SENATE BILL NO. 353

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

BY REQUEST OF THE STATE AUDITOR

IN THE SENATE

FEBRUARY 16, 1987	INTRODUCED AND REFERRED TO COMMITTEE ON PUBLIC HEALTH, WELFARE & SAFETY.
FEBRUARY 21, 1987	COMMITTEE RECOMMEND BILL DO PASS AS AMENDED. REPORT ADOPTED.
	STATEMENT OF INTENT ADOPTED.
FEBRUARY 24, 1987	PRINTING REPORT.
	SECOND READING, DO PASS.
FEBRUARY 25, 1987	ENGROSSING REPORT.
	THIRD READING, PASSED. AYES, 50; NOES, 0.
	TRANSMITTED TO HOUSE.

IN THE HOUSE

MARCH 3, 1987	INTRODUCED AND REFERRED TO COMMITTEE ON HUMAN SERVICES & AGING.
MARCH 13, 1987	ON MOTION, REREFERRED TO COMMITTEE ON BUSINESS & LABOR.
MARCH 27, 1987	COMMITTEE RECOMMEND BILL BE CONCURRED IN AS AMENDED. REPORT ADOPTED.
MARCH 28, 1987	SECOND READING, CONCURRED IN.
MARCH 30, 1987	THIRD READING, CONCURRED IN. AYES, 97; NOES, 1.
	RETURNED TO SENATE WITH AMENDMENTS.

IN THE SENATE

APRIL 2, 1987	RECEIVED FROM HOUSE.
	SECOND READING, AMENDMENTS CONCURRED IN.
APRIL 3, 1987	THIRD READING, AMENDMENTS CONCURRED IN.
	SENT TO ENROLLING.

1 Senate BILL NO. 353
2 INTRODUCED BY Meyer, Lory, Bengtson, Miller, Mazurek, Sands
3 BY REQUEST OF THE STATE AUDITOR
4
5 A BILL FOR AN ACT ENTITLED: "AN ACT TO REGULATE THE
6 FORMATION AND OPERATION OF HEALTH MAINTENANCE ORGANIZATIONS;
7 AMENDING SECTIONS 17-7-502 AND 33-22-111, MCA; AND PROVIDING
8 AN IMMEDIATE EFFECTIVE DATE AND AN APPLICABILITY PROVISION."
9
10 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:
11 NEW SECTION. Section 1. Short title. This act may be
12 cited as the "Montana Health Maintenance Organization Act".
13 NEW SECTION. Section 2. Definitions. As used in
14 [sections 1 through 29], unless the context requires
15 otherwise, the following definitions apply:
16 (1) "Agent" means an individual, partnership, or
17 corporation appointed or authorized by a health maintenance
18 organization to solicit applications for health care
19 services agreements on its behalf.
20 (2) "Basic health care services" means:
21 (a) consultative, diagnostic, therapeutic, and
22 referral services by a provider;
23 (b) inpatient hospital and provider care;
24 (c) outpatient medical services;
25 (d) medical treatment and referral services;

1 (e) accident and sickness services by a provider to
2 each newborn infant of an enrollee pursuant to [section
3 8(3)(e)];
4 (f) diagnostic laboratory and diagnostic and
5 therapeutic radiologic services; and
6 (g) preventive health services, including:
7 (i) immunizations;
8 (ii) well-child care from birth;
9 (iii) periodic health evaluations for adults;
10 (iv) voluntary family planning services;
11 (v) infertility services; and
12 (vi) children's eye and ear examinations conducted to
13 determine the need for vision and hearing correction.
14 (3) "Commissioner" means the commissioner of insurance
15 of the state of Montana.
16 (4) "Department of health" means the department of
17 health and environmental sciences provided for in 2-15-2101.
18 (5) "Director" means the director of the department of
19 health and environmental sciences provided for in 2-15-2102.
20 (6) "Enrollee" means a person:
21 (a) who enrolls in or contracts with a health
22 maintenance organization;
23 (b) on whose behalf a contract is made with a health
24 maintenance organization to receive health care services; or
25 (c) on whose behalf the health maintenance

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1 organization contracts to receive health care services.
2 (7) "Evidence of coverage" means a certificate,
3 agreement, policy, or contract issued to an enrollee setting
4 forth the coverage to which the enrollee is entitled.
5 (8) "Health care services" means:
6 (a) the services included in furnishing medical or
7 dental care to a person;
8 (b) the services included in hospitalizing a person;
9 (c) the services incident to furnishing medical or
10 dental care or hospitalization; or
11 (d) the services included in furnishing to a person
12 other services for the purpose of preventing, alleviating,
13 curing, or healing illness, injury, or physical disability.
14 (9) "Health care services agreement" means an
15 agreement for health care services between a health
16 maintenance organization and an enrollee.
17 (10) "Health maintenance organization" means a person
18 who provides or arranges for basic health care services to
19 enrollees on a prepaid or other financial basis, either
20 directly through provider employees or through contractual
21 or other arrangements with a provider or a group of
22 providers.
23 (11) "Person" means:
24 (a) an individual;
25 (b) a group of individuals;

1 (c) an insurer, as defined in 33-1-201;
2 (d) a health service corporation, as defined in
3 33-30-101;
4 (e) a corporation, partnership, facility, association,
5 or trust; or
6 (f) an institution of a governmental unit of any state
7 licensed by that state to provide health care, including but
8 not limited to a physician, hospital, hospital-related
9 facility, or long-term care facility.
10 (12) "Provider" means a physician, hospital,
11 hospital-related facility, long-term care facility, dentist,
12 osteopath, chiropractor, optometrist, podiatrist,
13 psychologist, licensed social worker, registered pharmacist,
14 or nurse specialist as specifically listed in 37-8-202 who
15 treats any illness or injury within the scope and
16 limitations of his practice or other person who is licensed
17 or otherwise authorized in this state to furnish health care
18 services.
19 (13) "Uncovered expenditures" mean the costs of health
20 care services that are covered by a health maintenance
21 organization and for which an enrollee is liable if the
22 health maintenance organization becomes insolvent.
23 NEW SECTION. Section 3. Establishment of health
24 maintenance organizations. (1) Notwithstanding any law of
25 this state to the contrary, a person may apply to the

1 commissioner for and obtain a certificate of authority to
2 establish and operate a health maintenance organization in
3 compliance with [sections 1 through 29]. A person may not
4 establish or operate a health maintenance organization in
5 this state except as authorized by a subsisting certificate
6 of authority issued to it by the commissioner. A foreign
7 person may qualify for a certificate of authority if it
8 first obtains from the secretary of state a certificate of
9 authority to transact business in this state as a foreign
10 corporation under 35-1-1001.
11 (2) Each health maintenance organization operating in
12 this state as of [the effective date of this act] shall
13 submit an application for a certificate of authority under
14 subsection (3) within 30 days of [the effective date of this
15 act]. Each such applicant may continue to operate in this
16 state until the commissioner acts upon the application. If
17 an application is denied under [section 4], the applicant
18 must be treated as a health maintenance organization whose
19 certificate of authority has been revoked.
20 (3) Each application of a health maintenance
21 organization, whether separately licensed or not, for a
22 certificate of authority must:
23 (a) be verified by an officer or authorized
24 representative of the applicant;
25 (b) be in a form prescribed by the commissioner;

1 (c) contain:
2 (i) the applicant's name;
3 (ii) the location of the applicant's home office or
4 principal office in the United States (if a foreign person);
5 (iii) the date of organization or incorporation;
6 (iv) the form of organization (including whether the
7 providers affiliated with the health maintenance
8 organization will be salaried employees or group or
9 individual contractors);
10 (v) the state or country of domicile; and
11 (vi) any additional information the commissioner may
12 reasonably require; and
13 (d) set forth the following information or be
14 accompanied by the following documents, as applicable:
15 (i) a copy of the applicant's organizational
16 documents, such as its corporate charters or articles of
17 incorporation, articles of association, partnership
18 agreement, trust agreement, or other applicable documents,
19 and all amendments thereto, certified by the public officer
20 with whom the originals were filed in the state or country
21 of domicile;
22 (ii) a copy of the bylaws, rules, and regulations, or
23 similar document, if any, regulating the conduct of the
24 applicant's internal affairs, certified by its secretary or
25 other officer having custody thereof;

1 (iii) a list of the names, addresses, and official
2 positions of the persons responsible for the conduct of the
3 applicant's affairs, including all members of the board of
4 directors, board of trustees, executive committee, or other
5 governing board or committee; the principal officers in the
6 case of a corporation; and the partners or members in the
7 case of a partnership or association;
8 (iv) a copy of any contract made or to be made between:
9 (A) any provider and the applicant; or
10 (B) any person listed in subsection (3)(d)(iii) and
11 the applicant. The applicant may file a list of providers
12 executing a standard contract and a copy of the contract
13 instead of copies of each executed contract.
14 (v) the extent to which any of the following will be
15 included in provider contracts and the form of any
16 provisions that:
17 (A) limit a provider's ability to seek reimbursement
18 for basic health care services or health care services from
19 an enrollee;
20 (B) permit or require a provider to assume a financial
21 risk in the health maintenance organization, including any
22 provisions for assessing the provider, adjusting capitation
23 or fee-for-service rates, or sharing in the earnings or
24 losses; and
25 (C) govern amending or terminating an agreement with a

1 provider;
2 (vi) a financial statement showing the applicant's
3 assets, liabilities, and sources of financial support. If
4 the applicant's financial affairs are audited by independent
5 certified public accountants, a copy of the applicant's most
6 recent certified financial statement satisfies this
7 requirement unless the commissioner directs that additional
8 or more recent financial information is required for the
9 proper administration of [sections 1 through 29].
10 (vii) a description of the proposed method of
11 marketing, a financial plan that includes a projection of
12 operating results anticipated until the organization has had
13 net income for at least 1 year, and a statement as to the
14 sources of working capital as well as any other source of
15 funding;
16 (viii) a summary of feasibility studies or marketing
17 surveys that support the financial and enrollment
18 projections for the plan, including the potential number of
19 enrollees in the operating territory, the projected number
20 of enrollees for the first 5 years, the underwriting
21 standards to be applied, and the method of marketing the
22 organization;
23 (ix) a power of attorney executed by the applicant, on
24 a form prescribed by the commissioner, appointing the
25 commissioner, his successors in office, and his authorized

1 deputies as the applicant's attorney to receive service of
2 legal process issued against it in this state;
3 (x) a statement reasonably describing the geographic
4 service area or areas to be served by county, including:
5 (A) a chart showing the number of primary and
6 specialty care providers with locations and service areas by
7 county;
8 (B) the method of handling emergency care, with the
9 location of each emergency care facility; and
10 (C) the method of handling out-of-area services;
11 (xi) a description of the way in which the health
12 maintenance organization provides services to enrollees in
13 each geographic service area, including the extent to which
14 a provider under contract with the health maintenance
15 organization provides primary care to those enrollees;
16 (xii) a description of the complaint procedures to be
17 used as required under [section 11];
18 (xiii) a description of the procedures and programs to
19 be implemented to meet the quality of health care
20 requirements in [section 4];
21 (xiv) a description of the mechanism by which enrollees
22 will be afforded an opportunity to participate in matters of
23 policy and operation under [section 6];
24 (xv) a summary of the way in which administrative
25 services will be provided, including the size and

1 qualifications of the administrative staff and the projected
2 cost of administration in relation to premium income. If the
3 health maintenance organization delegates management
4 authority for a major corporate function to a person outside
5 the organization, the health maintenance organization shall
6 include a copy of the contract in its application for a
7 certificate of authority. Contracts for delegated management
8 authority must be filed for approval with the commissioner
9 in accordance with the filing provisions of [section 8(7)].
10 All contracts must include:
11 (A) the services to be provided;
12 (B) the standards of performance for the manager;
13 (C) the method of payment, including any provisions
14 for the administrator to participate in the profits or
15 losses of the plan;
16 (D) the duration of the contract; and
17 (E) any provisions for modifying, terminating, or
18 renewing the contract.
19 (xvi) a summary of current and projected enrollment,
20 income from premiums by type of payer, other income,
21 administrative and other costs, the projected break-even
22 point (including the method of funding the accumulated
23 losses until the break-even point is reached), and the
24 assumptions made in developing projected operating results;
25 (xvii) 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) a summary of benefits to be offered enrollees, including any limitations and exclusions and the renewability of all contracts to be written;

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

(xx) 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 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.

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

1 personnel and facilities and enhancing availability,
2 accessibility, and continuity of service;
3 (b) arrangements, established in accordance with the
4 rules made by the department of health, for an ongoing
5 quality assurance program concerning health care processes
6 and outcomes; and
7 (c) a procedure, established in accordance with rules
8 of the department of health, to develop, compile, evaluate,
9 and report statistics relating to the cost of its
10 operations, the pattern of utilization of its services, the
11 availability and accessibility of its services, and any
12 other matters as may be reasonably required by the
13 department of health.
14 (2) Within 90 days of receipt of the application from
15 a health maintenance organization for issuance of a
16 certificate of authority, the department of health shall
17 certify to the commissioner that the proposed health
18 maintenance organization meets the requirements of
19 subsection (1) or shall notify the commissioner that the
20 health maintenance organization does not meet those
21 requirements and specify in what respects it is deficient.
22 The director may extend by not more than an additional 30
23 days the period within which he may certify to the
24 commissioner that the proposed health maintenance
25 organization meets or does not meet the requirements of

1 subsection (1) by giving notice of the extension to the
2 commissioner and the health maintenance organization before
3 the expiration of the initial 90-day period.
4 (3) The commissioner shall issue or deny a certificate
5 of authority to any person filing an application pursuant to
6 [section 3] within 180 days of receipt of the certification
7 from the department of health. The commissioner shall grant
8 a certificate of authority upon payment of the application
9 fee prescribed in [section 22] if the commissioner is
10 satisfied that each of the following conditions is met:
11 (a) The persons responsible for the conduct of the
12 applicant's affairs are competent, trustworthy, and of good
13 reputation.
14 (b) The department of health certifies, in accordance
15 with subsection (2), that the health maintenance
16 organization's proposed plan of operation meets the
17 requirements of subsection (1).
18 (c) The health maintenance organization will
19 effectively provide or arrange for the provision of basic
20 health care services on a prepaid basis, through insurance
21 or otherwise, except to the extent of reasonable
22 requirements for copayments.
23 (d) The health maintenance organization is financially
24 responsible and can reasonably be expected to meet its
25 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.

(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].

<u>NEW SECTION.</u> 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,

1 enrollment, and administration;
2 (e) the contracting with an insurer authorized to
3 transact insurance in this state, or with a health service
4 corporation authorized to do business in this state, for the
5 provision of insurance, indemnity, or reimbursement against
6 the cost of health care services provided by the health
7 maintenance organization; and
8 (f) the offering of other health care services in
9 addition to basic health care services.
10 (2) A health maintenance organization shall file
11 notice, with adequate supporting information, with the
12 commissioner before exercising a power granted in subsection
13 (1)(a), (1)(b), or (1)(d). The commissioner may disapprove
14 the exercise of a power only if, in his opinion, it would
15 substantially and adversely affect the financial soundness
16 of the health maintenance organization and endanger its
17 ability to meet its obligations. The commissioner may make
18 reasonable rules exempting from the filing requirement of
19 this subsection those activities having a de minimis effect.
20 The exercise of authority granted in subsections (1)(a),
21 (1)(b), and (1)(d) is subject to disapproval by the
22 commissioner. The commissioner may exempt certain contracts
23 from the filing requirement whenever exercise of the
24 authority granted in this section would have little or no
25 effect on the health maintenance organization's financial

1 condition and ability to meet obligations.
2 (3) Nothing in this section exempts the activities of
3 a health maintenance organization from any applicable
4 certificate of need requirements under Title 50, chapter 5,
5 parts 1 and 3.
6 NEW SECTION. Section 6. Governing body. (1) The
7 governing body of a health maintenance organization may
8 include providers or other individuals, or both.
9 (2) The governing body shall establish a mechanism to
10 give the enrollees an opportunity to participate in matters
11 of policy and operation through the establishment of
12 advisory panels, by the use of advisory referenda on major
13 policy decisions, or through the use of other mechanisms.
14 NEW SECTION. Section 7. Fiduciary responsibilities.
15 (1) Any director, officer, employee, or partner of a health
16 maintenance organization who receives, collects, disburses,
17 or invests funds in connection with the activities of the
18 health maintenance organization is responsible for the funds
19 in the manner of a fiduciary to the health maintenance
20 organization.
21 (2) A health maintenance organization shall maintain
22 in force a fidelity bond on employees and officers in an
23 amount not less than $100,000 or such other sum as may be
24 prescribed by the commissioner. Each bond must be written
25 with at least a 1-year discovery period and, if written with

1 less than a 3-year discovery period, must contain a
2 provision that a cancellation or termination of the bond,
3 whether by or at the request of the insured or by the
4 underwriter, may not take effect prior to the expiration of
5 90 days after written notice of the cancellation or
6 termination has been filed with the commissioner unless the
7 commissioner approves an earlier cancellation or termination
8 date.

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

19 (2) A health maintenance organization may not issue or
20 deliver an enrollment form, an evidence of coverage, or an
21 amendment to an approved enrollment form or evidence of
22 coverage to a person in this state before a copy of the
23 enrollment form, the evidence of coverage, or the amendment
24 to the approved enrollment form or evidence of coverage is
25 filed with and approved by the commissioner.

1 (3) An evidence of coverage issued or delivered to a
2 person resident in this state may not contain a provision or
3 statement that is unjust, unfair, inequitable, misleading,
4 or deceptive; that encourages misrepresentation; or that is
5 untrue, misleading, or deceptive as defined in [section
6 14(1)]. The evidence of coverage must contain:

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

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

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

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

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

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

23 (b) definitions of geographical service area,
24 emergency care, urgent care, out-of-area services,
25 dependent, and primary provider, if these terms or terms of

1 similar meaning are used in the evidence of coverage and
2 have an effect on the benefits covered by the plan. The
3 definition of geographical service area need not be stated
4 in the text of the evidence of coverage if the definition is
5 adequately described in an attachment, which is given to
6 each enrollee along with the evidence of coverage.
7 (c) clear disclosure of each provision that limits
8 benefits or access to service in the exclusions,
9 limitations, and exceptions sections of the evidence of
10 coverage. The exclusions, limitations, and exceptions that
11 must be disclosed include but are not limited to:
12 (i) emergency and urgent care;
13 (ii) restrictions on the selection of primary or
14 referral providers;
15 (iii) restrictions on changing providers during the
16 contract period;
17 (iv) out-of-pocket costs, including copayments and
18 deductibles;
19 (v) charges for missed appointments or other
20 administrative sanctions;
21 (vi) restrictions on access to care if copayments or
22 other charges are not paid; and
23 (vii) any restrictions on coverage for dependents who
24 do not reside in the service area.
25 (d) clear disclosure of any benefits for home health

1 care, skilled nursing care, kidney disease treatment,
2 diabetes, maternity benefits for dependent children,
3 alcoholism and other drug abuse, and nervous and mental
4 disorders;
5 (e) a provision requiring immediate accident and
6 sickness coverage, from and after the moment of birth, to
7 each newborn infant of an enrollee or his dependents;
8 (f) a provision offering medical treatment and
9 referral services to appropriate ancillary services for
10 mental illness and for the abuse of or addiction to alcohol
11 or drugs in accordance with the limits provided in
12 33-22-703;
13 (g) a provision as follows:
14 "Conformity With State Statutes: Any provision of this
15 evidence of coverage that on its effective date is in
16 conflict with the statutes of the state in which the insured
17 resides on that date is hereby amended to conform to the
18 minimum requirements of those statutes."
19 (h) a provision that the health maintenance
20 organization shall issue, without evidence of insurability,
21 to the enrollee, his dependents, or family members
22 continuing coverage on the enrollee, his dependents, or
23 family members:
24 (i) if the evidence of coverage or any portion of it
25 on an enrollee, his dependents, or family members covered

1 under the evidence of coverage ceases because of termination
2 of employment or of his membership in the class or classes
3 eligible for coverage under the policy or because his
4 employer discontinues his business or the coverage;
5 (ii) if the enrollee had been enrolled in the health
6 maintenance organization for a period of 3 months preceding
7 the termination of group coverage; and
8 (iii) if the enrollee applied for continuing coverage
9 within 31 days after the termination of group coverage. The
10 conversion contract may not exclude, as a preexisting
11 condition, any condition covered by the group contract from
12 which the enrollee converts.
13 (i) a provision that clearly describes the amount of
14 money an enrollee shall pay to the health maintenance
15 organization to be covered for basic health care services.
16 (4) A health maintenance organization may amend an
17 enrollment form or an evidence of coverage in a separate
18 document if the separate document is filed with and approved
19 by the commissioner and issued to the enrollee.
20 (5) (a) A health maintenance organization shall
21 provide the same coverage for newborn infants, required by
22 subsection (3)(e), as it provides for enrollees, except that
23 for newborn infants there may be no waiting or elimination
24 periods. A health maintenance organization may not assess a
25 deductible or reduce benefits applicable to the coverage for

1 newborn infants unless the deductible or reduction in
2 benefits is consistent with the deductible or reduction in
3 benefits applicable to all covered persons.
4 (b) A health maintenance organization may not issue or
5 amend an evidence of coverage in this state if it contains
6 any disclaimer, waiver, or other limitation of coverage
7 relative to the accident and sickness coverage or
8 insurability of newborn infants of an enrollee or his
9 dependents from and after the moment of birth.
10 (c) If a health maintenance organization requires
11 payment of a specific fee to provide coverage of a newborn
12 infant beyond 31 days of the date of birth of the infant,
13 the evidence of coverage may contain a provision that
14 requires notification to the health maintenance
15 organization, within 31 days after the date of birth, of the
16 birth of an infant and payment of the required fee.
17 (6) A health maintenance organization may not use a
18 schedule of charges for enrollee coverage for health care
19 services or an amendment to a schedule of charges before it
20 files a copy of the schedule of charges or the amendment to
21 it with the commissioner. A health maintenance organization
22 may evidence a subsequent amendment to a schedule of charges
23 in a separate document issued to the enrollee. The charges
24 in the schedule must be established in accordance with
25 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, 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 information he

considers necessary in determining whether to approve or disapprove a filing made pursuant to this section.

<u>NEW SECTION.</u> Section 9. Annual statement -- revocation for failure to file -- penalty for perjury. (1) 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 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].

NEW SECTION. Section 10. Information to enrollees. Each authorized health maintenance organization shall promptly provide to its enrollees notice 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).

1 (3) The commissioner may examine a complaint system.
2 NEW SECTION. Section 12. Investment regulations. A
3 domestic health maintenance organization may invest its
4 funds only as prescribed in rules adopted by the
5 commissioner.
6 NEW SECTION. Section 13. Protection against
7 insolvency. (1) Except as provided in subsections (4)
8 through (7), each authorized health maintenance organization
9 shall deposit with the commissioner cash, securities, or any
10 combination of cash or securities acceptable to the
11 commissioner in the amount set forth in this section.
12 (2) The amount of the deposit for a health maintenance
13 organization during the first year of its operation must be
14 the greater of:
15 (a) 5% of its estimated expenditures for health care
16 services for its first year of operation;
17 (b) twice its estimated average monthly uncovered
18 expenditures for its first year of operation; or
19 (c) $100,000.
20 (3) At the beginning of each succeeding year, unless
21 not applicable, the health maintenance organization shall
22 deposit with the commissioner cash, securities, or any
23 combination of cash or securities acceptable to the
24 commissioner, in an amount equal to 4% of its estimated
25 annual uncovered expenditures for that year.

1 (4) Unless not applicable, a health maintenance
2 organization that is in operation on [the effective date of
3 this act] shall make a deposit equal to the greater of:
4 (a) 1% of the preceding 12 months' uncovered
5 expenditures; or
6 (b) $100,000 on the first day of the fiscal year
7 beginning 6 months or more after [the effective date of this
8 act]. In the second fiscal year, if applicable, the amount
9 of the additional deposit must be equal to 2% of its
10 estimated annual uncovered expenditures. In the third fiscal
11 year, if applicable, the additional deposit must be equal to
12 3% of its estimated annual uncovered expenditures for that
13 year. In the fourth fiscal year and subsequent years, if
14 applicable, the additional deposit must be equal to 4% of
15 its estimated annual uncovered expenditures for each year.
16 Each year's estimate after the first year of operation must
17 reasonably reflect the preceding year's operating experience
18 and delivery arrangements.
19 (5) The commissioner may in his discretion waive any
20 of the deposit requirements set forth in subsections (1)
21 through (4) whenever he is satisfied that:
22 (a) the health maintenance organization has sufficient
23 net worth and an adequate history of generating net income
24 to assure its financial viability for the next year;
25 (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 [illegible] 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

1 the annual deposit requirement. If the amount of net worth
2 no longer supports a reduction of its required deposit, the
3 health maintenance organization shall immediately redeposit
4 $100,000 for each $250,000 of reduction in net worth, except
5 that its total deposit may not be required to exceed the
6 maximum required under this section.
7 (9) Each health maintenance organization shall have a
8 minimum capital of at least $200,000 in addition to any
9 deposit requirements under this section. The capital account
10 must be in excess of any accrued liabilities and be in the
11 form of cash, securities, or any combination of cash or
12 securities acceptable to the commissioner.
13 (10) Each health maintenance organization shall
14 demonstrate that if it becomes insolvent:
15 (a) enrollees hospitalized on the date of insolvency
16 will be covered until discharged; and
17 (b) enrollees will be entitled to similar alternate
18 insurance coverage that does not contain any medical
19 underwriting or preexisting limitation requirements.
20 NEW SECTION. Section 14. Prohibited practices. (1) A
21 health maintenance organization, or representative thereof,
22 may not cause or knowingly permit the use of advertising
23 that is untrue or misleading, solicitation that is untrue or
24 misleading, or any form of evidence of coverage that is
25 deceptive. For purposes of [sections 1 through 29]:

1 (a) a statement or item of information is considered
2 to be untrue if it does not conform to fact in any respect
3 that is or may be significant to an enrollee of, or person
4 considering enrollment in, a health maintenance
5 organization;
6 (b) a statement or item of information is considered
7 to be misleading, whether or not it may be literally untrue,
8 if, in the total context in which the statement is made or
9 the item of information is communicated, a reasonable
10 person, not possessing special knowledge regarding health
11 care coverage, may reasonably understand the statement or
12 item of information as indicating a benefit or advantage or
13 the absence of an exclusion, limitation, or disadvantage of
14 possible significance to an enrollee of, or person
15 considering enrollment in, a health maintenance organization
16 if the benefit or advantage or absence of limitation,
17 exclusion, or disadvantage does not in fact exist; and
18 (c) an evidence of coverage is considered to be
19 deceptive if, when taken as a whole and with consideration
20 given to typography, format, and language, it can cause a
21 reasonable person, not possessing special knowledge
22 regarding health maintenance organizations, to expect
23 benefits, services, charges, or other advantages that the
24 evidence of coverage does not provide or which the health
25 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) 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 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 months elapses, whichever comes first. The

1 premium on the individual coverage must be at the
2 then-customary rate applicable to the individual coverage
3 offered by the insurer, health service corporation, or
4 health maintenance organization that provides the alternate
5 insurance coverage.
6 (b) If a health maintenance organization disenrolls an
7 enrollee covered on an individual basis for any reason
8 except failure to pay required premiums, coverage must be
9 continued until the anniversary date of the policy or for 1
10 year, whichever is earlier. A health maintenance
11 organization that disenrolls an individual enrollee for
12 failure to pay a required premium or for fraudulent
13 statements on the enrollment form need not provide alternate
14 insurance coverage to that enrollee.
15 (6) A health maintenance organization may not refer to
16 itself as an insurer unless licensed as an insurer or use a
17 name deceptively similar to the name or description of an
18 insurer authorized to transact insurance in this state.
19 (7) A person may not refer to itself as a health
20 maintenance organization or HMO unless it holds a valid
21 certificate of authority issued by the commissioner.
22 NEW SECTION. Section 15. Agent license required --
23 application, issuance, renewal, fees -- penalty. (1) No
24 individual, partnership, or corporation may act as or hold
25 himself out to be an agent of a health maintenance

1 organization unless he is:
2 (a) licensed as a disability insurance agent by the
3 commissioner pursuant to chapter 17, parts 1, 2, and 4 of
4 this title; and
5 (b) appointed or authorized by the health maintenance
6 organization to solicit health care service agreements on
7 its behalf.
8 (2) Application, appointment and qualification for a
9 health maintenance organization agent license, fees
10 applicable to and the issuance of a health maintenance
11 organization agent license, and renewal of a health
12 maintenance organization agent license must be in accordance
13 with the provisions of chapter 17 that apply to a disability
14 insurance agent.
15 (3) An individual, partnership, or corporation who
16 holds a disability insurance agent license on [the effective
17 date of this act] need not requalify by an examination to be
18 licensed as a health maintenance organization agent.
19 (4) The commissioner may, in accordance with 33-1-313,
20 33-1-317, 33-17-411, and chapter 17, part 10, suspend,
21 revoke, refuse to issue or renew a health maintenance
22 organization agent license, or impose a fine upon the
23 licensee.
24 NEW SECTION. Section 16. Powers of insurers and
25 health service corporations. (1) An insurer authorized to

1 transact insurance in this state or a health service
2 corporation authorized to do business in this state may,
3 either directly or through a subsidiary or affiliate,
4 organize and operate a health maintenance organization under
5 the provisions of [sections 1 through 29]. Notwithstanding
6 any other law which may be inconsistent with this section,
7 two or more insurers, health service corporations, or
8 subsidiaries or affiliates thereof may jointly organize and
9 operate a health maintenance organization. The business of
10 insurance is considered to include the provision of health
11 care services by a health maintenance organization owned or
12 operated by an insurer or a subsidiary thereof.
13 (2) Notwithstanding any insurance or health service
14 corporation laws, an insurer or a health service corporation
15 may contract with a health maintenance organization to
16 provide insurance or similar protection against the cost of
17 care provided through a health maintenance organization and
18 to provide coverage if the health maintenance organization
19 fails to meet its obligations.
20 (3) The enrollees of a health maintenance organization
21 constitute a permissible group under this title. The insurer
22 or health service corporation may make benefit payments to
23 health maintenance organizations for health care services
24 rendered by providers under the contracts described in
25 subsection (2).

1 (4) Nothing in this section exempts a health
2 maintenance organization that provides health care services
3 from complying with the applicable certificate of need
4 requirements under Title 50, chapter 5, parts 1 and 3.
5 NEW SECTION. Section 17. Examination. (1) The
6 commissioner may examine the affairs of a health maintenance
7 organization and the providers with whom the health
8 maintenance organization has contracts, agreements, or other
9 arrangements as often as is reasonably necessary to protect
10 the interests of the people of this state. The commissioner
11 shall make such an examination at least once every 3 years.
12 (2) The department of health may examine the quality
13 of the health care services provided by any health
14 maintenance organization and the providers with whom the
15 health maintenance organization has contracts, agreements,
16 or other arrangements as often as is reasonably necessary to
17 protect the interests of the people of this state. The
18 department of health shall make such an examination at least
19 once every 3 years.
20 (3) Each authorized health maintenance organization
21 and provider shall submit its relevant books and records for
22 the examinations and in every way facilitate the
23 examinations. For the purpose of examination, the
24 commissioner and the department of health may administer
25 oaths to and examine the officers and agents of the health

1 maintenance organization and the principals of the providers
2 concerning their business.
3 (4) (a) (i) Upon presentation of a detailed account of
4 the charges and expenses of examinations by the
5 commissioner, the health maintenance organization being
6 examined shall pay to the examiner as necessarily incurred
7 on account of the examination the actual travel expenses, a
8 reasonable living-expense allowance, and a per diem, all at
9 reasonable rates customary therefor and as established or
10 adopted by the commissioner. The commissioner may present
11 such an account periodically during the course of the
12 examination or at the termination of the examination as the
13 commissioner considers proper. A person may not pay and an
14 examiner may not accept any additional emolument on account
15 of any such examination.
16 (ii) If a health maintenance organization fails to pay
17 the charges and expenses as referred to in subsection
18 (4)(a)(i), the commissioner shall pay them out of the funds
19 of the commissioner in the same manner as other
20 disbursements of such funds. The amount so paid must be a
21 lien upon all of the person's assets and property in this
22 state and may be recovered by suit by the attorney general
23 on behalf of the state of Montana and restored to the
24 appropriate fund.
25 (b) The expenses of examination conducted by the

1 director under this section must be assessed against the
2 health maintenance organization and remitted to the
3 director. Such remitted expenses are statutorily
4 appropriated to the department of health as provided in
5 17-7-502.
6 (5) In lieu of an examination, the commissioner or the
7 director may accept the report of an examination made by the
8 commissioner or the director of another state.
9 NEW SECTION. Section 18. Suspension or revocation of
10 certificate of authority. (1) The commissioner may in his
11 discretion suspend or revoke any certificate of authority
12 issued to a health maintenance organization under [sections
13 1 through 29] if he finds that any of the following
14 conditions exist:
15 (a) The health maintenance organization is operating
16 in contravention of its basic organizational document or in
17 a manner contrary to that described in any other information
18 submitted under [section 3], unless amendments to such
19 submissions have been filed with and approved by the
20 commissioner.
21 (b) The health maintenance organization issues
22 evidences of coverage or uses a schedule of charges for
23 health care services that do not comply with the
24 requirements of [section 8].
25 (c) The health maintenance organization does not

1 provide or arrange for basic health care services.
2 (d) The director certifies to the commissioner that:
3 (i) the health maintenance organization does not meet
4 the requirements of [section 4(1)]; or
5 (ii) the health maintenance organization is unable to
6 fulfill its obligations to furnish health care services.
7 (e) The health maintenance organization is no longer
8 financially responsible and may reasonably be expected to be
9 unable to meet its obligations to enrollees or prospective
10 enrollees.
11 (f) The health maintenance organization has failed to
12 implement a mechanism affording the enrollees an opportunity
13 to participate in matters of policy and operation under
14 [section 6].
15 (g) The health maintenance organization has failed to
16 implement the complaint system required by [section 11] to
17 resolve valid complaints in a reasonable manner.
18 (h) The health maintenance organization, or any person
19 on its behalf, has advertised or merchandised its services
20 in an untrue, misrepresentative, misleading, deceptive, or
21 unfair manner.
22 (i) The continued operation of the health maintenance
23 organization would be hazardous to its enrollees.
24 (j) The health maintenance organization has otherwise
25 failed to substantially comply with [sections 1 through 29].

1 (2) The commissioner may in his discretion suspend or
2 revoke a certificate of authority only if he complies with
3 the requirements of [section 21].
4 (3) When the certificate of authority of a health
5 maintenance organization is suspended, the health
6 maintenance organization may not, during the period of such
7 suspension, enroll any additional enrollees except newborn
8 infants or other newly acquired dependents of existing
9 enrollees and may not engage in any advertising or
10 solicitation.
11 (4) If the commissioner revokes the certificate of
12 authority of a health maintenance organization, the health
13 maintenance organization shall proceed, immediately
14 following the effective date of the order of revocation, to
15 wind up its affairs and may not transact further business
16 except as may be essential to the orderly conclusion of its
17 affairs. It may not engage in further advertising or
18 solicitation following the effective date of the order of
19 revocation. The commissioner may by written order permit
20 further operation of the health maintenance organization if
21 he finds further operation to be in the best interest of
22 enrollees to the extent that enrollees will be afforded the
23 greatest practical opportunity to obtain continuing health
24 care coverage.
25 NEW SECTION. Section 19. Supervision, rehabilitation,

1 or liquidation of a health maintenance organization. (1) The
2 supervision, rehabilitation, or liquidation of a health
3 maintenance organization is considered to be the
4 supervision, rehabilitation, or liquidation of an insurer
5 and must be conducted under the supervision of the
6 commissioner pursuant to chapter 2, part 13. The
7 commissioner may apply for an order directing him to
8 supervise, rehabilitate, or liquidate a health maintenance
9 organization upon any one or more grounds set out in
10 33-2-1321, 33-2-1331, or 33-2-1341 or when in his opinion
11 the continued operation of the health maintenance
12 organization would be hazardous either to the enrollees or
13 to the people of this state. Enrollees shall have the same
14 priority in the event of liquidation or rehabilitation as
15 the law provides to policyholders of an insurer.
16 (2) A claim by a health care provider for an uncovered
17 expenditure has the same priority as a claim by an enrollee
18 if the provider of services agrees not to assert the claim
19 against any enrollee of the health maintenance organization.
20 NEW SECTION. Section 20. Rules. (1) The commissioner
21 may, after notice and hearing, make reasonable rules
22 necessary to effectuate [sections 1 through 29].
23 (2) The department of health may make reasonable rules
24 necessary to effectuate [sections 1 through 29].
25 NEW SECTION. Section 21. Administrative procedures.

1 (1) When the commissioner has cause to believe that grounds
2 for the denial of an application for a certificate of
3 authority exist or that grounds for the suspension or
4 revocation of a certificate of authority exist, he shall
5 give written notice to the health maintenance organization
6 and the department of health specifically stating the
7 grounds for denial, suspension, or revocation and fixing a
8 time of at least 30 days after the notice for a hearing on
9 the matter.
10 (2) The director or his designated representative may
11 attend the hearing and may participate in the proceeding.
12 The recommendations and findings of the director with
13 respect to matters relating to the quality of health care
14 services provided in connection with any decision regarding
15 denial, suspension, or revocation of a certificate of
16 authority must be conclusive and binding upon the
17 commissioner. After the hearing, or upon the failure of the
18 health maintenance organization to appear at the hearing,
19 the commissioner shall make written findings and act as he
20 considers advisable. The commissioner shall mail the
21 written findings to the health maintenance organization and
22 submit a copy to the director. The action of the
23 commissioner and the recommendations and findings of the
24 director are subject to review by the district court having
25 jurisdiction. The court may, in disposing of the issue

1 before it, modify, affirm, or reverse the order of the
2 commissioner in whole or in part.
3 (3) The Montana Administrative Procedure Act, Title 2,
4 chapter 4, applies to proceedings under this section to the
5 extent it is not in conflict with this section.
6 NEW SECTION. Section 22. Fees. (1) Each health
7 maintenance organization shall pay to the commissioner the
8 following fees:
9 (a) for filing an application for a certificate of
10 authority or amendment thereto, $300;
11 (b) for filing an amendment to the organization
12 documents that requires approval, $25;
13 (c) for filing each annual statement, $25.
14 (2) All fees and miscellaneous charges, except fines
15 or penalties or those amounts received pursuant to [sections
16 9(3) and 23], collected by the commissioner pursuant to
17 [sections 1 through 29] and the rules adopted thereunder
18 must be deposited in the insurance regulatory trust account
19 pursuant to 17-2-121 through 17-2-123.
20 (3) The director may assess fees necessary and
21 adequate to cover the expenses of the director's functions,
22 other than examinations, under this chapter. Such fees are
23 statutorily appropriated to the department of health as
24 provided in 17-7-502.
25 NEW SECTION. Section 23. Penalties and enforcement.

1 (1) The commissioner may, in addition to suspension or
2 revocation of a certificate of authority under [section 18],
3 impose an administrative penalty in an amount not less than
4 $500 or more than $10,000 if he gives reasonable notice in
5 writing of the intent to levy the penalty and the health
6 maintenance organization has a reasonable time within which
7 to remedy the defect in its operations that gave rise to the
8 penalty citation. The commissioner may augment this penalty
9 by an amount equal to the sum that he calculates to be the
10 damages suffered by enrollees or other members of the
11 public.
12 (2) (a) If the commissioner or the director has cause
13 to believe that a violation of [sections 1 through 29] has
14 occurred or is threatened, the commissioner or the director
15 may:
16 (i) give notice to the health maintenance organization
17 and to the representatives or other persons who appear to be
18 involved in the suspected violation;
19 (ii) arrange a conference with the alleged violators or
20 their authorized representatives to attempt to ascertain the
21 facts relating to the suspected violation; and
22 (iii) if it appears that a violation has occurred or is
23 threatened, arrive at an adequate and effective means of
24 correcting or preventing the violation.
25 (b) Proceedings under this subsection are not governed

1 by any formal procedural requirements and may be conducted
2 in a manner the commissioner or the director considers
3 appropriate under the circumstances. However, unless
4 consented to by the health maintenance organization, no rule
5 or order may result from a conference until the requirements
6 of [section 21] or this section are satisfied.
7 (3) (a) The commissioner may issue an order directing
8 a health maintenance organization or its representative to
9 cease and desist from engaging in an act or practice in
10 violation of [sections 1 through 29].
11 (b) Within 15 days after service of the cease and
12 desist order, the respondent may request a hearing to
13 determine whether acts or practices in violation of
14 [sections 1 through 29] have occurred. The hearing must be
15 conducted pursuant to Title 2, chapter 4, part 6, and
16 judicial review must be available as provided by Title 2,
17 chapter 4, part 7.
18 (4) If a health maintenance organization violates a
19 provision of [sections 1 through 29] and the commissioner
20 elects not to issue a cease and desist order or if the
21 respondent does not comply with a cease and desist order
22 issued pursuant to subsection (3), the commissioner may
23 institute a proceeding to obtain injunctive or other
24 appropriate relief in the district court of Lewis and Clark
25 County.

1 NEW SECTION. Section 24. Statutory construction and
2 relationship to other laws. (1) Except as otherwise provided
3 in [sections 1 through 29], the insurance or health service
4 corporation laws do not apply to any health maintenance
5 organization authorized to transact business under [sections
6 1 through 29]. This provision does not apply to an insurer
7 or health service corporation licensed and regulated
8 pursuant to the insurance or health service corporation laws
9 of this state except with respect to its health maintenance
10 organization activities authorized and regulated pursuant to
11 [sections 1 through 29].
12 (2) Solicitation of enrollees by a health maintenance
13 organization granted a certificate of authority or its
14 representatives may not be construed as a violation of any
15 law relating to solicitation or advertising by health
16 professionals.
17 (3) A health maintenance organization authorized under
18 [sections 1 through 29] may not be considered to be
19 practicing medicine and is exempt from Title 37, chapter 3,
20 relating to the practice of medicine.
21 (4) The provisions of [sections 1 through 29] do not
22 exempt a health maintenance organization from the applicable
23 certificate of need requirements under Title 50, chapter 5,
24 parts 1 and 3.
25 NEW SECTION. Section 25. Filings and reports as

1 public documents. All applications, filings, and reports
2 required under [sections 1 through 29], except those that
3 contain trade secrets or privileged or confidential
4 commercial or financial information (other than an annual
5 financial statement that the commissioner may require under
6 [section 9]), are public documents.

7 NEW SECTION. Section 26. Confidentiality of medical
8 information. (1) Any data or information pertaining to the
9 diagnosis, treatment, or health of an enrollee or applicant
10 obtained from the enrollee, applicant, or a provider by a
11 health maintenance organization must be held in confidence
12 and may not be disclosed to any person except:

13 (a) to the extent that it may be necessary to carry
14 out the purposes of [sections 1 through 29];

15 (b) upon the express consent of the enrollee or
16 applicant;

17 (c) pursuant to statute or court order for the
18 production of evidence or the discovery thereof; or

19 (d) in the event of claim or litigation between the
20 enrollee or applicant and the health maintenance
21 organization wherein the data or information is pertinent.

22 (2) A health maintenance organization is entitled to
23 claim the same statutory privileges against disclosure that
24 the provider who furnished the information to the health
25 maintenance organization is entitled to claim.

1 NEW SECTION. Section 27. Authority of director to
2 contract. The director in carrying out his obligations under
3 [sections 4(1), 17(2), and 18(1)] may contract with
4 qualified persons to make recommendations concerning the
5 determinations he is required to make. The contractors'
6 recommendations may be accepted in full or in part by the
7 director.

8 NEW SECTION. Section 28. Acquisition, control, or
9 merger of a health maintenance organization. (1) Except as
10 provided in 33-2-1106 and subsection (2), no person may
11 tender for, request, or invite tenders of, or enter into an
12 agreement to exchange securities for or acquire in the open
13 market or otherwise, any voting security of a health
14 maintenance organization or enter into any other agreement
15 if, after the consummation thereof, that person would,
16 directly or indirectly, or by conversion or by exercise of
17 any right to acquire, be in control of the health
18 maintenance organization.

19 (2) No person may enter into an agreement to merge or
20 consolidate with or otherwise to acquire control of a health
21 maintenance organization, unless, at the time any offer,
22 request, or invitation is made or any agreement is entered
23 into, or prior to the acquisition of the securities if no
24 offer or agreement is involved, the acquiring person has
25 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 may not be required to pay more for health benefits as a result of the application of this section 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) the amount paid on behalf of its other employees or members of health benefits; or

(b) 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

1 services performed by a licensed professional counselor.
2 (2) Nothing in this section shall be construed as
3 enlarging the scope and limitations of practice of any of
4 the licensed professions enumerated in subsection (1); nor
5 shall this section be construed as amending, altering, or
6 repealing any statutes relating to the licensing or use of
7 hospitals."
8 Section 31. Section 17-7-502, MCA, is amended to read:
9 "17-7-502. Statutory appropriations -- definition --
10 requisites for validity. (1) A statutory appropriation is an
11 appropriation made by permanent law that authorizes spending
12 by a state agency without the need for a biennial
13 legislative appropriation or budget amendment.
14 (2) Except as provided in subsection (4), to be
15 effective, a statutory appropriation must comply with both
16 of the following provisions:
17 (a) The law containing the statutory authority must be
18 listed in subsection (3).
19 (b) The law or portion of the law making a statutory
20 appropriation must specifically state that a statutory
21 appropriation is made as provided in this section.
22 (3) The following laws are the only laws containing
23 statutory appropriations:
24 (a) 2-9-202;
25 (b) 2-17-105;

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

1 (bb) 19-12-301;
2 (cc) 19-13-604;
3 (dd) 20-6-406;
4 (ee) 20-8-111;
5 (ff) 23-5-612;
6 (gg) [section 17];
7 (hh) [section 22];
8 ~~(gg)~~(ii) 37-51-501;
9 ~~(hh)~~(jj) 53-24-206;
10 ~~(ii)~~(kk) 75-1-1101;
11 ~~(jj)~~(ll) 75-7-305;
12 ~~(kk)~~(mm) 80-2-103;
13 ~~(ll)~~(nn) 80-2-228;
14 ~~(mm)~~(oo) 90-3-301;
15 ~~(nn)~~(pp) 90-3-302;
16 ~~(oo)~~(qq) 90-15-103; and
17 ~~(pp)~~(rr) Sec. 13, HB 861, L. 1985.
18 (4) There is a statutory appropriation to pay the
19 principal, interest, premiums, and costs of issuing, paying,
20 and securing all bonds, notes, or other obligations, as due,
21 that have been authorized and issued pursuant to the laws of
22 Montana. Agencies that have entered into agreements
23 authorized by the laws of Montana to pay the state
24 treasurer, for deposit in accordance with 17-2-101 through
25 17-2-107, as determined by the state treasurer, an amount

1 sufficient to pay the principal and interest as due on the
2 bonds or notes have statutory appropriation authority for
3 such payments."
4 NEW SECTION. Section 32. Codification instruction.
5 Sections 1 through 29 are intended to be codified as an
6 integral part of Title 33, and the provisions of Title 33
7 apply to sections 1 through 29.
8 NEW SECTION. Section 33. Severability. If a part of
9 this act is invalid, all valid parts that are severable from
10 the invalid part remain in effect. If a part of this act is
11 invalid in one or more of its applications, the part remains
12 in effect in all valid applications that are severable from
13 the invalid applications.
14 NEW SECTION. Section 34. Effective date --
15 applicability. This act is effective on passage and approval
16 and applies to health maintenance organizations formed
17 before or after the effective date of this act.

-End-

STATE OF MONTANA - FISCAL NOTE
Form BD-15

In compliance with a written request, there is hereby submitted a Fiscal Note for SB353 , as introduced.

DESCRIPTION OF PROPOSED LEGISLATION:
An act to regulate the formation and operation of Health Maintenance Organizations; amending Sections 17-7-502 and 33-22-111, MCA; and providing an immediate effective date and an applicability provision.

ASSUMPTIONS:
1. There would be four HMO's authorized in FY88 and these companies would renew in FY89.
2. Each HMO will register 10 agents in FY88 and FY89.
3. There will be no additional staff required for the State Auditor.
4. The Department of Health and Environmental Sciences will require 1.0 additional FTE to administer the program.
5. DHES will contract for patient care assessments and complaint reviews at $35.00 per case.
6. An estimated number of 56,000 persons will be enrolled in HMO's, requiring 1,867 case reviews per year. (The enrolled population was estimated from combining the greater Helena, Missoula and Great Falls areas and larger population centers in the northeastern portion of the state. It was then assumed that about one-third of this total would enroll in HMO's.)
7. An estimated 225 complaints will be investigated per year.
8. The State Auditor will do ongoing financial audits of HMO's and DHES will be responsible for ongoing patient care assessments of HMO's.
9. If HMO's expand beyond currently estimated enrollment of 57,000 persons, costs and revenues will increase above those shown in this fiscal note.

FISCAL IMPACT:

	FY88		FY89	
	Current Law	Proposed Law	Current Law	Proposed Law
Expenditures:				
Personal Services	$ 0	$ 28,438	$ 0	$ 28,438
Operating Costs	0	78,887	0	78,887
Capital Outlay	0	3,000	0	0
TOTAL	$ 0	$ 110,325	$ 0	$ 107,325

David L. Hunter DATE 2/23/87
DAVID L. HUNTER, BUDGET DIRECTOR
Office of Budget and Program Planning

D Meyer DATE
DARRYL MEYER, PRIMARY SPONSOR

Fiscal Note for SB353, as introduced.

SB 353

FISCAL IMPACT:	FY88		FY89	
	Current Law	Proposed Law	Current Law	Proposed Law
Revenues:				
State Special Revenue	$ 0	$ 111,925	$ 0	$ 107,825
Net Impact:	$ 0	$ 1,600	$ 0	$ 500

NOTE: If University System employees are offered an HMO option as part of health care benefits, state costs could increase by about $260,000 each year. The state could expect an increase in costs of 2 - 5 % each year. See long-term effects.

LONG-RANGE EFFECTS OF PROPOSED LEGISLATION:
Most plans (including the state self-insured plan) will be impacted by the introduction of HMO's. Retirees are less likely to join HMO's because of long-term physician relationships and because many live out-of-state at least part of the year. The traditional plans end up with a larger retiree mix. In Kansas, which recently introduced HMO's, 29% of the active employees joined HMO's and only 2% of the retirees joined. Because retirees utilize the plan at a higher rate, a shift of current employees to HMO's results in higher costs to the state plan because fewer active employees would subsidize the retiree costs. With a shift similar to Kansas, the state could expect up to a 5% increase in cost to the state plan, probably resulting in pressure to increase the state share by a similar amount to maintain current benefits.

TECHNICAL OR MECHANICAL DEFECTS IN PROPOSED LEGISLATION OR CONFLICTS WITH EXISTING LEGISLATION:
This bill does not clearly specify the parameters of the patient care assessments to be performed by DHES. If DHES is required to perform a cost analysis as appropriate to the services delivered, personnel and operating costs to administer the proposed law will double.

SB 353

APPROVED BY COMMITTEE
ON PUBLIC HEALTH, WELFARE
& SAFETY

1 STATEMENT OF INTENT
2 SENATE BILL 353
3 Senate Public Health, Welfare, and Safety Committee
4
5 A statement of intent is required for this bill
6 because:
7 (1) it authorizes the commissioner of insurance of the
8 state of Montana (commissioner) and the department of health
9 and environmental sciences to adopt, after notice and
10 hearing, reasonable rules necessary or proper to effectuate
11 sections 1 through 29;
12 (2) section 3 authorizes the commissioner to make
13 reasonable rules exempting a health maintenance organization
14 from having to file a notice with the commissioner
15 describing material modifications of information required in
16 an application for a certificate of authority if the
17 commissioner considers the information unnecessary; and
18 (3) section 5 authorizes the commissioner to make
19 reasonable rules exempting a health maintenance organization
20 from having to file a notice with the commissioner before
21 exercising the powers granted in subsection (1)(a), (1)(b),
22 or (1)(d) if the commissioner believes exercising those
23 powers will have de minimis effect. The legislature expects
24 the commissioner to make only reasonable rules necessary to
25 effectuate or aid the effectuation of sections 1 through 29.

1 The legislature does not authorize the commissioner to adopt
2 rules that extend, modify, or conflict with either any law
3 of this state or any reasonable implications of those laws.
4 If reasonably possible, the commissioner shall set forth a
5 proposed rule or amendment to a rule in or with the required
6 notice of hearing. No rule or amendment to a rule by the
7 commissioner is effective until it has been on file in the
8 commissioner's office for at least 10 days.
9 In adopting rules prescribing investment regulations,
10 the commissioner shall use the NAIC Model Health Maintenance
11 Organization Investment Guidelines.
12 The commissioner and the department are urged to look
13 to regulations adopted by the state of Minnesota in
14 implementing chapter 62D of the Minnesota insurance code.

SECOND READING
SB 353

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~~ 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;

1 (b) on whose behalf a contract is made with a health
2 maintenance organization to receive health care services; or
3 (c) on whose behalf the health maintenance
4 organization contracts to receive health care services.
5 (7) "Evidence of coverage" means a certificate,
6 agreement, policy, or contract issued to an enrollee setting
7 forth the coverage to which the enrollee is entitled.
8 (8) "Health care services" means:
9 (a) the services included in furnishing medical or
10 dental care to a person;
11 (b) the services included in hospitalizing a person;
12 (c) the services incident to furnishing medical or
13 dental care or hospitalization; or
14 (d) the services included in furnishing to a person
15 other services for the purpose of preventing, alleviating,
16 curing, or healing illness, injury, or physical disability.
17 (9) "Health care services agreement" means an
18 agreement for health care services between a health
19 maintenance organization and an enrollee.
20 (10) "Health maintenance organization" means a person
21 who provides or arranges for basic health care services to
22 enrollees on a prepaid or other financial basis, either
23 directly through provider employees or through contractual
24 or other arrangements with a provider or a group of
25 providers.

1 (11) "Person" means:
2 (a) an individual;
3 (b) a group of individuals;
4 (c) an insurer, as defined in 33-1-201;
5 (d) a health service corporation, as defined in
6 33-30-101;
7 (e) a corporation, partnership, facility, association,
8 or trust; or
9 (f) an institution of a governmental unit of any state
10 licensed by that state to provide health care, including but
11 not limited to a physician, hospital, hospital-related
12 facility, or long-term care facility.
13 (12) "PLAN" MEANS A HEALTH MAINTENANCE ORGANIZATION
14 OPERATED BY AN INSURER OR HEALTH SERVICE CORPORATION AS AN
15 INTEGRAL PART OF THE CORPORATION AND NOT AS A SUBSIDIARY.
16 ~~(12)~~(13) "Provider" means a physician, hospital,
17 hospital-related facility, long-term care facility, dentist,
18 osteopath, chiropractor, optometrist, podiatrist,
19 psychologist, licensed social worker, registered pharmacist,
20 or nurse specialist as specifically listed in 37-8-202 who
21 treats any illness or injury within the scope and
22 limitations of his practice or other person who is licensed
23 or otherwise authorized in this state to furnish health care
24 services.
25 ~~(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

1 agreement, trust agreement, or other applicable documents,
2 and all amendments thereto, certified by the public officer
3 with whom the originals were filed in the state or country
4 of domicile;
5 (ii) a copy of the bylaws, rules, and regulations, or
6 similar document, if any, regulating the conduct of the
7 applicant's internal affairs, certified by its secretary or
8 other officer having custody thereof;
9 (iii) a list of the names, addresses, and official
10 positions of the persons responsible for the conduct of the
11 applicant's affairs, including all members of the board of
12 directors, board of trustees, executive committee, or other
13 governing board or committee; the principal officers in the
14 case of a corporation; and the partners or members in the
15 case of a partnership or association;
16 (iv) a copy of any contract made or to be made between:
17 (A) any provider and the applicant; or
18 (B) any person listed in subsection (3)(d)(iii) and
19 the applicant. The applicant may file a list of providers
20 executing a standard contract and a copy of the contract
21 instead of copies of each executed contract.
22 (v) the extent to which any of the following will be
23 included in provider contracts and the form of any
24 provisions that:
25 (A) limit a provider's ability to seek reimbursement

1 for basic health care services or health care services from
2 an enrollee;
3 (B) permit or require a provider to assume a financial
4 risk in the health maintenance organization, including any
5 provisions for assessing the provider, adjusting capitation
6 or fee-for-service rates, or sharing in the earnings or
7 losses; and
8 (C) govern amending or terminating an agreement with a
9 provider;
10 (vi) a financial statement showing the applicant's
11 assets, liabilities, and sources of financial support. If
12 the applicant's financial affairs are audited by independent
13 certified public accountants, a copy of the applicant's most
14 recent certified financial statement satisfies this
15 requirement unless the commissioner directs that additional
16 or more recent financial information is required for the
17 proper administration of [sections 1 through 29].
18 (vii) a description of the proposed method of
19 marketing, a financial plan that includes a projection of
20 operating results anticipated until the organization has had
21 net income for at least 1 year, and a statement as to the
22 sources of working capital as well as any other source of
23 funding;
24 ~~(viii) a summary of feasibility studies or marketing~~
25 ~~surveys that support the financial and enrollment~~

1 ~~projections--for-the-plan,-including-the-potential-number-of~~
2 ~~enrollees-in-the-operating-territory,-the--projected--number~~
3 ~~of--enrollees--for--the--first--5--years,--the--underwriting~~
4 ~~standards-to-be-applied,-and-the--method--of--marketing--the~~
5 ~~organization;~~
6 ~~(ix)~~(VIII) a power of attorney executed by the
7 applicant, on a form prescribed by the commissioner,
8 appointing the commissioner, his successors in office, and
9 his authorized deputies as the applicant's attorney to
10 receive service of legal process issued against it in this
11 state;
12 ~~(x)~~(IX) a statement reasonably describing the
13 geographic service area or areas to be served by county,
14 including:
15 (A) a chart showing the number of primary and
16 specialty care providers with locations and service areas by
17 county;
18 (B) the method of handling emergency care, with the
19 location of each emergency care facility; and
20 (C) the method of handling out-of-area services;
21 ~~(xi)~~(X) a description of the way in which the health
22 maintenance organization provides services to enrollees in
23 each geographic service area, including the extent to which
24 a provider under contract with the health maintenance
25 organization provides primary care to those enrollees;

1 ~~(xii)~~(XI) a description of the complaint procedures to
2 be used as required under [section 11];
3 ~~(xiii)~~(XII) a description of the procedures and
4 programs to be implemented to meet the quality of health
5 care requirements in [section 4];
6 ~~(xiv)~~(XIII) a description of the mechanism by which
7 enrollees will be afforded an opportunity to participate in
8 matters of policy and operation under [section 6];
9 ~~(xv)~~(XIV) a summary of the way in which administrative
10 services will be provided, including the size and
11 qualifications of the administrative staff and the projected
12 cost of administration in relation to premium income. If the
13 health maintenance organization delegates management
14 authority for a major corporate function to a person outside
15 the organization, the health maintenance organization shall
16 include a copy of the contract in its application for a
17 certificate of authority. Contracts for delegated management
18 authority must be filed for approval with the commissioner
19 in accordance with the filing provisions of [section 8(7)].
20 All contracts must include:
21 (A) the services to be provided;
22 (B) the standards of performance for the manager;
23 (C) the method of payment, including any provisions
24 for the administrator to participate in the profits or
25 losses of the plan;

1 (D) the duration of the contract; and
2 (E) any provisions for modifying, terminating, or
3 renewing the contract.
4 ~~(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;~~
10 ~~(xvii)~~ (XV) a summary of all financial guaranties by
11 providers, sponsors, affiliates, or parents within a holding
12 company system or any other guaranties that are intended to
13 ensure the financial success of the plan, including hold
14 harmless agreements by providers, insolvency insurance,
15 reinsurance, or other guaranties;
16 ~~(xviii)~~ (XVI) a summary of benefits to be offered
17 enrollees, including any limitations and exclusions and the
18 renewability of all contracts to be written;
19 ~~(xix)~~ (XVII) evidence that it can meet the requirement
20 of [section 13(10)]; and
21 ~~(xx)~~ (XVIII) any other information that the commissioner
22 may reasonably require to make the determinations required
23 in [section 4].
24 (4) Each health maintenance organization shall file
25 each substantial change, alteration, or amendment to the

1 information submitted under subsection (3) with the
2 commissioner at least 30 days prior to its effective date,
3 including changes in articles of incorporation and bylaws,
4 organization type, geographic service area, provider
5 contracts, provider availability, plan administration,
6 financial projections and guaranties, and any other change
7 that might affect the financial solvency of the plan. The
8 commissioner may, AFTER NOTICE AND HEARING, disapprove any
9 proposed change, alteration, or amendment to the business
10 plan. The commissioner may make reasonable rules exempting
11 from the filing requirements of this subsection those items
12 he considers unnecessary.
13 (5) An applicant or a health maintenance organization
14 holding a certificate of authority shall file with the
15 commissioner all contracts of reinsurance and any
16 modifications thereto. An agreement between a health
17 maintenance organization and an insurer is subject to Title
18 33, chapter 2, part 12. A reinsurance agreement must remain
19 in full force and effect for at least 90 days following
20 written notice of cancellation by either party by certified
21 mail to the commissioner.
22 (6) Each health maintenance organization shall
23 maintain, at its administrative office, and make available
24 to the commissioner upon request executed copies of all
25 provider contracts.

1 NEW SECTION. Section 4. Issuance of certificate of
2 authority. (1) Upon receipt of an application for issuance
3 of a certificate of authority, the commissioner shall
4 transmit copies of the application and accompanying
5 documents to the department of health. The department of
6 health shall determine whether the applicant for a
7 certificate of authority, with respect to health care
8 services to be furnished, has:
9 (a) demonstrated the willingness and potential ability
10 to assure that it will provide health care services in a
11 manner assuring availability and accessibility of adequate
12 personnel and facilities and enhancing availability,
13 accessibility, and continuity of service;
14 (b) arrangements, established in accordance with the
15 rules made by the department of health, for an ongoing
16 quality assurance program concerning health care processes
17 and-outcomes AVAILABILITY, ACCESSIBILITY, AND CONTINUITY OF
18 SERVICE; and
19 (c) a procedure, established in accordance with rules
20 of the department of health, to develop, compile, evaluate,
21 and report statistics relating to the cost of its
22 operations, the pattern of utilization of its services, the
23 availability and accessibility of its services, and any
24 other matters as may be reasonably required by the
25 department of health.

1 (2) Within 90 60 days of receipt of the application
2 from a health maintenance organization for issuance of a
3 certificate of authority, the department of health shall
4 certify to the commissioner that the proposed health
5 maintenance organization meets the requirements of
6 subsection (1) or shall, AFTER NOTICE AND HEARING, notify
7 the commissioner that the health maintenance organization
8 does not meet those requirements and specify in what
9 respects it is deficient. The director may extend by not
10 more than an additional 30 days the period within which he
11 may certify to the commissioner that the proposed health
12 maintenance organization meets or does not meet the
13 requirements of subsection (1) by giving notice of the
14 extension to the commissioner and the health maintenance
15 organization before the expiration of the initial 90-day
16 60-DAY period.
17 (3) The commissioner shall issue or deny a certificate
18 of authority to any person filing an application pursuant to
19 [section 3] within 180 days of receipt of the certification
20 from the department of health. The commissioner shall grant
21 a certificate of authority upon payment of the application
22 fee prescribed in [section 22] if the commissioner is
23 satisfied that each of the following conditions is met:
24 (a) The persons responsible for the conduct of the
25 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 disapprove the exercise of a power 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

1 of policy and operation through the establishment of
2 advisory panels, by the use of advisory referenda on major
3 policy decisions, or through the use of other mechanisms.
4 NEW SECTION. Section 7. Fiduciary responsibilities.
5 (1) Any director, officer, employee, or partner of a health
6 maintenance organization who receives, collects, disburses,
7 or invests funds in connection with the activities of the
8 health maintenance organization is responsible for the funds
9 in the manner of a fiduciary to the health maintenance
10 organization.
11 (2) A health maintenance organization shall maintain
12 in force a fidelity bond on employees and officers in an
13 amount not less than $100,000 or such other sum as may be
14 prescribed by the commissioner. Each bond must be written
15 with at least a 1-year discovery period and, if written with
16 less than a 3-year discovery period, must contain a
17 provision that a cancellation or termination of the bond,
18 whether by or at the request of the insured or by the
19 underwriter, may not take effect prior to the expiration of
20 90 days after written notice of the cancellation or
21 termination has been filed with the commissioner unless the
22 commissioner approves an earlier cancellation or termination
23 date.
24 NEW SECTION. Section 8. Evidence of coverage and
25 charges for health care services. (1) Every enrollee

1 residing in this state is entitled to an evidence of
2 coverage. The health maintenance organization shall issue
3 the evidence of coverage, except that if the enrollee
4 obtains coverage through an insurance policy issued by an
5 insurer or a contract issued by a health service
6 corporation, whether by option or otherwise, the insurer or
7 the health service corporation shall issue the evidence of
8 coverage.
9 (2) A health maintenance organization may not issue or
10 deliver an enrollment form, an evidence of coverage, or an
11 amendment to an approved enrollment form or evidence of
12 coverage to a person in this state before a copy of the
13 enrollment form, the evidence of coverage, or the amendment
14 to the approved enrollment form or evidence of coverage is
15 filed with and approved by the commissioner.
16 (3) An evidence of coverage issued or delivered to a
17 person resident in this state may not contain a provision or
18 statement that is unjust, unfair, inequitable, misleading,
19 or deceptive; that encourages misrepresentation; or that is
20 untrue, misleading, or deceptive as defined in [section
21 14(1)]. The evidence of coverage must contain:
22 (a) a clear and concise statement, if a contract, or a
23 reasonably complete summary, if a certificate, of:
24 (i) the health care services and the insurance or
25 other benefits, if any, to which the enrollee is entitled;

1 (ii) any limitations on the services, kinds of
2 services, or benefits to be provided, including any
3 deductible or copayment feature;
4 (iii) the location at which and the manner in which
5 information is available as to how services may be obtained;
6 (iv) the total amount of payment for health care
7 services and the indemnity or service benefits, if any, that
8 the enrollee is obligated to pay with respect to individual
9 contracts; and
10 (v) a clear and understandable description of the
11 health maintenance organization's method for resolving
12 enrollee complaints.
13 (b) definitions of geographical service area,
14 emergency care, urgent care, out-of-area services,
15 dependent, and primary provider, if these terms or terms of
16 similar meaning are used in the evidence of coverage and
17 have an effect on the benefits covered by the plan. The
18 definition of geographical service area need not be stated
19 in the text of the evidence of coverage if the definition is
20 adequately described in an attachment, which is given to
21 each enrollee along with the evidence of coverage.
22 (c) clear disclosure of each provision that limits
23 benefits or access to service in the exclusions,
24 limitations, and exceptions sections of the evidence of
25 coverage. The exclusions, limitations, and exceptions that

1 must be disclosed include but are not limited to:
2 (i) emergency and urgent care;
3 (ii) restrictions on the selection of primary or
4 referral providers;
5 (iii) restrictions on changing providers during the
6 contract period;
7 (iv) out-of-pocket costs, including copayments and
8 deductibles;
9 (v) charges for missed appointments or other
10 administrative sanctions;
11 (vi) restrictions on access to care if copayments or
12 other charges are not paid; and
13 (vii) any restrictions on coverage for dependents who
14 do not reside in the service area.
15 (d) clear disclosure of any benefits for home health
16 care, skilled nursing care, kidney disease treatment,
17 diabetes, maternity benefits for dependent children,
18 alcoholism and other drug abuse, and nervous and mental
19 disorders;
20 (e) a provision requiring immediate accident and
21 sickness coverage, from and after the moment of birth, to
22 each newborn infant of an enrollee or his dependents;
23 (f) a provision ~~offering~~ REQUIRING medical treatment
24 and referral services to appropriate ancillary services for
25 mental illness and for the abuse of or addiction to alcohol

1 or drugs in accordance with the limits provided in
2 33-22-703;
3 (g) a provision as follows:
4 "Conformity With State Statutes: Any provision of this
5 evidence of coverage that on its effective date is in
6 conflict with the statutes of the state in which the insured
7 resides on that date is hereby amended to conform to the
8 minimum requirements of those statutes."
9 (h) a provision that the health maintenance
10 organization shall issue, without evidence of insurability,
11 to the enrollee, his dependents, or family members
12 continuing coverage on the enrollee, his dependents, or
13 family members:
14 (i) if the evidence of coverage or any portion of it
15 on an enrollee, his dependents, or family members covered
16 under the evidence of coverage ceases because of termination
17 of employment or of his membership in the class or classes
18 eligible for coverage under the policy or because his
19 employer discontinues his business or the coverage;
20 (ii) if the enrollee had been enrolled in the health
21 maintenance organization for a period of 3 months preceding
22 the termination of group coverage; and
23 (iii) if the enrollee applied for continuing coverage
24 within 31 days after the termination of group coverage. The
25 conversion contract may not exclude, as a preexisting

1 condition, any condition covered by the group contract from
2 which the enrollee converts.
3 (i) a provision that clearly describes the amount of
4 money an enrollee shall pay to the health maintenance
5 organization to be covered for basic health care services.
6 (4) A health maintenance organization may amend an
7 enrollment form or an evidence of coverage in a separate
8 document if the separate document is filed with and approved
9 by the commissioner and issued to the enrollee.
10 (5) (a) A health maintenance organization shall
11 provide the same coverage for newborn infants, required by
12 subsection (3)(e), as it provides for enrollees, except that
13 for newborn infants there may be no waiting or elimination
14 periods. A health maintenance organization may not assess a
15 deductible or reduce benefits applicable to the coverage for
16 newborn infants unless the deductible or reduction in
17 benefits is consistent with the deductible or reduction in
18 benefits applicable to all covered persons.
19 (b) A health maintenance organization may not issue or
20 amend an evidence of coverage in this state if it contains
21 any disclaimer, waiver, or other limitation of coverage
22 relative to the accident and sickness coverage or
23 insurability of newborn infants of an enrollee or his
24 dependents from and after the moment of birth.
25 (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, 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 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

1 content required by the commissioner. The statement must be
2 verified by the oath of at least two principal officers of
3 the health maintenance organization. The commissioner may in
4 his discretion waive any verification under oath.
5 (2) At the time of filing its annual statement, the
6 health maintenance organization shall pay the commissioner
7 the fee for filing its statement as prescribed in [section
8 22]. The commissioner may refuse to accept the fee for
9 continuance of the insurer's certificate of authority, as
10 provided in [section 22], or may in his discretion suspend
11 or revoke the certificate of authority of a health
12 maintenance organization that fails to file an annual
13 statement when due.
14 (3) The commissioner may, AFTER NOTICE AND HEARING,
15 impose a fine not to exceed $5,000 per violation upon a
16 director, officer, partner, member, agent, or employee of a
17 health maintenance organization who knowingly subscribes to
18 or concurs in making or publishing an annual statement
19 required by law that contains a material statement which is
20 false.
21 (4) The commissioner may require such reports as he
22 considers reasonably necessary and appropriate to enable him
23 to carry out his duties under [sections 1 through 29],
24 INCLUDING BUT NOT LIMITED TO A STATEMENT OF OPERATIONS,
25 TRANSACTIONS, AND AFFAIRS OF A HEALTH MAINTENANCE

1 ORGANIZATION OPERATED BY AN INSURER OR A HEALTH SERVICE
2 CORPORATION AS A PLAN.
3 NEW SECTION. Section 10. Information to enrollees.
4 Each authorized health maintenance organization shall
5 ~~promptly~~ provide to its enrollees ~~notice~~ 30 DAYS' ADVANCE
6 NOTICE IN WRITING of any material change in the operation of
7 the health maintenance organization that will affect them
8 directly.
9 NEW SECTION. Section 11. Complaint system.
10 (1) (a) Each authorized health maintenance organization
11 shall establish and maintain a complaint system to provide
12 reasonable procedures to resolve written complaints
13 initiated by enrollees. A health maintenance organization
14 may not use a complaint system:
15 (i) before the commissioner approves it; and
16 (ii) unless the health maintenance organization
17 describes it in each evidence of coverage issued or
18 delivered to an enrollee in this state.
19 (b) Each time the health maintenance organization
20 denies a claim or initiates disenrollment, cancellation, or
21 nonrenewal, it shall notify the affected enrollee of the
22 right to file a complaint and the procedure for filing a
23 complaint.
24 (c) Each health maintenance organization shall
25 acknowledge a complaint within 10 days of receiving it.

1 (d) Each health maintenance organization shall retain
2 records of all complaints for 3 years and shall develop a
3 summary for each year that must include:
4 (i) a description of the procedures of the complaint
5 system;
6 (ii) the total number of complaints handled through the
7 complaint system, a compilation of causes underlying the
8 complaints filed, the date on which each complaint was
9 filed, the date on which each complaint was resolved, the
10 disposition of each complaint filed, the time it took to
11 process each complaint, and a summary of each administrative
12 change made because of a complaint; and
13 (iii) the number, amount, and disposition of
14 malpractice claims made by enrollees of the health
15 maintenance organization that were settled during the year
16 by the health maintenance organization.
17 (e) The health maintenance organization shall annually
18 on or before March 1 file with the commissioner the summary
19 described in subsection (1)(d) for the preceding year.
20 (2) The commissioner shall hold in confidence the
21 information provided by the health maintenance organization
22 pursuant to subsection (1)(d)(iii).
23 (3) The commissioner may examine a complaint system.
24 NEW SECTION. Section 12. Investment regulations. A
25 domestic health maintenance organization may invest its

1 funds only as prescribed in ~~rules--adopted--by--the~~
2 ~~commissioner~~ TITLE 33, CHAPTER 2, PART 8.
3 NEW SECTION. Section 13. Protection against
4 insolvency. (1) Except as provided in subsections (4)
5 through (7), each authorized health maintenance organization
6 shall deposit with the commissioner cash, securities, or any
7 combination of cash or securities acceptable to the
8 commissioner in the amount set forth in this section.
9 (2) The amount of the deposit for a health maintenance
10 organization during the first year of its operation must be
11 the greater of:
12 (a) 5% of its estimated expenditures for health care
13 services for its first year of operation;
14 (b) twice its estimated average monthly uncovered
15 expenditures for its first year of operation; or
16 (c) $100,000.
17 (3) At the beginning of each succeeding year, unless
18 not applicable, the health maintenance organization shall
19 deposit with the commissioner cash, securities, or any
20 combination of cash or securities acceptable to the
21 commissioner, in an amount equal to 4% of its estimated
22 annual uncovered expenditures for that year.
23 (4) Unless not applicable, a health maintenance
24 organization that is in operation on [the effective date of
25 this act] shall make a deposit equal to the greater of:

1 (a) 1% of the preceding 12 months' uncovered
2 expenditures; or
3 (b) $100,000 on the first day of the fiscal year
4 beginning 6 months or more after [the effective date of this
5 act]. In the second fiscal year, if applicable, the amount
6 of the additional deposit must be equal to 2% of its
7 estimated annual uncovered expenditures. In the third fiscal
8 year, if applicable, the additional deposit must be equal to
9 3% of its estimated annual uncovered expenditures for that
10 year. In the fourth fiscal year and subsequent years, if
11 applicable, the additional deposit must be equal to 4% of
12 its estimated annual uncovered expenditures for each year.
13 Each year's estimate after the first year of operation must
14 reasonably reflect the preceding year's operating experience
15 and delivery arrangements.
16 (5) The commissioner may in his discretion waive any
17 of the deposit requirements set forth in subsections (1)
18 through (4) whenever he is satisfied that:
19 (a) the health maintenance organization has sufficient
20 net worth and an adequate history of generating net income
21 to assure its financial viability for the next year;
22 (b) the health maintenance organization's performance
23 and obligations are guaranteed by an organization with
24 sufficient net worth and an adequate history of generating
25 net income; or

1 (c) the health maintenance organization's assets or
2 its contracts with insurers, health service corporations,
3 governments, or other organizations are reasonably
4 sufficient to assure the performance of its obligations.
5 (6) When a health maintenance organization achieves a
6 net worth not including land, buildings, and equipment of at
7 least $1 million or achieves a net worth including
8 organization-related land, buildings, and equipment of at
9 least $5 million the annual deposit requirement under
10 subsection (3) does not apply. The annual deposit
11 requirement under subsection (3) does not apply to a health
12 maintenance organization if the total amount of the
13 accumulated deposit is greater than the capital requirement
14 for the formation or admittance of a disability insurer in
15 this state. If the health maintenance organization has a
16 guaranteeing organization that has been in operation for at
17 least 5 years and has a net worth not including land,
18 buildings, and equipment of at least $1 million or that has
19 been in operation for at least 10 years and has a net worth
20 including organization-related land, buildings, and
21 equipment of at least $5 million, the annual deposit
22 requirement under subsection (3) does not apply. If the
23 guaranteeing organization is sponsoring more than one health
24 maintenance organization, however, the net worth requirement
25 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

1 maintenance organization or HMO unless it holds a valid
2 certificate of authority issued by the commissioner.
3 NEW SECTION. Section 15. Agent license required --
4 application, issuance, renewal, fees -- penalty. (1) No
5 individual, partnership, or corporation may act as or hold
6 himself out to be an agent of a health maintenance
7 organization unless he is:
8 (a) licensed as a disability insurance agent by the
9 commissioner pursuant to chapter 17, parts 1, 2, and 4 of
10 this title; and
11 (b) appointed or authorized by the health maintenance
12 organization to solicit health care service agreements on
13 its behalf.
14 (2) Application, appointment and qualification for a
15 health maintenance organization agent license, fees
16 applicable to and the issuance of a health maintenance
17 organization agent license, and renewal of a health
18 maintenance organization agent license must be in accordance
19 with the provisions of chapter 17 that apply to a disability
20 insurance agent.
21 (3) An individual, partnership, or corporation who
22 holds a disability insurance agent license on [the effective
23 date of this act] need not requalify by an examination to be
24 licensed as a health maintenance organization agent.
25 (4) The commissioner may, in accordance with 33-1-313,

1 33-1-317, 33-17-411, and chapter 17, part 10, suspend,
2 revoke, refuse to issue or renew a health maintenance
3 organization agent license, or impose a fine upon the
4 licensee.
5 NEW SECTION. Section 16. Powers of insurers and
6 health service corporations. (1) An insurer authorized to
7 transact insurance in this state or a health service
8 corporation authorized to do business in this state may,
9 either directly or through a subsidiary or affiliate,
10 organize and operate a health maintenance organization under
11 the provisions of [sections 1 through 29]. Notwithstanding
12 any other law which may be inconsistent with this section,
13 two or more insurers, health service corporations, or
14 subsidiaries or affiliates thereof may jointly organize and
15 operate a health maintenance organization. The business of
16 insurance is considered to include the provision of health
17 care services by a health maintenance organization owned or
18 operated by an insurer or a subsidiary thereof.
19 (2) Notwithstanding any insurance or health service
20 corporation laws, an insurer or a health service corporation
21 may contract with a health maintenance organization to
22 provide insurance or similar protection against the cost of
23 care provided through a health maintenance organization and
24 to provide coverage if the health maintenance organization
25 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

1 of the commissioner in the same manner as other
2 disbursements of such funds. The amount so paid must be a
3 lien upon all of the person's assets and property in this
4 state and may be recovered by suit by the attorney general
5 on behalf of the state of Montana and restored to the
6 appropriate fund.
7 (b) The expenses of examination conducted by the
8 director under this section must be assessed against the
9 health maintenance organization and remitted to the
10 director. Such remitted expenses are statutorily
11 appropriated to the department of health as provided in
12 17-7-502.
13 (5) In lieu of an examination, the commissioner or the
14 director may accept the report of an examination made by the
15 commissioner or the director of another state.
16 NEW SECTION. Section 18. Suspension or revocation of
17 certificate of authority. (1) The commissioner may in his
18 discretion suspend or revoke any certificate of authority
19 issued to a health maintenance organization under [sections
20 1 through 29] if he finds that any of the following
21 conditions exist:
22 (a) The health maintenance organization is operating
23 in contravention of its basic organizational document or in
24 a manner contrary to that described in any other information
25 submitted under [section 3], unless amendments to such

1 submissions have been filed with and approved by the
2 commissioner.
3 (b) The health maintenance organization issues
4 evidences of coverage or uses a schedule of charges for
5 health care services that do not comply with the
6 requirements of [section 8].
7 (c) The health maintenance organization does not
8 provide or arrange for basic health care services.
9 (d) The director, AFTER NOTICE AND HEARING, certifies
10 to the commissioner that:
11 (i) the health maintenance organization does not meet
12 the requirements of [section 4(1)]; or
13 (ii) the health maintenance organization is unable to
14 fulfill its obligations to furnish health care services.
15 (e) The health maintenance organization is no longer
16 financially responsible and may reasonably be expected to be
17 unable to meet its obligations to enrollees or prospective
18 enrollees.
19 (f) The health maintenance organization has failed to
20 implement a mechanism affording the enrollees an opportunity
21 to participate in matters of policy and operation under
22 [section 6].
23 (g) The health maintenance organization has failed to
24 implement the complaint system required by [section 11] to
25 resolve valid complaints in a reasonable manner.

1 (h) The health maintenance organization, or any person
2 on its behalf, has advertised or merchandised its services
3 in an untrue, misrepresentative, misleading, deceptive, or
4 unfair manner.
5 (i) The continued operation of the health maintenance
6 organization would be hazardous to its enrollees.
7 (j) The health maintenance organization has otherwise
8 failed to substantially comply with [sections 1 through 29].
9 (2) The commissioner may in his discretion suspend or
10 revoke a certificate of authority only if he complies with
11 the requirements of [section 21].
12 (3) When the certificate of authority of a health
13 maintenance organization is suspended, the health
14 maintenance organization may not, during the period of such
15 suspension, enroll any additional enrollees except newborn
16 infants or other newly acquired dependents of existing
17 enrollees and may not engage in any advertising or
18 solicitation.
19 (4) If the commissioner revokes the certificate of
20 authority of a health maintenance organization, the health
21 maintenance organization shall proceed, immediately
22 following the effective date of the order of revocation, to
23 wind up its affairs and may not transact further business
24 except as may be essential to the orderly conclusion of its
25 affairs. It may not engage in further advertising or

1 solicitation following the effective date of the order of
2 revocation. The commissioner may by written order permit
3 further operation of the health maintenance organization if
4 he finds further operation to be in the best interest of
5 enrollees to the extent that enrollees will be afforded the
6 greatest practical opportunity to obtain continuing health
7 care coverage.
8 NEW SECTION. Section 19. Supervision, rehabilitation,
9 or liquidation of a health maintenance organization. (1) The
10 supervision, rehabilitation, or liquidation of a health
11 maintenance organization is considered to be the
12 supervision, rehabilitation, or liquidation of an insurer
13 and must be conducted under the supervision of the
14 commissioner pursuant to chapter 2, part 13. The
15 commissioner may apply for an order directing him to
16 supervise, rehabilitate, or liquidate a health maintenance
17 organization upon any one or more grounds set out in
18 33-2-1321, 33-2-1331, or 33-2-1341 or when in his opinion
19 the continued operation of the health maintenance
20 organization would be hazardous either to the enrollees or
21 to the people of this state. Enrollees shall have the same
22 priority in the event of liquidation or rehabilitation as
23 the law provides to policyholders of an insurer.
24 (2) A claim by a health care provider for an uncovered
25 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 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,

1 APPLY.
2 NEW SECTION. Section 22. Fees. (1) Each health
3 maintenance organization shall pay to the commissioner the
4 following fees:
5 (a) for filing an application for a certificate of
6 authority or amendment thereto, $300;
7 (b) for filing an amendment to the organization
8 documents that requires approval, $25;
9 (c) for filing each annual statement, $25.
10 (2) All fees and miscellaneous charges, except fines
11 or penalties or those amounts received pursuant to [sections
12 9(3) and 23], collected by the commissioner pursuant to
13 [sections 1 through 29] and the rules adopted thereunder
14 must be deposited in the insurance regulatory trust account
15 pursuant to 17-2-121 through 17-2-123.
16 (3) The director may assess fees necessary and
17 adequate to cover the expenses of the director's functions,
18 other-than-examinations, under this chapter. Such--fees--are
19 statutorily--appropriated--to--the--department--of-health-as
20 provided-in-17-7-502. THESE FEES MUST BE DEPOSITED IN THE
21 GENERAL FUND.
22 NEW SECTION. Section 23. Penalties and enforcement.
23 (1) The commissioner may, in addition to suspension or
24 revocation of a certificate of authority under [section 18],
25 AFTER NOTICE AND HEARING, impose an administrative penalty

1 in an amount not less than $500 or more than $10,000 if he
2 gives reasonable notice in writing of the intent to levy the
3 penalty and the health maintenance organization has a
4 reasonable time within which to remedy the defect in its
5 operations that gave rise to the penalty citation. The
6 commissioner-may-augment-this-penalty-by-an-amount-equal--to
7 the--sum--that--he--calculates-to-be-the-damages-suffered-by
8 enrollees-or-other-members-of-the-public.
9 (2) (a) If the commissioner or the director has cause
10 to believe that a violation of [sections 1 through 29] has
11 occurred or is threatened, the commissioner or the director
12 may:
13 (i)(A) give notice to the health maintenance
14 organization and to the representatives or other persons who
15 appear to be involved in the suspected violation;
16 (ii)(B) arrange a conference with the alleged
17 violators or their authorized representatives to attempt to
18 ascertain the facts relating to the suspected violation; and
19 (iii)(C) if it appears that a violation has occurred
20 or is threatened, arrive at an adequate and effective means
21 of correcting or preventing the violation.
22 (b)--Proceedings-under-this-subsection-are-not-governed
23 by-any-formal-procedural-requirements-and-may--be--conducted
24 in--a--manner--the--commissioner--or--the-director-considers
25 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

1 commercial or financial information (other than an annual
2 financial statement that the commissioner may require under
3 [section 9]), are public documents.
4 NEW SECTION. Section 26. Confidentiality of medical
5 information. (1) Any data or information pertaining to the
6 diagnosis, treatment, or health of an enrollee or applicant
7 obtained from the enrollee, applicant, or a provider by a
8 health maintenance organization must be held in confidence
9 and may not be disclosed to any person except:
10 (a) to the extent that it may be necessary to carry
11 out the purposes of [sections 1 through 29];
12 (b) upon the express consent of the enrollee or
13 applicant;
14 (c) pursuant to statute or court order for the
15 production of evidence or the discovery thereof; or
16 (d) in the event of claim or litigation between the
17 enrollee or applicant and the health maintenance
18 organization wherein the data or information is pertinent.
19 (2) A health maintenance organization is entitled to
20 claim the same statutory privileges against disclosure that
21 the provider who furnished the information to the health
22 maintenance organization is entitled to claim.
23 NEW SECTION. Section 27. Authority of director to
24 contract. The director in carrying out his obligations under
25 [sections 4(1), 17(2), and 18(1)] may contract with

1 qualified persons to make recommendations concerning the
2 determinations he is required to make. The contractors'
3 recommendations may be accepted OR REJECTED in full or in
4 part by the director.
5 NEW SECTION. Section 28. Acquisition, control, or
6 merger of a health maintenance organization. (1) Except as
7 provided in 33-2-1106 and subsection (2), no person may
8 tender for, request, or invite tenders of, or enter into an
9 agreement to exchange securities for or acquire in the open
10 market or otherwise, any voting security of a health
11 maintenance organization or enter into any other agreement
12 if, after the consummation thereof, that person would,
13 directly or indirectly, or by conversion or by exercise of
14 any right to acquire, be in control of the health
15 maintenance organization.
16 (2) No person may enter into an agreement to merge or
17 consolidate with or otherwise to acquire control of a health
18 maintenance organization, unless, at the time any offer,
19 request, or invitation is made or any agreement is entered
20 into, or prior to the acquisition of the securities if no
21 offer or agreement is involved, the acquiring person has
22 filed with the commissioner and has sent to the health
23 maintenance organization information required by
24 33-2-1104(2) and the commissioner has approved the offer,
25 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.~~

1 ~~An-insurer-shall-offer,-at-additional-cost-to--the--insured,~~
2 ~~the--option--of-disability-and-health-insurance-coverage-for~~
3 ~~services-performed-by-a-licensed-professional-counselor.~~
4 ~~(2)--Nothing-in-this--section--shall--be--construed--as~~
5 ~~enlarging--the--scope--and-limitations-of-practice-of-any-of~~
6 ~~the-licensed-professions-enumerated-in-subsection--(1);--nor~~
7 ~~shall--this--section--be-construed-as-amending,-altering,-or~~
8 ~~repealing-any-statutes-relating-to-the-licensing-or--use--of~~
9 ~~hospitals."~~
10 ~~Section-31.--Section-17-7-502,-MCA,-is-amended-to-read:~~
11 ~~"17-7-502.--Statutory--appropriations-----definition---~~
12 ~~requisites-for-validity.--(1)-A-statutory--appropriation--is~~
13 ~~an--appropriation--made--by--permanent--law--that-authorizes~~
14 ~~spending-by-a-state-agency-without-the-need-for--a--biennial~~
15 ~~legislative-appropriation-or-budget-amendment.~~
16 ~~(2)--Except--as--provided--in--subsection--(4),--to--be~~
17 ~~effective,-a-statutory-appropriation-must-comply--with--both~~
18 ~~of-the-following-provisions:~~
19 ~~(a)--The-law-containing-the-statutory-authority-must-be~~
20 ~~listed-in-subsection-(3).~~
21 ~~(b)--The--law--or-portion-of-the-law-making-a-statutory~~
22 ~~appropriation--must--specifically--state--that--a--statutory~~
23 ~~appropriation-is-made-as-provided-in-this-section.~~
24 ~~(3)--The--following--laws--are-the-only-laws-containing~~
25 ~~statutory-appropriations:~~

1 ~~(a)--2-9-202;~~
2 ~~(b)--2-17-105;~~
3 ~~(c)--2-18-812;~~
4 ~~(d)--10-3-203;~~
5 ~~(e)--10-3-312;~~
6 ~~(f)--10-3-314;~~
7 ~~(g)--10-4-301;~~
8 ~~(h)--13-37-304;~~
9 ~~(i)--15-31-702;~~
10 ~~(j)--15-36-112;~~
11 ~~(k)--15-70-101;~~
12 ~~(l)--16-1-404;~~
13 ~~(m)--16-1-410;~~
14 ~~(n)--16-1-411;~~
15 ~~(o)--17-3-212;~~
16 ~~(p)--17-5-404;~~
17 ~~(q)--17-5-424;~~
18 ~~(r)--17-5-804;~~
19 ~~(s)--19-8-504;~~
20 ~~(t)--19-9-702;~~
21 ~~(u)--19-9-1007;~~
22 ~~(v)--19-10-205;~~
23 ~~(w)--19-10-305;~~
24 ~~(x)--19-10-506;~~
25 ~~(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;~~

~~(ll)(nn)-80-2-220;~~

~~(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 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 31. 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 32. 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 33. 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 34. 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-

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~~ 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:

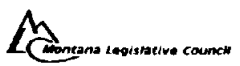
(1) "Agent" means an individual, partnership, or corporation appointed or authorized by a health maintenance organization to solicit applications for health care services agreements on its behalf.

(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;



THERE ARE NO CHANGES IN SB 353 AND DUE TO LENGTH WILL NOT BE RE-RUN. PLEASE REFER TO SECOND READING (YELLOW) COPY FOR COMPLETE TEXT.

THIRD READING

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.

REFERENCE BILL
SB 353

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."

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(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;

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

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

~~(xiv)~~(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];

~~(xv)~~(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.

1 (6) Each health maintenance organization shall
2 maintain, at its administrative office, and make available
3 to the commissioner upon request executed copies of all
4 provider contracts.
5 (7) THE COMMISSIONER MAY MAKE REASONABLE RULES
6 EXEMPTING AN INSURER OR HEALTH SERVICE CORPORATION OPERATING
7 A HEALTH MAINTENANCE ORGANIZATION AS A PLAN FROM THE FILING
8 REQUIREMENTS OF THIS SECTION IF INFORMATION REQUESTED IN THE
9 APPLICATION HAS BEEN SUBMITTED TO THE COMMISSIONER UNDER
10 OTHER LAWS AND RULES ADMINISTERED BY THE COMMISSIONER.
11 NEW SECTION. Section 4. Issuance of certificate of
12 authority. (1) Upon receipt of an application for issuance
13 of a certificate of authority, the commissioner shall
14 transmit copies of the application and accompanying
15 documents to the department of health. The department of
16 health shall determine whether the applicant for a
17 certificate of authority, with respect to health care
18 services to be furnished, has:
19 (a) demonstrated the willingness and potential ability
20 to assure that it will provide health care services in a
21 manner assuring availability and accessibility of adequate
22 personnel and facilities and enhancing availability,
23 accessibility, and continuity of service;
24 (b) arrangements, established in accordance with the
25 rules made by the department of health, for an ongoing

1 quality assurance program concerning health care ~~processes
2 and--outcomes~~ AVAILABILITY, ACCESSIBILITY, AND CONTINUITY OF
3 SERVICE; and
4 (c) a procedure, established in accordance with rules
5 of the department of health, to develop, compile, evaluate,
6 and report statistics relating to the cost of its
7 operations, the pattern of utilization of its services, the
8 availability and accessibility of its services, and any
9 other matters as may be reasonably required by the
10 department of health.
11 (2) Within ~~90~~ 60 days of receipt of the application
12 from a health maintenance organization for issuance of a
13 certificate of authority, the department of health shall
14 certify to the commissioner that the proposed health
15 maintenance organization meets the requirements of
16 subsection (1) or shall, AFTER NOTICE AND HEARING, notify
17 the commissioner that the health maintenance organization
18 does not meet those requirements and specify in what
19 respects it is deficient. The director may extend by not
20 more than an additional 30 days the period within which he
21 may certify to the commissioner that the proposed health
22 maintenance organization meets or does not meet the
23 requirements of subsection (1) by giving notice of the
24 extension to the commissioner and the health maintenance
25 organization before the expiration of the initial ~~90-day~~

1 60-DAY period.
2 (3) The commissioner shall issue or deny a certificate
3 of authority to any person filing an application pursuant to
4 [section 3] within 180 days of receipt of the certification
5 from the department of health. The commissioner shall grant
6 a certificate of authority upon payment of the application
7 fee prescribed in [section 22] if the commissioner is
8 satisfied that each of the following conditions is met:
9 (a) The persons responsible for the conduct of the
10 applicant's affairs are competent,-trustworthy,-and-of--good
11 reputation AND TRUSTWORTHY.
12 (b) The department of health certifies, in accordance
13 with subsection (2), that the health maintenance
14 organization's proposed plan of operation meets the
15 requirements of subsection (1).
16 (c) The health maintenance organization will
17 effectively provide or arrange for the provision of basic
18 health care services on a prepaid basis, through insurance
19 or otherwise, except to the extent of reasonable
20 requirements for copayments.
21 (d) The health maintenance organization is financially
22 responsible and can reasonably be expected to meet its
23 obligations to enrollees and prospective enrollees. In
24 making this determination, the commissioner may in his
25 discretion consider:

1 (i) the financial soundness of the arrangements for
2 health care services and the schedule of charges used in
3 connection therewith;
4 (ii) the adequacy of working capital;
5 (iii) any agreement with an insurer, a health service
6 corporation, a government, or any other organization for
7 ensuring the payment of the cost of health care services or
8 the provision for automatic applicability of an alternative
9 coverage in the event of discontinuance of the health
10 maintenance organization;
11 (iv) any agreement with providers for the provision of
12 health care services;
13 (v) any deposit of cash or securities submitted in
14 accordance with [section 13]; and
15 (vi) any additional information as the commissioner may
16 reasonably require.
17 (e) The enrollees will be afforded an opportunity to
18 participate in matters of policy and operation pursuant to
19 [section 6].
20 (f) Nothing in the proposed method of operation, as
21 shown by the information submitted pursuant to [section 3]
22 or by independent investigation, is-contrary-to--the--public
23 interest VIOLATES ANY PROVISION OF [SECTIONS 1 THROUGH 29]
24 OR RULES ADOPTED BY THE COMMISSIONER OR THE DEPARTMENT OF
25 HEALTH.

1 (g) Any deficiencies identified by the department of
2 health have been corrected.
3 (4) The commissioner may in his discretion deny a
4 certificate of authority only if he complies with the
5 requirements of [section 21].
6 NEW SECTION. Section 5. Powers of health maintenance
7 organizations. (1) The powers of a health maintenance
8 organization include but are not limited to the following:
9 (a) the purchase, lease, construction, renovation,
10 operation, or maintenance of a hospital, a medical facility,
11 or both, its ancillary equipment, and such property as may
12 reasonably be required for its principal office or for such
13 purposes as may be necessary in the transaction of the
14 business of the organization;
15 (b) the making of loans to a medical group under
16 contract with it in furtherance of its program or the making
17 of loans to a corporation under its control for the purpose
18 of acquiring or constructing a medical facility or hospital
19 or in furtherance of a program providing health care
20 services to enrollees;
21 (c) the furnishing of health care services through a
22 provider who is under contract with or employed by the
23 health maintenance organization;
24 (d) the contracting with a person for the performance
25 on its behalf of certain functions, such as marketing,

1 enrollment, and administration;
2 (e) the contracting with an insurer authorized to
3 transact insurance in this state, or with a health service
4 corporation authorized to do business in this state, for the
5 provision of insurance, indemnity, or reimbursement against
6 the cost of health care services provided by the health
7 maintenance organization; and
8 (f) the offering of other health care services in
9 addition to basic health care services.
10 (2) A health maintenance organization shall file
11 notice, with adequate supporting information, with the
12 commissioner before exercising a power granted in subsection
13 (1)(a), (1)(b), or (1)(d). The commissioner may, AFTER
14 NOTICE AND HEARING, WITHIN 60 DAYS disapprove the exercise
15 of a power UNDER SUBSECTION (1)(A), (1)(B), OR (1)(D) only
16 if, in his opinion, it would substantially and adversely
17 affect the financial soundness of the health maintenance
18 organization and endanger its ability to meet its
19 obligations. The commissioner may make reasonable rules
20 exempting from the filing requirement of this subsection
21 those activities having a de minimis effect. ~~The--exercise~~
22 ~~of--authority--granted--in--subsections--(1)(a),-(1)(b),-and~~
23 ~~(1)(d)-is-subject-to-disapproval-by--the--commissioner.~~ The
24 commissioner may exempt certain contracts from the filing
25 requirement whenever exercise of the authority granted in

1 this section would have little or no effect on the health
2 maintenance organization's financial condition and ability
3 to meet obligations.
4 (3) Nothing in this section exempts the activities of
5 a health maintenance organization from any applicable
6 certificate of need requirements under Title 50, chapter 5,
7 parts 1 and 3.
8 NEW SECTION. Section 6. Governing body. (1) The
9 governing body of a health maintenance organization may
10 include providers or other individuals, or both.
11 (2) The governing body shall establish a mechanism to
12 give the enrollees an opportunity to participate in matters
13 of policy and operation through the establishment of
14 advisory panels, by the use of advisory referenda on major
15 policy decisions, or through the use of other mechanisms.
16 NEW SECTION. Section 7. Fiduciary responsibilities.
17 (1) Any director, officer, employee, or partner of a health
18 maintenance organization who receives, collects, disburses,
19 or invests funds in connection with the activities of the
20 health maintenance organization is responsible for the funds
21 in the manner of a fiduciary to the health maintenance
22 organization.
23 (2) A health maintenance organization shall maintain
24 in force a fidelity bond on employees and officers in an
25 amount not less than $100,000 or such other sum as may be

1 prescribed by the commissioner. Each bond must be written
2 with at least a 1-year discovery period and, if written with
3 less than a 3-year discovery period, must contain a
4 provision that a cancellation or termination of the bond,
5 whether by or at the request of the insured or by the
6 underwriter, may not take effect prior to the expiration of
7 90 days after written notice of the cancellation or
8 termination has been filed with the commissioner unless the
9 commissioner approves an earlier cancellation or termination
10 date.
11 NEW SECTION. Section 8. Evidence of coverage and
12 charges for health care services. (1) Every enrollee
13 residing in this state is entitled to an evidence of
14 coverage. The health maintenance organization shall issue
15 the evidence of coverage, except that if the enrollee
16 obtains coverage through an insurance policy issued by an
17 insurer or a contract issued by a health service
18 corporation, whether by option or otherwise, the insurer or
19 the health service corporation shall issue the evidence of
20 coverage.
21 (2) A health maintenance organization may not issue or
22 deliver an enrollment form, an evidence of coverage, or an
23 amendment to an approved enrollment form or evidence of
24 coverage to a person in this state before a copy of the
25 enrollment form, the evidence of coverage, or the amendment

1 to the approved enrollment form or evidence of coverage is
2 filed with and approved by the commissioner.
3 (3) An evidence of coverage issued or delivered to a
4 person resident in this state may not contain a provision or
5 statement that is ~~unjust,-unfair,--inequitable,--misleading,~~
6 ~~or--deceptive,-that-encourages-misrepresentation,-or-that-is~~
7 untrue, misleading, or deceptive as defined in [section
8 14(1)]. The evidence of coverage must contain:
9 (a) a clear and concise statement, if a contract, or a
10 reasonably complete summary, if a certificate, of:
11 (i) the health care services and the insurance or
12 other benefits, if any, to which the enrollee is entitled;
13 (ii) any limitations on the services, kinds of
14 services, or benefits to be provided, including any
15 deductible or copayment feature;
16 (iii) the location at which and the manner in which
17 information is available as to how services may be obtained;
18 (iv) the total amount of payment for health care
19 services and the indemnity or service benefits, if any, that
20 the enrollee is obligated to pay with respect to individual
21 contracts; and
22 (v) a clear and understandable description of the
23 health maintenance organization's method for resolving
24 enrollee complaints.
25 (b) definitions of geographical service area,

1 emergency care, urgent care, out-of-area services,
2 dependent, and primary provider, if these terms or terms of
3 similar meaning are used in the evidence of coverage and
4 have an effect on the benefits covered by the plan. The
5 definition of geographical service area need not be stated
6 in the text of the evidence of coverage if the definition is
7 adequately described in an attachment, which is given to
8 each enrollee along with the evidence of coverage.
9 (c) clear disclosure of each provision that limits
10 benefits or access to service in the exclusions,
11 limitations, and exceptions sections of the evidence of
12 coverage. The exclusions, limitations, and exceptions that
13 must be disclosed include but are not limited to:
14 (i) emergency and urgent care;
15 (ii) restrictions on the selection of primary or
16 referral providers;
17 (iii) restrictions on changing providers during the
18 contract period;
19 (iv) out-of-pocket costs, including copayments and
20 deductibles;
21 (v) charges for missed appointments or other
22 administrative sanctions;
23 (vi) restrictions on access to care if copayments or
24 other charges are not paid; and
25 (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~~

1 ~~amendment-is-actuarially-justified-and-necessary-to-preserve~~
2 ~~the---financial---solvency---of---the---health---maintenance~~
3 ~~organization.--A--certification--by--a--qualified-actuary-or~~
4 ~~other-qualified-person-acceptable-to-the-commissioner-as--to~~
5 ~~the--appropriateness--of--the--use--of-the-charges,-based-on~~
6 ~~reasonable-assumptions,-must--accompany--the--filing,--along~~
7 ~~with-adequate-supporting-information.~~
8 (7) The commissioner shall, within ~~a-reasonable-period~~
9 60 DAYS, approve a form if the requirements of subsections
10 (1) through (5) are met. A health maintenance organization
11 may not issue a form ~~or-use-a-schedule-of-charges~~ before the
12 commissioner approves the form ~~or-the-health-maintenance~~
13 ~~organization--files--the--schedule--of---charges~~. If the
14 commissioner disapproves the filing, he shall notify the
15 filer. In the notice, the commissioner shall specify the
16 reasons for his disapproval. The commissioner shall grant a
17 hearing within 30 days after he receives a written request
18 by the filer.
19 (8) The commissioner may in his discretion require a
20 health maintenance organization to submit any RELEVANT
21 information he considers necessary in determining whether to
22 approve or disapprove a filing made pursuant to this
23 section.
24 NEW SECTION. Section 9. Annual statement --
25 revocation for failure to file -- penalty for perjury. (1)

1 ~~Each~~ UNLESS IT IS OPERATED BY AN INSURER OR A HEALTH SERVICE
2 CORPORATION AS A PLAN, EACH authorized health maintenance
3 organization shall annually on or before March 1 file with
4 the commissioner a full and true statement of its financial
5 condition, transactions, and affairs as of the preceding
6 December 31. The statement must be in the general form and
7 content required by the commissioner. The statement must be
8 verified by the oath of at least two principal officers of
9 the health maintenance organization. The commissioner may in
10 his discretion waive any verification under oath.
11 (2) At the time of filing its annual statement, the
12 health maintenance organization shall pay the commissioner
13 the fee for filing its statement as prescribed in [section
14 22]. The commissioner may refuse to accept the fee for
15 continuance of the insurer's certificate of authority, as
16 provided in [section 22], or may in his discretion suspend
17 or revoke the certificate of authority of a health
18 maintenance organization that fails to file an annual
19 statement when due.
20 (3) The commissioner may, AFTER NOTICE AND HEARING,
21 impose a fine not to exceed $5,000 per violation upon a
22 director, officer, partner, member, agent, or employee of a
23 health maintenance organization who knowingly subscribes to
24 or concurs in making or publishing an annual statement
25 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)

1 through (4) whenever he is satisfied that:
2 (a) the health maintenance organization has sufficient
3 net worth and an adequate history of generating net income
4 to assure its financial viability for the next year;
5 (b) the health maintenance organization's performance
6 and obligations are guaranteed by an organization with
7 sufficient net worth and an adequate history of generating
8 net income; or
9 (c) the health maintenance organization's assets or
10 its contracts with insurers, health service corporations,
11 governments, or other organizations are reasonably
12 sufficient to assure the performance of its obligations.
13 (6) When a health maintenance organization achieves a
14 net worth not including land, buildings, and equipment of at
15 least $1 million or achieves a net worth including
16 organization-related land, buildings, and equipment of at
17 least $5 million the annual deposit requirement under
18 subsection (3) does not apply. The annual deposit
19 requirement under subsection (3) does not apply to a health
20 maintenance organization if the total amount of the
21 accumulated deposit is greater than the capital requirement
22 for the formation or admittance of a disability insurer in
23 this state. If the health maintenance organization has a
24 guaranteeing organization that has been in operation for at
25 least 5 years and has a net worth not including land,

1 buildings, and equipment of at least $1 million or that has
2 been in operation for at least 10 years and has a net worth
3 including organization-related land, buildings, and
4 equipment of at least $5 million, the annual deposit
5 requirement under subsection (3) does not apply. If the
6 guaranteeing organization is sponsoring more than one health
7 maintenance organization, however, the net worth requirement
8 is increased by a multiple equal to the number of such
9 health maintenance organizations. This requirement to
10 maintain a deposit in excess of the deposit required of a
11 disability insurer does not apply during any time that the
12 guaranteeing organization maintains for each health
13 maintenance organization it sponsors a net worth at least
14 equal to the capital and surplus requirements for a
15 disability insurer.
16 (7) All income from deposits belongs to the depositing
17 health maintenance organization and must be paid to it as it
18 becomes available. A health maintenance organization that
19 has made a securities deposit may withdraw the deposit or
20 any part of it after making a substitute deposit of cash,
21 securities, or any combination of cash or securities of
22 equal amount and value. A health maintenance organization
23 may not substitute securities without prior approval by the
24 commissioner.
25 (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

1 ~~(c)~~ (B) an evidence of coverage is considered to be
2 deceptive if, when taken as a whole and with consideration
3 given to typography, format, and language, it can cause a
4 reasonable person, not possessing special knowledge
5 regarding health maintenance organizations, to expect
6 benefits, services, charges, or other advantages that the
7 evidence of coverage does not provide or which the health
8 maintenance organization issuing the evidence of coverage
9 does not regularly make available to enrollees covered under
10 the evidence of coverage.
11 (2) Title 33, chapter 18, applies to health
12 maintenance organizations and evidences of coverage issued
13 by a health maintenance organization, except to the extent
14 that the commissioner determines that the nature of health
15 maintenance organizations and evidences of coverage render
16 the chapter clearly inappropriate.
17 (3) A health maintenance organization shall clearly
18 disclose in the evidence of coverage the circumstances under
19 which it may disenroll, cancel, or refuse to renew an
20 enrollee. A health maintenance organization may only
21 disenroll, cancel, or refuse to renew an enrollee if the
22 enrollee:
23 (a) has failed to pay required premiums by the end of
24 the grace period;
25 (b) has committed acts of physical or verbal abuse

1 that pose a threat to providers or other enrollees of the
2 health maintenance organization;
3 (c) has allowed a nonenrollee to use the health
4 maintenance organization's certification card to obtain
5 services or has knowingly provided fraudulent information in
6 applying for coverage;
7 (d) has moved outside of the geographical service area
8 of the health maintenance organization; ~~or~~
9 (E) HAS VIOLATED RULES OF THE HEALTH MAINTENANCE
10 ORGANIZATION STATED IN THE EVIDENCE OF COVERAGE;
11 (F) HAS VIOLATED RULES ADOPTED BY THE COMMISSIONER FOR
12 ENROLLMENT IN A HEALTH MAINTENANCE ORGANIZATION; OR
13 ~~(e)~~ (G) is unable to establish or maintain a
14 satisfactory physician-patient relationship with the
15 physician responsible for the enrollee's care. Disenrollment
16 of an enrollee for this reason must be permitted only if the
17 health maintenance organization can demonstrate that it
18 provided the enrollee with the opportunity to select an
19 alternate primary care physician, made a reasonable effort
20 to assist the enrollee in establishing a satisfactory
21 physician-patient relationship, and informed the enrollee
22 that he may file a grievance on this matter.
23 (4) A health maintenance organization may not
24 disenroll an enrollee under subsection (3) for reasons
25 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.

<u>NEW SECTION.</u> 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.

<u>NEW SECTION.</u> 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

1 shall make such an examination at least once every 3 years.
2 (2) The department of health may examine the ~~quality~~
3 AVAILABILITY, ACCESSIBILITY, AND CONTINUITY of the health
4 care services provided by any health maintenance
5 organization and the providers with whom the health
6 maintenance organization has contracts, agreements, or other
7 arrangements as often as is reasonably necessary to protect
8 the interests of the people of this state. The department of
9 health shall make such an examination at least once every 3
10 years.
11 (3) Each authorized health maintenance organization
12 and provider shall submit its relevant books and records for
13 the examinations and in every way facilitate the
14 examinations. For the purpose of examination, the
15 commissioner and the department of health may administer
16 oaths to and examine the officers and agents of the health
17 maintenance organization and the principals of the providers
18 concerning their business.
19 (4) (a) (i) Upon presentation of a detailed account of
20 the charges and expenses of examinations by the
21 commissioner, the health maintenance organization being
22 examined shall pay to the examiner as necessarily incurred
23 on account of the examination the actual travel expenses, a
24 reasonable living-expense allowance, and a per diem, all at
25 reasonable rates customary therefor and as established or

1 adopted by the commissioner. The commissioner may present
2 such an account periodically during the course of the
3 examination or at the termination of the examination as the
4 commissioner considers proper. A person may not pay and an
5 examiner may not accept any additional emolument on account
6 of any such examination.
7 (ii) If a health maintenance organization fails to pay
8 the charges and expenses as referred to in subsection
9 (4)(a)(i), the commissioner shall pay them out of the funds
10 of the commissioner in the same manner as other
11 disbursements of such funds. The amount so paid must be a
12 lien upon all of the person's assets and property in this
13 state and may be recovered by suit by the attorney general
14 on behalf of the state of Montana and restored to the
15 appropriate fund.
16 (b) The expenses of examination conducted by the
17 director under this section must be assessed against the
18 health maintenance organization and remitted to the
19 director. Such remitted expenses are statutorily
20 appropriated to the department of health as provided in
21 17-7-502.
22 (5) In lieu of an examination, the commissioner or the
23 director may accept the report of an examination made by the
24 commissioner or the director of another state.
25 NEW SECTION. Section 18. Suspension or revocation of

1 certificate of authority. (1) The commissioner may in his
2 discretion suspend or revoke any certificate of authority
3 issued to a health maintenance organization under [sections
4 1 through 29] if he finds that any of the following
5 conditions exist:
6 (a) The health maintenance organization is operating
7 in contravention of its basic organizational document or in
8 a manner contrary to that described in any other information
9 submitted under [section 3] AND PROVIDED THAT SUCH OPERATION
10 ADVERSELY AFFECTS THE HEALTH MAINTENANCE ORGANIZATION'S
11 ABILITY TO PROVIDE BENEFITS AND OPERATE UNDER THE
12 APPLICATION APPROVED BY THE COMMISSIONER, unless amendments
13 to such submissions have been filed with and approved by the
14 commissioner.
15 (b) The health maintenance organization issues
16 evidences of coverage or uses a schedule of charges for
17 health care services that do not comply with the
18 requirements of [section 8].
19 (c) The health maintenance organization does not
20 provide or arrange for basic health care services.
21 (d) The director, AFTER NOTICE AND HEARING, certifies
22 to the commissioner that:
23 (i) the health maintenance organization does not meet
24 the requirements of [section 4(1)]; or
25 (ii) the health maintenance organization is unable to

1 fulfill its obligations to furnish health care services.
2 (e) The health maintenance organization is no longer
3 financially responsible and may reasonably be expected to be
4 unable to meet its obligations to enrollees or prospective
5 enrollees.
6 (f) The health maintenance organization has failed to
7 implement a mechanism affording the enrollees an opportunity
8 to participate in matters of policy and operation under
9 [section 6].
10 (g) The health maintenance organization has failed to
11 implement the complaint system required by [section 11] to
12 resolve valid complaints in a reasonable manner.
13 (h) The health maintenance organization, or any person
14 on its behalf, has advertised or merchandised its services
15 in an untrue, misrepresentative, misleading, deceptive, or
16 unfair manner.
17 (i) The continued operation of the health maintenance
18 organization would be hazardous to its enrollees.
19 (j) The health maintenance organization has otherwise
20 failed to substantially comply with [sections 1 through 29].
21 (2) The commissioner may in his discretion suspend or
22 revoke a certificate of authority only if he complies with
23 the requirements of [section 21].
24 (3) When the certificate of authority of a health
25 maintenance organization is suspended, the health

1 maintenance organization may not, during the period of such
2 suspension, enroll any additional enrollees except newborn
3 infants or other newly acquired dependents of existing
4 enrollees and may not engage in any advertising or
5 solicitation.

6 (4) If the commissioner revokes the certificate of
7 authority of a health maintenance organization, the health
8 maintenance organization shall proceed, immediately
9 following the effective date of the order of revocation, to
10 wind up its affairs and may not transact further business
11 except as may be essential to the orderly conclusion of its
12 affairs. It may not engage in further advertising or
13 solicitation following the effective date of the order of
14 revocation. The commissioner may by written order permit
15 further operation of the health maintenance organization if
16 he finds further operation to be in the best interest of
17 enrollees to the extent that enrollees will be afforded the
18 greatest practical opportunity to obtain continuing health
19 care coverage.

20 NEW SECTION. Section 19. Supervision, rehabilitation,
21 or liquidation of a health maintenance organization. (1) The
22 supervision, rehabilitation, or liquidation of a health
23 maintenance organization is considered to be the
24 supervision, rehabilitation, or liquidation of an insurer
25 and must be conducted under the supervision of the

1 commissioner pursuant to chapter 2, part 13. The
2 commissioner may apply for an order directing him to
3 supervise, rehabilitate, or liquidate a health maintenance
4 organization upon any one or more grounds set out in
5 33-2-1321, 33-2-1331, or 33-2-1341 or when in his opinion
6 the continued operation of the health maintenance
7 organization would be hazardous either to the enrollees or
8 to the people of this state. Enrollees shall have the same
9 priority in the event of liquidation or rehabilitation as
10 the law provides to policyholders of an insurer.

11 (2) A claim by a health care provider for an uncovered
12 expenditure has the same priority as a claim by an enrollee
13 if the provider of services agrees not to assert the claim
14 against any enrollee of the health maintenance organization.

15 NEW SECTION. Section 20. Rules. (1) The commissioner
16 may, after notice and hearing, make reasonable rules
17 necessary to effectuate [sections 1 through 29].

18 (2) The department of health may make reasonable rules
19 necessary to effectuate [sections 1 through 29].

20 NEW SECTION. Section 21. Administrative procedures.
21 (1) When the commissioner has cause to believe that grounds
22 for the denial of an application for a certificate of
23 authority exist or that grounds for the suspension or
24 revocation of a certificate of authority exist, he shall
25 give written notice to the health maintenance organization

1 and the department of health specifically stating the
2 grounds for denial, suspension, or revocation and fixing a
3 time of at least 30 days after the notice for a hearing on
4 the matter.
5 (2) The director or his designated representative may
6 attend the hearing and may participate in the proceeding.
7 The recommendations and findings of the director with
8 respect to matters relating to the ~~quality~~ AVAILABILITY,
9 ACCESSIBILITY, AND CONTINUITY of health care services
10 provided in connection with any decision regarding denial,
11 suspension, or revocation of a certificate of authority must
12 be conclusive and binding upon the commissioner. After the
13 hearing, or upon the failure of the health maintenance
14 organization to appear at the hearing, the commissioner
15 shall make written findings and act as he considers
16 advisable. The commissioner shall mail the written findings
17 to the health maintenance organization and submit a copy to
18 the director. The action of the commissioner and the
19 recommendations and findings of the director are subject to
20 review by the district court having jurisdiction. The court
21 may, in disposing of the issue before it, modify, affirm, or
22 reverse the order of the commissioner in whole or in part.
23 (3) ~~The-Montana-Administrative-Procedure-Act,-Title-2,~~
24 ~~chapter-4,-applies-to-proceedings-under-this-section-to--the~~
25 ~~extent-it-is-not-in-conflict-with-this-section.~~ WHERE NOTICE

1 AND HEARING ARE REQUIRED WITH REGARD TO ACTIONS TAKEN BY THE
2 COMMISSIONER UNDER [SECTIONS 1 THROUGH 29], THE REQUIREMENTS
3 OF 33-1-314 THROUGH 33-1-316 AND TITLE 33, CHAPTER 1, PART
4 7, APPLY, EXCEPT THAT THE FORMAL RULES OF PLEADING AND
5 EVIDENCE MUST BE OBSERVED. TO THE EXTENT THAT 33-1-314
6 THROUGH 33-1-316 AND TITLE 33, CHAPTER 1, PART 7, DO NOT
7 ADDRESS THE NOTICE AND HEARING REQUIREMENTS OF [SECTIONS 1
8 THROUGH 29], THE PROVISIONS OF TITLE 2, CHAPTER 4, PARTS 6
9 AND 7, APPLY.
10 (4) WHERE NOTICE AND HEARING ARE REQUIRED WITH REGARD
11 TO ACTIONS TAKEN BY THE DIRECTOR UNDER [SECTIONS 1 THROUGH
12 29], THE PROVISIONS OF TITLE 2, CHAPTER 4, PARTS 6 AND 7,
13 APPLY.
14 NEW SECTION. Section 22. Fees. (1) Each health
15 maintenance organization shall pay to the commissioner the
16 following fees:
17 (a) for filing an application for a certificate of
18 authority or amendment thereto, $300;
19 (b) for filing an amendment to the organization
20 documents that requires approval, $25;
21 (c) for filing each annual statement, $25;
22 (D) FOR ANNUAL CONTINUATION OF CERTIFICATE OF
23 AUTHORITY, $300.
24 (2) All fees and miscellaneous charges, except fines
25 or penalties or those amounts received pursuant to [sections

1 9(3) and 23], collected by the commissioner pursuant to
2 [sections 1 through 29] and the rules adopted thereunder
3 must be deposited in the insurance regulatory trust account
4 pursuant to 17-2-121 through 17-2-123.
5 (3) The director may assess fees necessary and
6 adequate to cover the expenses of the director's functions,
7 other--than--examinations, under this chapter. Such-fees-are
8 statutorily-appropriated-to--the--department--of--health--as
9 provided--in--17-7-502. THESE-FEES-MUST-BE-DEPOSITED-IN-THE
10 GENERAL-FUND. SUCH FEES ARE STATUTORILY APPROPRIATED TO THE
11 DEPARTMENT OF HEALTH AS PROVIDED IN 17-7-502.
12 NEW SECTION. Section 23. Penalties and enforcement.
13 (1) The commissioner may, in addition to suspension or
14 revocation of a certificate of authority under [section 18],
15 AFTER NOTICE AND HEARING, impose an administrative penalty
16 in an amount not less than $500 or more than $10,000 if he
17 gives reasonable notice in writing of the intent to levy the
18 penalty and the health maintenance organization has a
19 reasonable time within which to remedy the defect in its
20 operations that gave rise to the penalty citation. The
21 commissioner-may-augment-this-penalty-by-an-amount-equal--to
22 the--sum--that--he--calculates-to-be-the-damages-suffered-by
23 enrollees-or-other-members-of-the-public.
24 (2) (a) If the commissioner or the director has cause
25 to believe that a violation of [sections 1 through 29] has

1 occurred or is threatened, the commissioner or the director
2 may:
3 (i)(A) give notice to the health maintenance
4 organization and to the representatives or other persons who
5 appear to be involved in the suspected violation;
6 (ii)(B) arrange a conference with the alleged
7 violators or their authorized representatives to attempt to
8 ascertain the facts relating to the suspected violation; and
9 (iii)(C) if it appears that a violation has occurred
10 or is threatened, arrive at an adequate and effective means
11 of correcting or preventing the violation.
12 (b)--Proceedings-under-this-subsection-are-not-governed
13 by-any-formal-procedural-requirements-and-may--be--conducted
14 in--a--manner--the--commissioner--or--the-director-considers
15 appropriate--under--the---circumstances.---However,---unless
16 consented-to-by-the-health-maintenance-organization,-no-rule
17 or-order-may-result-from-a-conference-until-the-requirements
18 of-[section-21]-or-this-section-are-satisfied.
19 (3) (a) The commissioner may issue an order directing
20 a health maintenance organization or its representative to
21 cease and desist from engaging in an act or practice in
22 violation of [sections 1 through 29].
23 (b) Within 15 days after service of the cease and
24 desist order, the respondent may request a hearing to
25 determine whether acts or practices in violation of

1 [sections 1 through 29] have occurred. The hearing must be
2 conducted pursuant to Title 2, chapter 4, part 6, and
3 judicial review must be available as provided by Title 2,
4 chapter 4, part 7.
5 (4) If a health maintenance organization violates a
6 provision of [sections 1 through 29] and the commissioner
7 elects not to issue a cease and desist order or if the
8 respondent does not comply with a cease and desist order
9 issued pursuant to subsection (3), the commissioner may
10 institute a proceeding to obtain injunctive or other
11 appropriate relief in the district court of Lewis and Clark
12 County.
13 NEW SECTION. Section 24. Statutory construction and
14 relationship to other laws. (1) Except as otherwise provided
15 in [sections 1 through 29], the insurance or health service
16 corporation laws do not apply to any health maintenance
17 organization authorized to transact business under [sections
18 1 through 29]. This provision does not apply to an insurer
19 or health service corporation licensed and regulated
20 pursuant to the insurance or health service corporation laws
21 of this state except with respect to its health maintenance
22 organization activities authorized and regulated pursuant to
23 [sections 1 through 29].
24 (2) Solicitation of enrollees by a health maintenance
25 organization granted a certificate of authority or its

1 representatives may not be construed as a violation of any
2 law relating to solicitation or advertising by health
3 professionals.
4 (3) A health maintenance organization authorized under
5 [sections 1 through 29] may not be considered to be
6 practicing medicine and is exempt from Title 37, chapter 3,
7 relating to the practice of medicine.
8 (4) The provisions of [sections 1 through 29] do not
9 exempt a health maintenance organization from the applicable
10 certificate of need requirements under Title 50, chapter 5,
11 parts 1 and 3.
12 NEW SECTION. Section 25. Filings and reports as
13 public documents. All applications, filings, and reports
14 required under [sections 1 through 29], except those that
15 contain trade secrets or privileged or confidential
16 commercial or financial information (other than an annual
17 financial statement that the commissioner may require under
18 [section 9]), are public documents.
19 NEW SECTION. Section 26. Confidentiality of medical
20 information. (1) Any data or information pertaining to the
21 diagnosis, treatment, or health of an enrollee or applicant
22 obtained from the enrollee, applicant, or a provider by a
23 health maintenance organization must be held in confidence
24 and may not be disclosed to any person except:
25 (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~~

1 which--a--substantial--number--of--the--employees-or-members
2 reside.-If--there--is--a--prevailing--collective--bargaining
3 agreement,---the---selection---of---the--health--maintenance
4 organization-to-be-made-available-to-the-employees--must--be
5 made-pursuant-to-the-agreement.
6 (2) An employer in this state THAT OFFERS ITS
7 EMPLOYEES THE OPTION TO ENROLL IN A HEALTH MAINTENANCE
8 ORGANIZATION AND AN EMPLOYEE BENEFIT FUND IN THIS STATE THAT
9 OFFERS ITS MEMBERS THE OPTION TO ENROLL IN A HEALTH
10 MAINTENANCE ORGANIZATION may not be required to pay more for
11 health benefits as-a--result--of--the--application--of--this
12 section PROVIDED BY THE HEALTH MAINTENANCE ORGANIZATION than
13 it would otherwise be required to provide by any prevailing
14 collective bargaining agreement or other contract for the
15 provision of health benefits to its employees, if the
16 employer or benefits fund pays to the health maintenance
17 organization chosen by each employee or member an amount
18 equal to the lesser of:
19 (a)(1) the amount paid on behalf of its other
20 employees or members of health benefits; or
21 (b)(2) the health maintenance organization's charge
22 for coverage approved by the commissioner pursuant to
23 [section 8].
24 Section-30.--Section--33-22-111,--MCA,--is--amended--to
25 read:

1 "33-22-111.--Policies-to-provide-for-freedom-of--choice
2 of-practitioners----professional-practice-not-enlarged.--(1)
3 All Except--as--provided--in--[sections--1-through-29],-all
4 policies--of--disability--insurance,--including--individual,
5 group,--and--blanket-policies,-and-all-policies-insuring-the
6 payment-of-compensation-under-the-Workers'-Compensation--Act
7 shall--provide-the-insured-shall-have-full-freedom-of-choice
8 in-the-selection-of-any-duly--licensed--physician,--dentist,
9 osteopath,-----chiropractor,----optometrist,----chiropodist,
10 psychologist,-licensed-social-worker,-or-nurse-specialist-as
11 specifically-listed-in-37-8-202-for-treatment-of-any-illness
12 or-injury-within-the-scope-and-limitations-of-his--practice.
13 Whenever--such-policies-insure-against-the-expense-of-drugs,
14 the-insured--shall--have--full--freedom--of--choice--in--the
15 selection--of--any--duly-licensed-and-registered-pharmacist.
16 An-insurer-shall-offer,-at-additional-cost-to--the--insured,
17 the--option--of-disability-and-health-insurance-coverage-for
18 services-performed-by-a-licensed-professional-counselor.
19 (2)--Nothing-in-this--section--shall--be--construed--as
20 enlarging--the--scope--and-limitations-of-practice-of-any-of
21 the-licensed-professions-enumerated-in-subsection--(1);--nor
22 shall--this--section--be-construed-as-amending,-altering,-or
23 repealing-any-statutes-relating-to-the-licensing-or--use--of
24 hospitals."
25 Section-31.--Section-17-7-502,-MCA,-is-amended-to-read:

1 "17-7-502.--Statutory--appropriations-----definition---
2 requisites-for-validity.--(1)-A-statutory--appropriation--is
3 an--appropriation--made--by--permanent--law--that-authorizes
4 spending-by-a-state-agency-without-the-need-for--a--biennial
5 legislative-appropriation-or-budget-amendment.
6 (2)--Except--as--provided--in--subsection--(4),--to--be
7 effective,-a-statutory-appropriation-must-comply--with--both
8 of-the-following-provisions:
9 (a)--The-law-containing-the-statutory-authority-must-be
10 listed-in-subsection-(3).
11 (b)--The--law--or-portion-of-the-law-making-a-statutory
12 appropriation--must--specifically--state--that--a--statutory
13 appropriation-is-made-as-provided-in-this-section.
14 (3)--The--following--laws--are-the-only-laws-containing
15 statutory-appropriations:
16 (a)--2-9-202;
17 (b)--2-17-105;
18 (c)--2-18-812;
19 (d)--10-3-203;
20 (e)--10-3-312;
21 (f)--10-3-314;
22 (g)--10-4-301;
23 (h)--13-37-304;
24 (i)--15-31-702;
25 (j)--15-36-112;

1 (k)--15-70-101;
2 (l)--16-1-404;
3 (m)--16-1-410;
4 (n)--16-1-411;
5 (o)--17-3-212;
6 (p)--17-5-404;
7 (q)--17-5-424;
8 (r)--17-5-804;
9 (s)--19-8-504;
10 (t)--19-9-702;
11 (u)--19-9-1007;
12 (v)--19-10-205;
13 (w)--19-10-305;
14 (x)--19-10-506;
15 (y)--19-11-512;
16 (z)--19-11-513;
17 (aa)-19-11-606;
18 (bb)-19-12-301;
19 (cc)-19-13-604;
20 (dd)-20-6-406;
21 (ee)-20-8-111;
22 (ff)-23-5-612;
23 (gg)-[section-17];
24 (hh)-[section-22];
25 (gg)(ii)-37-51-501;

1 ~~(hh)~~(jj)~~-53-24-206;~~
2 ~~(ii)~~(kk)~~-75-1-1101;~~
3 ~~(jj)~~(ll)~~-75-7-305;~~
4 ~~(kk)~~(mm)~~-80-2-103;~~
5 ~~(ll)~~(nn)~~-80-2-228;~~
6 ~~(mm)~~(oo)~~-90-3-301;~~
7 ~~(nn)~~(pp)~~-90-3-302;~~
8 ~~(oo)~~(qq)~~-90-15-103;-and~~
9 ~~(pp)~~(rr)~~-Sec.-13,-HB-861,-L.-1985.~~
10 ~~(4)--There-is-a--statutory--appropriation--to--pay--the~~
11 ~~principal,-interest,-premiums,-and-costs-of-issuing,-paying,~~
12 ~~and-securing-all-bonds,-notes,-or-other-obligations,-as-due,~~
13 ~~that-have-been-authorized-and-issued-pursuant-to-the-laws-of~~
14 ~~Montana.---Agencies---that---have--entered--into--agreements~~
15 ~~authorized--by--the--laws--of--Montana--to--pay--the---state~~
16 ~~treasurer,--for--deposit-in-accordance-with-17-2-101-through~~
17 ~~17-2-107,-as-determined-by-the-state--treasurer,--an--amount~~
18 ~~sufficient--to--pay-the-principal-and-interest-as-due-on-the~~
19 ~~bonds-or-notes-have-statutory--appropriation--authority--for~~
20 ~~such-payments.~~"
21 SECTION 30. SECTION 17-7-502, MCA, IS AMENDED TO READ:
22 "17-7-502. Statutory appropriations -- definition --
23 requisites for validity. (1) A statutory appropriation is an
24 appropriation made by permanent law that authorizes spending
25 by a state agency without the need for a biennial

1 legislative appropriation or budget amendment.
2 (2) Except as provided in subsection (4), to be
3 effective, a statutory appropriation must comply with both
4 of the following provisions:
5 (a) The law containing the statutory authority must be
6 listed in subsection (3).
7 (b) The law or portion of the law making a statutory
8 appropriation must specifically state that a statutory
9 appropriation is made as provided in this section.
10 (3) The following laws are the only laws containing
11 statutory appropriations:
12 (a) 2-9-202;
13 (b) 2-17-105;
14 (c) 2-18-812;
15 (d) 10-3-203;
16 (e) 10-3-312;
17 (f) 10-3-314;
18 (g) 10-4-301;
19 (h) 13-37-304;
20 (i) 15-31-702;
21 (j) 15-36-112;
22 (k) 15-70-101;
23 (l) 16-1-404;
24 (m) 16-1-410;
25 (n) 16-1-411;

1 (o) 17-3-212;
2 (p) 17-5-404;
3 (q) 17-5-424;
4 (r) 17-5-804;
5 (s) 19-8-504;
6 (t) 19-9-702;
7 (u) 19-9-1007;
8 (v) 19-10-205;
9 (w) 19-10-305;
10 (x) 19-10-506;
11 (y) 19-11-512;
12 (z) 19-11-513;
13 (aa) 19-11-606;
14 (bb) 19-12-301;
15 (cc) 19-13-604;
16 (dd) 20-6-406;
17 (ee) 20-8-111;
18 (ff) 23-5-612;
19 (gg) [section 17];
20 (hh) [section 22];
21 ~~(gg)~~(ii) 37-51-501;
22 ~~(hh)~~(jj) 53-24-206;
23 ~~(ii)~~(kk) 75-1-1101;
24 ~~(jj)~~(ll) 75-7-305;
25 ~~(kk)~~(mm) 80-2-103;

1 ~~(ll)~~(nn) 80-2-228;
2 ~~(mm)~~(oo) 90-3-301;
3 ~~(nn)~~(pp) 90-3-302;
4 ~~(oo)~~(qq) 90-15-103; and
5 ~~(pp)~~(rr) Sec. 13, HB 861, L. 1985.
6 (4) There is a statutory appropriation to pay the
7 principal, interest, premiums, and costs of issuing, paying,
8 and securing all bonds, notes, or other obligations, as due,
9 that have been authorized and issued pursuant to the laws of
10 Montana. Agencies that have entered into agreements
11 authorized by the laws of Montana to pay the state
12 treasurer, for deposit in accordance with 17-2-101 through
13 17-2-107, as determined by the state treasurer, an amount
14 sufficient to pay the principal and interest as due on the
15 bonds or notes have statutory appropriation authority for
16 such payments."
17 SECTION 31. SECTION 33-1-102, MCA, IS AMENDED TO READ:
18 "33-1-102. Compliance required -- exceptions -- health
19 service corporations. (1) No person shall transact a
20 business of insurance in Montana or relative to a subject
21 resident, located, or to be performed in Montana without
22 complying with the applicable provisions of this code.
23 (2) No provision of this code shall apply with respect
24 to:
25 (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

1 this act is invalid, all valid parts that are severable from
2 the invalid part remain in effect. If a part of this act is
3 invalid in one or more of its applications, the part remains
4 in effect in all valid applications that are severable from
5 the invalid applications.
6 NEW SECTION. Section 35. Effective date --
7 applicability. ~~This--act-is~~ SECTION 20 AND THIS SECTION ARE
8 effective on passage and approval ~~and~~. THIS ACT applies to
9 health maintenance organizations formed before or after the
10 effective date of this act.

-End-

STANDING COMMITTEE REPORT

HOUSE 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.

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

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 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: "$25"
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.

"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;
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(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.

(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.

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.