MINUTES OF THE MEETING
BUSINESS AND LABOR COMMITTEE
50TH LEGISLATIVE SESSION

March 26, 1987

The meeting of the Business and Labor Committee was called to order by Chairman Les Kitselman on March 26, 1987 at 9:00 a.m. in Room 312-F of the State Capitol.

ROLL CALL: All members were present.

EXECUTIVE ACTION

ACTION ON HOUSE BILL 461

Rep. Dennis Nathe requested that House Bill No. 461 BE TABLED. The motion carried with three opposed.

ACTION ON SENATE BILL 353

Rep. Thomas moved SB 353 BE CONCURRED IN. Rep. Thomas moved to adopt the committee report and amendments. Chairman Kitselman discussed the amendments and mentioned that the Montana Psychological Association wanted to make sure that the board consisted of multi-disciplinary fields. He said the State Auditors language was accepted as amendment to the bill.

Rep. Brown commented that all the people had agreed to the amendments. The question was called. The motion carried with Reps. Jones and Brandewie opposed.

The question was called on the motion to be concurred as amended. The motion carried with Reps. Brandewie and Jones opposed.

ACTION ON SENATE BILL 371

Chairman Kitselman pointed out that one amendment on page 5 to page 6 that was not agreed on by the committee. Exhibit No. 1.

He said that was suggested by Steve Waldron but is the crux of what a preferred provider is. He said to compare the two programs, the health maintenance organization is a group of people that prepay and are assigned to a certain member health service group. The preferred provider organization are given a 25 percent differential in their medical charges and is selective on who belongs. He said the bill says a health care insurer may not deny a provider who agrees to the terms. He questioned whether the provider denied that

person would they be open to tort litigation on a discriminatory basis. He said the whole preferred provider agreement is based on discriminatory practices. He recommended that the language remain out of the bill. He said the bill is important to regulate the organization and provide consumer protection.

Rep. Swysgood questioned where one would take complaints. Chairman Kitselman explained it that a person would have to go to the preferred provider group to have the 25 percent differential. He pointed out that the discount encouraged employees to use their own facility. He said there were 93,000 contracts with Blue Cross Blue Shield. He said this still allows them to exist and provides consumer protection and regulation. He explained the pool core of doctors that deliver services under the preferred providers pay a lower fee. The question was called on adopting the committee report and amendments. The motion carried unanimously.

Rep. Thomas moved BE CONCURRED IN AS AMENDED. The motion carried unanimously.

ACTION ON SENATE BILL 315

Rep. Glaser, chairman of the subcommittee on SB 315, discussed the bill as a tool to protect workers and employers. He mentioned amendments proposed by the workers comp subcommittee. Rep. Glaser moved BE CONCURRED IN. Rep. Glaser moved the amendments.

He discussed amendments 12, 13, 14 and 15, on page 32 of the bill. Exhibit No. 2. He said there was a flaw in the bill. When someone is being rehabilitated and come back to where they can work the amendment says if there is a job opening and you are qualified the employer has an obligation to bring that person back. The person comes back as a new employee. He discussed amendment 49 that allows for termination of benefits for non-cooperation for rehabilitation services. He pointed out a concern by Rep. Driscoll. Rep. Driscoll commented on the rehabilitation disputes and how they are handled with portions being retroactive for administrative purposes.

Rep. Thomas moved the adoption of the subcommittee report and amendments. The question was called. The motion carried.

Rep. Glaser pointed out another amendment that needs to be considered on page 69 and 70. He said that after "provider" to insert "or the Department of Social and Rehabilitation Services". He pointed out that it was necessary to say Department of Social and Rehabilitation Services because it

was not defined in this act. Rep. Glaser moved the amendment.

Rep. Hanson asked if SRS had to review the case or why was SRS involved. Rep. Driscoll said that the intent was to make it clear that private providers and SRS could remove the case. Rep. Glaser said the division make the determination whether the person receiving the benefits is cooperating with the provider or SRS. He noted line 6, page 70. The question on the amendment was called. The motion carried with Reps. Swysgood and Hanson voting NO.

Rep. Driscoll stated that he disagreed with Rep. Glaser, that the bill was not a compromise, and passed the Senate on pure political power and that was how it would pass the House. He said the bill is cutting widows off if their spouse is killed. Presently the benefits are for life. The bill cuts them down to 500 weeks. On permanently totally disabled workers if they want a lump sum settlement to pay off past bill incurred because of the injury they would get an interest bearing loan. On partially disabled people, a wage supplement plan. The rehabilitative benefits come off the 500 weeks. Each degree of injury is given five weeks. The insurance industry said there is 40 percent savings in the bill for private and 25 percent estimated by the division. All the money spent in the state for Workers Comp, benefits are being cut $25 million dollars or more and no one else in the system is taking a cut. He said the bill would be amended for many years to come and by itself it does not solve the problem.

Rep. Thomas asked Rep. Glaser for an opinion on future management of the department. Rep. Glaser noted that because of the subcommittee, there had been 11 auditors in the department for a month, stacks of data on what was going right or wrong. Recommendations have been made to the department that they are implementing. He pointed the difficulty of running a business with politicians.

Rep. Hanson asked Rep. Driscoll about the 500 weeks whether it was retroactive or begin from the time the bill becomes effective. Rep. Smith said the bill would not go into effect until July 1. Rep. Glaser pointed out that an old contract could not be broke. He said a child is covered until they reach maturity.

The question was called on SB 315 being concurred in as amended. The motion carried with Reps. Pavlovich, Driscoll, Hanson, Nisbet voting NO.

ACTION ON SENATE BILL 385

Rep. Wallin moved BE CONCURRED IN. Rep. Wallin moved the amendments and included the effective date. He discussed the amendments as being tied in to the time and density of the population. Exhibit No. 3. The motion carried unanimously. Rep. Wallin moved the statement of intent. The motion carried unanimously.

Rep. Wallin moved BE CONCURRED IN AS AMENDED with statement of intent. The motion carried unanimously.

ACTION ON SENATE BILL 328

Rep. Brown moved BE CONCURRED IN. Rep. Brown moved the amendments as proposed by different groups at the subcommittee. She distributed the list of proposed amendments. Exhibit No. 4. She mentioned that state people in the business of printing proposed different amendments. She said the amendments would allow the Department of Administration to have an extension of rule making authority to be able to define what a public document is. The private printers did not want that in. Rep. Brown moved the amendments to SB 328.

Rep. Simon pointed out that there were a lot of questions left unanswered in the bill. He said there were ten different types of studies done on state printing in the last 8-9 years.

Rep. Brandewie said the problem would not be solved because state agencies were never going to cooperate. He said the agencies intend to surge forward in expanding their printing capacities and put private printers out of business in the state.

Rep. Simon said the legislature set up Publications and Graphics in an effort to save some taxpayer money. He said the state can provide services for in-house printing cheaper than the bidding process with commercial printers. He said the problem needs to be addressed and he would like to see as much of the printing done with local in-state printers as possible.

The question was called on the amendments. The motion carried unanimously.

Rep. Brandewie moved BE CONCURRED IN AS AMENDED. The motion carried with 6 opposed on a vote of 12-6.

ACTION ON SENATE BILL 291

Rep. Thomas moved BE CONCURRED IN. Rep. Thomas moved the Wood amendments. Exhibits No. 5, 6. He explained that this

allowed an out-of-state financial institution to acquire a failing in-state institution if there is no in-state institution bidding. It also provides that the institution be sound financially. He said the amendment needed to amend the effective date to be July 1, 1993 in case there was a problem it would coincide with a legislative year. He said this would provide for a five year trial period.

The question was called. The motion failed with two no votes.

Rep. Brandewie moved to TABLE the bill. The motion carried 13-5 with Reps. Wallin, Thomas, Swysgood, Brown, Kitselman voting NO.

ACTION ON SENATE BILL 34

Rep. Brandewie moved to lift SB 34 off the table. He said it was unfair to require corporations to pay unemployment tax to subsidize the rest of the state. Exhibit No. 7. He pointed out that a man can't lay himself off when he is self employed and expect to collect unemployment when he has a small corporation. The motion carried.

Rep. Brandewie moved BE CONCURRED IN. The motion carried with 4 opposed.

ACTION ON SENATE BILL 115

Rep. Brandewie moved to lift SB 115 from the table. He explained this was the continuing education for insurance people. The motion failed on a 9-9 tie vote.

ACTION ON SENATE BILL 856

Rep. Brown moved to lift SB 856 from the table. The motion failed.

ADJOURNMENT:

The meeting was adjourned at 10:30 a.m.

Les Kitselman

REP. LES KITSELMAN, Chairman

DAILY ROLL CALL

BUSINESS & LABOR COMMITTEE

50th LEGISLATIVE SESSION -- 1987

Date 3-26-87

| NAME | PRESENT | ABSENT | EXCUSED |
|---|---|---|---|
| REP. LES KITSELMAN, CHAIRMAN | ✓ | | |
| REP. FRED THOMAS, VICE-CHAIRMAN | ✓ | | |
| REP. BOB BACHINI | ✓ | | |
| REP. RAY BRANDEWIE | ✓ | | |
| REP. JAN BROWN | ✓ | | |
| REP. BEN COHEN | ✓ | | |
| REP. JERRY DRISCOLL | ✓ | | |
| REP. WILLIAM GLASER | ✓ | | |
| REP. LARRY GRINDE | ✓ | | |
| REP. STELLA JEAN HANSEN | ✓ | | |
| REP. TOM JONES | ✓ | | |
| REP. LLOYD MCCORMICK | ✓ | | |
| REP. GERALD NISBET | ✓ | | |
| REP. BOB PAVLOVICH | ✓ | | |
| REP. BRUCE SIMON | ✓ | | |
| REP. CLYDE SMITH | ✓ | | |
| REP. CHARLES SWYSGOOD | ✓ | | |
| REP. NORM WALLIN | ✓ | | |
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# STANDING COMMITTEE REPORT

EXHIBIT 1
DATE 3-26
HB SB371

MARCH 26 19 87

Mr. Speaker: We, the committee on BUSINESS AND LABOR

report SENATE BILL NO. 371

☐ do pass ☒ be concurred in ☒ as amended
☐ do not pass ☐ be not concurred in ☐ statement of intent attached

REP. LES KITSELMAN Chairman

AMENDMENTS AS FOLLOWS:

1) Title, line 8
Following: "PROVIDING AN"
Insert: "APPLICABILITY DATE AND AN"

2) Page 1, line 12
Strike: "6"
Insert: "7"

3) Page 1, line 13
Strike: "Health Care Reimbursement Reform"
Insert: "Preferred Provider Agreements"

4) Page 1, line 14
Following: line 13
Insert: "Section 2. Purpose. The purpose of [sections 1 through 7] is to allow a health care insurer providing disability insurance benefits to negotiate and contract with health care providers to: (1) provide health care services to its insureds or subscribers at a reduction in the fees customarily charged by the provider; or (2) enter into agreements in which the participating providers accept negotiated fees as payment in full for health care services the health care insurer is obligated to provide or pay for under the health benefit plan."
Renumber: subsequent sections

5) Page 1, line 15
Strike: "6"
Insert: "7"

6) Page 2, line 5
Following: line 4
Insert: "(3)" Health care insurer" means:
(a) an insurer that provides disability insurance as defined in 33-1-207;
(b) a health service corporation as defined in 33-30-101;

REP. KITSELMAN will sponsor

THIRD reading copy ( BLUE color )

(c) a health maintenance organization [as defined in section 2 of Senate Bill no. 353];
(d) a fraternal, benefit society as defined in 33-7-102;
(e) an administrator as defined in 33-17-601; or
(f) any other entity regulated by the commissioner that provides health coverage."
Renumber: subsequent subsections

7) Page 2, lines 7 through 9
Following: "authorization" on line 7
Strike: the remainder of line 7, line 8 in its entirety, and line 9 through "products"
Insert: "or services provided under Title 33, chapter 22, part 7"

8) Page 2, lines 14 through 17
Strike: subsection (5) in its entirety
Insert: "(6) "Preferred provider" means a provider or group of providers who have contracted to provide specified health care services.
(7) "Preferred provider agreement" means a contract between or on behalf of a health care insurer and a preferred provider."
Renumber: subsequent subsection

9) Page 2, line 20
Strike: "in this state"
Insert: "or services covered within Title 33, chapter 22, part 7"

10) Page 2, line 21
Following: line 20
Insert: "(9) "Subscriber" means a certificate holder or other person on whose behalf the health care insurer is providing or paying for health care coverage."

11) Page 2, line 23
Strike: "an"
Insert: "a health care"

12) Page 2, line 25
Strike: "The insurer's"

Les Kitselman
Chairman.

STATE PUB. CO.
Helena, Mont.

13) Page 3, line 1
Following: "insureds"
Insert: "or subscribers on whose behalf the health care insurer is providing health care coverage"
Following: "including"
Insert: "preferred provider"
Following: "to"
Insert: ": (i)"

14) Page 3, line 2
Following: ";"
Insert: "~~and~~ (ii) the amount and manner of payment to the provider;"

15) Page 3, line 12
Strike: "ARRANGEMENT"
Insert: "agreement"

16) Page 3, line 14
Strike: "MEDICALLY NECESSARY"
Insert: "health care services"
Strike: "EXPENSES"

17) Page 3, line 15
Strike: "6"
Insert: "7"

18) Page 3, line 22
Strike: "(2)"

19) Page 3, line 23
Following: "LEAST"
Insert: ": (a)"

20) Page 3, line 25
Strike: "ARRANGEMENT"
Insert: "agreement"

21) Page 4, line 3
Following: "PROVIDER"
Insert: "; and

(b) a provision that clearly identifies the difference in benefit levels for health care services of a preferred provider and benefit levels for the same health care services of a nonpreferred provider"

Chairman.

STATE PUB. CO.
Helena, Mont.

22) Page 4, line 4
Following: line 3
Insert: (2) A health care insurer may not require hospital staff privileges as criteria for designation as a preferred provider in a preferred provider agreement."

23) Page 4, line 5
Strike: "ARRANGEMENTS"
Insert: "agreements"

24) Page 4, line 6
Strike: "ARRANGEMENT"
Insert: "agreement"

25) Page 4, line 9
Strike: "POLICYHOLDERS"
Insert: "insureds"

26) Page 4, lines 11 through 16
Following: "(A) A" on line 11
Strike: the remainder of line 11, lines 12 through 15 in their entirety and line 16 through "ARRANGEMENTS"
Insert: "provision setting a payment difference for reimbursement of a nonpreferred provider as compared to a preferred provider. If the health benefit plan contains a payment difference provision, the payment difference may not exceed 25% of the reimbursement level at which a preferred provider would be reimbursed"

27) Page 4, line 20
Following: "OF"
Strike: " A PROVIDER ARRANGEMENT,"
Insert: "an"

28) Page 4, line 21
Following: "POLICY"
Strike: ","
Following: "CONTRACT"
Insert: "except those already approved by the commissioner"

29) Page 4, line 24, through page 5, line 1
Following: "rules" on line 24
Strike: the remainder of line 24, lines 25 and 1 in their entirety
Insert: "necessary to implement the provisions of"

Chairman.

STATE PUB. CO.
Helena, Mont.

30) Page 5, line 2
Strike: "6"
Insert: "7"

31) Page 5, line 4
Strike: "6"
Insert: "7"

32) Page 5, line 6
Strike: "6"
Insert: "7"

33) Page 5, line 7
Following: line 6
Insert: "Section 9. Coordination instruction. If Senate Bill No. 353, including the definition of "health maintenance organization", is not passed and approved, the bracketed language in section 3(3)(c) of this act is void."
Renumber: subsequent sections

34) Page 5, line 13
Following: line 12
Insert: "Section 11. Applicability -- filing with commissioner. On or before January 1, 1988, a health care insurer performing the functions enumerated in this act shall notify the commissioner of its existence and continue to operate subject to the provisions of this act."
Renumber: subsequent section

35) Page 5, line 13
Strike: "6"
Insert: "7"

Chairman.

3-26-87
EXHIBIT 2
DATE 3-26
HB SB315

Amendments to Senate Bill 315
Third reading copy (blue)
House Labor Subcommittee

1. Title, line 17.
Following: "39-71-122,"
Insert: "39-71-309,"

2. Title, line 20.
Following: "MCA;"
Insert: "MAKING CERTAIN PROVISIONS RETROACTIVE;"

3. Page 11, line 25.
Strike: "or"
Insert: ","
Following: "lodging"
Insert: ", rent, or housing"

4. Page 12, line 1.
Strike: ","
Insert: "and is"
Following: "on"
Strike: "the"
Insert: "its"
Strike: "of the" on line 1 through "housing" on line 2

5. Page 14, line 20.
Strike: "-- criminal penalty"

6. Page 15, line 7.
Following: "72"
Insert: ",other than the disputes described in subsection (2),"

7. Page 16, lines 7 and 8.
Strike: "A" on line 7 through "A" on line 8
Insert: "Upon motion of a party, the"

8. Page 16, line 9.
Strike: "the"
Insert: "either"

9. Page 16, line 13.
Strike: "(6)"
Insert: "(d)

10. Page 32, line 3.
Strike: "39-71-61"
Insert: "39-71-611"

11. Page 32, line 11.
Strike: "If"
Insert: "When"

12. Page 32, line 14.
Strike: "new hires"
Insert: "other applicants"

13. Page 32, line 15.
Strike: "within such 2-year period"
Strike: ":"

14. Page 32, line 16.
Strike: "(a)

15. Page 32, lines 17 through 19.
Strike: "; and" on line 17 through "applicants" on line 19

16. Page 33, line 4.
Strike: "injuries producing"

17. Page 35.
Following: line 16
Insert: "on"

18. Page 35, line 17.
Following: "more"
Strike: "that"
Insert: "than"

19. Page 36, line 4.
Strike: "injuries causing"
Insert: "permanent"

20. Page 36, line 5.
Following: "disability"
Insert: "-- impairment awards and wage supplements"

21. Page 36.
Following: line 15
Insert: "The benefits available for permanent partial disability are impairment awards and wage supplements."

22. Page 38, line 20.
Strike: "subsections"
Insert: "subsection"
Strike: "and (2)"

23. Page 39, line 14.
Following: "request of"
Strike: "he"
Insert: "the"

24. Page 39, line 15.
Following: "direct"
Strike: "a"
Insert: "the"

25. Page 39, line 23.
Strike: "10"
Insert: "30"

26. Page 40, line 25.
Strike: "a workers'"
Insert: "the"

27. Page 41, line 1.
Following: "subsection"
Strike: "(3)(b)(ii) or (3)(b)(iii)"
Insert: "(3)(b)(i) or (3)(b)(ii)"

28. Page 41, line 4.
Following: "subsection"
Strike: "(3)(b)(iii)"
Insert: "(3)(b)(ii)"

29. Page 41, line 14.
Following: "services"
Insert: "-- fee schedules and hospital rates"

30. Page 42, line 20.
Following: "January"
Insert: "1,"

31. Page 43, line 2.
Following: "January"
Insert: "1,"

32. Page 44, line 7.
Following: "total"
Insert: "disability"

33. Page 45, line 20.
Strike: "39-71-116"

34. Page 46, line 4.
Following: "and"
Strike: "39-71-116"

35. Page 46, line 8.
Following: "wage"
Insert: "at the time of injury"

36. Page 46, line 22.
Following: "through"
Strike: "39-71-116"

37. Page 49, line 2.
Strike: "and"
Insert: ","

38. Page 49, line 3.

Following: "payments"
Insert: ", and lump-sum advance payments"

39. Page 52, line 16.
Following: "agree"
Insert: "to a settlement"

40. Page 53, line 16.
Strike: "worker's"
Insert: "workers'"

41. Page 53, line 19.
Strike: "RELEASES"
Insert: "RELEASE"

42. Page 54, lines 11, 15, and 16.
Following: "lump-sum" (the second "lump-sum" on line 11)
Insert: "advance"

43. Page 54, line 25.
Strike: "accident"
Insert: "injury"

44. Page 55, line 2.
Strike: "accident"
Insert: "injury"

45. Page 66, line 3.
Strike: "services"
Insert: "appeals"

46. Page 67, line 15.
Strike: "nd"
Insert: "and"

47. Page 68, line 13.
Following: "a"
Insert: "total of"
Following: "$4,000"
Strike: "total"

48. Page 69, line 11.
Strike: "and"
Insert: "but"

49. Page 69, line 23.
Strike: "services"
Insert: "provider"

50. Page 70.
Following: line 24
Insert: "rehabilitation"
Strike: "under this part"

51. Page 72, line 8.
Following: "security"
Insert: ", in addition to the security described in subsection (1)"

52. Page 72, line 13.
Following: "security"
Insert: "provided for in subsection (2)"

53. Page 80, line 24.
Strike: "-- limitation"

54. Page 82, line 2.
Following: "or"
Insert: "by"

55. Page 83, line 16.
Strike: "as defined in"
Insert: ", damage, or death as set forth in"

56. Page 83, line 17.
Strike: "but which"
Insert: "and"

57. Page 83, line 18.
Strike: "is"

58. Page 84, line 5.
Strike: "(SiO SB2"
Insert: "($SiO_2$)"

59. Page 86, line 9.
Strike: "and"
Insert: "or"

60. Page 93, line 19.
Following: "39-71-122,"
Insert: "39-71-309,"

61. Page 93.
Following: line 7.
Insert: "(2) Sections 8 and 52 through 57 are intended to be codified as an integral part of Title 39, chapter 71, and the provisions of Title 39, chapter 71, apply to sections 8 and 52 through 57."

Renumber: subsequent subsections

62. Page 93, lines 9 through 11.
Strike: "The" on line 9 through "disputes" on line 11
Insert: "Sections 8 and 52 through 57"
Following: "apply"
Insert: "retroactively, within the meaning of 1-2-109,"

63. Page 93, line 12.
Following: "occurrence."
Insert: "With respect to rehabilitation disputes, sections 8, and 52 through 57 apply retroactively, within the meaning of 1-2-109, unless the division had jurisdiction over the dispute under the law in effect at the time of injury."

64. Page 93, lines 13 though 20.
Strike: subsection (2) in its entirety

Renumber: subsequent subsection

3-26-87

EXHIBIT 3
DATE 3-26
HB SB 385

Proposed Amendments to SB 385

Offered by Sen. Weeding

1. Page 8, line 20 through page 9, line 11.
Following: "(a)" on page 8, line 20
Strike: the remainder of line 20 through line 11 on page 9
Insert: "provides inpatient care to ill or injured persons prior to their transportation to a hospital or provides inpatient medical care to persons needing that care for a period of no longer than 96 hours; [redacted]

(b) either is located in a county with fewer than six residents per square mile or is located more than 35 road miles from the nearest hospital."

2. Page 16, line 16 through page 17, line 7.
Following: "(a)" on page 16, line 16
Strike: the remainder of line 16 through line 7 on page 17
Insert: "provides inpatient care to ill or injured persons prior to their transportation to a hospital or provides inpatient medical care to persons needing that care for a period of no longer than 96 hours; [redacted]

(b) either is located in a county with fewer than six residents per square mile or is located more than 35 road miles from the nearest hospital."

3. Page 20, line 6.
Following: line 6
Insert: "NEW SECTION. Section 3. Coordination instruction. If Senate Bill 246 and this bill are both passed and approved, the code commissioner shall add the term "medical assistance facility" to the list of facilities defined as "health care facilities" in 50-5-301, as amended by Senate Bill 246."
Renumber: subsequent section

# STATEMENT OF INTENT
## Senate Bill No. 385

A statement of intent is provided for this bill because it extends the authority of the Department of Health and Environmental Sciences to set licensure standards to cover medical assistance facilities. It is the intent of the legislature that the department adopt licensure standards for such facilities that include, but are not limited to, the following:

1. the types, training, and supervision of staff the facility must have, including either a physician, nurse practitioner, or physician assistant, with the restriction that a physician, nurse practitioner, or physician assistant need not be on site at all times but may be on call so long as they are available within 1 hour;

2. requirements for medical treatment protocols that must be utilized by staff;

3. review of a professional review organization or its equivalent to determine if the level of care provided is appropriate; and

4. a requirement that the facility have a referral agreement with a hospital ensuring acceptance of patients needing hospital-level care who are treated at the facility.

PROPOSED AMENDMENTS TO SB 328

EXHIBIT 4
DATE 3-26
HB SB 328

Ellen Feaver

1. Statement of Intent, line 9.
Following: "public."
Insert: "It is further intended that agencies may provide camera ready copy of documents considered to be for public dissemination to a commercial printer."

Ellen Feaver

2. Title, line 7.
Following: "FROM"
Insert: "printing documents intended for public dissemination or"

University System

3. Page 4, line 23.
Following: "(5)"
Strike: "Neither"
Insert: "Except for professional, scientific, literary journal, or other educational materials published by a unit of the university system or the superintendent of public instruction, neither"

Subcommittee Amendments

4. Page 4, line 25.
Reinsert ~~commercial~~

Subcommittee Amendments

5. Page 4, line 25, p. 5, line 1,
Following: printing~~,~~ delete
THAT IS PAID FOR ALL OR IN PART BY NONGOVERNMENT FUNDS.

Montana School Boards Association

6. Page 5, line 1.
Insert: After "non-government funds." the following: A school district may only engage in printing that is for a school or school related activity or organization.

University System

7. Page 7, line 3.
Following: "Include"
Insert: "professional, scientific, literary journals, or other educational materials published by a unit of the university system or the superintendent of public instruction or"

Ellen Feaver

8. Page 8, line 8.
Following: "INCLUDES"
Strike: "THOSE SERVICES DESCRIBED IN 18-4-123."
Insert: "the reproduction of an image from a printing surface generally made by a contact impression that causes a transfer of ink."

Ken Dunham

9. Page 8, line 9.
Following: 18-4-123
Insert: "Nothing in this act shall preclude state agencies from using (1) photocopiers to produce information for distribution to state employees or the public, or (2) typewriters, personal computers, and desktop computers for the preparation of camera-ready copy for printing."

Wood amendments

3-26-87

EXHIBIT 5
DATE 3-26
HB SB 291

Amend SB 291, 3rd reading bill, as follows:

1. P.3, line 8
Following: Line 7
Insert: NEW SECTION. Section 2. Acquisition of failed in-state financial institution by out-of-state institution - approval of department. (1) An out-of-state financial institution located in a reciprocal state may directly or indirectly acquire or acquire control of an in-state financial institution for which the Federal Deposit Insurance Corporation has been appointed a receiver, if the Federal Deposit Insurance Corporation has requested from in-state financial institutions for the assets of the institution and determined that none of the bids received has met the minimum requirements set by the corporation.
(2) The department shall approve the acquisition if it determines that the acquiring institution is financially sound according to commonly accepted standards of financial institutions examination.
Renumber following sections

2. P.3, line 22
Following: "state"
Strike: "."
Insert: "and;"

3. P.3, line 23
Following: "(b)"
Strike: "The department shall approve the acquisition"

4. P.4, line 16
Following: "state"
Strike: ". If the conditions are substantially the same as the conditions in this state, the department shall approve the acquisition"
Insert: "and"

5. P. 4, line 24
Following: "[section 2]"
Strike: "or"
Insert: "through"

6. P.4, line 25
Following: line 24
Strike: "3"
Insert: "4"

7. P.5, line 9
Following: "through"
Strike: "4"
Insert: "5"

8. P.5, line 13
Following: line 12
Insert: NEW SECTION. Termination date. This act shall terminate on ~~October 1, 1992~~. July 1991

3-26-87
EXHIBIT 6
DATE 3-26
HB SB 291

SB 291, 3rd reading

1. Wood amendment #1 - ok (p. 3, line 8)

2. p. 3, line 17
Following: "(2)"
Strike: "(a)"

3. p. 3, line 18
Following: "that"
Insert: "(a)"

Extend notice and hearing to determinations (b) and proposed (c) and (d) as well as (a), the reciprocity determination.

4. p. 3, line 22
Following: "state"
Strike: "."
Insert: ";"

(Wood amendment #2 without the "and")

5. p. 3, line 23
Following: "(b)"
Strike: "The department shall approve the acquisition if it determines that"

(Wood amendment #3 plus last four words for grammatical consistency)

6. p. 4, line 1
Following: "examination"
Insert: "; (c) that the acquiring institution will not control more than 8 percent of the total resources of all banks in this state; and (d) the proposed acquisition in its entirety cannot be made on terms as favorable to the seller by purchasers domiciled within this state."

7. p. 4, line 16

(Wood amendment #4 - ok)

8-9-10. p. 4, lines 24-25,
p. 5, line 9

(Wood amendments #5, 6, 7 - ok)

11. p. 5, line 13
Following: line 12
Insert: "NEW SECTION. Effective and termination dates. Section 2 is effective May 1, 1987. This act shall terminate on October 1, 199__."

Roger Tippy 3/25/87

EXHIBIT SB 34
DATE 3-26
HB SB34

Date | Prepared By | Work Paper No.
Reviewed By

# SCHEDULE OF UNEMPLOYMENT TAX
## FEDERAL & STATE

| | | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| | | | OPTION A STATE EXP. RATE 1% | OPTION B STATE EXP RATE 2.7% | OPTION C STATE EXP RATE 6% |
| 1 | ASSUMPTIONS: | | | | |
| 2 | 3 OFFICERS EACH WITH SALARY OF $12,200 | | | | |
| 3 | 4 EMPLOYEES EACH WITH SALARY OF $12,200 | | | | |
| 4 | | | | | |
| 5 | | | | | |
| 6 | | | | | |
| 7 | ALT 1: OFFICERS ARE | | | | |
| 8 | COVERED BY STATE UNEMPLOYMENT | | | | |
| 9 | | | | | |
| 10 | FEDERAL TAX (49,000 X .008) | | 392 | 392 | 392 |
| 11 | (SEE PART II, LINE 3 OF FORM 940) | | | | |
| 12 | STATE UNEMPLOYMENT | | | | |
| 13 | (85400 X EXP RATE) | | 854 | 2306 | 5124 |
| 14 | | | | | |
| 15 | TOTAL UNEMPLOYMENT TAX | | 1246 | 2698 | 5516 |
| 16 | | | | | |
| 17 | | | | | |
| 18 | | | | | |
| 19 | | | | | |
| 20 | ALT 2: OFFICERS ARE NOT | | | | |
| 21 | COVERED BY STATE UNEMPLOYMENT | | | | |
| 22 | | | | | |
| 23 | FEDERAL TAX | | 403 | 403 | 392 |
| 24 | (SEE PART III LINE 6 OF FORM 940) | | | | |
| 25 | | | | | |
| 26 | STATE UNEMPLOYMENT | | | | |
| 27 | (48,800 X EXP RATE) | | 488 | 1318 | 2928 |
| 28 | | | | | |
| 29 | TOTAL UNEMPLOYMENT TAX | | 891 | 1721 | 3320 |
| 30 | | | | | |
| 31 | EMPLOYER SAVINGS UNDER | | | | |
| 32 | ALT B (LINE 15 - LINE 29) | | 355 | 977 | 2196 |
| 33 | | | | | |
| 34 | | | | | |
| 35 | | | | | |
| 36 | | | | | |
| 37 | | | | | |
| 38 | | | | | |
| 39 | | | | | |
| 40 | | | | | |

OPTION A

Form **940**

Department of the Treasury
Internal Revenue Service

# Employer's Annual Federal Unemployment (FUTA) Tax Return

▶ For Paperwork Reduction Act Notice, see page 2.

OMB No. 1545-0028

**1985**

| | |
|---|---|
| T | |
| FF | |
| FD | |
| FP | |
| I | |
| T | |

**If incorrect, make any necessary change.** ▶

Name (as distinguished from trade name)

Trade name, if any

Address and ZIP code

Calendar Year **1985**

Employer identification number

A Did you pay all required contributions to your state unemployment fund by the due date of Form 940? (If none required, check "No.") . . . ☐ Yes ☐ No

If you checked the "Yes" box, enter amount of contributions paid to your state unemployment fund . . . . . ▶ $

B Are you required to pay contributions to only one state? . . . . . ☐ Yes ☐ No

If you checked the "Yes" box, (1) Enter the name of the state where you are required to pay contributions . . . . . ▶

(2) Enter your state reporting number(s) as shown on state unemployment tax return . . . . . ▶

## Part I Computation of Taxable Wages and Credit Reduction (To Be Completed by All Taxpayers)

| | | | |
|---|---|---|---|
| 1 | Total payments (including exempt payments) during the calendar year for services of employees | 1 | 85,400 |
| 2 | Exempt payments. (Explain each exemption shown, attaching additional sheets if necessary) ▶ | Amount paid 2 | |
| 3 | Payments for services of more than $7,000. Enter only the excess over the first $7,000 paid to individual employees not including exempt amounts shown on line 2. Do not use the state wage limitation | 3 36,400 | |
| 4 | Total exempt payments (add lines 2 and 3) | 4 | 36,400 |
| 5 | **Total taxable wages** (subtract line 4 from line 1). (If any part is exempt from state contributions, see instructions) ▶ | 5 | 49,000 |

6 Credit reduction for unrepaid advances to the states listed (by 2-letter Postal Service abbreviations). Enter the wages included on line 5 above for each state and multiply by the rate shown. (See the instructions.)

| | | | | | |
|---|---|---|---|---|---|
| (a) CT ____ x .007 ____ | (e) OH ____ x .008 ____ | | **Outside the United States** | | |
| (b) IL ____ x .009 ____ | (f) PA ____ x .009 ____ | | (i) PR ____ x .006 ____ | | |
| (c) LA ____ x .006 ____ | (g) VT ____ x .006 ____ | | (j) VI ____ x .012 ____ | | |
| (d) MN ____ x .011 ____ | (h) WV ____ x .008 ____ | | | | |

7 Total credit reduction (add lines 6(a) through 6(j) and enter in Part II, line 2 or Part III, line 4) . . . . . ▶ 7

## Part II Tax Due or Refund (Complete if You Checked the "Yes" Boxes in Both Questions A and B Above)

| | | | |
|---|---|---|---|
| 1 | FUTA tax. Multiply the wages in Part I, line 5, by .008 and enter here | 1 | 392 |
| 2 | Enter amount from Part I, line 7 | 2 | |
| 3 | **Total FUTA tax** (add lines 1 and 2) | 3 | 392 |
| 4 | Less: Total FUTA tax deposited for the year, including any overpayment applied from a prior year (from your records) | 4 | |
| 5 | **Balance due** (subtract line 4 from line 3—if over $100, see Part IV instructions). Pay to IRS . . . ▶ | 5 | |
| 6 | **Overpayment** (subtract line 3 from line 4). Check if it is to be: ☐ Applied to next return, or ☐ Refunded . . . ▶ | 6 | |

## Part III Tax Due or Refund (Complete if You Checked the "No" Box in Either Question A or B Above. Also complete Part V)

| | | | | |
|---|---|---|---|---|
| 1 | Gross FUTA tax. Multiply the wages in Part I, line 5, by .062 | | 1 | 3038 |
| 2 | Maximum credit. Multiply the wages in Part I, line 5, by .054 | 2 2646 | | |
| 3 | Enter the smaller of the amount in Part V, line 11, or Part III, line 2 | 3 2635 | | |
| 4 | Enter amount from Part I, line 7 | | 4 | – |
| 5 | **Credit allowable** (subtract line 4 from line 3) (If zero or less, enter 0.) | | 5 | 2635 |
| 6 | **Total FUTA tax** (subtract line 5 from line 1) | | 6 | 403 |
| 7 | Less: Total FUTA tax deposited for the year, including any overpayment applied from a prior year (from your records) | | 7 | |
| 8 | **Balance due** (subtract line 7 from line 6—if over $100, see Part IV instructions). Pay to IRS . . . ▶ | | 8 | |
| 9 | **Overpayment** (subtract line 6 from line 7). Check if it is to be: ☐ Applied to next return, or ☐ Refunded. . . ▶ | | 9 | |

## Part IV Record of Quarterly Federal Tax Liability for Unemployment Tax (Do not include state liability)

| Quarter | First | Second | Third | Fourth | Total for Year |
|---|---|---|---|---|---|
| Liability for quarter | | | | | |

**If you will not have to file returns in the future, write "Final" here (see general instruction "Who Must File") and sign the return** ▶

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete, and that no part of any payment made to a state unemployment fund claimed as a credit was or is to be deducted from the payments to employees.

Signature ▶ Title (Owner, etc.) ▶ Date ▶



A

OPTION A



**PART V Computation of Tentative Credit (Complete if You Checked the "No" Box in Either Question A or B on Page 1—See Instructions)**

| Name of state | State reporting number(s) as shown on employer's state contribution returns | Taxable payroll (as defined in state act) | State experience rate period 4 From— | State experience rate period 4 To— | State experience rate | Contributions if rate had been 5.4% (col. 3 x .054) | Contributions payable at experience rate (col. 3 x col. 5) | Additional credit (col. 6 minus col. 7) If 0 or less, enter 0. | Contributions actually paid to state |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | | | 5 | 6 | 7 | 8 | 9 |
| MT | | 48,800 | | | .01 | 2635 | 488 | 2147 | 488 |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| 10 Totals ▶ | | | | | | | | 2147 | 488 |
| 11 Total tentative credit (add line 10, columns 8 and 9—see instructions for limitations) ▶ | | | | | | | | | 2635 - |

**Paperwork Reduction Act Notice.**—We ask for this information to carry out the Internal Revenue laws of the United States. We need it to ensure that taxpayers are complying with these laws and to allow us to figure and collect the right amount of tax. You are required to give us this information.

**Changes You Should Note for 1985.**—The FUTA tax rate is now 6.2% charged on the $7,000 wage base. The maximum credit allowable against the tax for contributions to state (including Puerto Rico and the Virgin Islands) unemployment funds is now 5.4% of taxable FUTA wages. Noncash fringe benefits you provide may now be taxable. See **Circular E**, Publication 15, Employer's Tax Guide, for details.

The Service Center filing location for your state may have changed. See **Where To File**.

## General Instructions

**Purpose of Form.**—Use this form for your annual FUTA tax report. **Only the employer pays this tax.** The gross tax rate is 6.2% (.062), charged on the first $7,000 of wages paid to each employee during 1985.

## Who Must File

**Household Employers.**—You do not have to file this form unless you paid cash wages of $1,000 or more in any calendar quarter in 1984 or 1985 for household work in a private home, local college club, or a local chapter of a college fraternity or sorority. **Note:** *See **Publication 503**, Child and Dependent Care Credit, and Employment Taxes for Household Employers, for more information.*

**In General.**—You must file this form if you were other than a household or agricultural employer during 1984 or 1985 and you (a) paid wages of $1,500 or more in any calendar quarter or (b) had one or more employees for some part of a day in any 20 different weeks. Count all regular, temporary, and part-time employees. A partnership should not count its partners. If there is a change in ownership or other transfer of business during the year, each employer who meets test (a) or (b) above must file. Neither should report wages paid by the other. Organizations described in section 501(c)(3) of the Internal Revenue Code do not have to file.

**Agricultural Employers.**—You must file Form 940 if either of the following applies to you:

(1) You paid cash wages of $20,000 or more to farmworkers during any calendar quarter in 1984 or 1985.

(2) You employed 10 or more farmworkers during some part of a day (whether or not at the same time) for at least one day during any 20 different weeks in 1984 or 1985. Count aliens admitted to the United States on a temporary basis to perform farmwork to determine if you meet either of the above tests. However, wages paid to these aliens are not subject to FUTA tax before 1986.

## Completing Form 940

**Employers Who Are Not Required To Deposit FUTA Tax.**—If your total FUTA tax for 1985 is not more than $100, you do not have to deposit the tax. Make your FUTA tax payment when you file Form 940. If you do not have to deposit FUTA tax and you:

(a) made all required payments to your state unemployment fund by the due date of Form 940,

(b) are required to make payments to the unemployment fund of only one state, and

(c) paid wages subject to Federal unemployment tax that are also subject to state unemployment tax,

complete Parts I and II. Otherwise, complete Parts I, III, and V.

**Employers Who Are Required To Deposit FUTA Tax.**—If you meet tests (a), (b), and (c) above, complete Parts I, II, and IV. Otherwise, complete Parts I, III, IV, and V.

**If You Are Not Liable for FUTA Tax.**—If you receive Form 940 and are not liable for FUTA tax for 1985, write "Not Liable" across the front and return it to IRS. If you will not have to file returns after this, write "Final" on the line above the signature line and sign the return.

**Due Date.**—Form 940 for 1985 is due by January 31, 1986. However, if you made timely deposits in full payment of the tax due, your due date is February 10, 1986.

**Where To File.**—

| If your principal business, office or agency is located in: | File with the Internal Revenue Service Center at: |
|---|---|
| Alabama, Florida, Georgia, Mississippi, South Carolina | Atlanta, GA 31101 |
| New Jersey, New York City and counties of Nassau, Rockland, Suffolk, and Westchester | Holtsville, NY 00501 |
| New York (all other counties), Connecticut, Maine, Massachusetts, Minnesota, New Hampshire, Rhode Island, Vermont | Andover, MA 05501 |
| Illinois, Iowa, Missouri, Wisconsin | Kansas City, MO 64999 |
| Delaware, District of Columbia, Maryland, Pennsylvania, Puerto Rico, Virgin Islands | Philadelphia, PA 19255 |
| Kentucky, Michigan, Ohio, West Virginia | Cincinnati, OH 45999 |
| Kansas, Louisiana, New Mexico, Oklahoma, Texas | Austin, TX 73301 |
| Alaska, Arizona, California (counties of Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Glenn, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Nevada, Placer, Plumas, Sacramento, San Joaquin, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Yolo, and Yuba), Colorado, Idaho, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming | Ogden, UT 84201 |
| California (all other counties), Hawaii | Fresno, CA 93888 |
| Arkansas, Indiana, North Carolina, Tennessee, Virginia | Memphis, TN 37501 |

If you have no legal residence or principal place of business in any IRS district, file with the Internal Revenue Service Center, Philadelphia, PA 19255.

**Employer's Name, Address, and Identification Number.**—Use the preaddressed Form 940 mailed to you. If you must use a nonpreaddressed form, type or print your name, trade name, address, and employer identification number on it.

See **Publication 583,** Information for Business Taxpayers, for details on how to make tax deposits, file a return, etc., if these are due before you receive your number.

**Penalties and Interest.**—Avoid penalties and interest by making tax deposits when due and filing a correct return and paying the proper amount of tax when due. The law provides penalties for late deposits and late filing unless you show reasonable cause for the delay. If you file late, attach an explanation to the return. The law also provides a penalty of 25% of the overstatement if, without reasonable cause, you overstate the amount you deposited.

There are also penalties for willful failure to pay tax, keep records, make returns, and for filing false or fraudulent returns.

**Credit for Contributions Paid Into State Funds.**—You can claim credit for amounts you pay into a certified state (including Puerto Rico and the Virgin Islands) unemployment fund by the due date of Form 940.

"Contributions" are payments that state law requires you to make to an unemployment fund because you are an employer. These payments are "contributions" only to the extent that they are not deducted or deductible from the employees' pay.

You may not take credit for voluntary payments or for penalties or interest payments to a state. Nor may you take credit for any special assessment, surtax, surcharge, etc. by the state for paying interest on unrepaid Title XII loans from the Federal Government.

If you have been granted an experience rate lower than 5.4% (.054) by a state for the whole or part of the year, you are entitled to an additional credit. This credit is equal to the difference between actual payments and the amount you would have been required to pay at 5.4%.

The total credit allowable may not be more than 5.4% of taxable FUTA wages.

**Special Credit for Successor Employers.**—If you are claiming special credit as a successor employer, see Code section 3302(e) or Circular E, for the conditions you must meet.

**Amended Returns.**—If you are amending a previously filed return, complete a new Form 940, using the amounts that should have been used on the original return, and sign the return. Attach a statement explaining why you are filing an amended return. Be sure to use a Form 940 for the year you are amending. Write "AMENDED RETURN" at the top of the form and file it with the Internal Revenue Service Center where you filed the original return.

## Specific Instructions

***All filers must complete Questions A, B, and Part I and must sign the return.***

Use Part II if you paid contributions to only one state unemployment fund, you made all state payments by the due date of Form 940, and all the FUTA wages are subject to the state's unemployment fund taxes. Otherwise, skip Part II and complete Parts III and V.

Complete Part IV if your total tax for the year is more than $100.

*(Instructions continued on page 4.)*

OPTION B

Form **940**

Department of the Treasury
Internal Revenue Service

# Employer's Annual Federal Unemployment (FUTA) Tax Return

▶ For Paperwork Reduction Act Notice, see page 2.

OMB No. 1545-0028

**1985**

| | |
|---|---|
| T | |
| FF | |
| FD | |
| FP | |
| I | |
| T | |

If incorrect, make any necessary change. ▶

Name (as distinguished from trade name)

Trade name, if any

Address and ZIP code

Calendar Year **1985**

Employer identification number

A Did you pay all required contributions to your state unemployment fund by the due date of Form 940? (If none required, check "No.") . . . ☐ Yes ☐ No

If you checked the "Yes" box, enter amount of contributions paid to your state unemployment fund . . . . . ▶ $

B Are you required to pay contributions to only one state? . . . . . ☐ Yes ☐ No

If you checked the "Yes" box, (1) Enter the name of the state where you are required to pay contributions . . . . . ▶

(2) Enter your state reporting number(s) as shown on state unemployment tax return . . . . . ▶

## Part I Computation of Taxable Wages and Credit Reduction (To Be Completed by All Taxpayers)

| | | Amount paid | | |
|---|---|---|---|---|
| 1 | Total payments (including exempt payments) during the calendar year for services of employees | | 1 | 85,400 |
| 2 | Exempt payments. (Explain each exemption shown, attaching additional sheets if necessary) ▶ | | 2 | |
| 3 | Payments for services of more than $7,000. Enter only the excess over the first $7,000 paid to individual employees not including exempt amounts shown on line 2. Do not use the state wage limitation | 36,400 | | |
| 4 | Total exempt payments (add lines 2 and 3) | | 4 | 36,400 |
| 5 | **Total taxable wages** (subtract line 4 from line 1). (If any part is exempt from state contributions, see instructions) ▶ | | 5 | 49,000 |

6 Credit reduction for unrepaid advances to the states listed (by 2-letter Postal Service abbreviations). Enter the wages included on line 5 above for each state and multiply by the rate shown. (See the instructions.)

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| (a) | CT | x .007 | | (e) | OH | x .008 | | Outside the United States | | | |
| (b) | IL | x .009 | | (f) | PA | x .009 | | (i) | PR | x .006 | |
| (c) | LA | x .006 | | (g) | VT | x .006 | | (j) | VI | x .012 | |
| (d) | MN | x .011 | | (h) | WV | x .008 | | | | | |

7 Total credit reduction (add lines 6(a) through 6(j) and enter in Part II, line 2 or Part III, line 4) . . . . . ▶ 7

## Part II Tax Due or Refund (Complete if You Checked the "Yes" Boxes in Both Questions A and B Above)

| | | | |
|---|---|---|---|
| 1 | FUTA tax. Multiply the wages in Part I, line 5, by .008 and enter here | 1 | 392 |
| 2 | Enter amount from Part I, line 7 | 2 | |
| 3 | **Total FUTA tax** (add lines 1 and 2) | 3 | 392 |
| 4 | Less: Total FUTA tax deposited for the year, including any overpayment applied from a prior year (from your records) | 4 | |
| 5 | **Balance due** (subtract line 4 from line 3—if over $100, see Part IV instructions). Pay to IRS . . . ▶ | 5 | |
| 6 | **Overpayment** (subtract line 3 from line 4). Check if it is to be: ☐ Applied to next return, or ☐ Refunded . . . ▶ | 6 | |

## Part III Tax Due or Refund (Complete if You Checked the "No" Box in Either Question A or B Above. Also complete Part V)

| | | | | |
|---|---|---|---|---|
| 1 | Gross FUTA tax. Multiply the wages in Part I, line 5, by .062 | | 1 | 3038 |
| 2 | Maximum credit. Multiply the wages in Part I, line 5, by .054 | 2 2646 | | |
| 3 | Enter the smaller of the amount in Part V, line 11, or Part III, line 2 | 3 2635 | | |
| 4 | Enter amount from Part I, line 7 | | 4 | — |
| 5 | **Credit allowable** (subtract line 4 from line 3) (If zero or less, enter 0.) | | 5 | 2635 |
| 6 | **Total FUTA tax** (subtract line 5 from line 1) | | 6 | 403 |
| 7 | Less: Total FUTA tax deposited for the year, including any overpayment applied from a prior year (from your records) | | 7 | |
| 8 | **Balance due** (subtract line 7 from line 6—if over $100, see Part IV instructions). Pay to IRS . . . ▶ | | 8 | |
| 9 | **Overpayment** (subtract line 6 from line 7). Check if it is to be: ☐ Applied to next return, or ☐ Refunded. . . ▶ | | 9 | |

## Part IV Record of Quarterly Federal Tax Liability for Unemployment Tax (Do not include state liability)

| Quarter | First | Second | Third | Fourth | Total for Year |
|---|---|---|---|---|---|
| Liability for quarter | | | | | |

**If you will not have to file returns in the future, write "Final" here (see general instruction "Who Must File") and sign the return** ▶

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete, and that no part of any payment made to a state unemployment fund claimed as a credit was or is to be deducted from the payments to employees.

Signature ▶ Title (Owner, etc.) ▶ Date ▶



B

OPTION B



**PART V Computation of Tentative Credit (Complete if You Checked the "No" Box in Either Question A or B on Page 1—See Instructions)**

| Name of state | State reporting number(s) as shown on employer's state contribution returns | Taxable payroll (as defined in state act) | State experience rate period 4 From— | State experience rate period 4 To— | State experience rate | Contributions if rate had been 5.4% (col. 3 x .054) | Contributions payable at experience rate (col. 3 x col. 5) | Additional credit (col. 6 minus col. 7) If 0 or less, enter 0. | Contributions actually paid to state |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | | | 5 | 6 | 7 | 8 | 9 |
| MT | | 48800 | | | .027 | 2635 | 1318 | 1317 | 1318 |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| 10 Totals ▶ | | | | | | | | 1317 | 1318 |

11 Total tentative credit (add line 10, columns 8 and 9—see instructions for limitations) ▶ 2635

**Paperwork Reduction Act Notice.**—We ask for this information to carry out the Internal Revenue laws of the United States. We need it to ensure that taxpayers are complying with these laws and to allow us to figure and collect the right amount of tax. You are required to give us this information.

**Changes You Should Note for 1985.**—The FUTA tax rate is now 6.2% charged on the $7,000 wage base. The maximum credit allowable against the tax for contributions to state (including Puerto Rico and the Virgin Islands) unemployment funds is now 5.4% of taxable FUTA wages. Noncash fringe benefits you provide may now be taxable. See **Circular E**, Publication 15, Employer's Tax Guide, for details.

The Service Center filing location for your state may have changed. See **Where To File**.

## General Instructions

**Purpose of Form.**—Use this form for your annual FUTA tax report. **Only the employer pays this tax.** The gross tax rate is 6.2% (.062), charged on the first $7,000 of wages paid to each employee during 1985.

## Who Must File

**Household Employers.**—You do not have to file this form unless you paid cash wages of $1,000 or more in any calendar quarter in 1984 or 1985 for household work in a private home, local college club, or a local chapter of a college fraternity or sorority. **Note:** *See **Publication 503**, Child and Dependent Care Credit, and Employment Taxes for Household Employers, for more information.*

**In General.**—You must file this form if you were other than a household or agricultural employer during 1984 or 1985 and you (a) paid wages of $1,500 or more in any calendar quarter or (b) had one or more employees for some part of a day in any 20 different weeks. Count all regular, temporary, and part-time employees. A partnership should not count its partners. If there is a change in ownership or other transfer of business during the year, each employer who meets test (a) or (b) above must file. Neither should report wages paid by the other. Organizations described in section 501(c)(3) of the Internal Revenue Code do not have to file.

**Agricultural Employers.**—You must file Form 940 if either of the following applies to you:

(1) You paid cash wages of $20,000 or more to farmworkers during any calendar quarter in 1984 or 1985.

(2) You employed 10 or more farmworkers during some part of a day (whether or not at the same time) for at least one day during any 20 different weeks in 1984 or 1985. Count aliens admitted to the United States on a temporary basis to perform farmwork to determine if you meet either of the above tests. However, wages paid to these aliens are not subject to FUTA tax before 1986.

## Completing Form 940

**Employers Who Are Not Required To Deposit FUTA Tax.**—If your total FUTA tax for 1985 is not more than $100, you do not have to deposit the tax. Make your FUTA tax payment when you file Form 940. If you do not have to deposit FUTA tax and you:

(a) made all required payments to your state unemployment fund by the due date of Form 940,

(b) are required to make payments to the unemployment fund of only one state, and

(c) paid wages subject to Federal unemployment tax that are also subject to state unemployment tax,

complete Parts I and II. Otherwise, complete Parts I, III, and V.

**Employers Who Are Required To Deposit FUTA Tax.**—If you meet tests (a), (b), and (c) above, complete Parts I, II, and IV. Otherwise, complete Parts I, III, IV, and V.

**If You Are Not Liable for FUTA Tax.**—If you receive Form 940 and are not liable for FUTA tax for 1985, write "Not Liable" across the front and return it to IRS. If you will not have to file returns after this, write "Final" on the line above the signature line and sign the return.

**Due Date.**—Form 940 for 1985 is due by January 31, 1986. However, if you made timely deposits in full payment of the tax due, your due date is February 10, 1986.

### Where To File.—

| If your principal business, office or agency is located in: | File with the Internal Revenue Service Center at: |
|---|---|
| Alabama, Florida, Georgia, Mississippi, South Carolina | Atlanta, GA 31101 |
| New Jersey, New York City and counties of Nassau, Rockland, Suffolk, and Westchester | Holtsville, NY 00501 |
| New York (all other counties), Connecticut, Maine, Massachusetts, Minnesota, New Hampshire, Rhode Island, Vermont | Andover, MA 05501 |
| Illinois, Iowa, Missouri, Wisconsin | Kansas City, MO 64999 |
| Delaware, District of Columbia, Maryland, Pennsylvania, Puerto Rico, Virgin Islands | Philadelphia, PA 19255 |
| Kentucky, Michigan, Ohio, West Virginia | Cincinnati, OH 45999 |
| Kansas, Louisiana, New Mexico, Oklahoma, Texas | Austin, TX 73301 |
| Alaska, Arizona, California (counties of Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Glenn, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Nevada, Placer, Plumas, Sacramento, San Joaquin, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Yolo, and Yuba), Colorado, Idaho, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming | Ogden, UT 84201 |
| California (all other counties), Hawaii | Fresno, CA 93888 |
| Arkansas, Indiana, North Carolina, Tennessee, Virginia | Memphis, TN 37501 |

If you have no legal residence or principal place of business in any IRS district, file with the Internal Revenue Service Center, Philadelphia, PA 19255.

**Employer's Name, Address, and Identification Number.**—Use the preaddressed Form 940 mailed to you. If you must use a nonpreaddressed form, type or print your name, trade name, address, and employer identification number on it.

See **Publication 583,** Information for Business Taxpayers, for details on how to make tax deposits, file a return, etc., if these are due before you receive your number.

**Penalties and Interest.**—Avoid penalties and interest by making tax deposits when due and filing a correct return and paying the proper amount of tax when due. The law provides penalties for late deposits and late filing unless you show reasonable cause for the delay. If you file late, attach an explanation to the return. The law also provides a penalty of 25% of the overstatement if, without reasonable cause, you overstate the amount you deposited.

There are also penalties for willful failure to pay tax, keep records, make returns, and for filing false or fraudulent returns.

**Credit for Contributions Paid Into State Funds.**—You can claim credit for amounts you pay into a certified state (including Puerto Rico and the Virgin Islands) unemployment fund by the due date of Form 940.

"Contributions" are payments that state law requires you to make to an unemployment fund because you are an employer. These payments are "contributions" only to the extent that they are not deducted or deductible from the employees' pay.

You may not take credit for voluntary payments or for penalties or interest payments to a state. Nor may you take credit for any special assessment, surtax, surcharge, etc. by the state for paying interest on unrepaid Title XII loans from the Federal Government.

If you have been granted an experience rate lower than 5.4% (.054) by a state for the whole or part of the year, you are entitled to an additional credit. This credit is equal to the difference between actual payments and the amount you would have been required to pay at 5.4%.

The total credit allowable may not be more than 5.4% of taxable FUTA wages.

**Special Credit for Successor Employers.**—If you are claiming special credit as a successor employer, see Code section 3302(e) or Circular E, for the conditions you must meet.

**Amended Returns.**—If you are amending a previously filed return, complete a new Form 940, using the amounts that should have been used on the original return, and sign the return. Attach a statement explaining why you are filing an amended return. Be sure to use a Form 940 for the year you are amending. Write "AMENDED RETURN" at the top of the form and file it with the Internal Revenue Service Center where you filed the original return.

## Specific Instructions

***All filers must complete Questions A, B, and Part I and must sign the return.***

Use Part II if you paid contributions to only one state unemployment fund, you made all state payments by the due date of Form 940, and all the FUTA wages are subject to the state's unemployment fund taxes. Otherwise, skip Part II and complete Parts III and V.

Complete Part IV if your total tax for the year is more than $100.

*(Instructions continued on page 4.)*

OPTION C

Form **940**
Department of the Treasury
Internal Revenue Service

# Employer's Annual Federal Unemployment (FUTA) Tax Return

▶ For Paperwork Reduction Act Notice, see page 2.

OMB No. 1545-0028

**1985**

Calendar Year
**1985**
Employer identification number

EMPLOYER'S COPY

A Did you pay all required contributions to your state unemployment fund by the due date of Form 940? (If none required, check "No.") . . . ☐ Yes ☐ No
If you checked the "Yes" box, enter amount of contributions paid to your state unemployment fund . . . . . ▶ $

B Are you required to pay contributions to only one state? . . . . . ☐ Yes ☐ No
If you checked the "Yes" box, (1) Enter the name of the state where you are required to pay contributions . . . . . ▶
(2) Enter your state reporting number(s) as shown on state unemployment tax return . . . . . ▶

## Part I Computation of Taxable Wages and Credit Reduction (To Be Completed by All Taxpayers)

| | | | |
|---|---|---|---|
| 1 | Total payments (including exempt payments) during the calendar year for services of employees | 1 | 85400 |
| 2 | Exempt payments. (Explain each exemption shown, attaching additional sheets if necessary) ▶ | Amount paid 2 | |
| 3 | Payments for services of more than $7,000. Enter only the excess over the first $7,000 paid to individual employees not including exempt amounts shown on line 2. Do not use the state wage limitation | 3 36400 | |
| 4 | Total exempt payments (add lines 2 and 3) | 4 | 36400 |
| 5 | **Total taxable wages** (subtract line 4 from line 1). (If any part is exempt from state contributions, see instructions) ▶ | 5 | 49000 |

6 Credit reduction for unrepaid advances to the states listed (by 2-letter Postal Service abbreviations). Enter the wages included on line 5 above for each state and multiply by the rate shown. (See the instructions.)

| | | | | | |
|---|---|---|---|---|---|
| (a) CT ____ x .007 ____ | (e) OH ____ x .008 ____ | **Outside the United States** | | | |
| (b) IL ____ x .009 ____ | (f) PA ____ x .009 ____ | (i) PR ____ x .006 ____ | | | |
| (c) LA ____ x .006 ____ | (g) VT ____ x .006 ____ | (j) VI ____ x .012 ____ | | | |
| (d) MN ____ x .011 ____ | (h) WV ____ x .008 ____ | | | | |

7 Total credit reduction (add lines 6(a) through 6(j) and enter in Part II, line 2 or Part III, line 4) . . . . . ▶ 7

## Part II Tax Due or Refund (Complete if You Checked the "Yes" Boxes in Both Questions A and B Above)

| | | | |
|---|---|---|---|
| 1 | FUTA tax. Multiply the wages in Part I, line 5, by .008 and enter here | 1 | 392 |
| 2 | Enter amount from Part I, line 7 | 2 | |
| 3 | **Total FUTA tax** (add lines 1 and 2) | 3 | 392 |
| 4 | Less: Total FUTA tax deposited for the year, including any overpayment applied from a prior year (from your records) | 4 | |
| 5 | **Balance due** (subtract line 4 from line 3—if over $100, see Part IV instructions). Pay to IRS . . . ▶ | 5 | |
| 6 | **Overpayment** (subtract line 3 from line 4). Check if it is to be: ☐ Applied to next return, or ☐ Refunded . . . ▶ | 6 | |

## Part III Tax Due or Refund (Complete if You Checked the "No" Box in Either Question A or B Above. Also complete Part V)

| | | | | |
|---|---|---|---|---|
| 1 | Gross FUTA tax. Multiply the wages in Part I, line 5, by .062 | | 1 | 3038 |
| 2 | Maximum credit. Multiply the wages in Part I, line 5, by .054 | 2 2646 | | |
| 3 | Enter the smaller of the amount in Part V, line 11, or Part III, line 2 | 3 2646 | | |
| 4 | Enter amount from Part I, line 7 | | 4 | — |
| 5 | **Credit allowable** (subtract line 4 from line 3) (If zero or less, enter 0.) | | 5 | 2646 |
| 6 | **Total FUTA tax** (subtract line 5 from line 1) | | 6 | 392 |
| 7 | Less: Total FUTA tax deposited for the year, including any overpayment applied from a prior year (from your records) | | 7 | |
| 8 | **Balance due** (subtract line 7 from line 6—if over $100, see Part IV instructions). Pay to IRS . . . ▶ | | 8 | |
| 9 | **Overpayment** (subtract line 6 from line 7). Check if it is to be: ☐ Applied to next return, or ☐ Refunded. . . ▶ | | 9 | |

## Part IV Record of Quarterly Federal Tax Liability for Unemployment Tax (Do not include state liability)

| Quarter | First | Second | Third | Fourth | Total for Year |
|---|---|---|---|---|---|
| Liability for quarter | | | | | |

**If you will not have to file returns in the future, write "Final" here (see general instruction "Who Must File") and sign the return** ▶

**Keep This Copy for Your Records**—You must keep this copy and a copy of each related schedule or statement for a period of 4 years after the date the tax is due or paid, whichever is later. These copies must be available for inspection by the Internal Revenue Service.

**For More Information**—See Circular E and **Publication 539**, Employment Taxes, for more information. Household employers should see Publication 503.

C

OPTION C



## PART V Computation of Tentative Credit (Complete if You Checked the "No" Box in Either Question A or B on Page 1—See Instructions)

| Name of state | State reporting number(s) as shown on employer's state contribution returns | Taxable payroll (as defined in state act) | State experience rate period 4 From— | State experience rate period 4 To— | State experience rate | Contributions if rate had been 5.4% (col. 3 x .054) | Contributions payable at experience rate (col. 3 x col. 5) | Additional credit (col. 6 minus col. 7) If 0 or less, enter 0. | Contributions actually paid to state |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | | | 5 | 6 | 7 | 8 | 9 |
| MT | | 48,800 | | | .06 | 2635 | 2928 | - | 2928 |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| 10 Totals ▶ | | | | | | | | - | 2928 |
| 11 Total tentative credit (add line 10, columns 8 and 9—see instructions for limitations) ▶ | | | | | | | | 2928 | - |

### Part I.—Computation of Taxable Wages and Credit Reduction

**Line 1—Total payments.**—Enter the total payments you made to employees during the calendar year, even if they are not taxable. Include salaries, wages, commissions, fees, bonuses, vacation allowances, amounts paid to temporary or part-time employees, and the value of goods, lodging, food, clothing, and noncash fringe benefits. Enter the amount before any deductions.

How the payments are made is not important in determining if they are wages. Thus, you may pay wages for piecework or as a percentage of profits, and you may pay wages hourly, daily, weekly, monthly, or yearly. You may pay wages in cash or some other way, such as goods, lodging, food, or clothing. For items other than cash, use the fair market value at the time of payment.

**Line 2—Exempt payments.**—"Wages" and "employment" as defined for FUTA purposes do not include every payment and every kind of service an employee may perform. In general, payments excluded from wages and payments for services excepted from employment are not subject to tax. You may deduct these payments from total payments only if you explain them on line 2.

Enter such items as the following:

(1) Agricultural labor, if you (a) did not pay cash wages of $20,000 or more for such labor for any calendar quarter in 1984 or 1985 AND did not employ 10 or more farmworkers during any part of a day during any 20 different weeks in 1984 or 1985 or (b) paid wages to aliens admitted to the United States on a temporary basis to perform farmwork before 1986.

(2) Benefit payments for sickness or injury under a worker's compensation law.

(3) Household service if you did not pay cash wages of $1,000 or more in any calendar quarter in 1984 and 1985.

(4) Certain family employment.

(5) Certain fishing activities.

(6) Noncash payments for farmwork or household services in a private home that are included on line 1. Only cash wages to these workers are taxable.

(7) Value of certain meals and lodging.

(8) Any other exempt service or pay.

For more information, see Circular E.

**Line 3.**—Enter the total amounts of more than $7,000 you paid each employee. For example, if you have 10 employees to whom you paid $8,000 each during the year, enter $80,000 on line 1 and $10,000 on line 3. The $7,000 wage limitation is for FUTA purposes only. Do not use the state wage limitation for this entry.

**Line 5—Total taxable wages.**—If any part of these wages is exempt from state unemployment taxes, you must fill out Parts III and V, even if you checked "Yes" on questions A and B.

**Line 6.**—Enter any wages included on line 5 subject to the unemployment compensation laws of the states listed. (If in doubt, ask your local IRS office.) Multiply the wages by the appropriate rate. This adjustment increases the FUTA tax by the amount shown on line 7, by reducing the credit otherwise allowable against the FUTA tax for contributions made to state unemployment funds. (However, the increase cannot be more than the credit otherwise allowable.) **Note:** *The sum of the wages shown on line 6 cannot exceed the total taxable wages shown on line 5.* If no wages are subject, enter "none" on line 7.

### Part II.—Tax Due or Refund

Use this part only if you checked "Yes" for both questions A and B on page 1, and all your wages shown on line 5 of Part I are subject to the state's unemployment fund taxes. The tax rate of .008 gives you credit for your payments to your state's unemployment fund.

### Part III.—Tax Due or Refund

Use this part if you do not qualify for Part II.

**Line 3.**—Enter the smaller of (1) Part V, line 11—Total tentative credit, or (2) Part III, line 2—5.4% of taxable FUTA wages. This is the maximum credit allowable for your payments to the state unemployment fund.

**Line 4.**—Enter the amount from Part I, line 7. Subtract this amount from Part III, line 3. The result on line 5 is your allowable credit for payments to the state.

### Part IV.—Record of Federal Tax Liability

Complete this part if your total tax (Part II, line 3 or Part III, line 6) is over $100. To figure your FUTA tax liability **for each of the first 3 quarters of 1985**, multiply by .008 that part of the first $7,000 of each employee's annual wages you paid during the quarter. Enter this amount under that quarter.

**Your liability for the 4th quarter is the total tax** (Part II, line 3 or Part III, line 6) **minus your liability for the first 3 quarters of the year.** If this plus any undeposited amount from earlier quarters is over $100, deposit the entire amount by January 31 in a qualified depositary. If it is $100 or less, you can either make a deposit or pay it with your Form 940 by January 31.

The total liability must equal your total tax. Otherwise you may be charged a failure to deposit penalty figured on your average liability.

If the amount subject to deposit (plus any undeposited amount of $100 or less for any earlier quarter) is more than $100, deposit it by the last day of the first month following the close of the quarter.

If you deposited the correct amounts, following these rules, the balance due with Form 940 will never be more than $100.

Deposit FUTA tax in an authorized financial institution or the Federal Reserve Bank for your area. To avoid a possible penalty, do not mail deposits directly to IRS. Records of your deposits will be sent to IRS for crediting to your business accounts.

You must use a **Form 8109,** Federal Tax Deposit Coupon, when making each tax deposit. IRS will send you a book of deposit coupons when you apply for an employer identification number. Follow the instructions in the coupon book.

Taxpayers who willfully claim credit for deposits not made are subject to fines and other criminal penalties.

### Part V.—Computation of Tentative Credit

Complete this schedule if: (1) You made payments to the unemployment fund of more than one state; (2) You did not make all your state payments by the due date of Form 940; or (3) Any wages subject to FUTA tax were exempted from state unemployment taxes. If you have a state experience rate lower than 5.4% for all or part of the year, use columns 1 through 9. If you have no experience rate, use columns 1, 2, 3, and 9 only. If you have a rate of 5.4% or higher, use columns 1, 2, 3, 4, 5, and 9 only. If you were granted an experience rate for only part of the year or the rate was changed during the year, enter in the appropriate columns the period each separate rate applied to, your payroll rate, and required contributions for each period.

**Column 1.**—Enter the name of the state(s) (including Puerto Rico and the Virgin Islands) that you were required to pay contributions to.

**Column 2.**—Enter the state reporting number that was assigned to you when you registered as an employer with each state.

**Column 3.**—Enter the taxable payroll on which you must pay taxes to the unemployment fund of each state in column 1. If your experience rate is zero, enter the amount of wages that you would have had to pay on if the rate had not been granted.

**Columns 4 and 5.**—Your state experience rate is the rate at which the state taxes your payroll for state unemployment purposes. This rate may be adjusted from time to time based on your "experience" with the state fund, that is, unemployment compensation paid to your former employees and other factors. If you do not know your rate, contact your state unemployment security agency.

**Column 8.**—Subtract column 7 from column 6. If zero or less, enter "0."

**Column 9.**—Enter contributions actually paid into the state fund by the due date of Form 940. Do not include any special assessments, surtaxes, surcharges, etc., used by the state to pay interest on unrepaid advances from the Federal Government.

**Line 11.**—Add line 10, columns 8 and 9. The allowable credit for state contributions you make after the due date (or extended due date) for filing Form 940 may not be more than 90% of the credit that would have been allowed if you had paid the state contributions by the due date. For example, if $1,500 of state contributions were paid on time, and $1,000 was paid after the due date for filing Form 940, the total tentative credit on line 11 (assuming no additional credit (column 8)) would be $2,400 ($1,500 + $900 (90% of $1,000)).

**Note:** *If you are receiving additional credit (column 8) because your state experience rate is less than 5.4%, the additional credit is not subject to the 90% limitation.*

☆U.S. GOVERNMENT PRINTING OFFICE: 1985-463-055

# STANDING COMMITTEE REPORT

EXHIBIT_____
DATE 3-26
HB SB 353

MARCH 26 19 87

Mr. Speaker: We, the committee on BUSINESS AND LABOR

report SENATE BILL NO. 353

☐ do pass
☐ do not pass

☒ be concurred in
☐ be not concurred in

☒ as amended
☐ statement of intent attached

REP. LES KITSELMAN Chairman

AMENDMENTS AS FOLLOWS:

1) Title, line 7
Following: "33-22-111"
Insert: "17-7-502,"

2) Page 10, line 18
Strike: "for approval"

3) Page 10, line 19
Following: "{section 8(7)}"
Insert: ", however, nothing in this subsection deprives the health maintenance organization of its right to confidentiality of any proprietary information and the commissioner may not disclose that proprietary information to any other person"

4) Page 13, line 1
Following: Page 12, line 25
Insert: "(7) The commissioner may make reasonable rules exempting an insurer or health service corporation operating a health maintenance organization as a plan from the filing requirements of this section if information requested in the application has been submitted to the commissioner under other laws and rules administered by the commissioner."

5) Page 18, line 3
Following: "may"
Insert: ", after notice and hearing, within 60 days."

6) Page 18, line 4
Following: "power"
Insert: "under subsection (1)(a), (1)(b), or (1)(d)"

7) Page 18, lines 10, 11, and 12
Strike: lines 10 and 11 in their entirety and line 12 through "commissioner."

REP. KITSELMAN will sponsor

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8) Page 20, lines 18 and 19
Following: "is" on line 18
Strike: the remainder of line 18 and line 19 in its entirety

9) Page 23, line 1
Following: "limits"
Insert: "and coverage"

10) Page 23, line 2
Strike: "33-22-703;"
Insert: "Title 33, chapter 22, part 7, however, after the primary care physician refers an enrollee for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction.
(i) If an enrollee chooses a provider other than the health maintenance organization provider for such treatment and referral services, the enrollee's designated provider must limit his treatment and services to the scope of the referral in order to receive payment from the health maintenance organization.
(ii) The amount paid by the health maintenance organization to the enrollee's designated provider may not exceed the amount paid by the health maintenance organization to one of its providers for equivalent treatment or services."

11) Page 25, line 18, through page 26, line 2
Following: Page 25, line 17
Strike: lines 18 through 25 on page 25 and lines 1 and 2 on page 26 in their entirety

12) Page 26, lines 3 and 4
Strike: "a reasonable period"
Insert: "60 days"

13) Page 26, line 6
Strike: "or use a schedule of charges"

14) Page 26, lines 7 and 8
Following: "form" on line 7
Strike: the remainder of line 7 and line 8 through "charges."

Chairman.

STATE PUB. CO.
Helena, Mont.

15) Page 26, line 15
Following: "any"
Insert: "relevant"

16) Page 29, line 14
Strike: "A"
Insert: "Except for a health maintenance organization operated as a plan by a health service corporation, a"
17) Page 39, line 10
Following: "title"
Insert: "or licensed as an enrollment representative under 33-30-311 through 33-30-313"

18) Page 41, lines 13 through 15
Following: "organization" on line 13
Strike: the remainder of line 13, line 14 in its entirety and line 15 through "arrangements"

19) Page 43, line 25
Following: "(section3)
Insert: "and provided that such operation adversely affects the health maintenance organization's ability to provide benefits and operate under the application approved by the commissioner"

20) Page 47, line 21
Strike: "quality"
Insert: "availability, accessibility, and continuity"

21) Page 49, line 9
Following: "$35"
Insert: ";
(d) for annual continuation of certificate of authority, $300"

22) Page 49, lines 20 and 21
Following: "17-7-502." on line 20
Strike: the remainder of line 20 and line 21 in its entirety
Insert: "Such fees are statutorily appropriated to the department of health as provided in 17-7-502."

23) Page 60, line 6
Following: line 5
Insert: "Section 30. Section 17-7-502, MCA, is amended to read:

Chairman.

STATE PUB. CO.
Helena, Mont.

**17-7-502. Statutory appropriations -- definition -- requisites for validity.** (1) A statutory appropriation is an appropriation made by permanent law that authorizes spending by a state agency without the need for a biennial legislative appropriation or budget amendment.

(2) Except as provided in subsection (4), to be effective, a statutory appropriation must comply with both of the following provisions:

(a) The law containing the statutory authority must be listed in subsection (3).

(b) The law or portion of the law making a statutory appropriation must specifically state that a statutory appropriation is made as provided in this section.

(3) The following laws are the only laws containing statutory appropriations:

(a) 2-9-202;
(b) 2-17-105;
(c) 2-18-812;
(d) 10-3-203;
(e) 10-3-312;
(f) 10-3-314;
(g) 10-4-301;
(h) 13-37-304;
(i) 15-31-702;
(j) 15-36-112;
(k) 15-70-101;
(l) 16-1-404;
(m) 16-1-410;
(n) 16-1-411;
(o) 17-3-212;
(p) 17-5-404;
(q) 17-5-424;
(r) 17-5-804;
(s) 19-8-504;
(t) 19-9-702
(u) 19-9-1007;
(v) 19-10-205;
(w) 19-10-305;
(x) 19-10-506;
(y) 19-11-512;
(z) 19-11-513;
(aa) 19-11-606;
(bb) 19-12-301;
(cc) 19-13-604;
(dd) 20-6-406;

Chairman.

STATE PUB. CO.
Helena, Mont.

(ee) 20-8-111;
(ff) 23-5-612;
(gg) [section 17];
(hh) [section 22];
(ii) 37-51-501;
(jj) 53-24-206;
(kk) 75-1-1101;
(ll) 75-7-305;
(mm) 80-2-103;
(nn) 80-2-228;
(oo) 90-3-301;
(pp) 90-3-302;
(qq) 90-15-103; and
(rr) Sec. 13, HB 861, L. 1985.

(4) There is a statutory appropriation to pay the principal, interest, premiums, and costs of issuing, paying, and securing all bonds, notes, or other obligations, as due, that have been authorized and issued pursuant to the laws of Montana. Agencies that have entered into agreements authorized by the laws of Montana to pay the state treasurer, for deposit in accordance with 17-2-101 through 17-2-107, as determined by the state treasurer, an amount sufficient to pay the principal and interest as due on the bonds or notes have statutory appropriation authority for such payments."

Renumber: subsequent sections

Chairman.

STATE PUB. CO.
Helena, Mont.

STATEMENT OF INTENT

SB 353 - BLUE COPY

**AMENDMENTS AS FOLLOWS:**

1) Page 2

Strike: lines 9 through 14 in their entirety

Insert: "Any rule promulgated by the commissioner in regard to advisory boards of health maintenance organizations must require the membership of those advisory boards to multidisciplinary representatives."

Chairman.

STATE PUB. CO.
Helena, Mont.

# STANDING COMMITTEE REPORT

EXHIBIT
DATE 3-26-87
HB SB 315

March 26 19 87

Mr. Speaker: We, the committee on BUSINESS AND LABOR

report SENATE BILL NO. 315

☐ do pass
☐ do not pass

☒ be concurred in
☐ be not concurred in

☒ as amended
☐ statement of intent attached

REP. LES KITSELMAN Chairman

1. Title, page 2, line 17.
Following: "39-71-122,"
Insert: "39-71-309,"

2. Title, page 2, line 20.
Following: "MCA;"
Insert: "MAKING CERTAIN PROVISIONS RETROACTIVE;"

3. Page 11, line 25.
Strike: "or"
Insert: ","
Following: "lodging"
Insert: ", rent, or housing"

4. Page 12, line 1.
Strike: ","
Insert: "and is"
Following: "on"
Strike: "the"
Insert: "its"
Strike: "of the" on line 1 through "housing" on line 2

5. Page 14, line 20.
Strike: "-- criminal penalty"

6. Page 15, line 7.
Following: "72"
Insert: ", other than the disputes described in subsection (2),"

7. Page 16, lines 7 and 8.
Strike: "A" on line 7 through "A" on line 8
Insert: "Upon motion of a party, the"

Rep. Glaser will sponsor

THIRD reading copy ( BLUE color )

8. Page 16, line 9.
Strike: "the"
Insert: "either"

9. Page 16, line 13.
Strike: "(6)"
Insert: "(d)

10. Page 32, line 3.
Strike: "39-71-61"
Insert: "39-71-611"

11. Page 32, line 11.
Strike: "If"
Insert: "When"

12. Page 32, line 14.
Strike: "new hires"
Insert: "other applicants"

13. Page 32, line 15.
Strike: "within such 2-year period"
Strike: ":"

14. Page 32, line 16.
Strike: "(a)

15. Page 32, lines 17 through 19.
Strike: "; and" on line 17 through "applicants" on line 19

16. Page 33, line 4.
Strike: "injuries producing"

17. Page 35, line 17.
Following: line 16
Insert: "on"

18. Page 35, line 17.
Following: "more"
Strike: "that"
Insert: "than"

19. Page 36, line 4.
Strike: "injuries causing"
Insert: "permanent"

20. Page 36, line 5.
Following: "disability"
Insert: "-- impairment awards and wage supplements"

JAS

21. Page 36, line 16.
Following: line 15
Insert: "the benefits available for permanent partial disability and impairment awards and wage supplements."

22. Page 38, line 20.
Strike: "subsections"
Insert: "subsection"
Strike: "and (2)"

23. Page 39, line 14.
Following: "of"
Strike: "he"
Insert: "the"

24. Page 39, line 15.
Following: "direct"
Strike: "a"
Insert: "the"

25. Page 39, line 23.
Strike: "10"
Insert: "30"

26. Page 40, line 25.
Strike: "a workers'"
Insert: "the"

27. Page 41, line 1.
Following: "subsection"
Insert: "(3)(b)(i) or"
Following: "(3)(b)(ii)"
Strike: "or (3)(b)(iii)"

28. Page 41, line 4.
Following: "subsection"
Strike: "(3)(b)(iii)"
Insert: "(3)(b)(ii)"

29. Page 41, line 14.
Following: "services"
Insert: "-- fee schedules and hospital rates"

30. Page 42, line 20.
Following: "January"
Insert: "1,"

31. Page 43, line 2.
Following: "January"
Insert: "1,"

32. Page 44, line 7.
Following: "total"
Insert: "disability"

33. Page 45, line 20.
Strike: "39-71-116"

34. Page 46, line 4.
Following: "and"
Strike: "39-71-116"

35. Page 46, line 9.
Following: "wage"
Insert: "at the time of injury"

36. Page 46, line 22.
Following: "through"
Strike: "39-71-116"

37. Page 49, line 2.
Strike: "and"
Insert: ","

38. Page 49, line 3.
Following: "payments"
Insert: ", and lump-sum advance payments"

39. Page 52, line 16.
Following: "agree"
Insert: "to a settlement"

40. Page 53, line 16.
Strike: "[illegible]'s"
Insert: "[illegible]'"

41. Page 53, line 19.
Strike: "RELEASES"
Insert: "RELEASE"

42. Page 54, line 11.
Following: "all lump-sum"
Insert: "advance"

43. Page 54, line 15.
Following: "lump-sum"
Insert: "advance"

44. Page 54, line 16.
Following: "lump-sum"
Insert: "advance"

45. Page 54, line 25.
Strike: "accident"
Insert: "injury"

46. Page 55, line 2.
Strike: "accident"
Insert: "injury"

47. Page 66, line 3.
Strike: "services"
Insert: "appeals"

48. Page 67, line 15.
Strike: "nd"
Insert: "and"

49. Page 68, line 13.
Following: "a"
Insert: "total of"
Following: "$4,000"
Strike: "total"

50. Page 69, line 11.
Strike: "and"
Insert: "but"

51. Page 69, line 23.
Strike: "services"
Insert: "provider or the department of social and rehabilitation services"

52. Page 70, line 1.
Following: "provider"
Insert: "the department of social and rehabilitation services"

53. Page 70, line 25.
Following: line 24
Insert: "rehabilitation"
Strike: "under this part"

54. Page 72, line 8.
Following: "security"
Insert: "in addition to the security described in subsection (1)"

55. Page 72, line 13.
Following: "security"
Insert: "provided for in subsection (2)"

56. Page 80, line 24.
Strike: "-- limitation"

57. Page 82, line 2.
Following: "or"
Insert: "by"

58. Page 83, line 16.
Strike: "as defined in"
Insert: ", damage, or death as set forth in"

59. Page 83, line 17.
Strike: "but which"
Insert: "and"

60. Page 83, line 18.
Strike: "is"

61. Page 84, line 5.
Strike: "(SIO SB2"
Insert: "($SiO_2$)"

62. Page 86, line 9.
Strike: "and"
Insert: "or"

63. Page 91, line 19.
Following: "39-71-122,"
Insert: "39-71-309,"

64. Page 92, line 8.
Following: line 7
Insert: "(2) Sections 8 and 52 through 57 are intended to be codified as an integral part of Title 39, chapter 71, and the provisions of Title 39, chapter 71, apply to sections 8 and 52 through 57."

Renumber: subsequent subsections

65. **Page 93, lines** 9 through 11.
Strike: "The" on line 9 through "disputes" on line 11
Insert: "Sections 8 and 52 through 57"
Following: "apply"
Insert: "retroactively, within the meaning of 1-2-109,"

66. Page 93, line 12.
Following: "occurrence."
Insert: "With respect to rehabilitation disputes, sections 8, and 52 through 57 apply retroactively, within the meaning of 1-2-109, unless the division had jurisdiction over the dispute under the law in effect at the time of injury."

67. Page 93, lines 13 though 20.
Strike: subsection (2) in its entirety

Renumber: subsequent subsection

EXHIBIT
DATE 3-26
HB SB 34

# STANDING COMMITTEE REPORT

March 26 19 87

Mr. Speaker: We, the committee on BUSINESS AND LABOR

report SENATE BILL NO. 34

☐ do pass
☐ do not pass

☒ be concurred in
☐ be not concurred in

☐ as amended
☐ statement of intent attached

REP. LES KITSELMAN Chairman

Rep. Brandewie will sponsor

THIRD reading copy ( BLUE color )

# STANDING COMMITTEE REPORT

EXHIBIT
DATE 3-26
HB 385

MARCH 26 19 87

Mr. Speaker: We, the committee on BUSINESS AND LABOR

report SENATE BILL 385

☐ do pass
☐ do not pass

☒ be concurred in
☐ be not concurred in

☒ as amended
☒ statement of intent attached

REP. LES KITSELMAN Chairman

AMENDMENTS AS FOLLOWS:

1) Page 8, line 20 through page 9, line 11
Following: "(a)" on page 8, line 20
Strike: the remainder of line 20 through line 11 on page 9
Insert: "provides inpatient care to ill or injured persons prior to their transportation to a hospital or provides inpatient medical care to persons needing that care for a period of no longer than 96 hours; (b) either is located in a county with fewer than six residents per square mile or is located more than 35 road miles from the nearest hospital."

2) Page 16, line 16 through page 17, line 7
Following: "(a)" on page 16, line 16
Strike: the remainder of line 16 through line 7 on page 17
Insert: "provides inpatient care to ill or injured persons prior to their transportation to a hospital or provides inpatient medical care to persons needing that care for a period of no longer than 96 hours; (b) either is located in a county with fewer than six residents per square mile or is located more than 35 road miles from the nearest hospital."

3) Page 20, line 6
Following: line 6
Insert: "NEW SECTION. Section 3. Coordination instruction. If Senate Bill 246 and this bill are both passed and approved, the code commissioner shall add the term "medical assistance facility" to the list of facilities defined as "health care facilities" in 50-5-301, as amended by Senate Bill 246."
Renumber: subsequent section

3M1

Rep. Devlin will sponsor

THIRD reading copy ( BLUE color )

## STATEMENT OF INTENT

A statement of intent is provided for this bill because it extends the authority of the Department of Health and Environmental Sciences to set licensure standards to cover medical assistance facilities. It is the intent of the legislature that the department adopt licensure standards for such facilities that include, but are not limited to, the following:

1. the types, training, and supervision of staff the facility must have, including either a physician, nurse practitioner, or physician assistant, with the restriction that a physician, nurse practitioner, or physician assistant need not be on site at all times but may be on call so long as they are available within 1 hour;

2. requirements for medical treatment protocols that must be utilized by staff;

3. review of a professional review organization or its equivalent to determine if the level of care provided is appropriate; and

4. a requirement that the facility have a referral agreement with a hospital ensuring acceptance of patients needing hospital-level care who are treated at the facility.

Chairman.

STATE PUB. CO.
Helena, Mont.

3-26-87
EXHIBIT
DATE SB 353

STATEMENT OF INTENT

SENATE BILL 353

Senate Public Health, Welfare, and Safety Committee

A statement of intent is required for this bill because:

(1) it authorizes the commissioner of insurance of the state of Montana (commissioner) and the department of health and environmental sciences to adopt, after notice and hearing, reasonable rules necessary or proper to effectuate sections 1 through 29;

(2) section 3 authorizes the commissioner to make reasonable rules exempting a health maintenance organization from having to file a notice with the commissioner describing material modifications of information required in an application for a certificate of authority if the commissioner considers the information unnecessary; and

(3) section 5 authorizes the commissioner to make reasonable rules exempting a health maintenance organization from having to file a notice with the commissioner before exercising the powers granted in subsection (1)(a), (1)(b), or (1)(d) if the commissioner believes exercising those powers will have de minimis effect. The legislature expects the commissioner to make only reasonable rules necessary to effectuate or aid the effectuation of sections 1 through 29.

(over)

The legislature does not authorize the commissioner to adopt rules that extend, modify, or conflict with either any law of this state or any reasonable implications of those laws. If reasonably possible, the commissioner shall set forth a proposed rule or amendment to a rule in or with the required notice of hearing. No rule or amendment to a rule by the commissioner is effective until it has been on file in the commissioner's office for at least 10 days.

~~In--adopting--rules-prescribing-investment-regulations,~~ ~~the-commissioner-shall-use-the-NAIC-Model-Health-Maintenance~~ ~~Organization-Investment-Guidelines.~~

~~The-commissioner-and-the-department-are-urged--to--look~~ ~~to---regulations--adopted--by--the--state--of--Minnesota--in~~ ~~implementing-chapter-62D-of-the-Minnesota-insurance-code.~~

ANY RULE PROMULGATED BY THE COMMISSIONER IN REGARD TO ADVISORY BOARDS OF HEALTH MAINTENANCE ORGANIZATIONS MUST REQUIRE THE MEMBERSHIP OF THOSE ADVISORY BOARDS TO INCLUDE MULTIDISCIPLINARY REPRESENTATIVES.

# Statement of Intent
## SB 353 - Yellow Copy

1. Page 2,

Strike: lines 9 through 14 in their entirety

Insert: "Any rule promulgated by the commissioner in regard to advisory boards of health maintenance organizations must require the membership of those advisory boards to be multidisciplinary representatives."

SB 353 - yellow copy

1. Title, line 7
Following: "~~33-22-111~~"
Insert: "17-7-502,"

2. Page 10, line 18
Strike: "for approval"

3. Page 10, line 19
Following: "[section 8(7)]"
Insert: ", however, nothing in this subsection deprives the health maintenance organization of its right to confidentiality of any proprietary information and the commissioner may not disclose that proprietary information to any other person"

4. Page 13, line 1
Following: page 12, line 25
Insert: "(7) The commissioner may make reasonable rules exempting an insurer or health service corporation operating a health maintenance organization or a plan from the filing requirements of this section if information requested in the application has been submitted to the commissioner

under other laws and rules administered by the commissioner."

5. Page 18, line 3
Following: "may"
Insert: ", after notice and hearing, within 60 days

6. Page 18, line 4
Following: "power"
Insert: "under subsection (1)(a), (1)(b), or (1)(d)"

7. Page 18, lines 10, 11, and 12
Strike: lines 10 and 11 in their entirety and line 12 through "commissioner."

8. Page 20, lines 18 and 19
Following: "is" on line 18
Strike: the remainder of line 18 and line 19 in its entirety

9. Page 23, line 1
Following: "limits"
Insert: "and coverage"

10. Page 23, line 2
Strike: "33-22-703"
Insert: "Title 33, chapter 22, part 7; however, a health maintenance organization may

limit an enrollee to a health maintenance organization provider for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction."

[This amendment to be further modified upon agreement between concerned parties]

11. Page 25, line 18, through page 26, line 2
Following: Page 25, line 17
Strike: lines 18 through 25 on page 25 and lines 1 and 2 on page 26 in their entirety

13. Page 26, line 6
Strike: "or use a schedule of charges"

14 Page 26, lines 7 and 8
Following: "form" on line 7
Strike: the remainder of line 7 and line 8 through "charges."

12. Page 26, lines 3 and 4
Strike: "a reasonable period"
Insert: "60 days"

15 Page 26, line 15
Following: "any"
Insert: "relevant"

SB 353 - page 4

16. Page 29, line 24
Strike: "A"
Insert: "Except for a health maintenance organization operated as a plan by a health service corporation, a"

17. Page 39, line 3
Following: line 2
Insert: "(8) A health maintenance organization may not knowingly offer direct incentive payments or direct disincentive payment reductions to a physician as an inducement to limit services. As used in this subsection, "direct" means ... [language to be inserted]."

18. Page 39, line 10
Following: "title"
Insert: "or licensed as an enrollment representative under 33-30-311 through 33-30-313"

19. Page 41, lines 13 through 15
Following: "organization" on line 13
Strike: the remainder of line 13, line 14 in its entirety and line 15 through "arrangements"

20. Page 43, line 25
Following: "[section 3]
Insert: "and provided that such operation

adversely affects the health maintenance organization's ability to provide benefits and operate under the application approved by the commissioner."

21. Page 47, line 21
Strike: "quality"
Insert: "availability, accessibility, and continuity

22. Page 49, line 9
Following: "$25"
Insert: ";
(2) for annual continuation of certificate of authority, $300"

Insert amend 23 from page 6 >

24. Page 60, line 6
Following: line 5
Insert: "Section 30. Section 17-7-502, MCA, is amended to read:

"17-7-502. Statutory appropriations — definition — requisites for validity. (1) A statutory appropriation is an appropriation made by permanent law that authorizes spending by a state agency without the need for a biennial legislative appropriation or budget amendment.

(2) Except as provided in subsection (4), to be effective, a statutory appropriation must comply with both of the following provisions:

(a) The law containing the statutory authority must be listed in subsection (3).

(b) The law or portion of the law making a statutory appropriation must specifically state that a statutory appropriation is made as provided in this section.

(3) The following laws are the only laws containing statutory appropriations:

(a) 2-9-202;
(b) 2-17-105;
(c) 2-18-812;
(d) 10-3-203;
(e) 10-3-312;
(f) 10-3-314;
(g) 10-4-301;

(h) 13-37-304;
(i) 15-31-702;
(j) 15-36-112;
(k) 15-70-101;
(l) 16-1-404;
(m) 16-1-410;
(n) 16-1-411;
(o) 17-3-212;
(p) 17-5-404;
(q) 17-5-424;
(r) 17-5-804;
(s) 19-8-504;
(t) 19-9-702;
(u) 19-9-1007;
(v) 19-10-205;
(w) 19-10-305;
(x) 19-10-506;
(y) 19-11-512;
(z) 19-11-513;
(aa) 19-11-606;
(bb) 19-12-301;
(cc) 19-13-604;
(dd) 20-6-406;
(ee) 20-8-111;
(ff) 23-5-612;

(gg) [section 17];

(hh) [section 22];

~~(gg)~~ 37-51-501;
~~(hh)~~ 53-24-206;
~~(ii)~~ 75-1-1101;
~~(jj)~~ 75-7-305;
~~(kk)~~ 80-2-103;
~~(ll)~~ 80-2-228;
~~(mm)~~ 90-3-301;
~~(nn)~~ 90-3-302;
~~(oo)~~ 90-15-103; and
~~(pp)~~ Sec. 13, HB 861, L. 1985.

(4) There is a statutory appropriation to pay the principal, interest, premiums, and costs of issuing, paying, and securing all bonds, notes, or other obligations, as due, that have been authorized and issued pursuant to the laws of Montana. Agencies that have entered into agreements authorized by the laws of Montana to pay the state treasurer, for deposit in accordance with 17-2-101 through 17-2-107, as determined by the state treasurer, an amount sufficient to pay the principal and interest as due on the bonds or notes have statutory appropriation authority for such payments. "

Renumber: subsequent sections

23. Page 49, lines 20 and 21

Following: "~~17-7-502.~~" on line 20

Strike: the remainder of line 20 and line 21 in its entirety

Insert: " Such fees are statutorily appropriated to the

department of health as provide
in 17-7-502."

3-26-87

EXHIBIT 3.26
SB 371

SENATE BILL NO. 371

INTRODUCED BY REGAN, HIMSL

A BILL FOR AN ACT ENTITLED: "AN ACT PERMITTING INSURERS TO ENTER INTO AGREEMENTS WITH HEALTH CARE PROVIDERS AND TO ISSUE POLICIES THAT INCLUDE INCENTIVES ~~OR----LIMIT REIMBURSEMENT~~ FOR UTILIZING SERVICES RENDERED BY PROVIDERS WITH WHOM THE INSURER HAS AN AGREEMENT; AND PROVIDING AN ~~IMMEDIATE~~ APPLICABILITY DATE AND AN EFFECTIVE DATE."

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

Section 1. Short title. [Sections 1 through ~~4~~ 6 7] may be cited as the "~~Health-Care-Reimbursement-Reform~~ PREFERRED PROVIDER AGREEMENTS Act".

SECTION 2. PURPOSE. THE PURPOSE OF [SECTIONS 1 THROUGH 7] IS TO ALLOW A HEALTH CARE INSURER PROVIDING DISABILITY INSURANCE BENEFITS TO NEGOTIATE AND CONTRACT WITH HEALTH CARE PROVIDERS TO:

(1) PROVIDE HEALTH CARE SERVICES TO ITS INSUREDS OR SUBSCRIBERS AT A REDUCTION IN THE FEES CUSTOMARILY CHARGED BY THE PROVIDER; OR

(2) ENTER INTO AGREEMENTS IN WHICH THE PARTICIPATING PROVIDERS ACCEPT NEGOTIATED FEES AS PAYMENT IN FULL FOR HEALTH CARE SERVICES THE HEALTH CARE INSURER IS OBLIGATED TO PROVIDE OR PAY FOR UNDER THE HEALTH BENEFIT PLAN.

Section 3. Definitions. As used in [sections 1 through 4 6 7], the following definitions apply:

(1) "EMERGENCY SERVICES" MEANS SERVICES PROVIDED AFTER SUFFERING AN ACCIDENTAL BODILY INJURY OR THE SUDDEN ONSET OF A MEDICAL CONDITION MANIFESTING ITSELF BY ACUTE SYMPTOMS OF SUFFICIENT SEVERITY (INCLUDING SEVERE PAIN) THAT WITHOUT IMMEDIATE MEDICAL ATTENTION THE SUBSCRIBER OR INSURED COULD REASONABLY EXPECT THAT:

(A) HIS HEALTH WOULD BE IN SERIOUS JEOPARDY;

(B) HIS BODILY FUNCTIONS WOULD BE SERIOUSLY IMPAIRED; OR

(C) A BODILY ORGAN OR PART WOULD BE SERIOUSLY DAMAGED.

(2) "HEALTH BENEFIT PLAN" MEANS THE HEALTH INSURANCE POLICY OR SUBSCRIBER ARRANGEMENT BETWEEN THE INSURED OR SUBSCRIBER AND THE HEALTH CARE INSURER THAT DEFINES THE COVERED SERVICES AND BENEFIT LEVELS AVAILABLE.

(3) "HEALTH CARE INSURER" MEANS:

(A) AN INSURER THAT PROVIDES DISABILITY INSURANCE AS DEFINED IN 33-1-207;

(B) A HEALTH SERVICE CORPORATION AS DEFINED IN 33-30-101;

(C) A HEALTH MAINTENANCE ORGANIZATION [AS DEFINED IN SECTION 2 OF SENATE BILL NO. 353];

(D) A FRATERNAL BENEFIT SOCIETY AS DEFINED IN 33-7-102;

(E) AN ADMINISTRATOR AS DEFINED IN 33-17-601; OR

(F) ANY OTHER ENTITY REGULATED BY THE COMMISSIONER THAT PROVIDES HEALTH COVERAGE.

~~(1)~~(3)(4) "Health care services" means health care services or products rendered or sold by a provider within the scope of the provider's license or legal authorization~~, including--but--not--limited-to-hospital,-medical,-surgical, dental,-vision,-and-pharmaceutical-services-and-products~~ OR SERVICES PROVIDED UNDER TITLE 33, CHAPTER 22, PART 7.

~~(2)~~(4)(5) "Insured" means an individual entitled to reimbursement for expenses of health care services under a policy or subscriber contract issued or administered by an insurer.

~~(3)~~(5)~~--"Insurer"--means--an--insurance--company--or--a health-service-corporation-authorized-in-this-state-to-issue policies--or--subscriber-contracts-that-reimburse-an-insured for-expenses-of-health-care-services.~~

(6) "PREFERRED PROVIDER" MEANS A PROVIDER OR GROUP OF PROVIDERS WHO HAVE CONTRACTED TO PROVIDE SPECIFIED HEALTH CARE SERVICES.

(7) "PREFERRED PROVIDER AGREEMENT" MEANS A CONTRACT BETWEEN OR ON BEHALF OF A HEALTH CARE INSURER AND A PREFERRED PROVIDER.

~~(4)~~(6)(8) "Provider" means an individual or entity licensed or legally authorized to provide health care

services ~~in-this-state~~ OR SERVICES COVERED WITHIN TITLE 33, CHAPTER 22, PART 7.

(9) "SUBSCRIBER" MEANS A CERTIFICATE HOLDER OR OTHER PERSON ON WHOSE BEHALF THE HEALTH CARE INSURER IS PROVIDING OR PAYING FOR HEALTH CARE COVERAGE.

Section 4. Preferred provider agreements authorized. (1) Notwithstanding any other provision of law to the contrary, ~~an~~ A HEALTH CARE insurer may:

(a) enter into agreements with providers relating to health care services that may be rendered to ~~the--insurer's~~ insureds OR SUBSCRIBERS ON WHOSE BEHALF THE HEALTH CARE INSURER IS PROVIDING HEALTH CARE COVERAGE, including PREFERRED PROVIDER agreements relating to:

(I) the amounts an insured may be charged for services rendered; AND

(II) THE AMOUNT AND MANNER OF PAYMENT TO THE PROVIDER; and

(b) issue or administer policies or subscriber contracts in this state that~~:~~

~~(i)~~ include incentives for the insured to use the services of a provider that has entered into an agreement with the insurer pursuant to subsection (1)(a)~~;--or~~.

~~(ii) provide for reimbursement for health care services only--if--the--services--are-rendered-by-a-provider-that-has entered-into-an--agreement--with--the--insurer--pursuant--to~~

~~subsection-(1)(a).~~

(2) A PREFERRED PROVIDER ~~ARRANGEMENT~~ AGREEMENT ISSUED OR DELIVERED IN THIS STATE MAY NOT UNFAIRLY DENY HEALTH BENEFITS FOR ~~MEDICALLY--NECESSARY~~ HEALTH CARE SERVICES COVERED EXPENSES.

~~(2)~~(3) [Sections 1 through ~~4~~ 6 7] do not require that an insurer negotiate or enter into agreements with any specific provider or class of providers.

SECTION 5. INCENTIVES IN HEALTH BENEFIT PLANS. (1) A HEALTH CARE INSURER MAY ISSUE A POLICY OR A HEALTH BENEFIT PLAN THAT PROVIDES FOR INCENTIVES FOR COVERED PERSONS TO USE THE HEALTH CARE SERVICES OF PREFERRED PROVIDERS.

~~(2)~~ THE POLICY OR HEALTH BENEFIT PLAN MUST CONTAIN AT LEAST:

(A) A PROVISION THAT IF A COVERED PERSON RECEIVES EMERGENCY CARE FOR SERVICES SPECIFIED IN THE PREFERRED PROVIDER ~~ARRANGEMENT~~ AGREEMENT AND CANNOT REASONABLY REACH A PREFERRED PROVIDER, THE CARE RENDERED DURING THE COURSE OF THE EMERGENCY WILL BE REIMBURSED AS THOUGH THE COVERED PERSON HAD BEEN TREATED BY A PREFERRED PROVIDER; AND

(B) A PROVISION THAT CLEARLY IDENTIFIES THE DIFFERENCE IN BENEFIT LEVELS FOR HEALTH CARE SERVICES OF A PREFERRED PROVIDER AND BENEFIT LEVELS FOR THE SAME HEALTH CARE SERVICES OF A NONPREFERRED PROVIDER.

(2) A HEALTH CARE INSURER MAY NOT DENY A PROVIDER WHO

AGREES TO THE TERMS AND CONDITIONS OF A PREFERRED PROVIDER AGREEMENT THE RIGHT TO BECOME A PREFERRED PROVIDER.

(3) A HEALTH CARE INSURER MAY NOT REQUIRE HOSPITAL STAFF PRIVILEGES AS CRITERIA FOR DESIGNATION AS A PREFERRED PROVIDER IN A PREFERRED PROVIDER AGREEMENT.

SECTION 6. PERMISSIBLE PROVISIONS IN PROVIDER ~~ARRANGEMENTS~~ AGREEMENTS, INSURANCE POLICIES, AND SUBSCRIBER CONTRACTS. (1) A PROVIDER ~~ARRANGEMENT~~ AGREEMENT, INSURANCE POLICY, OR SUBSCRIBER CONTRACT ISSUED OR DELIVERED IN THIS STATE MAY CONTAIN CERTAIN OTHER COMPONENTS DESIGNED TO CONTROL THE COST AND IMPROVE THE QUALITY OF HEALTH CARE FOR ~~POLICYHOLDERS~~ INSUREDS AND SUBSCRIBERS, INCLUDING:

(A) A ~~PAYMENT--DIFFERENTIAL--OF--NOT--MORE--THAN--25%~~ ~~BETWEEN-USE-OF-PROVIDERS-WITH-ARRANGEMENTS-WITH--THE--HEALTH~~ ~~CARE-INSURER-AND-USE-OF-PROVIDERS-WITHOUT-SUCH-ARRANGEMENTS.~~ ~~THE---COMMISSIONER---MAY---BY---RULE--DETERMINE--APPROPRIATE~~ ~~DIFFERENTIALS-BETWEEN--COPAYMENTS,--DEDUCTIBLES,--AND--OTHER~~ ~~COST-SHARING---ARRANGEMENTS~~ PROVISION SETTING A PAYMENT DIFFERENCE FOR REIMBURSEMENT OF A NONPREFERRED PROVIDER AS COMPARED TO A PREFERRED PROVIDER. IF THE HEALTH BENEFIT PLAN CONTAINS A PAYMENT DIFFERENCE PROVISION, THE PAYMENT DIFFERENCE MAY NOT EXCEED 25% OF THE REIMBURSEMENT LEVEL AT WHICH A PREFERRED PROVIDER WOULD BE REIMBURSED.

(B) CONDITIONS, NOT INCONSISTENT WITH OTHER PROVISIONS OF [SECTIONS 1 THROUGH 6], DESIGNED TO GIVE POLICYHOLDERS OR

SUBSCRIBERS AN INCENTIVE TO CHOOSE A PARTICULAR PROVIDER.

(2) ALL TERMS OR CONDITIONS OF ~~A-PROVIDER-ARRANGEMENT,~~ AN INSURANCE POLICY, OR SUBSCRIBER CONTRACT EXCEPT THOSE ALREADY APPROVED BY THE COMMISSIONER ARE SUBJECT TO THE PRIOR APPROVAL OF THE COMMISSIONER.

Section 7. Rules. The commissioner shall promulgate rules ~~prescribing--reasonable--standards--relating--to--the accessibility--and--availability-of-health-care-services-for persons-insured-under-policies--or--contracts--described--in~~ NECESSARY TO IMPLEMENT THE PROVISIONS OF [~~section 3(1)(b)(iii)~~ SECTIONS 1 THROUGH 6 7].

Section 8. Codification instruction. Sections 1 through ~~4~~ 6 7 are intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to sections 1 through ~~4~~ 6 7.

SECTION 9. COORDINATION INSTRUCTION. IF SENATE BILL NO. 353, INCLUDING THE DEFINITION OF "HEALTH MAINTENANCE ORGANIZATION", IS NOT PASSED AND APPROVED, THE BRACKETED LANGUAGE IN SECTION 3(3)(C) OF THIS ACT IS VOID.

Section 10. 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 11. APPLICABILITY -- FILING WITH COMMISSIONER. ON OR BEFORE JANUARY 1, 1988, A HEALTH CARE INSURER PERFORMING THE FUNCTIONS ENUMERATED IN THIS ACT SHALL NOTIFY THE COMMISSIONER OF ITS EXISTENCE AND CONTINUE TO OPERATE SUBJECT TO THE PROVISIONS OF THIS ACT.

Section 12. Effective date. ~~This act is~~ SECTION 6 7 AND THIS SECTION ARE effective on passage and approval.

-End-

3-26-97
EXHIBIT
DATE 3-26
SB 353

STATEMENT OF INTENT

SENATE BILL 353

Senate Public Health, Welfare, and Safety Committee

A statement of intent is required for this bill because:

(1) it authorizes the commissioner of insurance of the state of Montana (commissioner) and the department of health and environmental sciences to adopt, after notice and hearing, reasonable rules necessary or proper to effectuate sections 1 through 29;

(2) section 3 authorizes the commissioner to make reasonable rules exempting a health maintenance organization from having to file a notice with the commissioner describing material modifications of information required in an application for a certificate of authority if the commissioner considers the information unnecessary; and

(3) section 5 authorizes the commissioner to make reasonable rules exempting a health maintenance organization from having to file a notice with the commissioner before exercising the powers granted in subsection (1)(a), (1)(b), or (1)(d) if the commissioner believes exercising those powers will have de minimis effect. The legislature expects the commissioner to make only reasonable rules necessary to effectuate or aid the effectuation of sections 1 through 29.

The legislature does not authorize the commissioner to adopt rules that extend, modify, or conflict with either any law of this state or any reasonable implications of those laws. If reasonably possible, the commissioner shall set forth a proposed rule or amendment to a rule in or with the required notice of hearing. No rule or amendment to a rule by the commissioner is effective until it has been on file in the commissioner's office for at least 10 days.

~~In--adopting--rules-prescribing-investment-regulations,~~ ~~the-commissioner-shall-use-the-NAIC-Model-Health-Maintenance Organization-Investment-Guidelines.~~

~~The-commissioner-and-the-department-are-urged--to--look to---regulations--adopted--by--the--state--of--Minnesota--in implementing-chapter-62D-of-the-Minnesota-insurance-code.~~

ANY RULE PROMULGATED BY THE COMMISSIONER IN REGARD TO ADVISORY BOARDS OF HEALTH MAINTENANCE ORGANIZATIONS MUST REQUIRE THE MEMBERSHIP OF THOSE ADVISORY BOARDS TO INCLUDE MULTIDISCIPLINARY REPRESENTATIVES.

SENATE BILL NO. 353

INTRODUCED BY MEYER, LORY, BENGTSON, MILLER, MCLANE, SANDS

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT TO REGULATE THE FORMATION AND OPERATION OF HEALTH MAINTENANCE ORGANIZATIONS; AMENDING SECTIONS ~~17-7-502 AND 33-22-111~~ 17-7-502, 33-1-102 AND 33-1-704, MCA; AND PROVIDING AN ~~IMMEDIATE~~ EFFECTIVE DATE AND AN APPLICABILITY PROVISION."

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

NEW SECTION. Section 1. Short title. This act may be cited as the "Montana Health Maintenance Organization Act".

NEW SECTION. Section 2. Definitions. As used in [sections 1 through 29], unless the context requires otherwise, the following definitions apply:

(1) "Agent" means an individual, partnership, or corporation appointed or authorized by a health maintenance organization to solicit applications for health care services agreements on its behalf.

(2) "Basic health care services" means:

(a) consultative, diagnostic, therapeutic, and referral services by a provider;

(b) inpatient hospital and provider care;

(c) outpatient medical services;

(d) medical treatment and referral services;

(e) accident and sickness services by a provider to each newborn infant of an enrollee pursuant to [section 8(3)(e)];

(F) CARE AND TREATMENT OF MENTAL ILLNESS, ALCOHOLISM, AND DRUG ADDICTION;

~~(f)~~(G) diagnostic laboratory and diagnostic and therapeutic radiologic services; and

~~(g)~~(H) preventive health services, including:

(i) immunizations;

(ii) well-child care from birth;

(iii) periodic health evaluations for adults;

(iv) voluntary family planning services;

(v) infertility services; and

(vi) children's eye and ear examinations conducted to determine the need for vision and hearing correction.

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

(4) "Department of health" means the department of health and environmental sciences provided for in 2-15-2101.

(5) "Director" means the director of the department of health and environmental sciences provided for in 2-15-2102.

(6) "Enrollee" means a person:

(a) who enrolls in or contracts with a health maintenance organization;

(b) on whose behalf a contract is made with a health maintenance organization to receive health care services; or

(c) on whose behalf the health maintenance organization contracts to receive health care services.

(7) "Evidence of coverage" means a certificate, agreement, policy, or contract issued to an enrollee setting forth the coverage to which the enrollee is entitled.

(8) "Health care services" means:

(a) the services included in furnishing medical or dental care to a person;

(b) the services included in hospitalizing a person;

(c) the services incident to furnishing medical or dental care or hospitalization; or

(d) the services included in furnishing to a person other services for the purpose of preventing, alleviating, curing, or healing illness, injury, or physical disability.

(9) "Health care services agreement" means an agreement for health care services between a health maintenance organization and an enrollee.

(10) "Health maintenance organization" means a person who provides or arranges for basic health care services to enrollees on a prepaid or other financial basis, either directly through provider employees or through contractual or other arrangements with a provider or a group of providers.

(11) "Person" means:

(a) an individual;

(b) a group of individuals;

(c) an insurer, as defined in 33-1-201;

(d) a health service corporation, as defined in 33-30-101;

(e) a corporation, partnership, facility, association, or trust; or

(f) an institution of a governmental unit of any state licensed by that state to provide health care, including but not limited to a physician, hospital, hospital-related facility, or long-term care facility.

(12) "PLAN" MEANS A HEALTH MAINTENANCE ORGANIZATION OPERATED BY AN INSURER OR HEALTH SERVICE CORPORATION AS AN INTEGRAL PART OF THE CORPORATION AND NOT AS A SUBSIDIARY.

~~(12)~~(13) "Provider" means a physician, hospital, hospital-related facility, long-term care facility, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, registered pharmacist, or nurse specialist as specifically listed in 37-8-202 who treats any illness or injury within the scope and limitations of his practice or other person who is licensed or otherwise authorized in this state to furnish health care services.

~~(13)~~(14) "Uncovered expenditures" mean the costs of

health care services that are covered by a health maintenance organization and for which an enrollee is liable if the health maintenance organization becomes insolvent.

NEW SECTION. Section 3. Establishment of health maintenance organizations. (1) Notwithstanding any law of this state to the contrary, a person may apply to the commissioner for and obtain a certificate of authority to establish and operate a health maintenance organization in compliance with [sections 1 through 29]. A person may not establish or operate a health maintenance organization in this state except as authorized by a subsisting certificate of authority issued to it by the commissioner. A foreign person may qualify for a certificate of authority if it first obtains from the secretary of state a certificate of authority to transact business in this state as a foreign corporation under 35-1-1001.

(2) Each health maintenance organization operating in this state as of [the effective date of this act] shall submit an application for a certificate of authority under subsection (3) within 30 days ~~of-{the-effective-date-of-this act}~~ AFTER THE EFFECTIVE DATE OF RULES ADOPTED BY THE COMMISSIONER AND THE DEPARTMENT OF HEALTH AS PROVIDED IN [SECTION 20]. Each such applicant may continue to operate in this state until the commissioner acts upon the application. If an application is denied under [section 4], the applicant

must be treated as a health maintenance organization whose certificate of authority has been revoked.

(3) Each application of a health maintenance organization, whether separately licensed or not, for a certificate of authority must:

(a) be verified by an officer or authorized representative of the applicant;

(b) be in a form prescribed by the commissioner;

(c) contain:

(i) the applicant's name;

(ii) the location of the applicant's home office or principal office in the United States (if a foreign person);

(iii) the date of organization or incorporation;

(iv) the form of organization (including whether the providers affiliated with the health maintenance organization will be salaried employees or group or individual contractors);

(v) the state or country of domicile; and

(vi) any additional information the commissioner may reasonably require; and

(d) set forth the following information or be accompanied by the following documents, as applicable:

(i) a copy of the applicant's organizational documents, such as its corporate charters or articles of incorporation, articles of association, partnership

agreement, trust agreement, or other applicable documents, and all amendments thereto, certified by the public officer with whom the originals were filed in the state or country of domicile;

(ii) a copy of the bylaws, rules, and regulations, or similar document, if any, regulating the conduct of the applicant's internal affairs, certified by its secretary or other officer having custody thereof;

(iii) a list of the names, addresses, and official positions of the persons responsible for the conduct of the applicant's affairs, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee; the principal officers in the case of a corporation; and the partners or members in the case of a partnership or association;

(iv) a copy of any contract made or to be made between:

(A) any provider and the applicant; or

(B) any person listed in subsection (3)(d)(iii) and the applicant. The applicant may file a list of providers executing a standard contract and a copy of the contract instead of copies of each executed contract.

(v) the extent to which any of the following will be included in provider contracts and the form of any provisions that:

(A) limit a provider's ability to seek reimbursement

for basic health care services or health care services from an enrollee;

(B) permit or require a provider to assume a financial risk in the health maintenance organization, including any provisions for assessing the provider, adjusting capitation or fee-for-service rates, or sharing in the earnings or losses; and

(C) govern amending or terminating an agreement with a provider;

(vi) a financial statement showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent certified financial statement satisfies this requirement unless the commissioner directs that additional or more recent financial information is required for the proper administration of [sections 1 through 29].

(vii) a description of the proposed method of marketing, a financial plan that includes a projection of operating results anticipated until the organization has had net income for at least 1 year, and a statement as to the sources of working capital as well as any other source of funding;

~~(viii) a summary of feasibility studies or marketing surveys that support the financial and enrollment~~

~~projections--for-the-plan,-including-the-potential-number-of enrollees-in-the-operating-territory,-the--projected--number of--enrollees--for--the--first--5--years,--the--underwriting standards-to-be-applied,-and-the--method--of--marketing--the organization;~~

~~(ix)~~(VIII) a power of attorney executed by the applicant, on a form prescribed by the commissioner, appointing the commissioner, his successors in office, and his authorized deputies as the applicant's attorney to receive service of legal process issued against it in this state;

~~(x)~~(IX) a statement reasonably describing the geographic service area or areas to be served by county, including:

(A) a chart showing the number of primary and specialty care providers with locations and service areas by county;

(B) the method of handling emergency care, with the location of each emergency care facility; and

(C) the method of handling out-of-area services;

~~(xi)~~(X) a description of the way in which the health maintenance organization provides services to enrollees in each geographic service area, including the extent to which a provider under contract with the health maintenance organization provides primary care to those enrollees;

~~(xiii)~~(XI) a description of the complaint procedures to be used as required under [section 11];

~~(xiv)~~(XII) a description of the procedures and programs to be implemented to meet the quality of health care requirements in [section 4];

~~(xv)~~(XIII) a description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under [section 6];

~~(xvi)~~(XIV) a summary of the way in which administrative services will be provided, including the size and qualifications of the administrative staff and the projected cost of administration in relation to premium income. If the health maintenance organization delegates management authority for a major corporate function to a person outside the organization, the health maintenance organization shall include a copy of the contract in its application for a certificate of authority. Contracts for delegated management authority must be filed ~~for approval~~ with the commissioner in accordance with the filing provisions of [section 8(7)], HOWEVER, NOTHING IN THIS SUBSECTION DEPRIVES THE HEALTH MAINTENANCE ORGANIZATION OF ITS RIGHT TO CONFIDENTIALITY OF ANY PROPRIETARY INFORMATION, AND THE COMMISSIONER MAY NOT DISCLOSE THAT PROPRIETARY INFORMATION TO ANY OTHER PERSON. All contracts must include:

(A) the services to be provided;

(B) the standards of performance for the manager;

(C) the method of payment, including any provisions for the administrator to participate in the profits or losses of the plan;

(D) the duration of the contract; and

(E) any provisions for modifying, terminating, or renewing the contract.

~~(xvi) a summary of current and projected enrollment, income from premiums by type of payer, other income, administrative and other costs, the projected break-even point (including the method of funding the accumulated losses until the break-even point is reached), and the assumptions made in developing projected operating results;~~

~~(xvii)~~(XV) a summary of all financial guaranties by providers, sponsors, affiliates, or parents within a holding company system or any other guaranties that are intended to ensure the financial success of the plan, including hold harmless agreements by providers, insolvency insurance, reinsurance, or other guaranties;

~~(xviii)~~(XVI) a summary of benefits to be offered enrollees, including any limitations and exclusions and the renewability of all contracts to be written;

~~(xix)~~(XVII) evidence that it can meet the requirement of [section 13(10)]; and

~~(xx)~~(XVIII) any other information that the commissioner

may reasonably require to make the determinations required in [section 4].

(4) Each health maintenance organization shall file each substantial change, alteration, or amendment to the information submitted under subsection (3) with the commissioner at least 30 days prior to its effective date, including changes in articles of incorporation and bylaws, organization type, geographic service area, provider contracts, provider availability, plan administration, financial projections and guaranties, and any other change that might affect the financial solvency of the plan. The commissioner may, AFTER NOTICE AND HEARING, disapprove any proposed change, alteration, or amendment to the business plan. The commissioner may make reasonable rules exempting from the filing requirements of this subsection those items he considers unnecessary.

(5) An applicant or a health maintenance organization holding a certificate of authority shall file with the commissioner all contracts of reinsurance and any modifications thereto. An agreement between a health maintenance organization and an insurer is subject to Title 33, chapter 2, part 12. A reinsurance agreement must remain in full force and effect for at least 90 days following written notice of cancellation by either party by certified mail to the commissioner.

(6) Each health maintenance organization shall maintain, at its administrative office, and make available to the commissioner upon request executed copies of all provider contracts.

(7) THE COMMISSIONER MAY MAKE REASONABLE RULES EXEMPTING AN INSURER OR HEALTH SERVICE CORPORATION OPERATING A HEALTH MAINTENANCE ORGANIZATION AS A PLAN FROM THE FILING REQUIREMENTS OF THIS SECTION IF INFORMATION REQUESTED IN THE APPLICATION HAS BEEN SUBMITTED TO THE COMMISSIONER UNDER OTHER LAWS AND RULES ADMINISTERED BY THE COMMISSIONER.

NEW SECTION. Section 4. Issuance of certificate of authority. (1) Upon receipt of an application for issuance of a certificate of authority, the commissioner shall transmit copies of the application and accompanying documents to the department of health. The department of health shall determine whether the applicant for a certificate of authority, with respect to health care services to be furnished, has:

(a) demonstrated the willingness and potential ability to assure that it will provide health care services in a manner assuring availability and accessibility of adequate personnel and facilities and enhancing availability, accessibility, and continuity of service;

(b) arrangements, established in accordance with the rules made by the department of health, for an ongoing

quality assurance program concerning health care ~~processes and--outcomes~~ AVAILABILITY, ACCESSIBILITY, AND CONTINUITY OF SERVICE; and

(c) a procedure, established in accordance with rules of the department of health, to develop, compile, evaluate, and report statistics relating to the cost of its operations, the pattern of utilization of its services, the availability and accessibility of its services, and any other matters as may be reasonably required by the department of health.

(2) Within ~~90~~ 60 days of receipt of the application from a health maintenance organization for issuance of a certificate of authority, the department of health shall certify to the commissioner that the proposed health maintenance organization meets the requirements of subsection (1) or shall, AFTER NOTICE AND HEARING, notify the commissioner that the health maintenance organization does not meet those requirements and specify in what respects it is deficient. The director may extend by not more than an additional 30 days the period within which he may certify to the commissioner that the proposed health maintenance organization meets or does not meet the requirements of subsection (1) by giving notice of the extension to the commissioner and the health maintenance organization before the expiration of the initial ~~90-day~~

60-DAY period.

(3) The commissioner shall issue or deny a certificate of authority to any person filing an application pursuant to [section 3] within 180 days of receipt of the certification from the department of health. The commissioner shall grant a certificate of authority upon payment of the application fee prescribed in [section 22] if the commissioner is satisfied that each of the following conditions is met:

(a) The persons responsible for the conduct of the applicant's affairs are competent~~,-trustworthy,-and-of--good reputation~~ AND TRUSTWORTHY.

(b) The department of health certifies, in accordance with subsection (2), that the health maintenance organization's proposed plan of operation meets the requirements of subsection (1).

(c) The health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments.

(d) The health maintenance organization is financially responsible and can reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner may in his discretion consider:

(i) the financial soundness of the arrangements for health care services and the schedule of charges used in connection therewith;

(ii) the adequacy of working capital;

(iii) any agreement with an insurer, a health service corporation, a government, or any other organization for ensuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the health maintenance organization;

(iv) any agreement with providers for the provision of health care services;

(v) any deposit of cash or securities submitted in accordance with [section 13]; and

(vi) any additional information as the commissioner may reasonably require.

(e) The enrollees will be afforded an opportunity to participate in matters of policy and operation pursuant to [section 6].

(f) Nothing in the proposed method of operation, as shown by the information submitted pursuant to [section 3] or by independent investigation, ~~is contrary to the public interest~~ VIOLATES ANY PROVISION OF [SECTIONS 1 THROUGH 29] OR RULES ADOPTED BY THE COMMISSIONER OR THE DEPARTMENT OF HEALTH.

(g) Any deficiencies identified by the department of health have been corrected.

(4) The commissioner may in his discretion deny a certificate of authority only if he complies with the requirements of [section 21].

NEW SECTION. Section 5. Powers of health maintenance organizations. (1) The powers of a health maintenance organization include but are not limited to the following:

(a) the purchase, lease, construction, renovation, operation, or maintenance of a hospital, a medical facility, or both, its ancillary equipment, and such property as may reasonably be required for its principal office or for such purposes as may be necessary in the transaction of the business of the organization;

(b) the making of loans to a medical group under contract with it in furtherance of its program or the making of loans to a corporation under its control for the purpose of acquiring or constructing a medical facility or hospital or in furtherance of a program providing health care services to enrollees;

(c) the furnishing of health care services through a provider who is under contract with or employed by the health maintenance organization;

(d) the contracting with a person for the performance on its behalf of certain functions, such as marketing,

enrollment, and administration;

(e) the contracting with an insurer authorized to transact insurance in this state, or with a health service corporation authorized to do business in this state, for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization; and

(f) the offering of other health care services in addition to basic health care services.

(2) A health maintenance organization shall file notice, with adequate supporting information, with the commissioner before exercising a power granted in subsection (1)(a), (1)(b), or (1)(d). The commissioner may, AFTER NOTICE AND HEARING, WITHIN 60 DAYS disapprove the exercise of a power UNDER SUBSECTION (1)(A), (1)(B), OR (1)(D) only if, in his opinion, it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. The commissioner may make reasonable rules exempting from the filing requirement of this subsection those activities having a de minimis effect. ~~The exercise of authority granted in subsections (1)(a), (1)(b), and (1)(d) is subject to disapproval by the commissioner.~~ The commissioner may exempt certain contracts from the filing requirement whenever exercise of the authority granted in

this section would have little or no effect on the health maintenance organization's financial condition and ability to meet obligations.

(3) Nothing in this section exempts the activities of a health maintenance organization from any applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

NEW SECTION. Section 6. Governing body. (1) The governing body of a health maintenance organization may include providers or other individuals, or both.

(2) The governing body shall establish a mechanism to give the enrollees an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions, or through the use of other mechanisms.

NEW SECTION. Section 7. Fiduciary responsibilities. (1) Any director, officer, employee, or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of the health maintenance organization is responsible for the funds in the manner of a fiduciary to the health maintenance organization.

(2) A health maintenance organization shall maintain in force a fidelity bond on employees and officers in an amount not less than $100,000 or such other sum as may be

prescribed by the commissioner. Each bond must be written with at least a 1-year discovery period and, if written with less than a 3-year discovery period, must contain a provision that a cancellation or termination of the bond, whether by or at the request of the insured or by the underwriter, may not take effect prior to the expiration of 90 days after written notice of the cancellation or termination has been filed with the commissioner unless the commissioner approves an earlier cancellation or termination date.

NEW SECTION. Section 8. Evidence of coverage and charges for health care services. (1) Every enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance policy issued by an insurer or a contract issued by a health service corporation, whether by option or otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

(2) A health maintenance organization may not issue or deliver an enrollment form, an evidence of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this state before a copy of the enrollment form, the evidence of coverage, or the amendment

to the approved enrollment form or evidence of coverage is filed with and approved by the commissioner.

(3) An evidence of coverage issued or delivered to a person resident in this state may not contain a provision or statement that is ~~unjust, unfair, inequitable, misleading, or deceptive, that encourages misrepresentation, or that is~~ untrue, misleading, or deceptive as defined in [section 14(1)]. The evidence of coverage must contain:

(a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate, of:

(i) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(ii) any limitations on the services, kinds of services, or benefits to be provided, including any deductible or copayment feature;

(iii) the location at which and the manner in which information is available as to how services may be obtained;

(iv) the total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts; and

(v) a clear and understandable description of the health maintenance organization's method for resolving enrollee complaints.

(b) definitions of geographical service area,

emergency care, urgent care, out-of-area services, dependent, and primary provider, if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment, which is given to each enrollee along with the evidence of coverage.

(c) clear disclosure of each provision that limits benefits or access to service in the exclusions, limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and exceptions that must be disclosed include but are not limited to:

(i) emergency and urgent care;

(ii) restrictions on the selection of primary or referral providers;

(iii) restrictions on changing providers during the contract period;

(iv) out-of-pocket costs, including copayments and deductibles;

(v) charges for missed appointments or other administrative sanctions;

(vi) restrictions on access to care if copayments or other charges are not paid; and

(vii) any restrictions on coverage for dependents who

do not reside in the service area.

(d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and nervous and mental disorders;

(e) a provision requiring immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of an enrollee or his dependents;

(f) a provision ~~offering~~ REQUIRING medical treatment and referral services to appropriate ancillary services for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits AND COVERAGE provided in ~~33-22-703;~~ TITLE 33, CHAPTER 22, PART 7; HOWEVER:

(I) AFTER THE PRIMARY CARE PHYSICIAN REFERS AN ENROLLEE FOR TREATMENT OF AND APPROPRIATE ANCILLARY SERVICES FOR MENTAL ILLNESS, ALCOHOLISM, OR DRUG ADDICTION, THE HEALTH MAINTENANCE ORGANIZATION MAY NOT LIMIT THE ENROLLEE TO A HEALTH MAINTENANCE ORGANIZATION PROVIDER FOR THE TREATMENT OF AND APPROPRIATE ANCILLARY SERVICES FOR MENTAL ILLNESS, ALCOHOLISM, OR DRUG ADDICTION;

(II) IF AN ENROLLEE CHOOSES A PROVIDER OTHER THAN THE HEALTH MAINTENANCE ORGANIZATION PROVIDER FOR SUCH TREATMENT AND REFERRAL SERVICES, THE ENROLLEE'S DESIGNATED PROVIDER MUST LIMIT HIS TREATMENT AND SERVICES TO THE SCOPE OF THE

REFERRAL IN ORDER TO RECEIVE PAYMENT FROM THE HEALTH MAINTENANCE ORGANIZATION;

(III) THE AMOUNT PAID BY THE HEALTH MAINTENANCE ORGANIZATION TO THE ENROLLEE'S DESIGNATED PROVIDER MAY NOT EXCEED THE AMOUNT PAID BY THE HEALTH MAINTENANCE ORGANIZATION TO ONE OF ITS PROVIDERS FOR EQUIVALENT TREATMENT OR SERVICES;

(g) a provision as follows:

"Conformity With State Statutes: Any provision of this evidence of coverage that on its effective date is in conflict with the statutes of the state in which the insured resides on that date is hereby amended to conform to the minimum requirements of those statutes."

(h) a provision that the health maintenance organization shall issue, without evidence of insurability, to the enrollee, his dependents, or family members continuing coverage on the enrollee, his dependents, or family members:

(i) if the evidence of coverage or any portion of it on an enrollee, his dependents, or family members covered under the evidence of coverage ceases because of termination of employment or of his membership in the class or classes eligible for coverage under the policy or because his employer discontinues his business or the coverage;

(ii) if the enrollee had been enrolled in the health

maintenance organization for a period of 3 months preceding the termination of group coverage; and

(iii) if the enrollee applied for continuing coverage within 31 days after the termination of group coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by the group contract from which the enrollee converts.

(i) a provision that clearly describes the amount of money an enrollee shall pay to the health maintenance organization to be covered for basic health care services.

(4) A health maintenance organization may amend an enrollment form or an evidence of coverage in a separate document if the separate document is filed with and approved by the commissioner and issued to the enrollee.

(5) (a) A health maintenance organization shall provide the same coverage for newborn infants, required by subsection (3)(e), as it provides for enrollees, except that for newborn infants there may be no waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.

(b) A health maintenance organization may not issue or amend an evidence of coverage in this state if it contains

any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an enrollee or his dependents from and after the moment of birth.

(c) If a health maintenance organization requires payment of a specific fee to provide coverage of a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain a provision that requires notification to the health maintenance organization, within 31 days after the date of birth, of the birth of an infant and payment of the required fee.

(6) A health maintenance organization may not use a schedule of charges for enrollee coverage for health care services or an amendment to a schedule of charges before it files a copy of the schedule of charges or the amendment to it with the commissioner. A health maintenance organization may evidence a subsequent amendment to a schedule of charges in a separate document issued to the enrollee. The charges in the schedule must be established in accordance with actuarial principles for various categories of enrollees, except that charges applicable to an enrollee must not be individually determined based on the status of his health. ~~However,--the--charges--may-not-be-excessive,-inadequate,-or unfairly-discriminatory-and-cannot--be--amended--more--often than--once--in--a--12-month--period--unless--a-more-frequent~~

~~amendment is actuarially justified and necessary to preserve the financial solvency of the health maintenance organization. A certification by a qualified actuary or other qualified person acceptable to the commissioner as to the appropriateness of the use of the charges, based on reasonable assumptions, must accompany the filing, along with adequate supporting information.~~

(7) The commissioner shall, within ~~a reasonable period~~ 60 DAYS, approve a form if the requirements of subsections (1) through (5) are met. A health maintenance organization may not issue a form ~~or use a schedule of charges~~ before the commissioner approves the form ~~or the health maintenance organization files the schedule of charges~~. If the commissioner disapproves the filing, he shall notify the filer. In the notice, the commissioner shall specify the reasons for his disapproval. The commissioner shall grant a hearing within 30 days after he receives a written request by the filer.

(8) The commissioner may in his discretion require a health maintenance organization to submit any RELEVANT information he considers necessary in determining whether to approve or disapprove a filing made pursuant to this section.

NEW SECTION. Section 9. Annual statement -- revocation for failure to file -- penalty for perjury. (1)

~~Each~~ UNLESS IT IS OPERATED BY AN INSURER OR A HEALTH SERVICE CORPORATION AS A PLAN, EACH authorized health maintenance organization shall annually on or before March 1 file with the commissioner a full and true statement of its financial condition, transactions, and affairs as of the preceding December 31. The statement must be in the general form and content required by the commissioner. The statement must be verified by the oath of at least two principal officers of the health maintenance organization. The commissioner may in his discretion waive any verification under oath.

(2) At the time of filing its annual statement, the health maintenance organization shall pay the commissioner the fee for filing its statement as prescribed in [section 22]. The commissioner may refuse to accept the fee for continuance of the insurer's certificate of authority, as provided in [section 22], or may in his discretion suspend or revoke the certificate of authority of a health maintenance organization that fails to file an annual statement when due.

(3) The commissioner may, AFTER NOTICE AND HEARING, impose a fine not to exceed $5,000 per violation upon a director, officer, partner, member, agent, or employee of a health maintenance organization who knowingly subscribes to or concurs in making or publishing an annual statement required by law that contains a material statement which is

false.

(4) The commissioner may require such reports as he considers reasonably necessary and appropriate to enable him to carry out his duties under [sections 1 through 29], INCLUDING BUT NOT LIMITED TO A STATEMENT OF OPERATIONS, TRANSACTIONS, AND AFFAIRS OF A HEALTH MAINTENANCE ORGANIZATION OPERATED BY AN INSURER OR A HEALTH SERVICE CORPORATION AS A PLAN.

NEW SECTION. Section 10. Information to enrollees. Each authorized health maintenance organization shall ~~promptly~~ provide to its enrollees ~~notice~~ 30 DAYS' ADVANCE NOTICE IN WRITING of any material change in the operation of the health maintenance organization that will affect them directly.

NEW SECTION. Section 11. Complaint system. (1) (a) Each authorized health maintenance organization shall establish and maintain a complaint system to provide reasonable procedures to resolve written complaints initiated by enrollees. A health maintenance organization may not use a complaint system:

(i) before the commissioner approves it; and

(ii) unless the health maintenance organization describes it in each evidence of coverage issued or delivered to an enrollee in this state.

(b) Each time the health maintenance organization

denies a claim or initiates disenrollment, cancellation, or nonrenewal, it shall notify the affected enrollee of the right to file a complaint and the procedure for filing a complaint.

(c) Each health maintenance organization shall acknowledge a complaint within 10 days of receiving it.

(d) Each health maintenance organization shall retain records of all complaints for 3 years and shall develop a summary for each year that must include:

(i) a description of the procedures of the complaint system;

(ii) the total number of complaints handled through the complaint system, a compilation of causes underlying the complaints filed, the date on which each complaint was filed, the date on which each complaint was resolved, the disposition of each complaint filed, the time it took to process each complaint, and a summary of each administrative change made because of a complaint; and

(iii) the number, amount, and disposition of malpractice claims made by enrollees of the health maintenance organization that were settled during the year by the health maintenance organization.

(e) The health maintenance organization shall annually on or before March 1 file with the commissioner the summary described in subsection (1)(d) for the preceding year.

(2) The commissioner shall hold in confidence the information provided by the health maintenance organization pursuant to subsection (1)(d)(iii).

(3) The commissioner may examine a complaint system.

NEW SECTION. Section 12. Investment regulations. ~~A~~ EXCEPT FOR A HEALTH MAINTENANCE ORGANIZATION OPERATED AS A PLAN BY A HEALTH SERVICE CORPORATION, A domestic health maintenance organization may invest its funds only as prescribed in ~~rules-adopted-by-the--commissioner~~ TITLE 33, CHAPTER 2, PART 8.

NEW SECTION. Section 13. Protection against insolvency. (1) Except as provided in subsections (4) through (7), each authorized health maintenance organization shall deposit with the commissioner cash, securities, or any combination of cash or securities acceptable to the commissioner in the amount set forth in this section.

(2) The amount of the deposit for a health maintenance organization during the first year of its operation must be the greater of:

(a) 5% of its estimated expenditures for health care services for its first year of operation;

(b) twice its estimated average monthly uncovered expenditures for its first year of operation; or

(c) $100,000.

(3) At the beginning of each succeeding year, unless

not applicable, the health maintenance organization shall deposit with the commissioner cash, securities, or any combination of cash or securities acceptable to the commissioner, in an amount equal to 4% of its estimated annual uncovered expenditures for that year.

(4) Unless not applicable, a health maintenance organization that is in operation on [the effective date of this act] shall make a deposit equal to the greater of:

(a) 1% of the preceding 12 months' uncovered expenditures; or

(b) $100,000 on the first day of the fiscal year beginning 6 months or more after [the effective date of this act]. In the second fiscal year, if applicable, the amount of the additional deposit must be equal to 2% of its estimated annual uncovered expenditures. In the third fiscal year, if applicable, the additional deposit must be equal to 3% of its estimated annual uncovered expenditures for that year. In the fourth fiscal year and subsequent years, if applicable, the additional deposit must be equal to 4% of its estimated annual uncovered expenditures for each year. Each year's estimate after the first year of operation must reasonably reflect the preceding year's operating experience and delivery arrangements.

(5) The commissioner may in his discretion waive any of the deposit requirements set forth in subsections (1)

through (4) whenever he is satisfied that:

(a) the health maintenance organization has sufficient net worth and an adequate history of generating net income to assure its financial viability for the next year;

(b) the health maintenance organization's performance and obligations are guaranteed by an organization with sufficient net worth and an adequate history of generating net income; or

(c) the health maintenance organization's assets or its contracts with insurers, health service corporations, governments, or other organizations are reasonably sufficient to assure the performance of its obligations.

(6) When a health maintenance organization achieves a net worth not including land, buildings, and equipment of at least $1 million or achieves a net worth including organization-related land, buildings, and equipment of at least $5 million the annual deposit requirement under subsection (3) does not apply. The annual deposit requirement under subsection (3) does not apply to a health maintenance organization if the total amount of the accumulated deposit is greater than the capital requirement for the formation or admittance of a disability insurer in this state. If the health maintenance organization has a guaranteeing organization that has been in operation for at least 5 years and has a net worth not including land,

buildings, and equipment of at least $1 million or that has been in operation for at least 10 years and has a net worth including organization-related land, buildings, and equipment of at least $5 million, the annual deposit requirement under subsection (3) does not apply. If the guaranteeing organization is sponsoring more than one health maintenance organization, however, the net worth requirement is increased by a multiple equal to the number of such health maintenance organizations. This requirement to maintain a deposit in excess of the deposit required of a disability insurer does not apply during any time that the guaranteeing organization maintains for each health maintenance organization it sponsors a net worth at least equal to the capital and surplus requirements for a disability insurer.

(7) All income from deposits belongs to the depositing health maintenance organization and must be paid to it as it becomes available. A health maintenance organization that has made a securities deposit may withdraw the deposit or any part of it after making a substitute deposit of cash, securities, or any combination of cash or securities of equal amount and value. A health maintenance organization may not substitute securities without prior approval by the commissioner.

(8) In any year in which an annual deposit is not

required of a health maintenance organization, at the health maintenance organization's request, the commissioner shall reduce the previously accumulated deposit by $100,000 for each $250,000 of net worth in excess of the amount that allows the health maintenance organization to be exempt from the annual deposit requirement. If the amount of net worth no longer supports a reduction of its required deposit, the health maintenance organization shall immediately redeposit $100,000 for each $250,000 of reduction in net worth, except that its total deposit may not be required to exceed the maximum required under this section.

(9) ~~Each~~ UNLESS IT IS OPERATED BY AN INSURER OR A HEALTH SERVICE CORPORATION AS A PLAN, EACH health maintenance organization shall have a minimum capital of at least $200,000 in addition to any deposit requirements under this section. The capital account must be in excess of any accrued liabilities and be in the form of cash, securities, or any combination of cash or securities acceptable to the commissioner.

(10) Each health maintenance organization shall demonstrate that if it becomes insolvent:

(a) enrollees hospitalized on the date of insolvency will be covered until discharged; and

(b) enrollees will be entitled to similar alternate insurance coverage that does not contain any medical

underwriting or preexisting limitation requirements.

NEW SECTION. Section 14. Prohibited practices. (1) A health maintenance organization, or representative thereof, may not cause or knowingly permit the use of advertising that is untrue or misleading, solicitation that is untrue or misleading, or any form of evidence of coverage that is deceptive. For purposes of [sections 1 through 29]:

~~(a)--a-statement-or-item-of-information--is--considered to--be--untrue-if-it-does-not-conform-to-fact-in-any-respect that-is-or-may-be-significant-to-an-enrollee-of,--or--person considering----enrollment----in,----a---health---maintenance organization;~~

~~(b)~~(A) a statement or item of information is considered to be misleading, whether or not it may be literally untrue, if, in the total context in which the statement is made or the item of information is communicated, a reasonable person, not possessing special knowledge regarding health care coverage, may reasonably understand the statement or item of information as indicating a benefit or advantage or the absence of an exclusion, limitation, or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a health maintenance organization if the benefit or advantage or absence of limitation, exclusion, or disadvantage does not in fact exist; and

~~(c)~~(B) an evidence of coverage is considered to be deceptive if, when taken as a whole and with consideration given to typography, format, and language, it can cause a reasonable person, not possessing special knowledge regarding health maintenance organizations, to expect benefits, services, charges, or other advantages that the evidence of coverage does not provide or which the health maintenance organization issuing the evidence of coverage does not regularly make available to enrollees covered under the evidence of coverage.

(2) Title 33, chapter 18, applies to health maintenance organizations and evidences of coverage issued by a health maintenance organization, except to the extent that the commissioner determines that the nature of health maintenance organizations and evidences of coverage render the chapter clearly inappropriate.

(3) A health maintenance organization shall clearly disclose in the evidence of coverage the circumstances under which it may disenroll, cancel, or refuse to renew an enrollee. A health maintenance organization may only disenroll, cancel, or refuse to renew an enrollee if the enrollee:

(a) has failed to pay required premiums by the end of the grace period;

(b) has committed acts of physical or verbal abuse

that pose a threat to providers or other enrollees of the health maintenance organization;

(c) has allowed a nonenrollee to use the health maintenance organization's certification card to obtain services or has knowingly provided fraudulent information in applying for coverage;

(d) has moved outside of the geographical service area of the health maintenance organization; ~~or~~

(E) HAS VIOLATED RULES OF THE HEALTH MAINTENANCE ORGANIZATION STATED IN THE EVIDENCE OF COVERAGE;

(F) HAS VIOLATED RULES ADOPTED BY THE COMMISSIONER FOR ENROLLMENT IN A HEALTH MAINTENANCE ORGANIZATION; OR

~~(e)~~(G) is unable to establish or maintain a satisfactory physician-patient relationship with the physician responsible for the enrollee's care. Disenrollment of an enrollee for this reason must be permitted only if the health maintenance organization can demonstrate that it provided the enrollee with the opportunity to select an alternate primary care physician, made a reasonable effort to assist the enrollee in establishing a satisfactory physician-patient relationship, and informed the enrollee that he may file a grievance on this matter.

(4) A health maintenance organization may not disenroll an enrollee under subsection (3) for reasons related to the physical or mental condition of the enrollee

or for any of the following reasons:

(a) failure of the enrollee to follow a prescribed course of treatment; or

(b) administrative actions, such as failure to keep an appointment.

(5) (a) A health maintenance organization that disenrolls a group certificate holder for any reason ~~except failure to pay required premiums~~ NOT LISTED IN SUBSECTION (3) OR PROVIDED IN RULES ADOPTED BY THE COMMISSIONER shall make arrangements to provide similar alternate insurance coverage to enrollees. The insurance coverage must be continued until the disenrolled group certificate holder finds its own coverage or a period of ~~36~~ 12 months elapses, whichever comes first. The premium on the individual coverage must be at the then-customary rate applicable to the individual coverage offered by the insurer, health service corporation, or health maintenance organization that provides the alternate insurance coverage.

(b) If a health maintenance organization disenrolls an enrollee covered on an individual basis for any reason ~~except failure to pay required premiums~~ NOT LISTED IN SUBSECTION (3) OR PROVIDED IN RULES ADOPTED BY THE COMMISSIONER, coverage must be continued until the anniversary date of the policy or for 1 year, whichever is earlier. A health maintenance organization that disenrolls

an individual enrollee for failure to pay a required premium or for fraudulent statements on the enrollment form need not provide alternate insurance coverage to that enrollee.

(6) A health maintenance organization may not refer to itself as an insurer unless licensed as an insurer or use a name deceptively similar to the name or description of an insurer authorized to transact insurance in this state.

(7) A person may not refer to itself as a health maintenance organization or HMO unless it holds a valid certificate of authority issued by the commissioner.

NEW SECTION. Section 15. Agent license required -- application, issuance, renewal, fees -- penalty. (1) No individual, partnership, or corporation may act as or hold himself out to be an agent of a health maintenance organization unless he is:

(a) licensed as a disability insurance agent by the commissioner pursuant to chapter 17, parts 1, 2, and 4 of this title OR LICENSED AS AN ENROLLMENT REPRESENTATIVE UNDER 33-30-311 THROUGH 33-30-313; and

(b) appointed or authorized by the health maintenance organization to solicit health care service agreements on its behalf.

(2) Application, appointment and qualification for a health maintenance organization agent license, fees applicable to and the issuance of a health maintenance

organization agent license, and renewal of a health maintenance organization agent license must be in accordance with the provisions of chapter 17 that apply to a disability insurance agent.

(3) An individual, partnership, or corporation who holds a disability insurance agent license on [the effective date of this act] need not requalify by an examination to be licensed as a health maintenance organization agent.

(4) The commissioner may, in accordance with 33-1-313, 33-1-317, 33-17-411, and chapter 17, part 10, suspend, revoke, refuse to issue or renew a health maintenance organization agent license, or impose a fine upon the licensee.

NEW SECTION. Section 16. Powers of insurers and health service corporations. (1) An insurer authorized to transact insurance in this state or a health service corporation authorized to do business in this state may, either directly or through a subsidiary or affiliate, organize and operate a health maintenance organization under the provisions of [sections 1 through 29]. Notwithstanding any other law which may be inconsistent with this section, two or more insurers, health service corporations, or subsidiaries or affiliates thereof may jointly organize and operate a health maintenance organization. The business of insurance is considered to include the provision of health

care services by a health maintenance organization owned or operated by an insurer or a subsidiary thereof.

(2) Notwithstanding any insurance or health service corporation laws, an insurer or a health service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through a health maintenance organization and to provide coverage if the health maintenance organization fails to meet its obligations.

(3) The enrollees of a health maintenance organization constitute a permissible group under this title. The insurer or health service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers under the contracts described in subsection (2).

(4) Nothing in this section exempts a health maintenance organization that provides health care services from complying with the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

NEW SECTION. Section 17. Examination. (1) The commissioner may examine the affairs of a health maintenance organization ~~and--the--providers--with--whom---the---health maintenance-organization-has-contracts,-agreements,-or-other arrangements~~ as often as is reasonably necessary to protect the interests of the people of this state. The commissioner

shall make such an examination at least once every 3 years.

(2) The department of health may examine the ~~quality~~ AVAILABILITY, ACCESSIBILITY, AND CONTINUITY of the health care services provided by any health maintenance organization and the providers with whom the health maintenance organization has contracts, agreements, or other arrangements as often as is reasonably necessary to protect the interests of the people of this state. The department of health shall make such an examination at least once every 3 years.

(3) Each authorized health maintenance organization and provider shall submit its relevant books and records for the examinations and in every way facilitate the examinations. For the purpose of examination, the commissioner and the department of health may administer oaths to and examine the officers and agents of the health maintenance organization and the principals of the providers concerning their business.

(4) (a) (i) Upon presentation of a detailed account of the charges and expenses of examinations by the commissioner, the health maintenance organization being examined shall pay to the examiner as necessarily incurred on account of the examination the actual travel expenses, a reasonable living-expense allowance, and a per diem, all at reasonable rates customary therefor and as established or

adopted by the commissioner. The commissioner may present such an account periodically during the course of the examination or at the termination of the examination as the commissioner considers proper. A person may not pay and an examiner may not accept any additional emolument on account of any such examination.

(ii) If a health maintenance organization fails to pay the charges and expenses as referred to in subsection (4)(a)(i), the commissioner shall pay them out of the funds of the commissioner in the same manner as other disbursements of such funds. The amount so paid must be a lien upon all of the person's assets and property in this state and may be recovered by suit by the attorney general on behalf of the state of Montana and restored to the appropriate fund.

(b) The expenses of examination conducted by the director under this section must be assessed against the health maintenance organization and remitted to the director. Such remitted expenses are statutorily appropriated to the department of health as provided in 17-7-502.

(5) In lieu of an examination, the commissioner or the director may accept the report of an examination made by the commissioner or the director of another state.

NEW SECTION. Section 18. Suspension or revocation of

certificate of authority. (1) The commissioner may in his discretion suspend or revoke any certificate of authority issued to a health maintenance organization under [sections 1 through 29] if he finds that any of the following conditions exist:

(a) The health maintenance organization is operating in contravention of its basic organizational document or in a manner contrary to that described in any other information submitted under [section 3] AND PROVIDED THAT SUCH OPERATION ADVERSELY AFFECTS THE HEALTH MAINTENANCE ORGANIZATION'S ABILITY TO PROVIDE BENEFITS AND OPERATE UNDER THE APPLICATION APPROVED BY THE COMMISSIONER, unless amendments to such submissions have been filed with and approved by the commissioner.

(b) The health maintenance organization issues evidences of coverage or uses a schedule of charges for health care services that do not comply with the requirements of [section 8].

(c) The health maintenance organization does not provide or arrange for basic health care services.

(d) The director, AFTER NOTICE AND HEARING, certifies to the commissioner that:

(i) the health maintenance organization does not meet the requirements of [section 4(1)]; or

(ii) the health maintenance organization is unable to

fulfill its obligations to furnish health care services.

(e) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.

(f) The health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation under [section 6].

(g) The health maintenance organization has failed to implement the complaint system required by [section 11] to resolve valid complaints in a reasonable manner.

(h) The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner.

(i) The continued operation of the health maintenance organization would be hazardous to its enrollees.

(j) The health maintenance organization has otherwise failed to substantially comply with [sections 1 through 29].

(2) The commissioner may in his discretion suspend or revoke a certificate of authority only if he complies with the requirements of [section 21].

(3) When the certificate of authority of a health maintenance organization is suspended, the health

maintenance organization may not, during the period of such suspension, enroll any additional enrollees except newborn infants or other newly acquired dependents of existing enrollees and may not engage in any advertising or solicitation.

(4) If the commissioner revokes the certificate of authority of a health maintenance organization, the health maintenance organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and may not transact further business except as may be essential to the orderly conclusion of its affairs. It may not engage in further advertising or solicitation following the effective date of the order of revocation. The commissioner may by written order permit further operation of the health maintenance organization if he finds further operation to be in the best interest of enrollees to the extent that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

NEW SECTION. Section 19. Supervision, rehabilitation, or liquidation of a health maintenance organization. (1) The supervision, rehabilitation, or liquidation of a health maintenance organization is considered to be the supervision, rehabilitation, or liquidation of an insurer and must be conducted under the supervision of the

commissioner pursuant to chapter 2, part 13. The commissioner may apply for an order directing him to supervise, rehabilitate, or liquidate a health maintenance organization upon any one or more grounds set out in 33-2-1321, 33-2-1331, or 33-2-1341 or when in his opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this state. Enrollees shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

(2) A claim by a health care provider for an uncovered expenditure has the same priority as a claim by an enrollee if the provider of services agrees not to assert the claim against any enrollee of the health maintenance organization.

NEW SECTION. Section 20. Rules. (1) The commissioner may, after notice and hearing, make reasonable rules necessary to effectuate [sections 1 through 29].

(2) The department of health may make reasonable rules necessary to effectuate [sections 1 through 29].

NEW SECTION. Section 21. Administrative procedures. (1) When the commissioner has cause to believe that grounds for the denial of an application for a certificate of authority exist or that grounds for the suspension or revocation of a certificate of authority exist, he shall give written notice to the health maintenance organization

and the department of health specifically stating the grounds for denial, suspension, or revocation and fixing a time of at least 30 days after the notice for a hearing on the matter.

(2) The director or his designated representative may attend the hearing and may participate in the proceeding. The recommendations and findings of the director with respect to matters relating to the ~~quality~~ AVAILABILITY, ACCESSIBILITY, AND CONTINUITY of health care services provided in connection with any decision regarding denial, suspension, or revocation of a certificate of authority must be conclusive and binding upon the commissioner. After the hearing, or upon the failure of the health maintenance organization to appear at the hearing, the commissioner shall make written findings and act as he considers advisable. The commissioner shall mail the written findings to the health maintenance organization and submit a copy to the director. The action of the commissioner and the recommendations and findings of the director are subject to review by the district court having jurisdiction. The court may, in disposing of the issue before it, modify, affirm, or reverse the order of the commissioner in whole or in part.

(3) ~~The Montana Administrative Procedure Act, Title 2, chapter 4, applies to proceedings under this section to the extent it is not in conflict with this section.~~ WHERE NOTICE

AND HEARING ARE REQUIRED WITH REGARD TO ACTIONS TAKEN BY THE COMMISSIONER UNDER [SECTIONS 1 THROUGH 29], THE REQUIREMENTS OF 33-1-314 THROUGH 33-1-316 AND TITLE 33, CHAPTER 1, PART 7, APPLY, EXCEPT THAT THE FORMAL RULES OF PLEADING AND EVIDENCE MUST BE OBSERVED. TO THE EXTENT THAT 33-1-314 THROUGH 33-1-316 AND TITLE 33, CHAPTER 1, PART 7, DO NOT ADDRESS THE NOTICE AND HEARING REQUIREMENTS OF [SECTIONS 1 THROUGH 29], THE PROVISIONS OF TITLE 2, CHAPTER 4, PARTS 6 AND 7, APPLY.

(4) WHERE NOTICE AND HEARING ARE REQUIRED WITH REGARD TO ACTIONS TAKEN BY THE DIRECTOR UNDER [SECTIONS 1 THROUGH 29], THE PROVISIONS OF TITLE 2, CHAPTER 4, PARTS 6 AND 7, APPLY.

NEW SECTION. Section 22. Fees. (1) Each health maintenance organization shall pay to the commissioner the following fees:

(a) for filing an application for a certificate of authority or amendment thereto, $300;

(b) for filing an amendment to the organization documents that requires approval, $25;

(c) for filing each annual statement, $25;

(D) FOR ANNUAL CONTINUATION OF CERTIFICATE OF AUTHORITY, $300.

(2) All fees and miscellaneous charges, except fines or penalties or those amounts received pursuant to [sections

9(3) and 23], collected by the commissioner pursuant to [sections 1 through 29] and the rules adopted thereunder must be deposited in the insurance regulatory trust account pursuant to 17-2-121 through 17-2-123.

(3) The director may assess fees necessary and adequate to cover the expenses of the director's functions~~, other--than--examinations,~~ under this chapter. ~~Such-fees-are statutorily-appropriated-to--the--department--of--health--as provided--in--17-7-502.~~ ~~THESE-FEES-MUST-BE-DEPOSITED-IN-THE GENERAL-FUND.~~ SUCH FEES ARE STATUTORILY APPROPRIATED TO THE DEPARTMENT OF HEALTH AS PROVIDED IN 17-7-502.

NEW SECTION. Section 23. Penalties and enforcement. (1) The commissioner may, in addition to suspension or revocation of a certificate of authority under [section 18], AFTER NOTICE AND HEARING, impose an administrative penalty in an amount not less than $500 or more than $10,000 if he gives reasonable notice in writing of the intent to levy the penalty and the health maintenance organization has a reasonable time within which to remedy the defect in its operations that gave rise to the penalty citation. ~~The commissioner-may-augment-this-penalty-by-an-amount-equal--to the--sum--that--he--calculates-to-be-the-damages-suffered-by enrollees-or-other-members-of-the-public.~~

(2) ~~(a)~~ If the commissioner or the director has cause to believe that a violation of [sections 1 through 29] has

occurred or is threatened, the commissioner or the director may:

~~(i)~~(A) give notice to the health maintenance organization and to the representatives or other persons who appear to be involved in the suspected violation;

~~(ii)~~(B) arrange a conference with the alleged violators or their authorized representatives to attempt to ascertain the facts relating to the suspected violation; and

~~(iii)~~(C) if it appears that a violation has occurred or is threatened, arrive at an adequate and effective means of correcting or preventing the violation.

~~(b) Proceedings under this subsection are not governed by any formal procedural requirements and may be conducted in a manner the commissioner or the director considers appropriate under the circumstances. However, unless consented to by the health maintenance organization, no rule or order may result from a conference until the requirements of [section 21] or this section are satisfied.~~

(3) (a) The commissioner may issue an order directing a health maintenance organization or its representative to cease and desist from engaging in an act or practice in violation of [sections 1 through 29].

(b) Within 15 days after service of the cease and desist order, the respondent may request a hearing to determine whether acts or practices in violation of

[sections 1 through 29] have occurred. The hearing must be conducted pursuant to Title 2, chapter 4, part 6, and judicial review must be available as provided by Title 2, chapter 4, part 7.

(4) If a health maintenance organization violates a provision of [sections 1 through 29] and the commissioner elects not to issue a cease and desist order or if the respondent does not comply with a cease and desist order issued pursuant to subsection (3), the commissioner may institute a proceeding to obtain injunctive or other appropriate relief in the district court of Lewis and Clark County.

NEW SECTION. Section 24. Statutory construction and relationship to other laws. (1) Except as otherwise provided in [sections 1 through 29], the insurance or health service corporation laws do not apply to any health maintenance organization authorized to transact business under [sections 1 through 29]. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to [sections 1 through 29].

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its

representatives may not be construed as a violation of any law relating to solicitation or advertising by health professionals.

(3) A health maintenance organization authorized under [sections 1 through 29] may not be considered to be practicing medicine and is exempt from Title 37, chapter 3, relating to the practice of medicine.

(4) The provisions of [sections 1 through 29] do not exempt a health maintenance organization from the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

NEW SECTION. Section 25. Filings and reports as public documents. All applications, filings, and reports required under [sections 1 through 29], except those that contain trade secrets or privileged or confidential commercial or financial information (other than an annual financial statement that the commissioner may require under [section 9]), are public documents.

NEW SECTION. Section 26. Confidentiality of medical information. (1) Any data or information pertaining to the diagnosis, treatment, or health of an enrollee or applicant obtained from the enrollee, applicant, or a provider by a health maintenance organization must be held in confidence and may not be disclosed to any person except:

(a) to the extent that it may be necessary to carry

out the purposes of [sections 1 through 29];

(b) upon the express consent of the enrollee or applicant;

(c) pursuant to statute or court order for the production of evidence or the discovery thereof; or

(d) in the event of claim or litigation between the enrollee or applicant and the health maintenance organization wherein the data or information is pertinent.

(2) A health maintenance organization is entitled to claim the same statutory privileges against disclosure that the provider who furnished the information to the health maintenance organization is entitled to claim.

NEW SECTION. Section 27. Authority of director to contract. The director in carrying out his obligations under [sections 4(1), 17(2), and 18(1)] may contract with qualified persons to make recommendations concerning the determinations he is required to make. The contractors' recommendations may be accepted OR REJECTED in full or in part by the director.

NEW SECTION. Section 28. Acquisition, control, or merger of a health maintenance organization. (1) Except as provided in 33-2-1106 and subsection (2), no person may 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, 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 person may 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) and the commissioner has approved the offer, request, invitation, agreement, or acquisition pursuant to 33-2-1105.

NEW SECTION. Section 29. Dual choice. ~~(1) Each public or private employer in this state that employs not less than 25 employees and offers its employees a health benefit plan and each employee benefit fund in this state that offers its members any form of disability insurance benefit shall make available to and inform its employees or members of the option to enroll in at least one health maintenance organization holding a valid certificate of authority that provides health care services in the geographic areas in~~

~~which--a--substantial--number--of--the--employees-or-members reside,--if--there--is--a--prevailing--collective--bargaining agreement,---the---selection---of---the--health--maintenance organization-to-be-made-available-to-the-employees--must--be made-pursuant-to-the-agreement.~~

~~(2)~~ An employer in this state THAT OFFERS ITS EMPLOYEES THE OPTION TO ENROLL IN A HEALTH MAINTENANCE ORGANIZATION AND AN EMPLOYEE BENEFIT FUND IN THIS STATE THAT OFFERS ITS MEMBERS THE OPTION TO ENROLL IN A HEALTH MAINTENANCE ORGANIZATION may not be required to pay more for health benefits ~~as-a--result--of--the--application--of--this section~~ PROVIDED BY THE HEALTH MAINTENANCE ORGANIZATION than it would otherwise be required to provide by any prevailing collective bargaining agreement or other contract for the provision of health benefits to its employees, if the employer or benefits fund pays to the health maintenance organization chosen by each employee or member an amount equal to the lesser of:

~~(a)~~(1) the amount paid on behalf of its other employees or members of health benefits; or

~~(b)~~(2) the health maintenance organization's charge for coverage approved by the commissioner pursuant to [section 8].

~~Section-30.--Section--33-22-111,--MCA,--is--amended--to read:~~

~~"33-22-111.--Policies-to-provide-for-freedom-of--choice of-practitioners----professional-practice-not-enlarged.--(1)~~ All Except--as--provided--in--~~(sections--1-through-29),~~ all policies--of--disability--insurance,--including--individual, group,--and--blanket-policies,-and-all-policies-insuring-the payment-of-compensation-under-the-Workers'-Compensation--Act shall--provide-the-insured-shall-have-full-freedom-of-choice in-the-selection-of-any-duly--licensed--physician,--dentist, osteopath,-----chiropractor,----optometrist,----chiropodist, psychologist,-licensed-social-worker,-or-nurse-specialist-as specifically-listed-in-37-8-202-for-treatment-of-any-illness or-injury-within-the-scope-and-limitations-of-his--practice. Whenever--such-policies-insure-against-the-expense-of-drugs, the-insured--shall--have--full--freedom--of--choice--in--the selection--of--any--duly-licensed-and-registered-pharmacist. An-insurer-shall-offer,-at-additional-cost-to--the--insured, the--option--of-disability-and-health-insurance-coverage-for services-performed-by-a-licensed-professional-counselor.

~~(2)~~--Nothing-in-this--section--shall--be--construed--as enlarging--the--scope--and-limitations-of-practice-of-any-of the-licensed-professions-enumerated-in-subsection--~~(1)~~,--nor shall--this--section--be-construed-as-amending,-altering,-or repealing-any-statutes-relating-to-the-licensing-or--use--of hospitals."

~~Section-31.--Section-17-7-502,-MCA,-is-amended-to-read:~~

~~"17-7-502.--Statutory--appropriations-----definition---requisites-for-validity.--(1)-A-statutory--appropriation--is an--appropriation--made--by--permanent--law--that-authorizes spending-by-a-state-agency-without-the-need-for--a--biennial legislative-appropriation-or-budget-amendment.~~

~~(2)--Except--as--provided--in--subsection--(4),--to--be effective,-a-statutory-appropriation-must-comply--with--both of-the-following-provisions:~~

~~(a)--The-law-containing-the-statutory-authority-must-be listed-in-subsection-(3).~~

~~(b)--The--law--or-portion-of-the-law-making-a-statutory appropriation--must--specifically--state--that--a--statutory appropriation-is-made-as-provided-in-this-section.~~

~~(3)--The--following--laws--are-the-only-laws-containing statutory-appropriations:~~

~~(a)--2-9-202,~~

~~(b)--2-17-105,~~

~~(c)--2-18-812,~~

~~(d)--10-3-203,~~

~~(e)--10-3-312,~~

~~(f)--10-3-314,~~

~~(g)--10-4-301,~~

~~(h)--13-37-304,~~

~~(i)--15-31-702,~~

~~(j)--15-36-112,~~

~~(k)--15-70-101;~~

~~(l)--16-1-404;~~

~~(m)--16-1-410;~~

~~(n)--16-1-411;~~

~~(o)--17-3-212;~~

~~(p)--17-5-404;~~

~~(q)--17-5-424;~~

~~(r)--17-5-804;~~

~~(s)--19-8-504;~~

~~(t)--19-9-702;~~

~~(u)--19-9-1007;~~

~~(v)--19-10-205;~~

~~(w)--19-10-305;~~

~~(x)--19-10-506;~~

~~(y)--19-11-512;~~

~~(z)--19-11-513;~~

~~(aa)-19-11-606;~~

~~(bb)-19-12-301;~~

~~(cc)-19-13-604;~~

~~(dd)-20-6-406;~~

~~(ee)-20-8-111;~~

~~(ff)-23-5-612;~~

(gg)-(section-17);

(hh)-(section-22);

~~(gg)~~(iii)-37-51-501;

~~(hh)~~ (jjj)-53-24-206,

~~(ii)~~ (kk)-75-1-1101,

~~(jj)~~ (lll)-75-7-305,

~~(kk)~~ (mm)-80-2-103,

~~(ll)~~ (nn)-80-2-228,

~~(mm)~~ (oo)-90-3-301,

~~(nn)~~ (pp)-90-3-302,

~~(oo)~~ (qq)-90-15-103,-and

~~(pp)~~ (rr)-Sec.-13,-HB-861,-L.-1985.

~~(4)--There-is-a--statutory--appropriation--to--pay--the principal,-interest,-premiums,-and-costs-of-issuing,-paying, and-securing-all-bonds,-notes,-or-other-obligations,-as-due, that-have-been-authorized-and-issued-pursuant-to-the-laws-of Montana.---Agencies---that---have--entered--into--agreements authorized--by--the--laws--of--Montana--to--pay--the---state treasurer,--for--deposit-in-accordance-with-17-2-101-through 17-2-107,-as-determined-by-the-state--treasurer,--an--amount sufficient--to--pay-the-principal-and-interest-as-due-on-the bonds-or-notes-have-statutory--appropriation--authority--for such-payments.~~"

SECTION 30. SECTION 17-7-502, MCA, IS AMENDED TO READ:

"17-7-502. Statutory appropriations -- definition -- requisites for validity. (1) A statutory appropriation is an appropriation made by permanent law that authorizes spending by a state agency without the need for a biennial

legislative appropriation or budget amendment.

(2) Except as provided in subsection (4), to be effective, a statutory appropriation must comply with both of the following provisions:

(a) The law containing the statutory authority must be listed in subsection (3).

(b) The law or portion of the law making a statutory appropriation must specifically state that a statutory appropriation is made as provided in this section.

(3) The following laws are the only laws containing statutory appropriations:

(a) 2-9-202;

(b) 2-17-105;

(c) 2-18-812;

(d) 10-3-203;

(e) 10-3-312;

(f) 10-3-314;

(g) 10-4-301;

(h) 13-37-304;

(i) 15-31-702;

(j) 15-36-112;

(k) 15-70-101;

(l) 16-1-404;

(m) 16-1-410;

(n) 16-1-411;

(o) 17-3-212;

(p) 17-5-404;

(q) 17-5-424;

(r) 17-5-804;

(s) 19-8-504;

(t) 19-9-702;

(u) 19-9-1007;

(v) 19-10-205;

(w) 19-10-305;

(x) 19-10-506;

(y) 19-11-512;

(z) 19-11-513;

(aa) 19-11-606;

(bb) 19-12-301;

(cc) 19-13-604;

(dd) 20-6-406;

(ee) 20-8-111;

(ff) 23-5-612;

(gg) [section 17];

(hh) [section 22];

~~(gg)~~(ii) 37-51-501;

~~(hh)~~(jj) 53-24-206;

~~(ii)~~(kk) 75-1-1101;

~~(jj)~~(ll) 75-7-305;

~~(kk)~~(mm) 80-2-103;

~~(ii)~~ (nn) 80-2-228;

~~(mm)~~ (oo) 90-3-301;

~~(nn)~~ (pp) 90-3-302;

~~(oo)~~ (qq) 90-15-103; and

~~(pp)~~ (rr) Sec. 13, HB 861, L. 1985.

(4) There is a statutory appropriation to pay the principal, interest, premiums, and costs of issuing, paying, and securing all bonds, notes, or other obligations, as due, that have been authorized and issued pursuant to the laws of Montana. Agencies that have entered into agreements authorized by the laws of Montana to pay the state treasurer, for deposit in accordance with 17-2-101 through 17-2-107, as determined by the state treasurer, an amount sufficient to pay the principal and interest as due on the bonds or notes have statutory appropriation authority for such payments."

SECTION 31. SECTION 33-1-102, MCA, IS AMENDED TO READ:

"33-1-102. Compliance required -- exceptions -- health service corporations. (1) No person shall transact a business of insurance in Montana or relative to a subject resident, located, or to be performed in Montana without complying with the applicable provisions of this code.

(2) No provision of this code shall apply with respect to:

(a) domestic farm mutual insurers as identified in

chapter 4, except as stated in chapter 4;

(b) domestic benevolent associations as identified in chapter 6, except as stated in chapter 6; and

(c) fraternal benefit societies, except as stated in chapter 7.

(3) This code shall not apply to health service corporations to the extent that the existence and operations of such corporations are authorized by Title 35, chapter 2, and related sections of the Montana Code Annotated.

(4) This code does not apply to health maintenance organizations to the extent that the existence and operations of such organizations are authorized by [sections 1 through 29]."

SECTION 32. SECTION 33-1-704, MCA, IS AMENDED TO READ:

"33-1-704. Hearing procedure. (1) All hearings shall be open to the public unless closed pursuant to the provisions of 2-3-203.

(2) The commissioner shall allow any party to the hearing to appear in person and by counsel, to be present during the giving of all evidence, to have a reasonable opportunity to inspect all documentary evidence and to examine witnesses, to present evidence in support of his interest, and to have subpoenas issued by the commissioner to compel attendance of witnesses and production of evidence in his behalf.

(3) The commissioner shall permit to become a party to the hearing by intervention, if timely, any person who was not an original party thereto and whose pecuniary interests will be directly and immediately affected by the commissioner's order made upon the hearing.

(4) ~~Formal~~ Except as provided in [section 21], rules of pleading or evidence need not be observed at any hearing.

(5) Upon written request seasonably made by a party to the hearing and at that person's expense, the commissioner shall cause a full stenographic record of the proceedings to be made by a competent reporter. If transcribed, a copy of such stenographic record shall be furnished to the commissioner without cost to the commissioner or the state and shall be a part of the commissioner's record of the hearing. If so transcribed, a copy of such stenographic record shall be furnished to any other party to such hearing at the request and expense of such other party. If no stenographic record is made or transcribed, the commissioner shall prepare an adequate record of the evidence and of the proceedings."

NEW SECTION. Section 33. Codification instruction. Sections 1 through 29 are intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to sections 1 through 29.

NEW SECTION. Section 34. 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.

NEW SECTION. Section 35. Effective date -- applicability. ~~This--act--is~~ SECTION 20 AND THIS SECTION ARE effective on passage and approval ~~and~~. THIS ACT applies to health maintenance organizations formed before or after the effective date of this act.

-End-