MINUTES

MONTANA SENATE
52nd LEGISLATURE - REGULAR SESSION

COMMITTEE ON BUSINESS & INDUSTRY

Call to Order: By Chairman J.D. Lynch, on January 10, 1991, at 10:00 a.m.

ROLL CALL

Members Present:
J.D. Lynch, Chairman (D)
John Jr. Kennedy, Vice Chairman (D)
Betty Bruski (D)
Eve Franklin (D)
Delwyn Gage (R)
Thomas Hager (R)
Jerry Noble (R)

Members Excused: Gene Thayer (R)
Bob Williams (D)

Staff Present: Bart Campbell (Legislative Council).

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Announcements/Discussion: Senator Lynch announced that executive action for SB 2 initially planned for today, will be acted on Monday, January 14 on request of some people that couldn't attend the meeting today. Also in regards to SB 16 from January 9, 1991, a motion was made by Senator Gage that a request for a committee bill be made for section 19 and using the language submitted in amendment form by Mona Jamieson. A roll call vote was taken and the motion was passed.

HEARING ON SENATE BILL 20

Presentation and Opening Statement by Sponsor:

Senator Bernie Swift, district 32, opened with an amendment to a branch banking bill. This is to clarify that the intent of this is that we would not in any case be confronted with duplicating branches in cities, as found in this piece of legislation. There was some inadvertent changes in the legislative council when the final bill was formed that left a slight question as far as that matter was concerned. So the

reason of this is to be sure that we avoid any duplication of branches in cities as defined in this bill.

Proponents' Testimony:

John Cadby, with the Montana bankers association testified that the bill simply makes it clear that there is only branch in a barren town within the county or neighboring county of the headquarter bank. There is four branches that have been so created in the past two years since the 1989 session.

Opponents' Testimony:

None

Questions From Committee Members:

Senator Lynch wondered if this had any adverse affects on Butte, or Anaconda because they do not have counties and cities.

John Cadby answered by saying that this would not have any adverse affects on Butte or Anaconda. Butte and Anaconda both have banks in these cities.

Senator Noble wondered if the bill passed last year was a disaster to some portions.

John Cadby answered by saying the affect it has had today is the first bank system merged into one bank in Billings. So the first bank in Helena is technically a branch of the headquarter bank in Billings. The first interstate banks in Kalispell and Great Falls have merged into one bank in Kalispell. So the first interstate bank in Great Falls is now a branch of Kalispell.

Joe Thares, international independent bankers, commented that John covered the major activity of the bill with exceptions of maybe three that may merge in the future.

Senator Gage asked if there is a definition of city in the banking laws.

John Cadby answered by saying the definition of city in HB 151 means a city, town, or municipality incorporated or unincorporated that is an aggregation of inhabitance and structures sufficient to constitute a distinct place.

Closing by Sponsor:

Senator Swift asked to give the bill a due pass. By unanimous vote SB 20 was given a due pass.

HEARING ON AMENDMENTS ON SB 16

Presentation and Opening Statement by Sponsor:

Bart Campbell, researcher for Business and Industry, presented the amendments that he prepared (See Exhibit 1).

Proponents' Testimony:

None

Opponents' Testimony:

None

Questions From Committee Members:

Senator Thayer asked if there was more things added to the amendments than discussed in the committee hearing.

Bart Campbell replied that Susan Witte and Dave Barnhill had these amendments and described the house keeping of it. They actually explained those sections that were in their amendments in their testimony yesterday, January 9, 1991.

Senator Thayer asked on page 22 lines 14-19 how Bart changed the wording.

Bart Campbell replied that he hadn't changed anything on these lines because the last that he had recalled there had been a question about what this meant. Dave Barnhill said what that meant is the state of Montana. He did not hear anybody say that they did not like that section, so he did not change that section.

Closing by Sponsor:

Senator Lynch entertained a motion to amend SB 16 with the suggested amendments.

Senator Williams motioned to amend.

The amendments passed 8 of 9.

Senator Williams motioned to due pass SB 16 as amended.

Senate bill 16 passed unanimously with amendments.

ADJOURNMENT

Adjournment At: 11:20 a.m.

J.D. LYNCH, Chairman

DARA ANDERSON, Secretary

JL/da

Amendments to Senate Bill No. 0016
First Reading Copy

Requested by Gage
For the Committee on Business and Industry

Prepared by Bart Campbell
January 10, 1991

1. Title, line 10.
Strike: "AND"

2. Title, line 10.
Following: "SECTIONS"
Insert: "33-1-704,"

3. Title, line 11.
Following: "33-7-406,"
Insert: "33-17-102,"

4. Title, line 13.
Following: "33-22-1504,"
Insert: "33-22-1511, 33-22-1512,"

5. Title, line 13.
Following: "33-22-1513,"
Insert: "33-22-1514, 33-22-1515, 33-22-1516, 33-22-1521,"

6. Title, line 14.
Strike: "33-22-1704,"

7. Title, line 15.
Following: "MCA"
Insert: "; and repealing section 33-22-1522, MCA"

8. Page 22, line 14.
Following: "provision"
Insert: "or the equivalent thereto"

9. Page 26, lines 1 and 2.
Following: "association"
Strike: "through the lead carrier"
Insert: "that is certified by the association as required by 33-22-1521"

10. Page 27, lines 18 through 21.
Strike: subsection (10) in its entirety
Renumber: subsequent subsection

11. Page 31, line 21 through page 33, line 3.
Strike: Section 19 in its entirety
Renumber: subsequent sections

12. Page 34, line 23.
Following: "license"
Insert: "to a company"

13. Page 35, line 24.
Following: "~~such~~"
Insert: "the commissioner may not require"

14. Page 35, line 24.
Following: "~~be~~"
Strike: "is not required"

15. Page 36, line 15.
Following: "provision"
Insert: "or the equivalent thereto"

16. Page 36, line 24.
Following: "provision"
Insert: "or the equivalent thereto"

17. Page 37, line 8.
Following: "provision"
Insert: "or the equivalent thereto"

18. Page 37, following line 13.
Insert: "

Section 26 Section 33-17-102, MCA, is amended to read:

"33-17-102. Definitions. As used in this title, the following definitions apply:

(1) "Adjuster" means a person who, on behalf of the insurer, for compensation as an independent contractor or as the employee of an independent contractor or for fee or commission investigates and negotiates settlement of claims arising under insurance contracts or otherwise acts on behalf of the insurer. The term does not include a:

(a) licensed attorney who is qualified to practice law in this state;

(b) salaried employee of an insurer or of a managing general agent; or

(c) licensed insurance producer who adjusts or assists in adjustment of losses arising under policies issued by the insurer.

(2) "Adjuster license" means a document issued by the commissioner that authorizes a person to act as an adjuster.

(3) (a) "Administrator" means a person who collects charges or premiums from residents of this state in connection with life, disability, property, or casualty insurance or annuities or who adjusts or settles claims on such coverage.

(b) The term does not mean:

(i) an employer on behalf of its employees or on behalf of the employees of one or more subsidiaries of affiliated corporations of the employer;

(ii) a union on behalf of its members;

(iii) (A) an insurer that is either authorized in this state or acting as an insurer with respect to a policy lawfully issued

and delivered by it in and pursuant to the laws of a state in which the insurer is authorized to transact insurance; or

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

(iv) a life, disability, property, or casualty insurance producer who is licensed in this state and whose activities are limited exclusively to the sale of insurance;

(v) a creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors;

(vi) a trust established in conformity with 29 U.S.C. 186 or the trustees, agents, and employees of the trust;

(vii) a trust exempt from taxation under section 501(a) of the Internal Revenue Code or the trustees and employees of the trust;

(viii) a custodian acting pursuant to a custodian account that meets the requirements of section 401(f) of the Internal Revenue Code or the agents and employees of the custodian;

(ix) a bank, credit union, or other financial institution that is subject to supervision or examination by federal or state banking authorities;

(x) a company that issues credit cards and that advances for and collects premiums or charges from its credit card holders who have authorized it to do so, if the company does not adjust or settle claims; or

(xi) a person who adjusts or settles claims in the normal course of his practice or employment as an attorney and who does not collect charges or premiums in connection with life or disability insurance or annuities.

(4) "Administrator license" means a document issued by the commissioner that authorizes a person to act as an administrator.

(5) "Consultant" means a person who for a fee examines, appraises, reviews, or evaluates an insurance policy, annuity, or pension contract, plan, or program or who makes recommendations or gives advice on an insurance policy, annuity, or pension contract, plan, or program.

(6) "Consultant license" means a document issued by the commissioner that authorizes a person to act as an insurance consultant.

(7) "Controlled business" means insurance procured or to be procured by or through a person upon the life, person, property, or risks of himself, his spouse, his employer, or his business.

(8) "Individual" means a private or natural person, as distinguished from a partnership, corporation, or association.

(9) "Insurance producer", except as provided in 33-17-103:

(a) means:

(i) a person who solicits, negotiates, effects, procures, delivers, renews, continues, or binds:

(A) policies of insurance for risks residing, located, or to be performed in this state; or

(B) membership contracts as defined in 33-30-101;

(ii) a managing general agent. For purposes of this definition, a "managing general agent" is a person who, on behalf of an insurer, exercises general supervision over the business of the insurer in this state <u>or in any other state</u>, including the authority to contract with an insurance producer for the insurer

and terminate those contracts.

(b) does not mean a customer service representative. For purposes of this definition, a "customer service representative" means a salaried employee of an insurance producer who assists and is responsible to the insurance producer.

(10) "License" means a document issued by the commissioner that authorizes a person to act as an insurance producer for the kinds of insurance specified in the document. The license itself does not create actual, apparent, or inherent authority in the holder to represent or commit an insurer to a binding agreement.

(11) "Person" means an individual, partnership, corporation, association, or other legal entity.

(12) "Public adjuster" means an adjuster employed by and representing the interests of the insured."

Section 27. Section 33-22-1511, MCA, is amended to read:

"**33-22-1511. Minimum benefits of association plan.** The association through the association plan shall offer a policy that provides at least the benefits ~~of a qualified plan as~~ required by 33-22-1521."

Section 28. Section 33-22-1512, MCA, is amended to read:

"**33-22-1512. Association plan premium.** The association shall establish the schedule of premiums to be charged eligible persons for membership in the association plan. The schedule of premiums may not be less than 150% or more than 400% of the average premium rates charged by the five ~~largest~~ insurers with the largest premium amount of individual ~~qualified plan~~ plans of major medical insurance in force in this state. The premium rates of the five insurers used to establish the premium rates for each type of coverage offered by the association must be determined by the commissioner from information provided annually by all insurers at the request of the commissioner. ~~The information requested must include the number of qualified plans or actuarial equivalent plans offered by each insurer, the rates charged by the insurer for each type of plan offered by the insurer, and any other information the commissioner considers necessary.~~ The association shall utilize generally acceptable actuarial principles and structurally compatible rates."

Section 29. Section 33-22-1514, MCA, is amended to read:

"**33-22-1514. Administration of association plan -- rules.** ~~(1) Any member of the association may submit to the commissioner policies to be proposed to serve as the association plan. The commissioner shall prescribe by rule the time and manner of the submission.~~

~~(2)~~(1) ~~Upon the commissioner's approval of the policy forms and contracts submitted, the association shall select policies and contracts by a member or members of the association to be the association plan.~~ The association shall select one lead carrier to issue the ~~qualified plans~~ association plan. The board of directors of the association shall prepare appropriate specifications and bid forms and may solicit bids from licensed administrators and the members of the association for the purpose of selecting the lead carrier. The selection of the lead carrier

must be based upon criteria established by the board of directors.

~~(3)~~(2) The lead carrier shall perform all administrative and claims payment functions required by this section upon the commissioner's approval of the policy forms and contracts submitted. The lead carrier shall provide these services for a period of at least 3 years, unless a request to terminate is approved by the association and the commissioner. The association and the commissioner shall approve or deny a request to terminate within 90 days of its receipt. A failure to make a final decision on a request to terminate within the specified period is considered an approval. The association shall invite submissions of policy forms from members of the association, including the lead carrier, 6 months prior to the expiration of each 3-year period. The association shall follow the procedure provided in subsection ~~(2)~~(1) in selecting a lead carrier for the subsequent 3-year period or, if a request to terminate is approved, on or before the end of the 3-year period.

~~(4)~~(3) The lead carrier shall provide all eligible persons involved in the association plan an individual certificate setting forth a statement as to the insurance protection to which the person is entitled, the method and place of filing claims, and to whom benefits are payable. The certificate must indicate that coverage was obtained through the association.

~~(5)~~(4) The lead carrier shall submit to the association and the commissioner on a semiannual basis a report of the operation of the association plan. The association must determine the specific information to be contained in the report prior to the effective date of the association plan.

~~(6)~~(5) The lead carrier shall pay all claims pursuant to this part and shall indicate that the claim was paid by the association plan. Each claim payment must include information specifying the procedure involved in the event a dispute over the amount of payment arises.

~~(7)~~(6) The lead carrier must be reimbursed from the association plan premiums received for its direct and indirect expenses. Direct and indirect expenses include a prorated reimbursement for the portion of the lead carrier's administrative, printing, claims administration, management, and building overhead expenses, which are assignable to the maintenance and administration of the association plan. The association must approve cost accounting methods to substantiate the lead carrier's cost reports consistent with generally accepted accounting principles. Direct and indirect expenses may not include costs directly related to the original submission of policy forms prior to selection as the lead carrier.

~~(8)~~(7) The lead carrier is, when carrying out its duties under this part, an independent contractor for the association and is individually liable for its actions, subject to the laws of this state."

Section 30. Section 33-22-1515, MCA, is amended to read:

"**33-22-1515. Solicitation of eligible persons.** (1) The association, pursuant to a plan approved by the commissioner, shall disseminate appropriate information to the residents of

this state regarding the existence of the association plan and the means of enrollment. Means of communication may include use of the press, radio, and television, as well as publication in appropriate state offices and publications.

(2) The association shall devise and implement means of maintaining public awareness of this part and shall administer this part in a manner which facilitates public participation in the association plan.

(3) All licensed disability insurance producers may engage in the selling or marketing of ~~qualified~~ the association ~~plans~~ plan. The lead carrier shall pay an insurance producer's referral fee of $25 to each licensed disability insurance producer who refers an applicant to the association plan, if the applicant is accepted. The referral fees must be paid ~~to~~ by the lead carrier from money received as premiums for the association plan.

(4) An insurer, society, or health service corporation that rejects or applies underwriting restrictions to an applicant for disability insurance must notify the applicant of the existence of the association plan, requirements for being accepted in it, and the procedure for applying to it."

Section 31. Section 33-22-1516, MCA, is amended to read:

"**33-22-1516. Enrollment by eligible person.** (1) The association plan must be open for enrollment by eligible persons. An eligible person may enroll in the plan by submission of a certificate of eligibility to the lead carrier. The certificate must provide:

(a) the name, address, and age of the applicant and length of the applicant's residence in this state;

(b) the name, address, and age of spouse and children, if any, if they are to be insured;

(c) written evidence that he fulfills all of the elements of an eligible person, as defined in 33-22-1501; and

(d) a designation of coverage desired.

(2) Within 30 days of receipt of the certificate, the lead carrier shall either reject the application for failing to comply with the requirements of subsection (1) or forward the eligible person a notice of acceptance and billing information. Insurance is effective on the first of the month following acceptance.

(3) An eligible person may not purchase more than one policy from the association plan.

(4) A person who obtains coverage pursuant to this section may not be covered for any preexisting condition during the first 12 months of coverage under the association plan if the person was diagnosed or treated for that condition during the 5 years immediately preceding the filing of an application. This subsection does not apply to a person who has had continuous coverage under an individual, family, or group policy during the year immediately preceding the filing of an application and whose cancellation date was within 30 days prior to the date of submission of a certificate of eligibility to the lead carrier for nonelective procedures.

(5) A change of residence from Montana to another state immediately terminates eligibility for renewal of coverage under the association plan."

Section 32. Section 33-22-1521, MCA, is amended to read:

"**33-22-1521. ~~Qualified~~ Association plan -- minimum benefits.** A plan of health coverage must be certified as a ~~qualified~~ association plan if it otherwise meets the requirements of Title 33, chapters 15, 22 (excepting part 7), and 30, and other laws of this state, whether or not the policy is issued in this state, and meets or exceeds the following minimum standards:

(1) The minimum benefits for an insured must, subject to the other provisions of this section, be equal to at least 80% of the covered expenses required by this section in excess of an annual deductible that does not exceed $1,000 per person. The coverage must include a limitation of $5,000 per person on the total annual out-of-pocket expenses for services covered under this section. Coverage must be subject to a maximum lifetime benefit, but such maximums may not be less than $100,000.

(2) Covered expenses must be the usual and customary charges for the following services and articles when prescribed by a physician or other licensed health care professional provided for in 33-22-111:

(a) hospital services;

(b) professional services for the diagnosis or treatment of injuries, illness, or conditions, other than dental;

(c) use of radium or other radioactive materials;

(d) oxygen;

(e) anesthetics;

(f) diagnostic x-rays and laboratory tests, except as specifically provided in subsection (3);

(g) services of a physical therapist;

(h) transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition;

(i) oral surgery for the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth or in connection with TMJ;

(j) rental or purchase of medical equipment, which shall be reimbursed after the deductible has been met at the rate of 50%, up to a maximum of $1,000;

(k) prosthetics, other than dental; and

(l) services of a licensed home health agency, up to a maximum of 180 visits per year.

(3) (a) Covered expenses for the services or articles specified in this section do not include:

(i) drugs requiring a physician's prescription;

(ii) services of a nursing home;

(iii) home and office calls, except as specifically provided in subsection (2);

(iv) rental or purchase of durable medical equipment, except as specifically provided in subsection (2);

(v) the first $20 of diagnostic x-ray and laboratory charges in each 14-day period;

(vi) oral surgery, except as specifically provided in subsection (2);

(vii) that part of a charge for services or articles which exceeds the prevailing charge in the locality where the service is provided; or

(viii) care that is primarily for custodial or domiciliary purposes which would not qualify as eligible services under medicare.

(b) Covered expenses for the services or articles specified in this section do not include charges for:

(i) care or for any injury or disease either arising out of an injury in the course of employment and subject to a workers' compensation or similar law, for which benefits are payable under another policy of disability insurance or medicare;

(ii) treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or congenital bodily defect to restore normal bodily functions;

(iii) travel other than transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition;

(iv) confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as medically necessary by a physician;

(v) services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles;

(vi) organ transplants, including bone marrow transplants;

(vii) room and board for a nonemergency admission on Friday or Saturday;

(viii) pregnancy, except complications of pregnancy;

(ix) routine well baby care;

(x) complications to a newborn, unless no other source of coverage is available;

(xi) sterilization or reversal of sterilization;

(xii) abortion, unless the life of the mother would be endangered if the fetus were carried to term;

(xiii) weight modification or modification of the body to improve the mental or emotional well-being of an insured;

(xiv) artificial insemination or treatment for infertility; or

(xv) breast augmentation or reduction."

Section 33. 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) Except as provided in 33-31-404, rules of pleading ~~or~~

~~evidence~~ need not be observed at any hearing, but the rules of evidence must be observed.

(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 34. {standard} Repealer.** Section 33-22-1522, MCA, is repealed."

DATE 1/10/91

COMMITTEE ON BUSINESS & INDUSTRY

VISITORS' REGISTER

NAME	REPRESENTING	BILL #	Check One	
			Support	Oppose
William Geary	MBA - Helena	SB 20	X	
Dave Bandel	Insurance dept	SB 16 SB 2	X X	
Mary McCue	MTB Helena	SB20	X	
Joe Thares	MT. IND. BANKERS	SB 20	X	
John T Cadby	MT Bankers Assn	SB 20	X	

(Please leave prepared statement with Secretary)

ROLL CALL

BUSINESS & INDUSTRY COMMITTEE

52nd. LEGISLATIVE SESSION -- 1991 Date 1/10/91

NAME	PRESENT	ABSENT	EXCUSED
1 Senator Bruski	X		
2 Senator Franklin	X		
3 Senator Gage	X		
4 Senator Hager	X		
8 Senator Kennedy	X		
9 Senator Lynch	X		
5 Senator Noble	X		
6 Senator Thayer		X	X
7 Senator Williams		X	X

Each day attach to minutes.

ROLL CALL VOTE

SENATE COMMITTEE Business and Industry

Date 1/10/91 Bill No. SB16 Time 10:00

NAME	YES	NO
Senator Bruski	X	
Senator Franklin	X	
Senator Gage	X	
Senator Hager	X	
Senator Noble	X	
Senator Thayer	X	
Senator Williams	X	
Senator Kennedy	X	
Senator Lynch	X	

Dara Anderson
Secretary

JD Lynch
Chairman

Motion: DUE PASS SB16 (WITH ADMENDMTS

1987

ROLL CALL VOTE

SENATE COMMITTEE Business and Industry

Date 1/10/91 Bill No. _____ Time 10:00

NAME	YES	NO
Senator Bruski	X	
Senator Franklin	X	
Senator Gage	X	
Senator Hager	X	
Senator Noble	X	
Senator Thayer	X	
Senator Williams	X	
Senator Kennedy	X	
Senator Lynch	X	

Dara Anderson
Secretary

JD Lynch
Chairman

Motion: AMEND SB16 PASSED

1987

ROLL CALL VOTE

SENATE COMMITTEE Business and Industry

Date 1/10/91 Bill No. SB20 Time 10:00

NAME	YES	NO
Senator Bruski	X	
Senator Franklin	X	
Senator Gage	X	
Senator Hager	X	
Senator Noble	X	
Senator Thayer	X	
Senator Williams	X	
Senator Kennedy	X	
Senator Lynch	X	

Dara Anderson
Secretary

JD Lynch
Chairman

Motion: DUE PASS SB 20

1987

ROLL CALL VOTE

SENATE COMMITTEE Business and Industry

Date 1/10/91 Bill No. 16 SEC. 19 Time 10:00

NAME	YES	NO
Senator Bruski	X	
Senator Franklin	X	
Senator Gage	X	
Senator Hager	X	
Senator Noble	X	
Senator Thayer		✓
Senator Williams	X	
Senator Kennedy	X	
Senator Lynch	X	

Dara Anderson
Secretary

JD Lynch
Chairman

Motion: TO MAKE SEC. 19 A BILL FOR EXEC. ACTION.

1987

STANDING COMMITTEE REPORT

MR. PRESIDENT:

We, your committee on Business and Industry having had under consideration Senate Bill 16 (first reading copy -- white), respectfully report that Senate Bill 16 be amended and as so amended do pass:

1. Title, line 10.
Strike: "AND"

2. Title, line 10.
Following: "SECTIONS"
Insert: "33-1-704,"

3. Title, line 11.
Following: "33-7-406,"
Insert: "33-17-102,"

4. Title, line 13.
Following: "33-22-1504,"
Insert: "33-22-1511, 33-22-1512,"

5. Title, line 13.
Following: "33-22-1513,"
Insert: "33-22-1514, 33-22-1515, 33-22-1516, 33-22-1521,"

6. Title, line 14.
Strike: "33-22-1704,"

7. Title, line 15.
Following: "MCA"
Insert: "; and repealing section 33-22-1522, MCA"

8. Page 22, line 14.
Following: "provision"
Insert: "or the equivalent thereto"

9. Page 26, lines 1 and 2.
Following: "association"
Strike: "through the lead carrier"
Insert: "that is certified by the association as required by 33-22-1521"

10. Page 27, lines 18 through 21.
Strike: subsection (10) in its entirety
Renumber: subsequent subsection

11. Page 31, line 21 through page 33, line 3.
Strike: Section 19 in its entirety

SB 1/10 8:50

Renumber: subsequent sections

12. Page 34, line 23.
Following: "license"
Insert: "to a company"

13. Page 35, line 24.
Following: "~~such~~"
Insert: "the commissioner may not require"

14. Page 35, line 24.
Following: "~~be~~"
Strike: "is not required"

15. Page 36, line 15.
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Insert: "or the equivalent thereto"

18. Page 37, following line 13.
Insert: "

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(1) "Adjuster" means a person who, on behalf of the insurer, for compensation as an independent contractor or as the employee of an independent contractor or for fee or commission investigates and negotiates settlement of claims arising under insurance contracts or otherwise acts on behalf of the insurer. The term does not include a:

(a) licensed attorney who is qualified to practice law in this state;

(b) salaried employee of an insurer or of a managing general agent; or

(c) licensed insurance producer who adjusts or assists in adjustment of losses arising under policies issued by the insurer.

(2) "Adjuster [illegible]

adjusts or settles claims on such coverage.

(b) The term does not mean:

(i) an employer on behalf of its employees or on behalf of the employees of one or more subsidiaries of affiliated corporations of the employer;

(ii) a union on behalf of its members;

(iii) (A) an insurer that is either authorized in this state or acting as an insurer with respect to a policy lawfully issued and delivered by it in and pursuant to the laws of a state in which the insurer is authorized to transact insurance; or

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

(iv) a life, disability, property, or casualty insurance producer who is licensed in this state and whose activities are limited exclusively to the sale of insurance;

(v) a creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors;

(vi) a trust established in conformity with 29 U.S.C. 186 or the trustees, agents, and employees of the trust;

(vii) a trust exempt from taxation under section 501(a) of the Internal Revenue Code or the trustees and employees of the trust;

(viii) a custodian acting pursuant to a custodian account that meets the requirements of section 401(f) of the Internal Revenue Code or the agents and employees of the custodian;

(ix) a bank, credit union, or other financial institution that is subject to supervision or examination by federal or state banking authorities;

(x) a company that issues credit cards and that advances for and collects premiums or charges from its credit card holders who have authorized it to do so, if the company does not adjust or settle claims; or

(xi) a person who adjusts or settles claims in the normal course of his practice or employment as an attorney and who does not collect charges or premiums in connection with life or [illegible] insurance or annuities.

[illegible]istrator license" means a document issued by the [illegible] authorizes a person to act as an administrator.

[illegible] person who for a fee examines, [illegible] an insurance policy, annuity, or [illegible] recommendations [illegible] portion [illegible] the

(8) "Individual" means a private or natural person, as distinguished from a partnership, corporation, or association.

(9) "Insurance producer", except as provided in 33-17-103:

(a) means:

(i) a person who solicits, negotiates, effects, procures, delivers, renews, continues, or binds:

(A) policies of insurance for risks residing, located, or to be performed in this state; or

(B) membership contracts as defined in 33-30-101;

(ii) a managing general agent. For purposes of this definition, a "managing general agent" is a person who, on behalf of an insurer, exercises general supervision over the business of the insurer in this state or in any other state, including the authority to contract with an insurance producer for the insurer and terminate those contracts.

(b) does not mean a customer service representative. For purposes of this definition, a "customer service representative" means a salaried employee of an insurance producer who assists and is responsible to the insurance producer.

(10) "License" means a document issued by the commissioner that authorizes a person to act as an insurance producer for the kinds of insurance specified in the document. The license itself does not create actual, apparent, or inherent authority in the holder to represent or commit an insurer to a binding agreement.

(11) "Person" means an individual, partnership, corporation, association, or other legal entity.

(12) "Public adjuster" means an adjuster employed by and representing the interests of the insured."

Section 27. Section 33-22-1511, MCA, is amended to read:

"33-22-1511. Minimum benefits of association plan. The association through the association plan shall offer a policy that provides at least the benefits ~~of a qualified plan as~~ required by 33-22-1521."

Section 28. Section 33-22-1512, MCA, is amended to read:

"33-22-1512. Association plan premium. The association shall establish the schedule of premiums to be charged eligible persons for membership in the association plan. The schedule of premiums may not be less than 150% or more than 400% of the average premium rates charged by the five ~~largest~~ insurers with the largest premium amount of individual ~~qualified plan~~ plans of major medical insurance in force in this state. The premium rates of the five insurers used to establish the premium rates for each type of coverage offered by the association must be determined by the commissioner from information provided annually by all insurers at the request of the commissioner. ~~The information requested must include the number of qualified plans or actuarial equivalent plans offered by each insurer, the rates charged by~~

~~the insurer for each type of plan offered by the insurer, and any other information the commissioner considers necessary.~~ The association shall utilize generally acceptable actuarial principles and structurally compatible rates."

Section 29. Section 33-22-1514, MCA, is amended to read:

"33-22-1514. Administration of association plan -- rules. ~~(1) Any member of the association may submit to the commissioner policies to be proposed to serve as the association plan. The commissioner shall prescribe by rule the time and manner of the submission.~~

~~(2)~~(1) ~~Upon the commissioner's approval of the policy forms and contracts submitted, the association shall select policies and contracts by a member or members of the association to be the association plan.~~ The association shall select one lead carrier to issue the ~~qualified plans~~ association plan. The board of directors of the association shall prepare appropriate specifications and bid forms and may solicit bids from licensed administrators and the members of the association for the purpose of selecting the lead carrier. The selection of the lead carrier must be based upon criteria established by the board of directors.

~~(3)~~(2) The lead carrier shall perform all administrative and claims payment functions required by this section upon the commissioner's approval of the policy forms and contracts submitted. The lead carrier shall provide these services for a period of at least 3 years, unless a request to terminate is approved by the association and the commissioner. The association and the commissioner shall approve or deny a request to terminate within 90 days of its receipt. A failure to make a final decision on a request to terminate within the specified period is considered an approval. The association shall invite submissions of policy forms from members of the association, including the lead carrier, 6 months prior to the expiration of each 3-year period. The association shall follow the procedure provided in subsection ~~(2)~~(1) in selecting a lead carrier for the subsequent 3-year period or, if a request to terminate is approved, on or before the end of the 3-year period.

~~(4)~~(3) The lead carrier shall provide all eligible persons involved in the association plan an individual certificate setting forth a statement as to the insurance protection to which the person is entitled, the method and place of filing claims, and to whom benefits are payable. The certificate must indicate that coverage was obtained through the association.

~~(5)~~(4) The lead carrier shall submit to the association and the commissioner on a semiannual basis a report of the operation of the association plan. The association must determine the specific information to be contained in the report prior to the effective date of the association plan.

~~(6)~~(5) The lead carrier shall pay all claims pursuant to this part and shall indicate that the claim was paid by the association plan. Each claim payment must include information specifying the procedure involved in the event a dispute over the amount of payment arises.

~~(7)~~(6) The lead carrier must be reimbursed from the association plan premiums received for its direct and indirect expenses. Direct and indirect expenses include a prorated reimbursement for the portion of the lead carrier's administrative, printing, claims administration, management, and building overhead expenses, which are assignable to the maintenance and administration of the association plan. The association must approve cost accounting methods to substantiate the lead carrier's cost reports consistent with generally accepted accounting principles. Direct and indirect expenses may not include costs directly related to the original submission of policy forms prior to selection as the lead carrier.

~~(8)~~(7) The lead carrier is, when carrying out its duties under this part, an independent contractor for the association and is individually liable for its actions, subject to the laws of this state."

Section 30. Section 33-22-1515, MCA, is amended to read:

"33-22-1515. Solicitation of eligible persons. (1) The association, pursuant to a plan approved by the commissioner, shall disseminate appropriate information to the residents of this state regarding the existence of the association plan and the means of enrollment. Means of communication may include use of the press, radio, and television, as well as publication in appropriate state offices and publications.

(2) The association shall devise and implement means of maintaining public awareness of this part and shall administer this part in a manner which facilitates public participation in the association plan.

(3) All licensed disability insurance producers may engage in the selling or marketing of ~~qualified~~ the association ~~plans~~ plan. The lead carrier shall pay an insurance producer's referral fee of $25 to each licensed disability insurance producer who refers an applicant to the association plan, if the applicant is accepted. The referral fees must be paid ~~to~~ by the lead carrier from money received as premiums for the association plan.

(4) An insurer, society, or health service corporation that rejects or applies underwriting restrictions to an applicant for disability insurance must notify the applicant of the existence of the association plan, requirements for being accepted in it, and the procedure for applying to it."

Section 31. Section 33-22-1516, MCA, is amended to read:

"33-22-1516. Enrollment by eligible person. (1) The

association plan must be open for enrollment by eligible persons. An eligible person may enroll in the plan by submission of a certificate of eligibility to the lead carrier. The certificate must provide:

(a) the name, address, and age of the applicant and length of the applicant's residence in this state;

(b) the name, address, and age of spouse and children, if any, if they are to be insured;

(c) written evidence that he fulfills all of the elements of an eligible person, as defined in 33-22-1501; and

(d) a designation of coverage desired.

(2) Within 30 days of receipt of the certificate, the lead carrier shall either reject the application for failing to comply with the requirements of subsection (1) or forward the eligible person a notice of acceptance and billing information. Insurance is effective on the first of the month following acceptance.

(3) An eligible person may not purchase more than one policy from the association plan.

(4) A person who obtains coverage pursuant to this section may not be covered for any preexisting condition during the first 12 months of coverage under the association plan if the person was diagnosed or treated for that condition during the 5 years immediately preceding the filing of an application. This subsection does not apply to a person who has had continuous coverage under an individual, family, or group policy during the year immediately preceding the filing of an application and whose cancellation date was within 30 days prior to the date of submission of a certificate of eligibility to the lead carrier for nonelective procedures.

(5) A change of residence from Montana to another state immediately terminates eligibility for renewal of coverage under the association plan."

Section 32. Section 33-22-1521, MCA, is amended to read:

"33-22-1521. ~~Qualified~~ Association plan -- minimum benefits. A plan of health coverage must be certified as a ~~qualified~~ association plan if it otherwise meets the requirements of Title 33, chapters 15, 22 (excepting part 7), and 30, and other laws of this state, whether or not the policy is issued in this state, and meets or exceeds the following minimum standards:

(1) The minimum benefits for an insured must, subject to the other provisions of this section, be equal to at least 80% of the covered expenses required by this section in excess of an annual deductible that does not exceed $1,000 per person. The coverage must include a limitation of $5,000 per person on the total annual out-of-pocket expenses for services covered under this section. Coverage must be subject to a maximum lifetime benefit, but such maximums may not be less than $100,000.

(2) Covered expenses must be the usual and customary charges for the following services and articles when prescribed by a physician or other licensed health care professional provided for in 33-22-111:

(a) hospital services;

(b) professional services for the diagnosis or treatment of injuries, illness, or conditions, other than dental;

(c) use of radium or other radioactive materials;

(d) oxygen;

(e) anesthetics;

(f) diagnostic x-rays and laboratory tests, except as specifically provided in subsection (3);

(g) services of a physical therapist;

(h) transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition;

(i) oral surgery for the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth or in connection with TMJ;

(j) rental or purchase of medical equipment, which shall be reimbursed after the deductible has been met at the rate of 50%, up to a maximum of $1,000;

(k) prosthetics, other than dental; and

(l) services of a licensed home health agency, up to a maximum of 180 visits per year.

(3) (a) Covered expenses for the services or articles specified in this section do not include:

(i) drugs requiring a physician's prescription;

(ii) services of a nursing home;

(iii) home and office calls, except as specifically provided in subsection (2);

(iv) rental or purchase of durable medical equipment, except as specifically provided in subsection (2);

(v) the first $20 of diagnostic x-ray and laboratory charges in each 14-day period;

(vi) oral surgery, except as specifically provided in subsection (2);

(vii) that part of a charge for services or articles which exceeds the prevailing charge in the locality where the service is provided; or

(viii) care that is primarily for custodial or domiciliary purposes which would not qualify as eligible services under medicare.

(b) Covered expenses for the services or articles specified in this section do not include charges for:

(i) care or for any injury or disease either arising out of an injury in the course of employment and subject to a workers' compensation or similar law, for which benefits are payable under another policy of disability insurance or medicare;

(ii) treatment for cosmetic purposes other than surgery for

the repair or treatment of an injury or congenital bodily defect to restore normal bodily functions;

(iii) travel other than transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition;

(iv) confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as medically necessary by a physician;

(v) services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles;

(vi) organ transplants, including bone marrow transplants;

(vii) room and board for a nonemergency admission on Friday or Saturday;

(viii) pregnancy, except complications of pregnancy;

(ix) routine well baby care;

(x) complications to a newborn, unless no other source of coverage is available;

(xi) sterilization or reversal of sterilization;

(xii) abortion, unless the life of the mother would be endangered if the fetus were carried to term;

(xiii) weight modification or modification of the body to improve the mental or emotional well-being of an insured;

(xiv) artificial insemination or treatment for infertility; or

(xv) breast augmentation or reduction."

Section 33. 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) Except as provided in 33-31-404, rules of pleading ~~or evidence~~ need not be observed at any hearing, but the rules of evidence must be observed.

(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 34. {standard} Repealer. Section 33-22-1522, MCA, is repealed."

Renumber: subsequent sections

Signed: _____
John "J.D." Lynch, Chairman

STANDING COMMITTEE REPORT

January 10, 1991

MR. PRESIDENT:

We, your committee on Business and Industry having had under consideration Senate Bill 20 (first reading copy -- white), respectfully report that Senate Bill 20 do pass.

Signed: _____
John "J.D." Lynch, Chairman

SB 1/10 2:50

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