means:

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

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

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

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

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

~~(6)~~(8) "NAIC" means the national association of insurance commissioners.

~~(7)~~(9) "Negative trend" means, with respect to a life or health insurer, a negative trend over a period of time, as determined in accordance with the trend test calculation included in the RBC instructions.

~~(8)~~(10) (a) "Property and casualty insurer" means:

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

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

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

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

~~(9)~~(11) "RBC instructions" means the RBC report, including risk-based capital instructions adopted by the NAIC, as the RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

~~(10)~~(12) "RBC level" means an insurer's authorized control level RBC, company action level RBC, mandatory control level RBC, or regulatory action level RBC, in which:

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

(b) (i) "company action level RBC" means, with respect to any insurer except the state fund as provided in subsection ~~(10)(b)(ii)~~ (12)(b)(ii), the product of 2 and its authorized control level RBC;

(ii) "company action level RBC" for the state fund is the product of 4 and its authorized control level RBC;

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

(d) (i) "regulatory action level RBC" means, except for the state fund as provided in subsection ~~(10)(d)(ii)~~ (12)(d)(ii), the product of 1.5 and its authorized control level RBC;

(ii) "regulatory action level RBC" for the state fund is the product of 3 and its authorized control level RBC.

~~(11)~~(13) "RBC plan" means a comprehensive financial plan containing the elements specified in 33-2-1904(2). If the commissioner rejects the RBC plan and it is revised by the insurer, with or without the commissioner's recommendation, the plan must be called a revised RBC plan.

~~(12)~~(14) "RBC report" means the report required in 33-2-1903.

~~(13)~~(15) "Total adjusted capital" means the sum of:

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

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

Section 18. Section 33-2-1903, MCA, is amended to read:

"33-2-1903. RBC reports. (1) Each domestic insurer shall, on or before each March 1 filing date, prepare and submit to the commissioner a report of its RBC levels as of the end of the previous calendar year in a form and containing information as required by the RBC instructions. In addition, each domestic insurer shall

file its RBC report:

(a) with the NAIC in accordance with the RBC instructions; and

(b) with the insurance commissioner in any state in which the insurer is authorized to do business if that insurance commissioner has notified the insurer of the request in writing, in which case the insurer shall file its RBC report not later than the later of:

(i) 15 days from the receipt of notice to file its RBC report with that state; or

(ii) the March 1 filing date.

(2) A life and disability insurer's RBC must be determined in accordance with the formula set forth in the RBC instructions. The formula must take into account and may adjust for the covariance between:

(a) the risk with respect to the insurer's assets;

(b) the risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

(c) the interest rate risk with respect to the insurer's business; and

(d) all other business risks and other relevant risks as are set forth in the RBC instructions and determined in each case by applying the factors in the manner set forth in the RBC instructions.

(3) A property and casualty insurer's RBC must be determined in accordance with the formula set forth in the RBC instructions. The formula must take into account and may be adjusted for the covariance between:

(a) asset risk;

(b) credit risk;

(c) underwriting risk; and

(d) all other business risks and other relevant risks set forth in the RBC instructions and determined in each case by applying the factors in the manner set forth in the RBC instructions.

(4) A health organization's RBC must be determined in accordance with the formula set forth in the RBC instructions. The formula must take into account and may be adjusted for the covariance between:

(a) asset risk;

(b) credit risk;

(c) underwriting risk; and

(d) all other business risks and other relevant risks set forth in the RBC instructions and determined in each case by applying the factors in the manner set forth in the RBC instructions.

~~(4)~~(5) An excess of capital over the amount produced by the risk-based capital requirements contained

in this part and the formulas, schedules, and instructions referenced in 33-2-1906 through 33-2-1913 is desirable in the business of insurance. Accordingly, insurers should seek to maintain capital above the RBC levels required by this part. Additional capital is used and useful in the insurance business and helps to secure an insurer against various risks inherent in or affecting the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in this part.

~~(5)~~(6) If a domestic insurer files an RBC report that in the judgment of the commissioner is inaccurate, the commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice must contain a statement of the reason for the adjustment. An RBC report adjusted as provided in this subsection is referred to as an adjusted RBC report."

Section 19. Section 33-2-1904, MCA, is amended to read:

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

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

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

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

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

(B) has a negative trend; or

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

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

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

(iv) for a health organization, the insurer has total adjusted capital that:

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

(B) triggers the trend test determined in accordance with the trend test calculation included in the health

RBC instructions;

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

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

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

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

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

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

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

(3) The RBC plan must be submitted:

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

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

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

and shall submit the revised RBC plan to the commissioner:

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

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

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

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

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

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

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

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

Section 20. Section 33-2-1907, MCA, is amended to read:

"33-2-1907. Mandatory control level event. (1) "Mandatory control level event" means any of the following events:

(a) the filing of an RBC report that indicates that the insurer's total adjusted capital is less than its mandatory control level RBC;

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

(2) In the event of a mandatory control level event:

(a) with respect to a life or disability insurer or a health organization, the commissioner shall take the actions that are necessary to place the insurer under regulatory control under Title 33, chapter 2, part 13. In that event, the mandatory control level event must be considered sufficient grounds for the commissioner to take

action under Title 33, chapter 2, part 13, and the commissioner shall have the rights, powers, and duties with respect to the insurer as are set forth in Title 33, chapter 2, part 13. If the commissioner takes an action pursuant to an adjusted RBC report, the insurer is entitled to the protections of 33-2-1321 through 33-2-1323 pertaining to summary proceedings. Notwithstanding any of the foregoing, the commissioner may forego action for up to 90 days after the mandatory control level event if the commissioner finds that there is a reasonable expectation that the mandatory control level event may be eliminated within the 90-day period.

(b) with respect to a property and casualty insurer, the commissioner shall take the actions necessary to place the insurer under regulatory control under Title 33, chapter 2, part 13, or, in the case of an insurer that is not writing business and that is running-off its existing business, may allow the insurer to continue its runoff under the supervision of the commissioner. In either event, the mandatory control level event must be considered sufficient grounds for the commissioner to take action under Title 33, chapter 2, part 13, and the commissioner shall have the rights, powers, and duties with respect to the insurer as are set forth in Title 33, chapter 2, part 13. If the commissioner takes an action pursuant to an adjusted RBC report, the insurer is entitled to the protections of 33-2-1321 through 33-2-1323 pertaining to summary proceedings. Notwithstanding any of the foregoing, the commissioner may forego action for up to 90 days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the 90-day period."

Section 21. Section 33-2-1910, MCA, is amended to read:

"33-2-1910. Supplemental provisions -- rules -- exemption. (1) The provisions of this part are supplemental to any other provisions of the laws of this state and do not preclude or limit any other powers or duties of the commissioner under the law, including but not limited to Title 33, chapter 2, part 13.

(2) The commissioner may adopt reasonable rules necessary for the implementation of this part.

(3) The commissioner may exempt from the application of this part any domestic property and casualty insurer that:

(a) writes direct business only in this state;

(b) writes direct annual premiums of $2 million or less; and

(c) does not assume reinsurance in excess of 5% of direct premium written.

(4) The commissioner may exempt from the application of this part any domestic health organization that:

(a) writes direct business only in this state;

(b) assumes no reinsurance in excess of 5% of direct premium written;

(c) writes direct annual premiums for comprehensive medical business of $1 million or less; and

(d) is a limited health service organization that covers less than 1,000 lives."

Section 22. Codification instruction. [Sections 1 through 9] 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 1 through 9].

Section 23. 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 24. Effective dates. (1) Except as provided in subsection (2), [this act] is effective October 1, 2017.

(2) [Sections 1 through 9] are effective January 1, 2018.

- END -

I hereby certify that the within bill,

HB 0120, originated in the House.

_____

Speaker of the House

Signed this _____ day

of _____, 2017.

_____

Chief Clerk of the House

_____

President of the Senate

Signed this _____ day

of _____, 2017.

HOUSE BILL NO. 120

INTRODUCED BY J. BACHMEIER

BY REQUEST OF THE STATE AUDITOR

AN ACT REVISING LAWS PERTAINING TO THE INSURANCE COMMISSIONER'S REGULATION OF INSURERS; CREATING THE CORPORATE GOVERNANCE ANNUAL DISCLOSURE ACT; PROVIDING FOR A LATE FILING PENALTY; ADDING RISK-BASED CAPITAL LAWS FOR HEALTH MAINTENANCE ORGANIZATIONS; PROVIDING RULEMAKING AUTHORITY; AMENDING SECTIONS 33-1-409, 33-2-1104, 33-2-1105, 33-2-1111, 33-2-1113, 33-2-1115, 33-2-1216, 33-2-1902, 33-2-1903, 33-2-1904, 33-2-1907, AND 33-2-1910, MCA; AND PROVIDING EFFECTIVE DATES.