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The Montana Administrative Register (MAR), a monthly publication, has three sections. The notice section contains state agencies' proposed new, amended or repealed rules, the rationale for the change, date and address of public hearing and where written comments may be submitted. The rule section indicates that the proposed rule action is adopted and lists any changes made since the proposed stage. The interpretation section contains the attorney general's opinions and state declaratory rulings. Special notices and tables are inserted at the back of each register.

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STATE COMPENSATION
MUTUAL INSURANCE FUND

In the matter of the adoption of Rules I through XI relating to the organization and board meetings of the State Fund and the establishment of premium rates.) NOTICE OF PUBLIC HEARING) FOR THE PROPOSED ADOPTION) OF RULES RELATING TO) STATE FUND ORGANIZATION,) BOARD MEETINGS, AND) PREMIUM RATES

TO: All Interested Persons

1. On December 7, 1990, a public hearing will be held at 2:00 p.m. in Room 303 of the State Compensation Mutual Insurance Fund Building, 5 South Last Chance Gulch, Helena Montana, to consider the proposed adoption of new rules relating to organization of the State Compensation Mutual Insurance Fund, meetings of the State Fund Board of Directors, and the establishment of premium rates for State Fund policyholders.

2. The rules as proposed to be adopted appear as follows:

RULE I. ORGANIZATIONAL RULE (1) Organization of the State Compensation Mutual Insurance Fund:

(a) History. The State Compensation Mutual Insurance Fund (state fund) was implemented under the provisions of Sec. 39-71-2313, MCA (1989) on January 1, 1990. Its functions and responsibilities are set forth in Title 39, chapter 71, part 23, MCA.

(b) Departments. The state fund consists of the following departments:

(i) Underwriting department;

(ii) Benefits department;

(iii) Legal department; and

(iv) Administrative and finance department.

(c) Board of Directors. The board of directors, appointed by the governor, is responsible for the management and control of the state fund.

(d) President. The president, appointed by the board of directors, has general responsibility for the operations of the state fund.

(e) Executive Vice-President. The executive vice-president has the responsibility of assisting the president in the implementation of policy and procedures under the direction of the president, as well as the responsibility for data processing services.

(f) Executive Staff. The executive staff performs general administrative functions for the president and vice-president of the state fund. Its activities include, but are not limited to, personnel, special projects, and support.

(2) Functions of Department.

(a) Underwriting Department. The underwriting department has the responsibility of underwriting and administering policies of workers' compensation insurance. Its activities

include marketing, issuance, and cancellation of policies; safety; audits; and employer services regarding policies of insurance.

(b) Benefits Department. The benefits department has the responsibility for all aspects of administering and adjusting claims for benefits.

(c) Legal Department. The legal department is responsible for providing legal services to the state fund.

(d) Administrative and Finance Department. The administrative and finance department has the responsibility of performing accounting and related services, providing administrative support, and assisting in compliance with state budgetary laws and procedures.

(3) Information or submissions. General inquiries regarding the state fund may be addressed to the executive vice-president. Specific inquiries regarding the functions of each department may be addressed to the vice-president who heads the particular department. The address of the state fund is 5 South Last Chance Gulch, Helena, Montana 59601.

(4) Charts of Agency Organization. A descriptive chart of the state fund is attached as the following page and is incorporated in this rule. (AUTH: 2-4-201, MCA; IMP: 2-4-201, MCA.)

RULE II. OPEN MEETINGS (1) All meetings of the state fund board of directors are open to the public, subject to the provisions of Title 2, chapter 3, part 2, MCA. The date, time, and place of a meeting of the board of directors may be obtained by contacting the State Fund, 5 South Last Chance Gulch, Helena, Montana 59601 or by calling (406) 444-6518. (AUTH: 2-3-103, MCA; IMP: 2-3-103, MCA.)

RULE III. METHOD FOR ASSIGNMENT OF CLASSIFICATIONS OF EMPLOYMENTS (1) Risks insured by the state fund must be divided by the state fund into classifications. An individual classification must group together risks, so that each classification reflects exposures common to those employers in the classification.

(2) An employer covered by a state fund policy must be assigned a classification according to the type of exposure to risk within the employer's business. The classification generally includes all the various types of labor of the business. If a single classification is not sufficient to describe the risk, more than one classification may be assigned to the employer.

(3) The state fund shall assign its insureds to classifications contained in the classifications section of the State Compensation Insurance Fund Policy Services Underwriting Manual issued July 1, 1990. That section of the manual is hereby incorporated by reference. Copies of the classification section of the manual may be obtained from the Underwriting Department of the State Fund, 5 South Last Chance Gulch, Helena, Montana 59601. (AUTH: 39-71-2316, MCA; IMP:39-71-2311, 39-71-2316, MCA.)

RULE IV. CALCULATION OF EXPERIENCE RATES (1) For each classification, the state fund shall calculate an experience rate based upon the experience of the class. The experience rate must be based on a review of the total incurred losses and total payroll in the classification during up to 10 full fiscal years immediately preceding the date of review, adjusted by an expense ratio. "Fiscal year" means the year beginning July 1.

(2) The experience rate for a classification must assume an expense ratio that takes into account operational and administrative costs. (AUTH: 39-71-2316, MCA; IMP: 39-71-2311, 39-71-2316, MCA.)

RULE V. CALCULATION OF CREDIBILITY WEIGHTED RATES (1) If the payroll, premium, and losses in a particular classification are not sufficient to provide a meaningful and credible statistical basis for estimating an equitable distribution of costs, the state fund actuary shall determine a credibility weighted rate for each classification.

(2) The credibility weighted rate is assigned to a classification in order to modify the experience rate. It is based on the actuary's determination of the reliability and predictability of the classification statistical data. In determining the credibility weighted rates, the state fund actuary shall consider the experience rate, existing manual rate, payroll, premium, and losses. (AUTH: 39-71-2316, MCA; IMP: 39-71-2311, 39-71-2316, MCA.)

RULE VI. DETERMINATION OF AGGREGATE REVENUE REQUIREMENTS (1) In order to determine the premium rate to be charged to an insured covered by the state fund for the following fiscal year, the state fund shall actuarially determine the projected revenue requirements for the year. The projected total revenue must be sufficient to cover:

(a) the value of claims, as determined by actuarial analysis, expected to be incurred as a direct result of covered accidents during the following fiscal year;

(b) operational and administrative expenses, claims adjustment expense related to covered claims, and other expenses required to operate the state fund for the fiscal year; and

(c) an amount sufficient to maintain appropriate contingency reserves and policy holder surplus.

(2) In determining the projected revenue requirements for the following state fund fiscal year, the state fund actuary shall consider:

(a) the present financial condition of the state fund;

(b) trends in the number of accidents incurred during the immediately preceding period of up to 12 years;

(c) trends in the cost of accidents incurred during the immediately preceding period of up to 12 years;

(d) the estimate of investment and other income accruing to the state fund for the following fiscal year;

(e) recent court decisions that may affect the liability of the state fund;

(f) legislative changes in the statutory benefit scheme;

(g) factors relating to maintenance of the policy base of the state fund;

(h) the anticipated changes in covered payroll during the year for which the premium rates will be in effect; and

(i) other factors the state fund considers relevant in establishing an accurate projection of revenue requirements. (AUTH: 39-71-2316, MCA; IMP: 39-71-2311, 39-71-2316, MCA.)

RULE VII. PREMIUM RATESETTING (1) Except as provided in subsections (2) through (4), to establish a premium rate for a classification for the following fiscal year, the state fund shall apply a factor to each credibility weighted rate in an amount sufficient to ensure that the aggregate of the premium for all classifications provides an amount sufficient to meet the actuarially determined aggregate revenue projections.

(2) The state fund shall evaluate an individual classification to determine whether the process for setting the premium rate results in an equitable rate based on an analysis of the losses and the premium amount and, if the rate is not equitable, may adjust it so that it is equitable.

(3) If appropriate, the state fund may review National Council on Compensation Insurance (NCCI) rates for the same classification in determining a premium rate.

(4) The state fund, subject to the approval of the state fund board of directors, may limit the percentage amount of premium rate increases or decreases if the limitation is applied to all classifications and the state fund is maintained on an actuarially sound basis. In establishing a limitation, the state fund may consider such factors as market share, catastrophic or unusual losses, rate stabilization, and economic impact on the state fund. (AUTH: 39-71-2316, MCA; IMP: 39-71-2311, 39-71-2316, MCA.)

RULE VIII. EXPERIENCE MODIFICATION FACTOR (1) An insured, whose premium level qualifies, must be assigned an experience modification factor that reflects the insured's actual experience in comparison to the expected experience. "Experience modification factor" means a factor derived from an evaluation of payroll and accident experience in previous policy periods that is based on the formula of a national rating organization.

(2) The state fund shall use the methods used by the workers' compensation rating organization to identify a qualified insured and determine the insured's experience modification factor in order to reward an insured with a good safety record and penalize an insured with a poor safety record.

(3) The state fund may use only experience incurred within the state in determining an experience modification factor. (AUTH: 39-71-2316, MCA; IMP: 39-71-2311, 39-71-2316, MCA.)

RULE IX. VARIABLE PRICING WITHIN A CLASSIFICATION (1) Effective July 1, 1991, the state fund shall implement variable pricing levels within individual classifications based upon:

(a) the amount of premium paid by an insured;
(b) the insured's loss ratio; and
(c) a record of timely premium payment.
(2) An insured is subject to variable pricing until the amount of premium paid by the insured results in an experience modification of the insured's premium rate. (AUTH: 39-71-2316, MCA; IMP: 39-71-2311, MCA.)

RULE X. VOLUME DISCOUNT (1) The state fund may provide to insureds covered by the state fund a fiscal year percentage reduction of premium, based on premium volume. (AUTH: 39-71-2316, MCA; IMP: 39-71-2311, 39-71-2316, MCA.)

RULE XI. MINIMUM YEARLY PREMIUM (1) As permitted by 39-71-2316, MCA, the state fund, subject to the approval of the state fund board of directors, may charge a minimum yearly premium in order to cover its administrative costs for coverage of a small employer.
(2) In calculating a minimum yearly premium, the state fund shall identify the direct and indirect costs associated with the administration of all insurance policy contracts. The costs then must be divided by the number of employers insured by the state fund. Each employer insured by the state fund must be assessed and pay no less than the minimum yearly premium. (AUTH: 39-71-2316, MCA; IMP: 39-71-2316, MCA.)

3. Section 2-4-201(1), MCA, requires each state agency to adopt as a rule a description of its organization, stating the general course and method of its operation and methods whereby the public may obtain information or make submissions or requests. Rule I is necessary to effectuate this statutory requirement. It describes the operating organization of the state fund and provides the method for obtaining information from and submitting information to the state fund.
Section 2-3-103, MCA, requires each state agency to develop, by rule, procedures for permitting and encouraging the public to participate in agency decisions that are of significant interest to the public. Rule II is necessary to effectuate this statutory requirement because it provides that the meetings of the state fund board of directors will be open to the public and advises the public of the means of obtaining notice of the meetings.
Section 39-71-2311, MCA, requires the state fund to be neither more nor less than self-supporting and that premium rates be set at least annually at a level sufficient to ensure the adequate funding of the insurance program. Section 39-71-2316, MCA, provides that the state fund may adopt classifications and charge premiums for the classifications so that the state fund will be neither more nor less than self-supporting. The state fund is proposing to adopt Rules III through XI to establish a process for setting premium rates that ensures that the state fund will be actuarially sound and not more nor less than self-supporting, and that equitably distributes the costs of the state fund insurance program among

its policyholders.

Rule III establishes a classification system that groups together employers with a similar exposure to losses. The system establishes each classification as both homogeneous and large enough to provide a meaningful statistical base in order to ensure an equitable distribution of costs. This classification system also ensures the integrity of the data base which is essential to pricing and experience rating. The rule requires the state fund to assign an employer to a classification that best describes the employer's business and includes all the various types of labor. The classification by the employer's general risk is intended to promote safety and loss prevention because grouping employers by the nature of their business provides an industry with the incentive to control its own workers' compensation costs through industrywide safety and loss prevention programs.

RULE IV establishes a procedure by which the state fund may use the past insurance experience of a classification to forecast or predict future losses in order to provide the most appropriate rate for the classification. This process helps to ensure that the costs of providing workers' compensation insurance are equitably distributed among state fund policyholders.

Rule V provides a procedure by which the state fund may, if a classification does not have sufficient experience to provide a meaningful statistical base, assign a credibility factor to the classification to arrive at a credibility weighted rate that allows the rate to be more fairly determined.

Rule VI is necessary to ensure that, as required by 39-71-2311, MCA, premium rates are set at a level sufficient to adequately fund the insurance program and predict future costs. The proposed rule requires the state fund, through its actuary, to adequately predict the revenue requirements for the policy year. The rule states the cost elements that must be fully funded through premium collection and the relevant factors that must be considered in arriving at an accurate projection of aggregate revenue requirements.

Rule VII sets forth process by which the state fund sets a premium rate for an individual classification in order to ensure that the insurance program is self-supporting, as required by 39-71-2311 and 39-71-2316, MCA. The rule requires the state fund to apply a load factor, either upwards or downwards, in order to raise sufficient premium to satisfy aggregate revenue projections. The rule also allows the state fund to analyze an individual classification to determine if the rate is fair and to adjust it if it is not appropriate, based on an analysis of the losses and the premium amount. This process is necessary to allow the state fund to set its rates so that one classification is not assuming more than its equitable share of the costs of providing insurance. The rule also allows the state fund to set a cap on rates, either upwards or downwards, in order to ensure that a rate for a classification does not fluctuate too widely.

Rules VIII and IX establish two separate methods for "implementing variable pricing levels within individual rate

classifications to reward an employer with a good safety record and penalize an employer with a poor safety record", as required by 39-71-2311, MCA. Rule VIII allows the state fund to provide the individual insured with a rate that best indicates the insured's own potential for incurring claims. This ensures that the insured's premium rate is appropriate for the insurance protection being provided and also provides an incentive for loss prevention. Rule IX allows for several separate levels of pricing within an individual classification as a further method of providing an incentive for the insured to develop and maintain a good safety record.

Rule X allows the state fund to provide a volume discount for its insureds based on their premium volume. This type of discount is offered by other workers' compensation insurers. The rule is necessary to allow the state fund to give its larger insureds credit for the economies of scale in expenses to service them. The rule also allows the state fund to develop and maintain its market share in order to attract and keep the better risks that offset the poorer risks which the state fund, as the insurer of last resort, is required by 39-71-2311, MCA, to insure.

Rule XI is necessary to establish the method whereby the state fund may set a minimum yearly premium, as allowed by 39-71-2316, MCA, to recoup the costs of servicing a smaller policyholder. The rule clarifies that the costs of administering all policies must be added together and all state fund insureds must pay at least the amount established by dividing those costs by the number of insureds.

4. Interested persons may present their data, views, or arguments, either orally or in writing, at the hearing. Written testimony may be submitted to state fund attorney Nancy Butler, Legal Department, State Compensation Mutual Insurance Fund, 5 South Last Chance Gulch, Helena, Montana 59601, no later than December 14, 1990.

5. The State Fund Legal and Underwriting Departments have been designated to preside over and conduct the hearing.

State Compensation Mutual Insurance Fund

By: Patrick J. Sweeney, President

Certified to the Secretary of State November 5, 1990

BEFORE THE DEPARTMENT OF ADMINISTRATION
OF THE STATE OF MONTANA

In the matter of the proposed amendment of ARM 2.21.3802, 2.21.3803, 2.21.3807, 2.21.3808, 2.21.3811, 2.21.5006, 2.21.5007, the repeal of ARM 2.21.3812 and the adoption of two new rules relating to probation, recruitment and selection, and reduction in work force	NOTICE OF PUBLIC HEARING ON THE AMENDMENT OF ARM 2.21.3802, 2.21.3803, 2.21.3807, 2.21.3808, 2.21.3811, 2.21.5006, 2.21.5007, THE REPEAL OF ARM 2.21.3812 AND THE ADOPTION OF TWO NEW RULES RELATING TO PROBATION, RECRUITMENT AND SELECTION, AND REDUCTION IN WORK FORCE

TO: All Interested Persons.

1. On December 11, 1990, at 9:00 a.m. in Room 136, Mitchell Building, Helena, Montana, a public hearing will be held to consider the amendment of ARM 2.21.3802, 2.21.3803, 2.21.3807, 2.21.3808, 2.21.3811, 2.21.5006, 2.21.5007, the repeal of ARM 2.21.3812 and the adoption of two new rules relating to probation, recruitment and selection and reduction in work force.

2. The rule proposed to be repealed is found at page 2-1139 of the Administrative Rules of Montana.

3. The rules proposed to be amended provide as follows:

2.21.3802 POLICY AND OBJECTIVES (1) It is the policy of the state of Montana that an employee newly hired ~~or transferred~~ into a permanent position shall complete a probationary period.

(2) Remains the same.

(Auth. 2-18-102, MCA; Imp. 2-18-102, MCA)

2.21.3803 DEFINITIONS As used in this sub-chapter, the following definitions apply:

(1) - (5) Remain the same.

(6) "Probationary period" means a trial period established by an agency when an employee is newly hired ~~or transferred~~ to state government ~~into~~ in a permanent or seasonal position to assess the employee's abilities to perform job duties; to assess the employee's conduct on the job, and to determine if the employee should be retained beyond the probationary period and attain permanent status.

(7) - (11) Remain the same.

(Auth. 2-18-102, MCA; Imp. 2-18-102, MCA)

2.21.3807 PERMANENT STATUS (1) - (2) Remain the same.

(3) An employee who has attained permanent status in an agency and who transfers to another agency retains permanent status. The employee has no rights to the position held in the former agency.

(4) Where a position or work unit is transferred between agencies as a result of reorganization, an employee retains permanent status in the agency to which the position or work unit transfers. The employee shall have no rights to a position in the agency from which the position or work unit is transferred.

~~(3)~~ (5) Remains the same.

(6) Pay for an employee who transfers shall be administered in compliance with the pay plan rules, policy 3-0505, Montana operations manual, volume III. (Copies available at the state personnel division, department of administration.)

(Auth. 2-18-102, MCA; Imp. 2-18-102, MCA)

2.21.3808 PROBATIONARY PERIOD (1) An agency shall establish a probationary period for employees newly hired ~~or transferred~~ into permanent or seasonal positions and set the length of the probationary period.

(2) - (6) Remain the same.

(Auth. 2-18-102, MCA; Imp. 2-18-102, MCA)

2.21.3811 PROMOTED OR REASSIGNED EMPLOYEES (1) An employee who has attained permanent status and who is ~~internally~~ promoted, reassigned or whose position is reclassified shall retain permanent status in the new position, as provided in ARM 2.21.3806, unless the employing agency has adopted a policy in compliance with ARM 2.21.1205, providing for a trial period as described in (2) below.

(2) - (3) Remain the same.

(Auth. 2-18-102, MCA; Imp. 2-18-102, MCA)

2.21.5006 DEFINITIONS (1) - (4) Remain the same.

(5) "Notice of anticipated lay-off" means a written notice informing an employee that the agency anticipates he will be laid off. The notice must provide a tentative effective date of lay-off, and notification to other agencies that the employee is eligible for employment preference.

(Auth. 2-18-102, MCA; Imp. 2-18-102, MCA)

2.21.5007 POLICY (1) If it is necessary to achieve a reduction in the work force, consideration must be given to the programs to be carried out by the agency and the staff structure which, after the reduction, will most expeditiously achieve program objectives. Accordingly, employees will be retained giving consideration to the importance of the following qualities possessed by the work force: skill and length of continuous service ~~in the agency.~~ with state government.

(2) Remains the same.

(3) Skill should be applied first and only if skill does not differentiate between employees should length of service ~~in the agency~~ with state government then be considered.

(4) An employee must be given written notice a minimum of 10 working days preceding the effective date of the lay-off. An employee should be counseled as much in advance of the anticipated action as possible regarding available options and reasons for lay-off. An employee becomes eligible for preference in state

employment on the date he receives a written notice of anticipated lay-off or a formal notice of lay-off.

(5) A central registry of laid off employees will be established by the department of administration, as provided in Rule I.

~~(5)~~ (6) Agencies shall maintain a roster of employees who have been laid off and offer reinstatement on a "last-out/first-in" basis by skill match and job classification. An employee shall be reinstated to the same position or a position in the same class when such a position becomes vacant in the agency from which the employee was laid off if such vacancy occurs during the employee's preference period. Specific reinstatement offers shall be made to the employee in writing. The employee must accept or reject the reinstatement offer in writing within 5 working days following receipt of the offer. If a reinstatement offer is rejected by the employee, the employee loses all rights to the employment offered. An agency is no longer required to reinstate or grant preference to a laid-off employee who has rejected a previous reinstatement offer. Such rejection ends the preference period.

~~(6)~~ (7) Each agency shall make a concerted effort to make other agencies aware of both the names of persons laid off and their job classifications, and agencies with vacancies shall give hiring preference over others of equal qualifications for a period starting the date the employee receives a notice of anticipated lay off or the formal notice of lay-off and for ~~of~~ one calendar year from the effective date of lay-off. The preference is provided to employees laid off from ~~that agency or other~~ any state agen~~cies~~y. It is the employee's responsibility to apply for ~~those~~ vacant positions, to participate in the voluntary reduction in force registry created in Rule I ~~for which the employee wants to be considered~~ and to make his eligibility for ~~lay-off~~ reduction-in-force preference known to the hiring agency.

~~(7)~~ (8) Acceptance of a permanent position with a state agency ends preference provided in ~~(6)~~ (7) above; however, an employee retains reinstatement rights as provided in ~~(5).~~ (6). If an employee is subsequently terminated for reasons other than lay-off as defined in this rule, the employee loses preference and reinstatement rights.

~~(8)~~ (9) All privileges and benefits extended by this rule end at the end of the ~~one-year~~ preference period.

~~(9)~~ (10) If the lay-off is anticipated to last longer than 15 working days, the employee shall be terminated. Upon termination due to reduction in work force, the employee shall cash out accumulated annual leave and sick leave and may cash out retirement contributions or the agency may allow the employee to maintain accumulated annual leave and sick leave for a period of one calendar year from the effective date of lay-off, even though terminated. An employee must receive cash out for accrued leave credits at the end of the preference period or if hired by another agency, unless the hiring agency agrees to assume the liability for the accrued leave credits. (Accumulated vacation credits may be used to delay the termination date in lieu of a lump sum

payment. This delay is for employee convenience only and does not alter the effective date of lay-off or extend the preference period.)

~~(10)~~ (11) Upon recall from a lay-off or upon placement of an employee during the preference period necessitated by a lay-off, the employee's salary shall be determined as if the employee had never been laid off. If recall or placement is with another agency, pay plan rule employee initiated transfer between agencies shall apply. The employee need not serve the qualifying period for use of annual leave and sick leave.

~~(11)~~ (12) An employee who is reinstated to a grade lower than the one held at lay-off should be treated as a voluntary demotion under the pay plan rules. The employee receives the same step as the position from which he was laid-off at the grade assigned to the new position.

~~(12)~~ (13) An employee who is demoted as the result of a RIF, but who is not laid-off, may, at the agency's discretion, receive up to a maximum of 180 days of salary protection, depending on budgetary constraints.

~~(13)~~ (14) In some cases, a demotion as a result of a RIF may be considered "exceptional circumstances" for purposes of a pay plan exception.

~~(14)~~ (15) If an individual re-enters state employment after the preference period has expired, that individual's salary shall be step 1 of the assigned grade. Further, the employee must begin anew earning time toward the qualifying period for annual leave and sick leave. A termination caused by lay-off shall not constitute a break in service for longevity purposes unless the employee has refused to accept a reinstatement offer. Only actual years of service count toward longevity.

~~(15)~~ (16) Lay-off shall not be used as an alternative to discharging an employee for cause or disciplinary purposes. Unsatisfactory employees should be terminated subsequent to complete and appropriate evaluation, review and documentation. If an unsatisfactory employee is laid off without appropriate evaluation, review and documentation, the employee must be treated the same as any other laid-off employee.

~~(16)~~ (17) In the process of achieving necessary reduction in the work force, an intra-department "bumping process" wherein individuals may be assigned to lower classifications within a series in lieu of a lay-off can be used. This "bumping process" policy must be described in writing, posted for employees to see and submitted to the state personnel division, department of administration. Bumping is at the agency's discretion, not the employee's. If an agency chooses to allow bumping, the agency must have a written policy which must be applied consistently. The policy must identify work units and classes in which bumping may occur. The criteria used to bump must be as job specific as possible and the results of the bumping process should not have disparate impact on any protected group of employees, i.e. women, minorities, the handicapped.

~~(17)~~ (18) The lay-off policy described above will apply to permanent, full or part-time employees, and would not apply to

seasonal employees whose employment is regularly interrupted by the seasonal nature of their work or to temporary employees with a specific employment period.

(Auth. 2-18-02, MCA; Imp. 2-18-102, MCA)

4. Proposed Rule I would be incorporated into the Reduction in Work Force Policy, ARM 2.21.5005 et seq. Proposed Rule II would be incorporated into the Recruitment and Selection Policy, ARM 2.21.3701 et seq. The proposed rules provide as follows:

RULE I REDUCTION-IN-FORCE REGISTRY (1) The department of administration will establish a central registry to collect the names and state applications of employees who have received notice of lay-off. Placement on the registry does not represent any promise of employment.

(2) Submission of an application by an employee is voluntary.

(3) Agency personnel officers or other state hiring officials may search the registry for applicants for a vacant position before any other solicitation for applications takes place.

(4) Qualified applicants may be hired without a competitive process or a competitive selection process may be used.

(5) Veteran's Employment Preference and Handicapped Person's Employment Preference must be applied when appropriate.

(6) The department of administration will hold applications, sorted by job classification, for review by departments. The department will not search, sort, screen, or refer applicants to other departments.

(7) Placement in a position ends participation on the registry. The department of administration should be notified if an applicant is placed.

(8) The end of the preference period also ends participation on the registry.

(Auth. 2-18-102, MCA; Imp. 2-18-102, MCA)

RULE II REDUCTION IN FORCE REGISTRY OPTION (1) The department of administration will establish a voluntary registry of names and state applications of employees slated for layoff, as provided in Rule I [proposed above for adoption into the Reduction in Work Force Policy.] Departments may search this registry for applicants before any other solicitation for applications takes place.

(2) Use of the registry is at the department's discretion.

(3) Qualified applicants from the registry may be hired without a competitive process or a competitive selection process may be used.

(4) Veteran's Employment Preference and Handicapped Person's Employment Preference must be applied when appropriate.

(Auth. 2-18-102, MCA; Imp. 2-18-102, MCA)

5. Historically, state agencies have functioned independently when hiring employees or when selecting employees for lay-off or recall. Employees accrue certain rights and benefits only in the agency in which they are currently employed, for example, the right to compete internally for jobs or the right to reinstatement

following a reduction in force. Those rights and benefits do not extend to other state agencies. For these purposes, a person is an employee of the Department of Administration or the Department of Highways -- not an employee of the State of Montana.

There is a desire to see the state function as "one company" in our personnel rules and practices by allowing freer movement of employees between agencies. This approach will give management greater flexibility to carry out its objectives. In the case of the rule changes proposed here, it will enhance employees' ability to retain employment and the benefits of attaining permanent status if their positions are affected by reduction in work force.

These proposed rule changes are reasonably necessary to implement this broader change in the philosophy of how the state as an employer treats its employees.

The proposed amendment of ARM 2.21.3802, 2.21.3803, 2.21.3807, 2.21.3808 and 2.21.3811 and the proposed repeal of ARM 2.21.3812 all affect treatment of employees who have attained permanent status with an agency and who transfer to another agency. An employee attains permanent employment status after successfully completing a probationary period in a permanent position. The employee acquires several important rights as the result of attaining permanent status, including the right to progressive discipline, protection from discharge without good cause, the right to file a grievance, and right to recall or preference in reemployment if laid off during reduction in force.

Under the Wrongful Discharge From Employment Act (39-2-904 et seq., MCA), "A discharge is wrongful only if . . . "(2) The discharge was not for good cause and the employee had completed the employer's probationary period of employment." Under current administrative rules, an employee who is promoted internally does not lose permanent status. When an employee transfers to a job in another agency, the employee loses permanent status and must complete a probationary period in the new agency.

There have been no cases challenging the legality of removing permanent status from an employee who is promoted or transferred across agency lines. Retaining current practice could represent a potential liability in a wrongful discharge claim, if the transferred employee could make the argument that he already had completed a probationary period and was not discharged for good cause.

The change is proposed to allow the state to handle transferring employees between departments in the same manner as moving between positions or divisions in the same department. Loss of permanent status represents a major difference in how we treat employees and may inhibit employees from applying for positions in other agencies. Managers may want to retain probationary periods in a transfer because they feel it gives them more flexibility. In practice, the number of transferring employees

who are terminated during a new probationary period is extremely small.

ARM 2.21.5007 is proposed for amendment to modify how we determine an employee's length of service. Length of continuous service in an agency may be a determining factor used to select employees who will be retained during a reduction in force. Skill is the factor which is applied first. If skill does not differentiate between employees, length of service then is applied. Often an evaluation of skills will be the determining factor and length of service does not become an issue. If not, length of service is used. Presently, length of service with the agency and not state government as a whole is used.

Redefining length of service as continuous service in state government would give an advantage in retention during RIFs to longer-term state employees, regardless of where their years of service occurred. It would disadvantage an employee with longer service in a department, but shorter overall service with the state.

ARM 2.21.5006 and 2.21.5007 are proposed for amendment to expand the period in which employees affected by reduction in force may receive employment preference. Current practice disadvantages employees about to be laid off because they are forced to compete for positions on the open market in their own or other agencies without any special consideration given to the fact they will shortly lose their jobs. Employees do not receive preference for other state jobs until after the lay-off is effective. Agencies are required to give a minimum 10-day written notice of layoff.

Under this proposed change, agencies could give earlier, tentative notice to employees that positions might be affected by layoffs and extend the RIF employment preference at that time. The formal, written notice required by the rules would finalize the action.

ARM 2.21.5007 is proposed for amendment and new rules are proposed for both the Reduction in Work Force and Recruitment and Selection policies to provide an alternative way of placing employees who have been affected by a reduction in force. Under current rules, a department must make other agencies aware of the names of employees who have been laid off. Usually this is done by circulating a list of names and position titles. The laid off employee receives RIF preference, but no other special consideration.

Under these rule changes, a central registry of laid off employees would be established in the Department of Administration. Participation by employees would be voluntary and would not represent any promise of employment. Department personnel officers would be able to search the registry for applicants before any other solicitation of applications takes place.

Qualified persons could be hired without a competitive process or a selection process could be used. Veteran's or Handicapped Employment Preference can be applied when appropriate. Agencies may be motivated to use the list to fill vacancies quickly and avoid lengthy recruitment and selection processes.

The Department of Administration would simply hold the applications, sorted by job classification, for review by the departments. DOA would not search, sort, screen, or refer the applicants for other agencies.

5. Interested parties may submit their data, views, or arguments concerning the proposed amendment to:

Laurie Ekanger, Administrator
State Personnel Division
Department of Administration
Room 130, Mitchell Building
Helena, Montana 59620

no later than December 17, 1990.

6. James A. Edgcomb, Personnel Policy Coordinator, State Personnel Division, Department of Administration, Mitchell Building, Helena, Montana, 59620, has been designated to preside over and conduct the hearing.

7. The authority of the agency to make the proposed amendment is based on 2-18-102, MCA, and the rules implement 2-18-102, MCA.

/s/ Dave Ashley
Dave Ashley, Acting Director
Department of Administration

Certified to the Secretary of State November 5, 1990.

BEFORE THE STATE AUDITOR
AND COMMISSIONER OF INSURANCE
OF THE STATE OF MONTANA

In the matter of the proposed adoption of rules pertaining to long-term care insurance	))))	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION

TO: All Interested Persons.

1. On December 5, 1990, at 9:00 a.m., a public hearing will be held in Room 260 of the Mitchell Building, 111 Sanders, Helena, Montana, to consider the proposed adoption of rules pertaining to long-term care insurance.

2. The proposed rules do not replace or modify any section currently found in the Administrative Rules of Montana.

3. The proposed rules provide as follows:

RULE I PURPOSE AND SCOPE (1) In accordance with 33-22-1101, et seq., MCA, the commissioner of insurance declares that the purpose of these rules is to implement Title 33, chapter 22, part 11, MCA.

(2) Except as otherwise specifically provided, these rules apply to all long-term care insurance policies or group certificates delivered or issued for delivery in this state on or after January 1, 1991, by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations, and all similar organizations.

(3) Group policies or certificates issued for delivery outside this state are subject to these rules and Title 33 of the Montana Code Annotated.

AUTH: 33-1-313, 33-22-1121, MCA IMP: 33-22-1101 through 33-22-1121, MCA

RULE II DEFINITIONS (1) For the purpose of these rules, the terms "long-term care insurance," "group long-term care insurance," "applicant," "policy," and "certificate" shall have the meanings provided under 33-22-1107, MCA.

AUTH: 33-1-313, 33-22-1121, MCA IMP: 33-22-1101 through 33-22-1121, MCA

RULE III POLICY DEFINITIONS (1) No long-term care insurance policy or group certificate delivered or issued for delivery in Montana shall use the terms set forth below, unless the terms are defined in the policy or group certificate and the definitions satisfy the following requirements:

(2) "Acute condition" means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

(3) "Home health care services" means medical and non-medical services, provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living, and respite care services.

(4) "Irreversible dementia" means deterioration or loss of intellectual faculties, reasoning power, memory, and will due to organic brain disease characterized by confusion, disorientation, apathy and stupor of varying degrees which is not capable of being reversed and from which recovery is impossible.

(5) "Medicare" shall be defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof" or words of similar import.

(6) "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

(7) "Skilled nursing care," "intermediate care," "personal care," "home care," and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

(8) All providers of services, including but not limited to "skilled nursing facility," "extended care facility," "intermediate care facility," "convalescent nursing home," "personal care facility," and "home care agency" shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

AUTH: 33-1-313, 33-22-1121, MCA IMP: 33-22-1101 through 33-22-1121, MCA

RULE IV POLICY PRACTICES AND PROVISIONS (1) The terms "guaranteed renewable" and "noncancellable" shall not be used in any individual long-term care insurance policy or group certificate without further explanatory language in accordance with the disclosure requirements of [RULE V].

(2) No such policy or certificate issued to an individual shall contain renewal provisions less favorable to the insured than "guaranteed renewable." The commissioner of insurance may authorize nonrenewal on a statewide basis, on terms and conditions deemed necessary by the commissioner of insurance, to best protect the interests of the insureds, if the insurer demonstrates:

(a) that renewal will jeopardize the insurer's solvency; or

(b) that the actual paid claims and expenses have substantially exceeded the premium and investment income associated with the policies; and

(c) the policies will continue to experience substantial and unexpected losses over their lifetime; and

(d) the projected loss experience of the policies cannot be significantly improved or mitigated through reasonable rate adjustments or other reasonable methods; and

(e) the insurer has made repeated and good faith attempts to stabilize loss experience of the policies, including the timely filing for rate adjustments.

(3) The term "guaranteed renewable" means the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

(4) The term "noncancellable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

(5) No policy or group certificate may be delivered or issued for delivery in this state as long-term care insurance if such policy or group certificate limits or excludes coverage by type of illness, treatment, medical condition or accident, except it may include exclusions or limits for:

(a) preexisting conditions or diseases;

(b) mental or nervous disorders; however, this shall not permit exclusion of limitation of benefits on the basis of Alzheimer's disease or irreversible dementia;

(c) alcoholism and drug addiction;

(d) illness, treatment or medical condition arising out of:

(i) war or act of war, whether declared or undeclared;

(ii) participation in a felony, riot or insurrection;

(iii) service in the armed forces or units auxiliary thereto;

(iv) sane or insane suicide, attempted suicide or intentionally self-inflicted injury; or

(v) aviation, which exclusion applies only to non-fare-paying passengers;

(e) treatment provided in a government facility, unless coverage is otherwise required by law;

(f) services for which benefits are available under medicare or a governmental program other than medicaid, or under a state or federal worker's compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law;

(g) services provided by a member of the insured's immediate family or for which no charge is normally made in the absence of insurance.

(h) This section is not intended to prohibit exclusions or limitations by territorial limitations.

(6) Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

(7) Group long-term care insurance policies or certificates issued in Montana on or after January 1, 1991, shall provide covered individuals with a basis for continuation or conversion of coverage.

(a) For the purposes of this section, "a basis for continuation of coverage" means a policy provision which maintains coverage under the existing group policy or certificate when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies or certificates which restrict provision of benefits and services to, or contain incentives to use certain health care providers or facilities may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy or certificate. The commissioner of insurance may make a determination as to the substantial equivalency of benefits, and in doing so, may take into consideration the differences between managed care and non-managed care plans, including, but not limited to, health care provider system arrangements, service availability, benefit levels and administrative complexity.

(b) For the purposes of this section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy or certificate would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy or certificate in its entirety or with respect to an insured class, and who has been continuously insured under the group policy or certificate and any group policy or certificate which it replaced, for at least three months immediately prior to termination, shall be entitled to the issuance of a converted policy or certificate by the insurer under whose group policy or certificate the individual is covered, without evidence of insurability.

(c) For the purposes of this section, "converted policy" means a policy or certificate of long-term care insurance providing benefits identical to or benefits determined by the commissioner of insurance to be substantially equivalent to or in excess of those provided under the group policy or certificate from which conversion is made. Where the group policy or certificate from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain health care providers or facilities, the commissioner of insurance, in making a determination as to the substantial equivalency of benefits, may take into

consideration the differences between managed care and non-managed care plans, including, but not limited to, health care provider system arrangements, service availability, benefit levels and administrative complexity.

(d) Written application for the converted policy or certificate shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one days after termination of coverage under the group policy or certificate. The converted policy or certificate shall be issued effective on the day following the termination of coverage under the group policy or certificate, and shall be renewable annually.

(e) Unless the group policy or certificate from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy or certificate from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy or certificate replaced.

(f) Continuation of coverage or issuance of a converted policy shall be mandatory except where:

(i) termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

(ii) the terminating coverage is replaced not later than thirty-one days after termination, by group coverage effective on the day following the termination of coverage:

(A) providing benefits identical to or benefits determined by the commissioner of insurance to be substantially equivalent to or in excess of those provided by terminating coverage; and

(B) the premium for which is calculated in a manner consistent with the requirements of (e) of this subsection.

(g) Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than one hundred percent of incurred expenses. Such provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

(h) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy or certificate from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy or certificate remained in force and effect.

(i) Nothwithstanding any other provision of this section, any insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person, shall be entitled to continuation of coverage under the group policy or certificate upon termination of the qualifying relationship by death or dissolution of marriage.

(j) For the purposes of this section, a "managed-care plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific health care provider networks.

AUTH: 33-1-313, 33-22-1121, MCA IMP: 33-22-1101 through 33-22-1121, MCA

RULE V REQUIRED DISCLOSURE PROVISIONS (1) Individual long-term care insurance policies shall contain a renewability provision. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed. This provision shall not apply to policies which do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

(2) Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider or endorsement.

(3) A long-term care insurance policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import shall include a definition of such terms in the policy or certificate and an explanation of such terms in its accompanying outline of coverage.

(4) If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "preexisting condition limitations."

(5) A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in 33-22-1115(2), MCA, shall set forth a description of such limitations or conditions, including any

required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "limitations or conditions on eligibility for benefits."

AUTH: 33-1-313, 33-22-1121, MCA IMP: 33-22-1101 through 33-22-1121, MCA

RULE VI PROHIBITION AGAINST POST-CLAIMS UNDERWRITING

(1) All applications for long-term care insurance policies or certificates except those which are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

(2) If an application for long-term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed. If the medications listed in such application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

(3) Except for policies or certificates which are guaranteed issue, the following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate:

Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy.

(4) The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery:

Caution: The issuance of this long-term care insurance [policy][certificate] is based upon your responses to the questions on your application. A copy of your [application][enrollment form] [is enclosed][was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

(5) Prior to issuance of a long-term care policy or certificate to an applicant age eighty or older, the insurer shall obtain one of the following:

(a) a report of a physical examination;
(b) an assessment of functional capacity;
(c) an attending physician's statement; or
(d) copies of medical records.

(6) A copy of the completed application or enrollment form, whichever is applicable, shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

(7) Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those which the insured voluntarily effectuated and shall annually furnish this information to the commissioner of insurance in the format prescribed by the National Association of Insurance Commissioners.

AUTH: 33-1-313, 33-22-1121, MCA IMP: 33-22-1101 through 33-22-1121, MCA

RULE VII MINIMUM STANDARDS FOR HOME HEALTH CARE BENEFITS IN LONG-TERM CARE INSURANCE POLICIES (1) A long-term care insurance policy or certificate may not, if it provides benefits for home health care services, limit or exclude benefits:

(a) by requiring that the insured or claimant would need skilled care in a skilled nursing facility if home health care services were not provided;

(b) by requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services in a home or community setting before home health care services are covered;

(c) by limiting eligible services to services provided by registered nurses or licensed practical nurses;

(d) by requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification;

(e) by requiring that the insured or claimant have an acute condition before home health care services are covered; and

(f) by limiting benefits to services provided by medicare-certified agencies or providers.

(2) Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

AUTH: 33-1-313, 33-22-1121, MCA IMP: 33-22-1101 through 33-22-1121, MCA

RULE VIII REQUIREMENT TO OFFER INFLATION PROTECTION (1) No insurer may offer a long-term insurance policy unless the insurer also offers to the policyholder the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy.

Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

(a) increases benefit levels annually in a manner so that the increases are compounded annually;

(b) guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined; or

(c) covers a specified percentage of actual or reasonable charges.

(2) Where the policy is issued to a group, the required offer in subsection (1) above shall be made to the group policyholder; except, if the policy is issued to a group defined in 33-22-1107(3)(d), MCA, other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder.

(3) The offer in subsection (1) above shall not be required of:

(a) life insurance policies or riders containing accelerated long-term care benefits, nor

(b) expense incurred long-term care insurance policies.

(4) Insurers shall include the following information in or with the outline of coverage:

(a) a graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty-year period; and

(b) any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall also disclose the magnitude of the potential premiums the applicant would need to pay at ages seventy-five and eighty-five for benefit increases.

(c) An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

AUTH: 33-1-313, 33-22-1121, MCA IMP: 33-22-1101 through 33-22-1121, MCA

RULE IX REQUIREMENTS FOR REPLACEMENT (1) Individual and direct response solicited long-term care insurance application forms shall include a question designed to elicit information as to whether the proposed insurance policy is intended to replace any other accident and sickness or long-term care insurance policy presently in force. A supplementary application or other form to be signed by the applicant containing such a question shall be used.

(2) Upon determining that a sale will involve replacement, an insurer; other than an insurer using direct response solicitation methods, or its producer; shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement

of accident and sickness or long-term care coverage. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

According to [your application][information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

_____
(Date)

_____
(Applicant's Signature)

(3) Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

According to [your application][information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by [company name] insurance company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. You may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

3. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

_____
(Company Name)

AUTH: 33-1-313, 33-22-1121, MCA IMP: 33-22-1101 through 33-22-1121, MCA

RULE X DISCRETIONARY POWERS OF COMMISSIONER OF INSURANCE (1) The commissioner of insurance may upon written request

issue an order to modify or suspend a specific provision or provisions of this regulation with respect to a specific long-term care insurance policy or certificate upon a written finding that:

(a) the modification or suspension would be in the best interest of the insureds; and

(b) the purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

(c) the modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or

(i) the policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or

(ii) the modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

AUTH: 33-1-313, 33-22-1121, MCA IMP: 33-22-1101 through 33-22-1121, MCA

RULE XI RESERVE STANDARDS (1) When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for such benefits shall be determined in accordance with 33-2-523, MCA. Claim reserves must also be established in the case when such policy or rider is in claim status.

(2) Reserves for policies and riders subject to this subsection should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

(3) In the development and calculation of reserves for policies and riders subject to this subsection, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

(a) definition of insured events;

(b) covered long-term care facilities;

(c) existence of home convalescence care coverage;

(d) definition of facilities;

(e) existence of absence of barriers to eligibility;

(f) premium waiver provision;

(g) renewability;
(h) ability to raise premiums;
(i) marketing method;
(j) underwriting procedures;
(k) claims adjustment procedures;
(l) waiting period;
(m) maximum benefit;
(n) availability of eligible facilities;
(o) margins in claim costs;
(p) optional nature of benefit;
(q) delay in eligibility for benefit;
(r) inflation protection provisions; and
(s) guaranteed insurability option.

(4) Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

(5) When long-term care benefits are provided other than as in subsection (1) above, reserves shall be determined as acceptable to the commissioner of insurance.

AUTH: 33-1-313, 33-22-1121, MCA IMP: 33-22-1101 through 33-22-1121, MCA

RULE XII LOSS RATIO (1) Benefits under individual long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent, calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

(a) statistical credibility of incurred claims experience and earned premiums;
(b) the period for which rates are computed to provide coverage;
(c) experienced and projected trends;
(d) concentration of experience within early policy duration;
(e) expected claim fluctuation;
(f) experience refunds, adjustments or dividends;
(g) renewability features;
(h) all appropriate expense factors;
(i) interest;
(j) experimental nature of the coverage;
(k) policy reserves;
(l) mix of business by risk classification; and
(m) product features such as long elimination periods, high deductibles and high maximum limits.

AUTH: 33-1-313, 33-22-1121, MCA IMP: 33-22-1101 through 33-22-1121, MCA

RULE XIII FILING REQUIREMENT (1) Prior to an insurer or similar organization offering group long-term care insurance to a resident of Montana pursuant to 33-22-1120, MCA, it shall file with the commissioner of insurance evidence that the group

policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this state.

AUTH: 33-1-313, 33-22-1121, MCA IMP: 33-22-1101 through 33-22-1121, MCA

RULE XIV STANDARD FORMAT OUTLINE OF COVERAGE

(1) The outline of coverage shall be a free-standing document, using no smaller than ten point type.

(2) The outline of coverage shall contain no material of an advertising nature.

(3) Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring.

(4) Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

(5) Format for outline of coverage:

[COMPANY NAME]

[ADDRESS-CITY & STATE]

[TELEPHONE NUMBER]

LONG-TERM CARE INSURANCE

OUTLINE OF COVERAGE

[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

Caution: The issuance of this long-term care insurance [policy][certificate] is based upon your responses to the questions on your application. A copy of your [application][enrollment form] [is enclosed][was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [an individual policy of insurance]([a group policy] which was issued in the [indicate jurisdiction in which group policy was issued]).

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

   (a) [Provide a brief description of the right to return--"free look" provision of the policy.]

   (b) [include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include description of them.]

4. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for medicare, review the medicare supplement buyer's guide available from the insurance company.

   (a) [For producers] Neither [insert company name] nor its producers represent medicare, the federal government or any state government.

   (b) [For direct response] [insert company name] is not representing medicare, the federal government or any state government.

5. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

   This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations][waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

6. BENEFITS PROVIDED BY THIS POLICY.

(a) (Covered services, related deductible(s), waiting periods, elimination periods and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) [Non-institutional benefits, by skill level.]

[Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.]

7. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Non-eligible facilities/provider;

(c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.)'

(d) Exclusions/exceptions;

(e) Limitations.]

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in (6) above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

8. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

(a) That the benefit level will not increase over time;

(b) Any automatic benefit adjustment provisions;

(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which

benefits will be increased over time if not by a specified amount or percentage;

(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

(e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

9. TERMS UNDER WHICH THE POLICY (OR CERTIFICATE) MAY BE CONTINUED IN FORCE OR DISCONTINUED.

[(a) Describe the policy renewability provisions;

(b) For group coverage, specifically describe continuation conversion provisions applicable to the certificate and group policy;

(c) Describe waiver of premium provisions or state that there are not such provisions;

(d) State whether or not the company has a right to change premium, and if such a right exists, describe clearly and concisely each circumstance under which premium may change.]

10. ALZHEIMER'S DISEASE, IRREVERSIBLE DEMENTIA, AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease, irreversible dementia, or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

11. PREMIUM.

[(a) State the total annual premium for the policy;

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

12. ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used;

(b) Describe other important features.]

AUTH: 33-1-313, 33-22-1121, MCA IMP: 33-22-1101 through 33-22-1121, MCA

RULE XV REQUIREMENT TO DELIVER SHOPPER'S GUIDE (1) A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the commissioner of insurance, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

(a) In the case of producer solicitations, an agent must deliver the shopper's guide prior to the presentation of an application or enrollment form.

(b) In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.

(2) Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under 33-22-1111, MCA.

AUTH: 33-1-313, 33-22-1121, MCA IMP: 33-22-1101 through 33-22-1121, MCA

RULE XVI EFFECTIVE DATE (1) These rules shall be effective on February 1, 1991.

AUTH: 33-1-313, 33-22-1121, MCA IMP: 33-22-1101 through 33-22-1121, MCA

4. The rules are necessary to establish standards for long-term care insurance policies and certificates delivered or issued for delivery in Montana. They will assist insurers and insurance producers in complying with Title 33, Chapter 22, Part 11, MCA.

5. Interested persons may present their data, views, or arguments, either orally or in writing, at the hearing. Written testimony may be submitted to Carol Jean "C.J." Lassila, State Auditor's Office, P.O. Box 4009, Helena, MT 59604-4009 no later than December 13, 1990.

6. Carol Jean "C.J" Lassila, Attorney for the State Auditor and Commissioner of Insurance, has been designated to preside over and conduct the hearing.

Andrea "Andy" Bennett
State Auditor and
Commissioner of Insurance

Certified to the Secretary of State this 5th day of November, 1990.

BEFORE THE MONTANA SCIENCE AND TECHNOLOGY ALLIANCE
STATE OF MONTANA
DEPARTMENT OF COMMERCE

In the matter of the proposed adoption and incorporation by reference of rules implementing the Montana Environmental Policy Act	)))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED ADOPTION AND INCORPORATION BY REFERENCE OF RULES IMPLEMENTING THE MONTANA ENVIRONMENTAL POLICY ACT

TO: All Interested Persons:

1. On December 18, 1990, between 9:00 a.m. and 11:30 a.m., the Montana Board of Science and Technology Development (Board) will hold a public hearing in the 4th Floor Conference Room of the Power Block, in Helena, Montana, to consider the proposed adoption and incorporation by reference of rules implementing the Montana Environmental Policy Act (MEPA). The rules proposed to be adopted and incorporated by reference are those rules already adopted by the Department of Commerce to implement MEPA.

2. The proposed new rule will read as follows:

"I ADOPTION OF MEPA RULES (1) The Montana Board of Science and Technology Development adopts the MEPA rules of the Department of Commerce as set forth in ARM 8.2.302, 8.2.303 and 8.2.305 through ARM 8.2.327, except that the terms "the agency", "the department" and "the board" mean the Montana Board of Science and Technology Development as created pursuant to section 2-15-1818."

Auth: Sec. 2-3-103, 2-4-201, MCA; IMP, Sec. 75-1-201, MCA

REASON: The Board is proposing to adopt the Department of Commerce's MEPA rules and incorporate them by reference, in order to implement and comply with MEPA. The rules that the Board is adopting and incorporating by reference are the rules that the Department of Commerce has already adopted to implement MEPA. The Department's MEPA rules reflect the model and uniform MEPA rules adopted by many other agencies in the executive branch.

The model MEPA rules establish, among other requirements and procedures, the following: General Requirements of the Environmental Review Process; Determining the Significance of Impacts; Preparation and Contents of Environmental Assessments; Determining the Scope of an EIS; EIS's General Requirements; Preparation and Contents of Draft and Final EISs; Adoption of an Existing EIS; Interagency Cooperation; Joint EISs and EAs; Preparation, Content, and Distribution of a Programmatic Review; Record of Decision for Actions Requiring EISs; Public Hearings; and Fees: Determination of Authority to Impose Fees and Determination of Amount.

3. A copy of ARM 8.2.302 through 8.2.327 can be obtained at the offices of the Board located at 46 North Last Chance Gulch, 2B, Helena, Montana.

4. Interested persons may present their views and comments either orally or in writing at the hearing. Written comments may also be submitted to Mr. Carl Russell, Executive Director, Montana Board of Science and Technology Development, 46 North Last Chance Gulch, 2B, Helena, MT 59620 no later than 5:00 p.m. on December 18, 1990. The record of the hearing will be deemed closed at that time.

5. Mona Jamison has been designated to preside over and conduct the hearing.

MONTANA BOARD OF SCIENCE AND
TECHNOLOGY DEVELOPMENT
MR. CHASE HIBBARD, CHAIRMAN

BY: _____
ANDY POOLE, DEPUTY DIRECTOR
DEPARTMENT OF COMMERCE

Certified to the Secretary of State, November 5, 1990.

BEFORE THE SUPERINTENDENT OF PUBLIC INSTRUCTION
OF THE STATE OF MONTANA

In the matter of the proposed amendment of rule relating to guaranteed tax base) NOTICE OF PROPOSED AMENDMENT OF ARM 10.21.104

NO PUBLIC HEARING CONTEMPLATED

To: All interested persons

1. On December 17, 1990, the Superintendent of Public Instruction proposes to amend Rule 10.21.104.

2. The rule, as proposed to be amended, new material underlined, deleted material interlined, provides as follows:

10.21.104 DISTRIBUTION AND REVERSION OF GTB AID

(1) Remains the same.

(2) County officials shall distribute ~~any~~ GTB aid received in support of elementary and high school retirement levies to all school districts within the county in the same manner as other revenues deposited in the elementary and high school retirement fund are distributed as provided in ARM 10.10.309.

(3) In accordance with section 20-9-368(4), MCA, ~~GTB aid is provided to counties and districts to finance a portion of general fund budget expenditures and retirement expenditures.~~ districts will revert guaranteed tax base aid in proportion to the amount budgeted in general fund but not expended. Counties will revert guaranteed tax base aid for retirement expenditures in proportion to the total district amounts budgeted but not expended by the districts. ~~By September 1 of each year, any unexpended balance of GTB aid received during the previous fiscal year must be reported to OPI on forms it provides.~~ To ensure that GTB aid reversions are being made in accordance with section 20-9-368, MCA, OPI will calculate the amount of the reversion from data contained in reports districts and counties are required to submit to OPI. OPI will deduct ~~this balance~~ the amount of the reversion from the equalization and GTB aid payments made to the district or county during the next fiscal year. In the instance where a district or county must revert GTB aid but will not receive GTB aid in the next fiscal year and no cash is immediately available to districts or counties for direct reversion, the GTB reversion liability shall carry forward until paid.

Formula to calculate amount of GTB reversion:

[(total amount budgeted - total actual expended) x (GTB subsidy/total amount budgeted)]

~~(4) The amount of the unexpended balance of GTB aid for permissive levies is calculated at the end of each fiscal year as follows:~~

~~(a) the district must determine the ratio total GTB aid for permissive levies received during the fiscal year bears to revenue deposited into the general fund that year, excluding the revenue listed in ARM 10.22.103(6);~~

~~(b) the district must multiply this ratio times the district's unreserved balance in the general fund that year, excluding the revenue listed in ARM 10.22.103(6);~~

~~(c) the product is the unexpended GTB aid the district must report to OPI. Formula:~~

~~{GTB aid/[general fund revenue-certain revenues]} X [unreserved general fund balance-certain revenues] = unexpended GTB aid~~

~~(5) The amount of the unexpended balance of GTB aid for retirement levies is calculated at the end of each fiscal year as follows:~~

~~(a) the district must determine the ratio total GTB aid for retirement levies received during the fiscal year bears to the total retirement revenue received during the year;~~

~~(b) the district must multiply this ratio times the unreserved balance in the retirement fund;~~

~~(c) the product is the unexpended GTB aid the district must report to OPI. Formula:~~

~~{GTB aid/retirement fund revenue} x retirement fund unreserved balance = unexpended GTB aid~~

~~(6) To ensure that GTB aid reversions are being made in accordance with section 20-9-368, MCA, OPI will review:~~

~~(a) Data contained in reports districts and counties are required to submit to OPI; and~~

~~(b) records of district payments to the teachers' retirement system, the public employees' retirement system, the unemployment insurance division, department of labor, and the social security administration.~~

(AUTH: 20-9-369, MCA; IMP: 20-9-366 through 20-9-369, MCA)

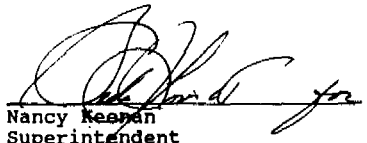
3. Parts of the rule were contrary to 20-9-368(4) and had to be deleted. As the GTB was intended as an equalization system, it would be best to simply include GTB with other county revenues rather than attempting to distribute and track it separately to each district. OPI is not required to review reports.

4. Interested persons may submit their data, views or arguments concerning the proposed rule changes in writing to the Office of Public Instruction, Room 106, State Capitol, Helena, Montana 59620, no later than 5:00 p.m. on December 14, 1990.

5. If a person who is directly affected by the proposed amendment wishes to express his/her data, views and arguments orally or in writing at a public hearing s/he must make written request for a hearing and submit this request along with any written comments s/he may have to the Office of Public Instruction, Room 106, State Capitol, Helena, Montana 59620, no later than 5:00 p.m. on December 14, 1990.

6. If OPI receives requests for a public hearing on the proposed amendment from either 10% or 25, whichever is less, of the persons who are directly affected by the proposed amendment from the Administrative Code Committee of the Legislature; from a governmental subdivision or agency; or from an association having not less than 25 members who will be directly affected,

a hearing will be held at a later date. Ten percent (10%) of those persons directly affected has been determined to be 55 persons based on total budgeting elementary and high school districts. Notice of the hearing will be published in the Montana Administrative Register.



Nancy Keenan
Superintendent
Office of Public Instruction

Certified to the Secretary of State November 5, 1990.

BEFORE THE SUPERINTENDENT OF PUBLIC INSTRUCTION
OF THE STATE OF MONTANA

In the matter of the proposed amendment of rules relating to permissive amount, voted amount, and school levies	NOTICE OF PROPOSED AMENDMENT OF ARM 10.23.101 and 10.23.104

NO PUBLIC HEARING CONTEMPLATED

To: All interested persons

1. On December 17, 1990, the Superintendent of Public Instruction proposes to amend Rules 10.23.101 and 10.23.104.

2. The rules, as proposed to be amended, new material underlined, deleted material interlined, provide as follows:

10.23.101 DEFINITIONS

(1) through (6) remain the same.

(7) "Net district requirement" is the total district retirement budget including amounts for new operating reserves less estimated district revenues.

(8) "Net county retirement levy requirement" is the total net district requirement for all elementary schools and all high schools less estimated county revenues.

(AUTH: 20-9-102, MCA; IMP: 20-9-145, 20-9-353, MCA)

10.23.104 RETIREMENT LEVIES

(1) Net county retirement levy requirement for elementary and high school retirement funds are ~~determined in accordance with section 20-9-501, MCA.~~ defined in ARM 10.23.101.

(2) To determine the retirement mills needed, the net county retirement ~~net~~ levy requirement for each fund is divided by:

(a) ~~for districts eligible for GTB aid,~~ the sum of~~:~~ ~~(i)~~ the county's taxable valuation as defined in ARM 10.21.101(2)(c) divided by 1000 plus

(b) the state subsidy per mill for elementary and high school retirement funds provided to each county by the office of public instruction. The state subsidy per mill shall be calculated as follows:

~~(ii)~~ (i) the difference between the statewide mill value per ANB as defined in ARM 10.21.101(1)(e) or (f) and the county mill value per ANB as defined in ARM 10.21.101(3)(g) or (h) multiplied by the district's ANB as defined in ARM 10.21.101 (2)(c).

~~Formula:~~

~~net levy requirement/((county taxable value/1000) + [(statewide mill value per ANB - county mill value per ANB) X ANB])~~

~~(b) for districts that are not eligible for GTB aid, the district's taxable valuation, as defined in 10.21.101(3)(e).~~

~~Formula:~~

~~net levy requirement/county taxable value = retirement mills~~

(3) Remains the same.

(4) When reporting the net county retirement levy requirements to the county commissioners in accordance with section 20-9-501, MCA, each county superintendent must report the following information for each county eligible for GTB aid:

(a) ~~the final county mill value per elementary ANB, county mill value per high school ANB, statewide mill value per elementary ANB, and statewide mill value per high school ANB, as provided by OPI in accordance with 10.21.103(5); and~~ the state subsidy for elementary and high school retirement funds;

(b) the calculation used to determine the mills needed to fund the net county retirement levy requirements.

(AUTH: 20-9-102, 20-9-369, MCA; IMP: 20-9-501, 20-9-368, MCA)

3. The first rule above is being changed to establish definitions for the two separate components of the county-wide retirement levy calculation: "net district requirement" and "net county retirement levy requirement." The second rule is necessary to change to allow easier calculation of the county retirement levy; to indicate that OPI will provide State Subsidy per Mill (GTB) figures for use in the calculation; and replace complicated formula with State Subsidy per Mill where possible.

4. Interested persons may submit their data, views or arguments concerning the proposed rule changes in writing to the Office of Public Instruction, Room 106, State Capitol, Helena, Montana 59620, no later than 5:00 p.m. on December 14, 1990.

5. If a person who is directly affected by the proposed amendment wishes to express his/her data, views and arguments orally or in writing at a public hearing s/he must make written request for a hearing and submit this request along with any written comments s/he may have to the Office of Public Instruction, Room 106, State Capitol, Helena, Montana 59620, no later than 5:00 p.m. on December 14, 1990.

6. If OPI receives requests for a public hearing on the proposed amendment from either 10% or 25, whichever is less, of the persons who are directly affected by the proposed amendment from the Administrative Code Committee of the Legislature; from a governmental subdivision or agency; or from an association having not less than 25 members who will be directly affected, a hearing will be held at a later date. Ten percent (10%) of those persons directly affected has been determined to be 55 persons based on total budgeting elementary and high school districts. Notice of the hearing will be published in the Montana Administrative Register.

Nancy Keenan
Superintendent
Office of Public Instruction

Certified to the Secretary of State November 5, 1990.

BEFORE THE SUPERINTENDENT OF PUBLIC INSTRUCTION
OF THE STATE OF MONTANA

In the matter of the proposed amendment of rule relating to accounting practices and tuition	NOTICE OF PROPOSED AMENDMENT OF ARM 10.10.309

NO PUBLIC HEARING CONTEMPLATED

To: All interested persons

1. On December 17, 1990, the Superintendent of Public Instruction proposes to amend Rule 10.10.309.

2. The rule, as proposed to be amended, new material underlined, provides as follows:

10.10.309 DISTRIBUTION OF COUNTY-WIDE RETIREMENT FUNDS

(1) The county superintendent of schools shall distribute the cash balance in the county-wide retirement fund to district funds on a monthly basis in the proportion each district's net district requirement bears to the total of all net district requirements. Net district requirement is defined as the total district retirement budget including amounts for new operating reserves less estimated district revenues.

(2) The cash balance in the elementary and high school county-wide retirement funds at fiscal year end must be zero if distributions to school districts are less than 100% of the total net district requirements for the current or prior years.

(3) The cash balance in the elementary and high school county-wide retirement funds at fiscal year end must be reappropriated to reduce the levies if distributions to school districts are 100% of the total net district requirements for the current or prior years.

(AUTH: 20-9-102, MCA; IMP: 20-9-213, MCA)

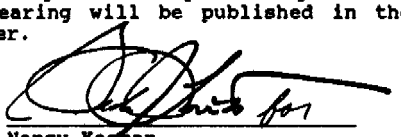
3. The rule change is necessary to provide that county-wide retirement funds are distributed to the schools or reappropriated to reduce the levies in the next fiscal year. Several counties were maintaining large "unexplained" cash balances in the county-wide retirement funds on June 30th.

4. Interested persons may submit their data, views or arguments concerning the proposed rule changes in writing to the Office of Public Instruction, Room 106, State Capitol, Helena, Montana 59620, no later than 5:00 p.m. on December 14, 1990.

5. If a person who is directly affected by the proposed amendment wishes to express his data, views and arguments orally or in writing at a public hearing s/he must make written request for a hearing and submit this request along with any written comments s/he may have to the Office of Public Instruction, Room 106, State Capitol, Helena, Montana 59620, no later than 5:00 p.m. on December 14, 1990.

6. If OPI receives requests for a public hearing on the proposed amendment from either 10% or 25, whichever is less, of

the persons who are directly affected by the proposed amendment from the Administrative Code Committee of the Legislature; from a governmental subdivision or agency; or from an association having not less than 25 members who will be directly affected, a hearing will be held at a later date. Ten percent (10%) of those persons directly affected has been determined to be 55 persons based on total budgeting elementary and high school districts. Notice of the hearing will be published in the Montana Administrative Register.



Nancy Keenan
Superintendent
Office of Public Instruction

Certified to the Secretary of State November 5, 1990.

BEFORE THE DEPARTMENT OF
FAMILY SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rule 11.16.170, pertaining to prohibition of day care in adult foster homes, Rule 11.16.128, pertaining to licensing of adult foster homes, Rules 11.16.101, and 11.16.102, and the repeal of 11.16.103, pertaining to department services provided to, and procedures for, adult foster homes.	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULE 11.16.170, PERTAINING TO PROHIBITION OF DAY CARE IN ADULT FOSTER HOMES, RULE 11.16.128, PERTAINING TO LICENSING OF ADULT FOSTER HOMES, RULES 11.16.101, AND 11.16.102, AND THE PROPOSED REPEAL OF RULE 11.16.103, PERTAINING TO DEPARTMENT SERVICES PROVIDED TO, AND PROCEDURES FOR, ADULT FOSTER HOMES.

TO: All Interested Persons

1. On December 10, 1990, at 1:30 o'clock, p.m., a public hearing will be held in the conference room of the Department of Family Services offices, located at 48 North Last Chance Gulch, Helena, Montana to consider the proposed amendment of Rule 11.16.170, pertaining to prohibition of day care in adult foster homes, Rule 11.16.128, pertaining to licensing of adult foster homes, Rules 11.16.101 and 11.16.102, and the proposed repeal of Rule 11.16.103, pertaining to department services provided to, and procedures for, adult foster homes.

2. The rules proposed to be amended or repealed read as follows:

11.16.170 ADULT FOSTER HOME, PROHIBITED PRACTICES

Subsections (1) and (2) remain the same.

(3) A foster home shall not provide day care services to adults or children.

AUTH: Sec. 53-5-304, MCA. IMP: Sec. 53-5-303, MCA.

REASON: The department has concluded that clients in adult foster homes can be better cared for if day care services are not also provided by the operator.

11.16.128 ADULT FOSTER HOME, LICENSES

Subsections (1) and (4) remain the same.

~~(5) The department may in its discretion issue a provisional license for any period, not to exceed 6 months, to any license applicant that has met all applicable requirements for fire safety and has submitted a written plan approved by the department to comply fully with all minimum requirements established by these rules within the time period covered by the provisional license.~~

AUTH: 53-3-304, MCA. IMP: 53-3-303, MCA.

REASON: Provisional licensing is no longer provided by Montana law, and therefore, the above provision must be deleted.

11.16.101 GENERAL The department shall provide the following:

(1) ~~preplacement planning with individual being considered for foster care, including other concerned persons such as family and physicians~~ staff to license and reevaluate and renew licenses for adult foster care;

(2) ~~preplacement planning with prospective foster parents~~ assistance in applying to adult foster home operators for placement of eligible individuals in adult foster homes upon request made to the local DFS office by any relative, other concerned individuals, medical facility, or doctor, desiring to make such application;

(3) counseling services to client and foster family around adjustment;

(4) a study of a home's eligibility for licensing as an adult foster care home upon written request addressed to the appropriate regional DFS office made by any individual or married couple age 18 or over.

~~(5) arrange for foster care payments and personal allowance for client; and~~

~~(6) plan with client and other concerned persons if it is necessary to remove client from foster home.~~

AUTH: Sec. 53-5-304, MCA. IMP: Sec. 53-5-303, MCA.

REASON: The changes more clearly reflect services currently available.

11.16.102 ~~PROCEDURES FOR OBTAINING SERVICES~~ ELIGIBILITY AND PROCEDURE REQUIREMENTS FOR FOSTER CARE HOMES AND PLACEMENT (1) ~~Any adult who is eligible for SSI payments may request placement in an adult foster home by signing a form obtainable from any DFS office.~~ Individuals considered for placement in adult foster care must meet the department's definition of being an aged or a disabled person.

(2) ~~Any relative, other concerned individual, medical facility or doctor, or other agency may request placement of an eligible individual in an adult foster home by signing a form obtainable from any DFS office.~~ Persons applying for approval to provide adult foster care may apply at the appropriate regional DFS office.

(3) ~~The social worker assigned to the adult service case may request placement of the client in an adult foster home, with the agreement of the client.~~ Persons applying for approval to provide adult foster care must be studied and evaluated by a department social worker in terms of physical facilities to be utilized and personal qualifications of foster parents to provide such care.

(4) ~~Any individual or married couple may request to be studied as an adult foster home. Request may be made in person, in writing or by telephone to the local county welfare office. Applicants must complete and sign an application obtainable from any DFS office.~~ The study and evaluation is reviewed by the social service supervisor who has the final decision as to whether or not a home will be certified for adult foster care.

(5) The applicant is advised in writing as to the decision, and the reasons supporting the decision if denied, in regard to the application to provide adult foster care.

AUTH. Sec. 53-3-304, MCA IMP. Sec. 53-3-303, MCA

REASON: The changes more clearly reflect requirements of current procedures and the range of services available.

3. The Rule 11.16.103 ELIGIBILITY AND PROCEDURE REQUIREMENTS as proposed to be repealed is on pages 11-753 to 11-754 of the Administrative Rules of Montana.

REASON: All provisions of this rule which remain applicable have been incorporated into Rule 11.16.102.

AUTH: Sec. 53-3-304, MCA IMP: Sec. 53-3-303, MCA

4. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Office of Legal Affairs, Department of Family Services, P.O. Box 8005, Helena, Montana 59604, no later than December 13, 1990.

5. The Office of Legal Affairs, Department of Family Services has been designated to preside over and conduct the hearing.

Director, Department of Family Services

Certified to the Secretary of State October 31, 1990.

**BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA**

IN THE MATTER OF THE AMENDMENT of ARM 42.22.1311 relating to Industrial Machinery and Equipment Trend Factors	NOTICE OF PUBLIC HEARING on the PROPOSED AMENDMENT of Rule 42.22.1311 relating to Industrial Machinery and Equipment Trend Factors

TO: All Interested Persons:

1. On December 10 1990, at 9:30 a.m., a public hearing will be held in the Fourth Floor Conference Room, Mitchell Building, Helena, Montana, to consider the amendment of ARM 42.22.1311, relating to industrial machinery and equipment trend factors.

2. The amendment as proposed provides as follows:

42.22.1311 INDUSTRIAL MACHINERY AND EQUIPMENT TREND FACTORS (1) The department of revenue will utilize the machinery and equipment trend factors which are set forth on the following tables. The trend factors will be used to value industrial machinery and equipment for ad valorem tax purposes pursuant to ARM 42.22.1306. The department uses annual cost indexes from Marshall Valuation Service. The current index is divided by the annual index for each year to arrive at a trending factor. Industries with similar trending factors are grouped. The schedules in the rule reflect an average of trend factors for each industry group. Where no index existed in the Marshall Valuation Service for a particular industry, that industry was grouped with other industries using similar equipment.

~~INDUSTRIAL MACHINERY AND EQUIPMENT TREND FACTORS~~
~~1989 = 1004~~

~~YEAR~~	~~TABLE 1~~	~~TABLE 2~~	~~TABLE 3~~	~~TABLE 4~~	~~TABLE 5~~	~~TABLE 6~~
~~1989~~	~~1.000~~	~~1.000~~	~~1.000~~	~~1.000~~	~~1.000~~	~~1.000~~
~~1988~~	~~1.055~~	~~1.052~~	~~1.050~~	~~1.056~~	~~1.053~~	~~1.050~~
~~1987~~	~~1.102~~	~~1.087~~	~~1.092~~	~~1.110~~	~~1.095~~	~~1.107~~
~~1986~~	~~1.120~~	~~1.097~~	~~1.100~~	~~1.123~~	~~1.110~~	~~1.122~~
~~1985~~	~~1.137~~	~~1.104~~	~~1.117~~	~~1.129~~	~~1.110~~	~~1.135~~
~~1984~~	~~1.150~~	~~1.110~~	~~1.132~~	~~1.144~~	~~1.135~~	~~1.152~~
~~1983~~	~~1.180~~	~~1.143~~	~~1.162~~	~~1.176~~	~~1.165~~	~~1.180~~
~~1982~~	~~1.200~~	~~1.166~~	~~1.184~~	~~1.194~~	~~1.180~~	~~1.196~~
~~1981~~	~~1.265~~	~~1.230~~	~~1.242~~	~~1.243~~	~~1.240~~	~~1.250~~
~~1980~~	~~1.399~~	~~1.366~~	~~1.374~~	~~1.367~~	~~1.382~~	~~1.381~~
~~1979~~	~~1.545~~	~~1.501~~	~~1.508~~	~~1.510~~	~~1.526~~	~~1.531~~
~~1978~~	~~1.692~~	~~1.641~~	~~1.641~~	~~1.664~~	~~1.666~~	~~1.671~~
~~1977~~	~~1.822~~	~~1.769~~	~~1.767~~	~~1.776~~	~~1.794~~	~~1.795~~
~~1976~~	~~1.933~~	~~1.872~~	~~1.860~~	~~1.866~~	~~1.906~~	~~1.876~~
~~1975~~	~~2.053~~	~~1.995~~	~~1.977~~	~~1.981~~	~~2.031~~	~~1.980~~
~~1974~~	~~2.303~~	~~2.280~~	~~2.192~~	~~2.215~~	~~2.306~~	~~2.239~~

~~1973-----2,659-----2,645-----2,537-----2,635-----2,696-----2,626~~
~~1972-----2,756-----2,736-----2,622-----2,805~~
~~1971-----2,865-----2,830-----2,709-----2,907~~
~~1970-----3,062-----3,007-----2,875-----3,061~~

INDUSTRIAL MACHINERY AND EQUIPMENT TREND FACTORS
1990 = 100%

YEAR	TABLE 1	TABLE 2	TABLE 3	TABLE 4	TABLE 5	TABLE 6
1990	1.000	1.000	1.000	1.000	1.000	1.000
1989	1.027	1.029	1.026	1.022	1.028	1.026
1988	1.084	1.083	1.079	1.080	1.083	1.085
1987	1.133	1.120	1.122	1.135	1.127	1.135
1986	1.152	1.132	1.138	1.148	1.142	1.150
1985	1.169	1.139	1.147	1.154	1.151	1.160
1984	1.190	1.155	1.162	1.169	1.167	1.176
1983	1.221	1.184	1.194	1.203	1.198	1.205
1982	1.240	1.207	1.217	1.221	1.221	1.221
1981	1.300	1.274	1.275	1.271	1.282	1.277
1980	1.437	1.414	1.407	1.396	1.420	1.411
1979	1.588	1.554	1.543	1.554	1.568	1.561
1978	1.752	1.697	1.682	1.700	1.732	1.707
1977	1.888	1.812	1.817	1.814	1.864	1.833
1976	1.988	1.937	1.916	1.907	1.964	1.929
1975	2.117	2.053	2.049	2.022	2.087	2.042
1974	2.363	2.346	2.257	2.281	2.367	2.306
1973	2.738	2.722	2.588	2.698	2.770	2.695
1972	2.838	2.816	2.673	2.802	2.882	2.797
1971	2.950	2.912	2.761	2.913	2.987	2.908

TABLE 1:

BAKING (12)
FISH CANNING (12)
MEAT PACKING (12)
HONEY PROCESSING (12)
CANDY & CONFECTIONERY (20)
FRUIT CANNING (12)
RUBBER & VULCANIZING (15)
CREAMERY & DAIRY (12)
PRINTING (12)

TABLE 2:

CEMENT MANUFACTURING (20)
ORE MILLING &
CONCENTRATING (15)
CONCRETE READY MIX (18)
BENTONITE (20)
VERMICULITE PROCESSING (~~20~~15)
STONE PRODUCTS (15)
CONCRETE PRODUCTS (~~10~~20)
GYPSUM (20)

TABLE 4:

ELECTRICAL EQUIPMENT
MANUFACTURING (10)
ELECTRIC POWER EQUIPMENT (16)
HYDROELECTRIC GENERATION (20)
STEAM POWER GENERATION (16)
COAL FIRED POWER GENERATION
(16)
ELECTRONIC COMPONENT
MANUFACTURING (10)
LAUNDRY & DRYCLEANING (10)
~~ELECTRONIC COMPONENT MFG. (10)~~
AIRCRAFT & AIRFRAME MFG. (15)

TABLE 5:

CHEMICAL MANUFACTURING (12)
~~CLAY PRODUCTS (15)~~
CONTRACTOR EQUIPMENT (10)
SULPHUR MANUFACTURING (12)

OXYGEN GENERATION (20)
WOOD PELLET PLANT (16)

TALC BENEFICATION (20)
LIME & CALCIUM BENEFICATION(20)
COAL CRUSHING & HANDLING (20)
GRAPHITE PRODUCTS (20)
HEAP LEACH PADS (5)
HEAP LEACH MECHANICAL (20)
NONFERROUS SMELTING (15)
UNDERGROUND MINING (10)
OPEN PIT MINING & QUARRYING(15)
PHOSPHATE BENEFICATION (20)
CLAY PRODUCTS (15)

TABLE 3:

TEXTILE FABRICATION (10)
LEATHER FABRICATION (20)
PULP & PAPER MANUFACTURING(13)
CARDBOARD CONTAINER
FABRICATION (20)
WOODWORKING (20)
FURNITURE MANUFACTURING (10)
SAWMILL EQUIPMENT (10)

REFRIGERATION (12)
FRUIT PACKING (12)
PAINT MANUFACTURING (12)
EGG PACKING (20)
INDUSTRIAL SHOP EQUIPMENT (10)
METAL MACHINING & MILLING (15)
FOUNDRY (15)
RIFLE MANUFACTURING (15)
PLASTIC PRODUCTS MFG. (20)
POLYSTYRENE (20)
~~PRINTING-(12)~~
FERTILIZING MANUFACTURING (12)
METAL FABRICATION (20)

TABLE 6:

BREWING & DISTILLING (20)
VEGETABLE OIL EXTRACTION (20)
GASOHOL PLANT (15)
ALCOHOL PLANT (15)
BOTTLING (12)
~~CREAMERY & DAIRY-(12)~~
FLOUR MILLING (16)
FEED MILLING (16)
SEED TREATING & CLEANING (16)
CEREAL PRODUCTS (16)
GRAIN HANDLING FACILITIES (16)

~~TABLE-7----TABLE-8~~

~~-1,000-----1,000~~
~~-1,050-----1,055~~
~~-1,000-----1,101~~
~~-1,103-----1,109~~
~~-1,110-----1,115~~
~~-1,124-----1,129~~
~~-1,152-----1,153~~
~~-1,173-----1,167~~
~~-1,224-----1,233~~
~~-1,348-----1,372~~
~~-1,474-----1,523~~
~~-1,637-----1,660~~
~~-1,775-----1,788~~
~~-1,878-----1,886~~
~~-2,017-----1,994~~
~~-2,208-----2,245~~
~~-2,587-----2,634~~
~~-2,589-----2,720~~
~~-2,673-----2,828~~
~~-2,828-----3,021~~

YEAR	TABLE 7	TABLE 8
1990	1.000	1.000
1989	1.024	1.026
1988	1.069	1.078
1987	1.104	1.123
1986	1.119	1.126
1985	1.127	1.127
1984	1.140	1.140
1983	1.166	1.161
1982	1.179	1.172
1981	1.232	1.249
1980	1.363	1.400
1979	1.484	1.556
1978	1.618	1.700
1977	1.743	1.834
1976	1.839	1.941
1975	1.988	2.051
1974	2.166	2.304
1973	2.447	2.714
1972	2.506	2.816
1971	2.601	2.927

TABLE 7:

~~WOODWORKING-(20)~~
WAREHOUSING (10)
~~PEAT-MOSS-BAGGING-PLANT-(20)~~
FERTILIZER DISTRIBUTION (10)
~~FURNITURE-MANUFACTURING-(20)~~
~~SAWMILL-EQUIPMENT-(10)~~
PEAT MOSS BAGGING PLANT (20)

TABLE 8:

~~BREWING-&-DISTILLING-(20)~~
PETROLEUM (16)
~~VEGETABLE-OIL-EXTRACTION-(20)~~
~~GASOHOL-PLANT-(15)~~
~~ALCOHOL-PLANT-(15)~~
~~NATURAL-GAS-PROCESSING-(16)~~
~~STATIONARY-ASPHALT-PLANT-(15)~~
~~SUGAR-REFINERY-(10)~~
OIL REFINING (16)
STATIONARY ASPHALT PLANT (15)
SUGAR REFINERY (10)
NATURAL GAS PROCESSING (16)

Note: 1. The number in each parenthesis above indicates assigned economic life expectancies.
Note: 2. Lab equipment is to be included in its related industry's table at 10-year life expectancy.

(2) The application of the trend factors set forth in subsection (1) will be as reflected in the following example:

EXAMPLE

The Trending/Depreciation Procedure

In order to use the economic age-life method to value machinery and equipment, several steps must be followed:

1. Determine the economic life of the subject industry.
2. Acquire a set of reasonable trends for that economic life.
3. Acquire the original installed cost (direct and indirect) for the subject equipment.
4. Apply the appropriate trend factor to the original installed cost to determine replacement cost new (RCN).
5. Depreciate the RCN on the basis of age to arrive at sound value.

Example:

Industry - Sawmill
Economic Life - 10 years
~~1986~~ 1990 Table - Table ~~6~~ 3 (Subsection 1)

Case	I	II
Equipment - Motor		
Original Installed Cost	$ 200	$ 100
Year Installed	1980	1972

Case I

Cost	$ 200	
x Trend	~~1.227~~ 1.407	
RCN	~~245~~ 281	
x % Good	~~.49~~ .20	
Sound Value	$ ~~120~~ 56	

Case II

Cost	$ 100	
x Trend	~~1.596~~ 2.673*	
RCN	~~160~~ 267	
x % Good	.20	
Sound Value	$ ~~32~~ 53	

*The trending factor is applied only to the last year of the economic life. Although the equipment is ~~15~~ 18 years old, it is trended by the 10th year trend.

3. The authority for the department to amend this rule is found at 15-1-201, MCA, and implements 15-6-138 and 15-8-111, MCA.

4. The Department is proposing the amendment because 15-8-111, MCA, requires the department to value all property at 100 percent of its market value except as provided in subsection (5) of 15-8-111 and 15-7-111, MCA. Through the use of administrative rules, the department has adopted the concept of trending and depreciating to arrive at market value for industrial machinery and equipment, furniture and fixtures.

The method by which trending and depreciation schedules are derived is described in the existing administrative rules and

that method is not being changed. The methodology results in annual changes to the trending schedules. The schedule changes will, in most cases, result in valuation decreases in comparison to the previous year.

No other changes to the Industrial Property administrative Rules have been made.

5. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to:

Cleo Anderson
Department of Revenue
Office of Legal Affairs
Mitchell Building
Helena, Montana 59620

no later than December 14, 1990.

6. Cleo Anderson, Department of Revenue, Office of Legal Affairs, has been designated to preside over and conduct the hearing.

DENIS ADAMS, Director
Department of Revenue

Certified to Secretary of State November 5, 1990.

BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA

IN THE MATTER OF THE AMENDMENT of ARM 42.17.105 relating to Computation of Withholding Surtax	NOTICE OF PROPOSED AMENDMENT of ARM 42.17.105 relating to Computation of Withholding Surtax

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On January 1, 1991, the Department proposes to amend 42.17.105 relating to computation of withholding surtax.

2. The rule as proposed to be amended provides as follows:

42.17.105 COMPUTATION OF WITHHOLDING (1) The amount of tax withheld per payroll period shall be calculated according to the following four-step formula:

(a) $Y = PZ$

where Z is the individual's gross earnings for the payroll period; and

Y is the individual's annualized gross earnings.

In these calculations, the quantity P (number of payroll periods during the year) has one of the following values:

Annual payroll period	P = 1
Monthly payroll period	P = 12
Semimonthly payroll period	P = 24
Biweekly payroll period	P = 26
Weekly payroll period	P = 52

(b) $T = Y - 1400N$

where T is the annualized ~~net gross income~~ earnings; and

N is the number of withholding ~~exemptions~~ allowances claimed.

If T in Step (b) is less than or equal to 0, then the amount to be withheld during the pay period is 0. If T is greater than 0, then the annualized tax liability is calculated using:

(c) $X = A + B(T-C)$ where X is the individual's annualized tax liability the parameters A, B and C are chosen from the following rate schedule:

At Least	But Less Than	A	B	C
$ 0	$ 6,590	$ 0	~~2.7%~~ 2.6%	$ 0
6,590	14,600	171.34	~~4.6%~~ 4.4%	6,590
14,600	32,000	523.78	~~6.4%~~ 6.1%	14,600
32,000 and over		1,585.18	~~6.8%~~ 6.5%	32,000

(d) $W = \frac{X}{P}$

where W is the amount to be withheld for the payroll period;
X is the annualized tax liability; and
P is the number of payroll periods during the year.

(2) This rule is effective for tax periods beginning ~~January 1, 1990~~ January 1, 1991.

3. The authority for the department to amend this rule is found at 15-30-305, MCA, and implements 15-30-108 and 15-30-202, MCA.

4. ARM 42.17.105 is proposed to be amended primarily because the 5% surtax has expired. The withholding rates must reflect the elimination of the 5% surtax which was expired after tax year 1990. Other insignificant verbiage changes were made to parallel the language provided in taxpayer information booklets.

5. Interested parties may submit their data, views, or arguments concerning the proposed amendment in writing to:

Cleo Anderson
Department of Revenue
Office of Legal Affairs
Mitchell Building
Helena, Montana 59620

no later than December 14, 1990.

6. If a person who is directly affected by the proposed adoption wishes to express his data, views and arguments orally or in writing at a public hearing, he must make written request for a hearing and submit this request along with any written comments he has to Cleo Anderson at the above address no later than December 14, 1990.

7. If the agency receives requests for a public hearing on the proposed adoption from either 10% or 25, whichever is less, of the persons who are directly affected by the proposed adoption; from the Administrative Code Committee of the Legislature; from a governmental subdivision, or agency; or from an association having no less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be 25.

DENIS ADAMS, Director
Department of Revenue

Certified to Secretary of State November 5, 1990.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rules 46.12.503, 46.12.590 and 46.12.592 pertaining to disproportionate share for inpatient psychiatric hospitals	)))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULES 46.12.503, 46.12.590 AND 46.12.592 PERTAINING TO DISPROPORTIONATE SHARE FOR INPATIENT PSYCHIATRIC HOSPITALS

TO: All Interested Persons

1. On December 6, 1990, at 9:00 a.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed amendment of Rules 46.12.503, 46.12.590 and 46.12.592 pertaining to disproportionate share for inpatient psychiatric hospitals.

2. The rules as proposed to be amended provide as follows:

46.12.503 INPATIENT HOSPITAL SERVICES, DEFINITION
Subsections (1) through (11) remain the same.
(12) "Disproportionate share hospital" means a hospital, including a psychiatric inpatient hospital facility, which meets the following criteria:
(a) it has a medicaid inpatient utilization rate of at least one standard deviation above the mean medicaid inpatient utilization rate for all hospitals receiving medicaid payments in the state, or a low income utilization rate exceeding 25 percent; and
Subsections (12)(b) through (12)(c)(ii) remain the same.
(13) "Medicaid inpatient utilization rate" means the hospital's percentage rate computed by dividing the total number of medicaid inpatient days in the hospital's fiscal year by the total number of the hospital's inpatient days in that same period. The period used will be the most recent calendar year for which final cost reports are available for all hospital providers, including psychiatric inpatient hospital facilities.
Subsections (14) through (16) remain the same.

AUTH: 53-6-113 MCA
IMP: 53-6-101 MCA

46.12.590 INPATIENT PSYCHIATRIC SERVICES, PURPOSE AND DEFINITIONS Subsections (1) through (2)(q) remain the same.
(r) "Disproportionate share hospital" means a hospital, including a psychiatric inpatient hospital facility, which meets the following criteria:

(i) it has a medicaid inpatient utilization rate of at least one standard deviation above the mean medicaid inpatient utilization rate for all hospitals receiving medicaid payments in the state, or a low income utilization rate exceeding 25 percent;

(ii) urban hospitals must have at least two obstetricians with staff privileges who have agreed to provide obstetric services to medicaid patients. Rural hospitals must have at least two physicians with staff privileges to perform non-emergent obstetric procedures who have agreed to provide obstetric services to medicaid recipients; and

(iii) subsection (ii) does not apply to hospitals which:

(A) serve inpatients who are predominantly individuals under 18 years of age; or

(B) do not offer non-emergent obstetric services as of December 21, 1987.

(s) "Medicaid inpatient utilization rate" means the hospital's percentage rate computed by dividing the total number of medicaid inpatient days in the hospital's fiscal year by the total number of the hospital's inpatient days in that same period. The period used will be the most recent calendar year for which final cost reports are available for all hospital providers, including psychiatric inpatient hospital facilities.

(t) "Low income utilization rate" is the percentage rate computed as follows:

(i) (A + B)/C + (D/E) where:

(A) "A" is the total medicaid payments to the hospital for patient services in the hospital's fiscal year;

(B) "B" is the cash subsidies received directly from state and local governments for patient services in the hospital's fiscal year;

(C) "C" is the total revenues of the hospital for patient services, including the amount of such cash subsidies in the hospital's fiscal year;

(D) "D" is the total hospital charges for inpatient hospital services attributable to charity care in the hospital's fiscal year. This amount shall not include contractual allowances and discounts (other than for indigent patients not eligible for public assistance); and

(E) "E" is the hospital's total charges for inpatient hospital services in the hospital's fiscal year.

(ii) The above amounts used in the formula must be from the hospital's most recent fiscal year for which costs have been settled with the department.

(u) "Urban hospital" means an acute care hospital that is located within a metropolitan statistical area as defined by the federal executive office of management and budget.

(v) "Rural hospital" means an acute care hospital that is not located within a metropolitan statistical area as defined by the federal executive office of management and budget.

Subsections (3) through (6) remain the same.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 MCA

46.12.592 INPATIENT PSYCHIATRIC SERVICES, REIMBURSEMENT Subsections (1) through (8)(b) remain the same.

(9) Disproportionate share hospitals shall receive an additional payment amount equal to the product of the hospital's rate times the adjustment percentage of:

(a) 4 percent for rural hospitals, and

(b) 5 percent for urban hospitals having less than 100 beds.

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 MCA

3. Under section 1923(b) of the Social Security Act, disproportionate share (DS) reimbursement for hospitals which serve a disproportionate number of Medicaid recipients or low income patients is allowed. This rule change is necessary to include Inpatient Psychiatric Hospitals for Individuals Under Age 21 in those hospitals that are considered in the calculation for DS reimbursement, as required by federal law. Psychiatric hospitals entitled to a disproportionate share adjustment (DSA) under this rule will receive payments calculated on the facility's interim rate, but subject to determination of overpayment or underpayment in the annual cost settlement process. The method of calculating and paying other hospitals, if any, entitled to a DSA will not be changed by the proposed rule.

4. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, MT 59604-4210, no later than December 14, 1990.

5. The Office of Legal Affairs, Department of Social and Rehabilitation Services has been designated to preside over and conduct the hearing.

Director, Social and Rehabilitation Services

Certified to the Secretary of State November 5, 1990.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rules 46.12.2003 and 46.12.2013 pertaining to pharmacy pricing codes for drugs administered by physicians and nurse specialists	)))))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULES 46.12.2003 AND 46.12.2013 PERTAINING TO PHARMACY PRICING CODES FOR DRUGS ADMINISTERED BY PHYSICIANS AND NURSE SPECIALISTS

TO: All Interested Persons

1. On December 6, 1990, at 10:00 a.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed amendment of Rules 46.12.2003 and 46.12.2013 pertaining to pharmacy pricing codes for drugs administered by physicians and nurse specialists.

2. The rules as proposed to be amended provide as follows:

46.12.2003 PHYSICIAN SERVICES, REIMBURSEMENT/GENERAL REQUIREMENTS AND MODIFIERS Subsections (1) through (3) remain the same.

(4) Reimbursement to physicians for physician-administered drugs which are billed under HCPCS "J" and "Q" codes will be the Montana estimated acquisition cost or maximum allowable cost, or the provider's usual and customary charge, whichever is lower. No dispensing fee will be paid to physicians.

(a) The maximum allowable cost limitation shall not apply in those cases under subsection (4) where the physician certifies in their own handwriting that in their medical judgment a specific brand name drug is medically necessary for a particular patient. Acceptable certification statements are "brand necessary" or "brand required." A check-off box on a form or a rubber stamp is not acceptable.

Original subsection (4) remains the same in text but is renumbered as subsection (5).

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-101 and 53-6-113 MCA

46.12.2013 NURSE SPECIALIST SERVICES, REIMBURSEMENT Subsections (1) through (6) remain the same.

(7) Reimbursement to nurse specialists for drugs administered by nurse specialists and which are billed under HCPCS "J" and "Q" codes will be the Montana estimated acquisi-

tion cost or maximum allowable cost, or the provider's usual and customary charge, whichever is lower. Reimbursement will be available only to nurse specialists who are authorized to prescribe or dispense the medication provided. No dispensing fee will be paid to nurse specialists.

(a) The maximum allowable cost limitation shall not apply in those cases under subsection (4) where the prescribing physician certifies in their own handwriting that in their medical judgment a specific brand name drug is medically necessary for a particular patient. Acceptable certification statements are "brand necessary" or "brand required." A check-off box on a form or a rubber stamp is not acceptable.

Original subsections (7) through (7)(h) remain the same in text but are renumbered as subsections (8) through (8)(h).

AUTH: Sec. 53-2-201 and 53-6-113 MCA
IMP: Sec. 53-6-101 MCA

3. ARM 46.12.2003 and 2013 are being amended to alleviate the problem of inadequate reimbursement to physicians and nurse specialists for those drugs which are administered by these practitioners. Such drugs are those billed under HCPCS "J" and "Q" codes. Current reimbursement methodology fails to meet the costs of such drugs, and may discourage practitioners from providing such drugs. The proposed amendments are necessary to revise the reimbursement methodology to cover the costs of these drugs.

4. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, MT 59604-4210, no later than December 14, 1990.

5. The Office of Legal Affairs, Department of Social and Rehabilitation Services has been designated to preside over and conduct the hearing.

/s/ [illegible] for
Director, Social and Rehabilitation Services

Certified to the Secretary of State November 5, 1990.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the adoption of Rules I and II and the amendment of Rules 46.25.101, 46.25.751 and 46.25.752 pertaining to general relief medical assistance	))))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED ADOPTION OF RULES I AND II AND THE AMENDMENT OF RULES 46.25.101, 46.25.751 AND 46.25.752 PERTAINING TO GENERAL RELIEF MEDICAL ASSISTANCE

TO: All Interested Persons

1. On December 6, 1990, at 2:00 p.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed adoption of Rules I and II and the amendment of Rules 46.25.101, 46.25.751 and 46.25.752 pertaining to general relief medical assistance.

2. The rules as proposed to be adopted provide as follows:

[RULE I] USE OF DESIGNATED REVIEW ORGANIZATIONS (1) The department for purposes of the general relief medical program may delegate determination of medical necessity, restricted provider and service access, selection of providers, prior authorization, and other functions to designated review organizations.

AUTH: Sec. 53-2-201, 53-2-803 and 53-3-114 MCA
IMP: Sec. 53-2-803, 53-3-310 and 53-3-313 MCA

[RULE II] FAIR HEARINGS (1) Any person who is dissatisfied with an action or determination made by the department or one of its designated review organizations concerning that person's eligibility for or receipt of services under the general relief medical program, may request a fair hearing provided for in chapter 2, subchapter 2 of Title 46 of the Administrative Rules of Montana.

AUTH: Sec. 53-2-201, 53-2-803 and 53-3-114 MCA
IMP: Sec. 53-2-803, 53-3-113, 53-3-310 and 53-3-313 MCA

3. The rules as proposed to be amended provide as follows:

46.25.101 DEFINITIONS Subsections (1) through (10) remain the same.

(11) "Emergency services" means inpatient and outpatient hospital services that are necessary to prevent the death or serious impairment of a person.

Original subsections (11) through (21)(a) remain the same in text but will be renumbered as subsections (12) through (22)(a).

(b) "General relief medical household" means all persons who ~~are legally responsible for each other and live in the same residence~~ reside in the same residence and are either married to each other or are parents or children of other persons living in the same residence are considered to be one household for purposes of determining general relief medical assistance.

Original subsections (22) through (45) remain the same in text but will be renumbered as subsections (23) through (46).

AUTH: Sec. 53-2-201, 53-3-102, 53-2-803, 53-3-109 and 53-3-114 MCA

Sec. Sec. 53-2-201, 53-2-301, 53-2-802, 53-3-109, 53-3-304 and 53-3-305 MCA

46.25.751 SELECTION OF MEDICAL PROVIDER Subsection (1) remains the same.

(2) A general relief medical assistance recipient may be restricted to utilizing designated providers and restricted in the use of services if the department determines that the recipient's utilization is excessive, inappropriate, or fraudulent with respect to medical need.

(a) Restrictions may be imposed on physician services, drugs or any other services covered by the general relief medical assistance program when:

(i) the recipient's medical condition does not warrant the service or frequency of services;

(ii) there is unwarranted multiple provider usage which results in the receipt of unnecessary services;

(iii) there is repeated use of emergency rooms for routine medical services;

(iv) there is admission of or conviction for forgery of general relief medical drug prescriptions by the recipient; or

(v) the recipient utilizes a general relief medical authorization letter in any unlawful or fraudulent manner.

(b) Payment records, reports from medical consultants, and other pertinent recipient or service information may be used by the department in decisions related to recipient overutilization or other abuse.

(c) A recipient's restriction will not apply to other members of the household.

(d) Payment for medical services provided to a restricted recipient will be made only to the designated providers except when emergency services are required, when the primary physician refers the recipient to another physician or when the department approves the service prior to performance.

(e) Recipients will be notified in writing at least ten days prior to the date of the intended action restricting medical services which are to be paid for by the general relief medical program.

(f) The recipient will have an opportunity to designate the providers he prefers and his preference will be approved unless the department determines:

(i) that the provider has been sanctioned in accordance with ARM 46.12.401 or ARM 46.25.746;

(ii) that the provider has not properly managed the medical care of a recipient who has been restricted;

(iii) the provider is not an appropriate provider for the medical service; or

(iv) that the provider will not accept the recipient as a patient.

(g) If the recipient does not provide to the department in writing their provider preference prior to the issuance of the general relief medical authorization letter for the month that the intended action is to take place, the recipient's authorization letter may be held for 15 days from the date of intended action in order for the department to make the selections.

(h) If the department is unable to obtain a primary physician for the restricted recipient, all non-emergency services must be prior authorized by the department.

(i) Restricted recipients may request a change of providers. The request must be in writing and submitted to the department for approval. Provider changes will not be approved unless the department determines that there is good cause for the requested provider changes. The department will have 30 days to take action on the request.

(j) The department will review the restriction on a recipient one year from the date of the imposition of the restriction. Restriction may be continued if:

(i) the department determines the recipient's utilization or attempts at utilization remains excessive and/or unwarranted;

(ii) the designated physician recommends, with supporting rationale, that the recipient should remain restricted; or

(iii) the recipient has received or attempted to receive unauthorized services.

AUTH: Sec. 53-2-201, 53-2-803 and 53-3-114 MCA
IMP: Sec. 53-3-310, 53-3-313 and 53-2-803 MCA

46.25.752 SCOPE OF GENERAL RELIEF MEDICAL ASSISTANCE

(1) Services will be provided to alleviate ~~the~~ a specific serious medical condition in the amount and scope ~~not to exceed those~~ provided under the medicaid program described at Title 46, chapter 12 of the Administrative Rules of Montana, ~~with the following limitations:~~

(2) The following services are not covered:

(a) ~~No~~ experimental services ~~will be allowed~~; and

(b) inpatient or residential psychiatric service.

(~~b~~3) Cosmetic services ~~will be allowed~~ are covered as follows:

(~~i~~a) when a medical review indicates the condition poses a serious medical risk; and

(~~ii~~b) the department has granted prior authorization.

~~(c) the department will review the medical necessity of hospitalization for acute care.~~

Original subsection (2) remains the same in text but will be renumbered as subsection (4).

(~~3~~5) ~~Prior authorization must be received prior to~~ The department may require prior authorization for services rendered within the period of the treatment of the serious medical condition except for covered emergency services rendered within 90 days prior to application.

(6) Emergency services will only be reimbursed if:

(a) reviewed and approved by a designated review organization; and

(b) the care is an allowable service.

(7) The department will review the medical necessity of hospitalization for acute care.

AUTH: Sec. 53-2-201, 53-2-803 and 53-3-114 MCA
IMP: Sec. 53-3-310, 53-3-313 and 53-2-803 MCA

4. The proposed rule changes implement a managed care system to control recipient abuse of services, provide for the delegation of program management to designated review organizations, provide for the provision of fair hearings to recipients and provide for the amount and scope of services. The definition of general relief medical household is being amended to be the same as that provided in statute. These changes will improve management of the general relief medical program by clarifying current authority and implementing new management controls.

5. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, MT 59604-4210, no later than December 14, 1990.

6. The Office of Legal Affairs, Department of Social and Rehabilitation Services has been designated to preside over and conduct the hearing.

Director, Social and Rehabilitation Services

Certified to the Secretary of State November 5, 1990.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rule 46.12.3401 pertaining to presumptive and continuous eligibility for medicaid services	)))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULE 46.12.3401 PERTAINING TO PRESUMPTIVE AND CONTINUOUS ELIGIBILITY FOR MEDICAID SERVICES

TO: All Interested Persons

1. On December 6, at 1:00 p.m., a public hearing will be held in the auditorium of the Social and Rehabilitation Services Building, 111 Sanders, Helena, Montana to consider the proposed amendment of Rule 46.12.3401 pertaining to presumptive and continuous eligibility for medicaid services

2. The rule as proposed to be amended provides as follows:

46.12.3401 GROUPS COVERED, NON-INSTITUTIONALIZED AFDC-RELATED FAMILIES AND CHILDREN Subsection (1) remains the same.

(a) individuals receiving AFDC~~,~~;

Subsections (1)(a)(i) through (1)(b)(i) remain the same.

(ii) participants in a work supplementation program under T~~t~~itle IV-A of the Social Security Act and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program~~,~~;

(iii) individuals whose AFDC is terminated ~~because the family becomes ineligible because of~~ due to collection or increased collection of child support. These individuals will continue to receive medicaid for four (4) months~~,~~;

(iv) individuals whose AFDC is terminated because of loss of the $30 and one-third (1/3) disregard at the end of four (4) months or the $30 disregard at the end of eight (8) months. These individuals will continue to receive medicaid up to twelve (12) months~~,~~; and

(v) individuals under age 21 who currently reside in Montana and are receiving foster care or adoption assistance under Title IV-E of the Social Security Act, whether or not such assistance originated in Montana. Eligibility requirements for Title IV-E foster care and adoption assistance are found in ARM 46.10.307~~,~~.

Subsections (1)(c) through (1)(c)(ii) remain the same.

(A) ~~t~~This twelve (12) month period of continued medicaid coverage begins the month following the date of AFDC closure, or, if AFDC eligibility ends prior to the month of closure, with the first month in which AFDC was erroneously paid.

(B) ~~t~~The transitional medical assistance is not available to any family who received AFDC because of fraud during the last six months prior to the beginning of the transitional period.

Subsection (1)(d) remains the same.

(e) individuals who would be eligible for AFDC except for failure to meet the ~~WIN~~ JOBS participation requirements found in ARM 46.10.~~300~~801 through 46.10.847.

(f) a pregnant woman whose pregnancy has been verified and whose family income and resources meet the requirements listed in ARM 46.10.403 and 46.10.406~~,~~;

(i) ~~t~~The unborn child shall be considered ~~as~~ an additional member of the assistance unit for purposes of determining eligibility.

(g) a pregnant woman whose pregnancy has been verified and whose family income does not exceed 133% of the federal poverty guidelines~~,~~;

(i) ~~t~~The unborn child shall be considered ~~as~~ an additional member of the assistance unit for purposes of determining eligibility.

(h) a pregnant woman during a period of presumptive eligibility;

(i) Presumptive eligibility is established by submission of an application by the applicant on the form specified by the department, to a qualified presumptive eligibility provider, verification of pregnancy and a determination by the qualified presumptive eligibility provider that applicant's household income does not exceed 133% of the federal poverty guidelines for the household.

(A) A qualified presumptive eligibility provider is an entity which meets the requirements specified in section 3570.2 of the state medicaid manual, published by the health care financing administration of the U.S. department of health and human services and who is enrolled with the department as a qualified presumptive eligibility provider under the presumptive eligibility program. Section 3570.2 of the state medicaid manual is hereby adopted and incorporated herein by this reference. A copy of the manual section may be obtained from the Department of Social and Rehabilitation Services, Family Assistance Division, P.O. Box 4210, Helena, MT 59604-4210.

(B) Presumptive eligibility shall be effective for a period of 14 days. Upon submission of a medicaid application to the department during the initial 14-day period, presumptive eligibility shall be extended until the department determines that the applicant is ineligible for medicaid or the end of 45 days from initial establishment of presumptive eligibility, whichever is earlier. An individual is limited to one presumptive eligibility period per pregnancy.

(C) An applicant or recipient whose presumptive eligibility is terminated based upon expiration of the initial 14-day period without submission of a medicaid application to the department or based upon expiration of the 45-day period without

a determination of medicaid eligibility shall not be entitled to a fair hearing with respect to such termination, regardless of the provisions of ARM 46.2.202.

(ii) During a period of presumptive eligibility, a pregnant woman is limited to ambulatory prenatal care services covered under the Montana medicaid program. Such services may be provided by any medicaid provider eligible to receive medicaid reimbursement for such services under applicable law and regulations.

(i) a pregnant woman who becomes ineligible for AFDC, SSI or medicaid due solely to increased income and whose pregnancy is disclosed to the department and verified prior to closure of AFDC, SSI or medicaid;

(i) Eligibility shall be continuous without lapse in medicaid eligibility from the prior AFDC, SSI or medicaid eligibility and shall terminate on the last day of the month in which the sixtieth postpartum day occurs.

(ii) During a period of eligibility under this subsection, a pregnant woman is limited to services covered under the Montana medicaid program related to pregnancy and conditions which may complicate pregnancy, including prenatal care, delivery, post partum and family planning services.

(~~h~~j) a child born on or after October 1, 1983, whose family income and resources meet the requirements listed in ARM 46.10.403 and 46.10.406~~;~~;

(~~i~~k) a child through the month of the sixth birthday whose family income does not exceed 133% of the federal poverty guidelines~~;~~;

(~~j~~l) individuals under the age of 21 who are receiving foster care or subsidized adoption payments through child welfare services~~;~~;

(i) ~~t~~These individuals must have full or partial financial responsibility assumed by public agencies and must have been placed in foster homes, private institutions or private homes by a non-profit agency.

(~~k~~m) a child of a minor custodial parent when the custodial parent is living in the child's grandparent's home and the grandparent's income is the sole reason rendering the child ineligible for AFDC;

(~~l~~n) needy caretaker relatives as defined in ARM 46.10.302 who have in their care an individual under age 19 who is eligible for medicaid~~;~~; and

(~~m~~o) individuals who would be eligible for, but are not receiving, AFDC.

Subsections (2) through (3)(c) remain the same.

(4) Medicaid may be provided for up to three months prior to the date of application for individuals listed in 1(a), 1(b)(i), 1(b)(v), 1(d), (e), (f), (g), (h), (i), (j), (k), and (l) if all financial and non-financial criteria are met for any of those months. For individuals listed in 1(g) and (i) retroactive eligibility cannot begin prior to July 1, 1989.

AUTH: Sec. 53-4-212 MCA
IMP: Sec. 53-6-101, 53-6-131 and 53-4-231 MCA

3. The amendment of ARM 46.12.3401(1)(e) is necessary because the Work Incentive program (WIN) no longer exists. The Job Opportunities and Basic Skills program (JOBS) has been created through the Family Support Act of 1988 and implemented by prior rule amendment. This amendment clarifies that Montana provides Medicaid eligibility to individuals and their families who would be eligible for AFDC except for failure to meet JOBS requirements.

This rule change is also necessary to implement two new Medicaid programs authorized by federal law to improve services to pregnant women. The first program is Presumptive Eligibility. The Omnibus Budget Reconciliation Act of 1986 allows provision of ambulatory prenatal care to pregnant women during a presumptive eligibility period before they have formally applied for Medicaid.

The second program is Continuous Eligibility. Some low income pregnant women lose eligibility for Medicaid because of increased income. Some of these women remain uninsured and cannot afford adequate prenatal and delivery expenses. This new program allows ongoing Medicaid benefits throughout the course of the pregnancy, thus helping to reduce the risk of high cost infants and infant mortality.

4. Interested parties may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to the Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, MT 59604-4210, no later than December 14, 1990.

5. The Office of Legal Affairs, Department of Social and Rehabilitation Services has been designated to preside over and conduct the hearing.

Director, Social and Rehabilitation Services

Certified to the Secretary of State November 5, 1990.

BEFORE THE BUILDING CODES BUREAU
STATE OF MONTANA
DEPARTMENT OF COMMERCE

In the matter of the amendment of rules pertaining to incorporation by reference of codes, standards and adoption of new rules	))))	NOTICE OF AMENDMENT OF 8.70.101, 8.70.103, 8.70.105, 8.70.108, 8.70.303, 8.70.401, 8.70.501, 8.70.602 AND ADOPTION OF NEW RULE I (8.70.110)

TO: All Interested Persons:

1. On September 13, 1990, the Building Codes Bureau published a notice of public hearing on the proposed amendment of the above-stated rules and the adoption of the above-referenced rule, at page 1756, 1990 Montana Administrative Register, issue number 17. The hearing was held on October 10, 1990, at 9:00 a.m., in the downstairs conference room of the Department of Commerce.

2. The Bureau amended and adopted the rules as proposed but added footnote 11 to the Minimum Required Plumbing Fixture chart. Footnote 11 will appear after "Day Care" in the second section of the chart. The language for footnote 11 should read:

"If the total number of students plus staff exceeds 20, must provide separate male and female toilets."

3. Comments received were in support of the proposed amendment and adoption. No other comments or testimony were received.

BUILDING CODES BUREAU
JAMES BROWN, BUREAU CHIEF

BY: _____
ANDY POOLE, DEPUTY DIRECTOR
DEPARTMENT OF COMMERCE

Certified to the Secretary of State, November 5, 1990.

BEFORE THE MONTANA LOTTERY
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of a rule pertaining to instant tickets) NOTICE OF AMENDMENT OF 8.127.1002 INSTANT TICKET PRICE

TO: All Interested Persons:

1. On September 13, 1990, the Montana Lottery published a notice of proposed amendment of the above-stated rule at page 1765, 1990 Montana Administrative Register, issue number 17.

2. The Lottery amended the rule exactly as proposed.

3. One comment was received from the staff of the Administrative Code Committee stating that a statement of reasonable necessity was not included in the proposal. The reason for the amendment is as follows:

REASON: To allow flexibility of ticket price and allow commission to make determination of price based on different types of games that are offered.

4. No other comments or testimony were received.

MONTANA LOTTERY
PAT DEVRIES, CHAIRPERSON

BY: _____
ANDY POOLE, DEPUTY DIRECTOR
DEPARTMENT OF COMMERCE

Certified to the Secretary of State, November 5, 1990.

BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA

IN THE MATTER OF THE ADOPTION of NEW Rule I (42.25.1401) and Rule II (42.25.1402) relating to Local Government Severance Tax Distribution Procedures	)))))	NOTICE OF THE ADOPTION of NEW Rule I (42.25.1401) and Rule II (42.25.1402) relating to Local Government Severance Tax Distribution Procedures

TO: All Interested Persons:

1. On August 30, 1990, the Department of Revenue published notice of the proposed adoption of new rule I (42.25.1401) and rule II (42.25.1402) relating to local government severance tax distribution procedures at page 1664 of the 1990 Montana Administrative Register, issue no. 16.

2. No written comments were received. Therefore, the Department adopts ARM 42.25.1401 and 42.25.1402 as proposed.

Denis Adams

DENIS ADAMS, Director
Department of Revenue

Certified to Secretary of State November 5, 1990.

BEFORE THE DEPARTMENT OF REVENUE
OF THE STATE OF MONTANA

IN THE MATTER OF THE AMENDMENT of ARM 42.28.405 relating to Special Fuel Dealers Tax Returns	NOTICE OF THE AMENDMENT of ARM 42.28.405 relating to Special Fuel Dealers Tax Returns

TO: All Interested Persons:

1. On August 30, 1990, the Department of Revenue published notice of the proposed amendment of ARM 42.28.405 relating to special fuel dealers tax returns at page 1667 of the 1990 Montana Administrative Register, issue no. 16.

2. No written comments were received. Therefore, the Department amends ARM 42.28.405 as proposed.

DENIS ADAMS, Director
Department of Revenue

Certified to Secretary of State November 5, 1990.

BEFORE THE DEPARTMENT OF SOCIAL
AND REHABILITATION SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rule 46.10.409 pertaining to the sliding fee scale for transitional child care	))))	NOTICE OF THE AMENDMENT OF RULE 46.10.409 PERTAINING TO THE SLIDING FEE SCALE FOR TRANSITIONAL CHILD CARE

TO: All Interested Persons

1. On August 30, 1990, the Department of Social and Rehabilitation Services published notice of the proposed amendment of Rule 46.10.409 pertaining to the sliding fee scale for transitional child care at page 1685 of the 1990 Montana Administrative Register, issue number 16.

2. The Department has amended Rule 46.10.409 as proposed.

3. No written comments or testimony were received.

Julia E. Bolton

Director, Social and Rehabilitation Services

Certified to the Secretary of State November 5, 1990.

VOLUME NO. 43 OPINION NO. 73

CORPORATIONS - Prohibition on distribution of state agency list of corporations as mailing list;
PRIVACY - Use of state agency list of corporations as mailing list;
RIGHT TO KNOW - Use of state agency list of corporations as mailing list;
SECRETARY OF STATE - Prohibition on distribution of list of corporations as mailing list;
MONTANA CODE ANNOTATED - Section 2-6-109;
MONTANA CONSTITUTION - Article II, sections 9, 10;
OPINIONS OF THE ATTORNEY GENERAL - 42 Op. Att'y Gen. No. 119 (1988), 38 Op. Att'y Gen. No. 59 (1979).

HELD: The prohibition of section 2-6-109, MCA, against the distribution of mailing lists by state agencies applies to mailing lists of both individual persons and corporations. 38 Op. Att'y Gen. No. 59 at 207 (1979) is overruled insofar as it conflicts with the holding of this opinion.

October 31, 1990

The Honorable Mike Cooney
Secretary of State
Room 225, State Capitol
Helena MT 59620

Dear Mr. Cooney:

You have requested my opinion concerning the following question:

> Should 38 Op. Att'y Gen. No. 59 (1979) concerning distribution of state agency mailing lists be overruled in light of subsequent case law?

Your question is prompted by an individual's request that he be provided with a list of all nonprofit corporations in good standing on file in the Secretary of State's office. Furthermore, that individual has indicated that he intends to use the requested information as a mailing list, as that phrase has been defined by the Attorney General. See 38 Op. Att'y Gen. No. 59 at 210-11 (1979). The question raised by the request is whether the Secretary of State can lawfully release the list for use as a mailing list in light of the restrictions set forth in section 2-6-109, MCA, which provides:

(1) Except as provided in subsections (3), (4), (5), and (6), in order to protect the privacy of those who deal with state and local government:

(a) no agency may distribute or sell for use as a mailing list any list of persons without first securing the permission of those on the list; and

(b) no list of persons prepared by the agency may be used as a mailing list except by the agency or another agency without first securing the permission of those on the list.

(2) As used in this section, "agency" means any board, bureau, commission, department, division, authority, or officer of the state or a local government.

(3) Except as provided in 30-9-403, this section does not prevent an individual from compiling a mailing list by examination of original documents or applications which are otherwise open to public inspection.

(4) This section does not apply to the lists of registered electors and the new voter lists provided for in 13-2-115 and 13-38-103, to lists of the names of employees governed by Title 39, chapter 31, or to lists of persons holding driver's licenses provided for under 61-5-126.

(5) This section shall not prevent an agency from providing a list to persons providing prelicensing or continuing educational courses subject to Title 20, chapter 30, or specifically exempted therefrom as provided in 20-30-102.

(6) This section does not apply to the right of access either by Montana law enforcement agencies or, by purchase or otherwise, of public records dealing with motor vehicle registration.

(7) A person violating the provisions of subsection (1)(b) is guilty of a misdemeanor.

The issue raised by your request was previously addressed in 38 Op. Att'y Gen. No. 59 at 207 (1979). Noting that section 2-6-109, MCA, must be construed in a manner consistent with the Montana Constitution, Article II, sections 9 and 10 (the right to know and right of privacy provisions, respectively), the Attorney General held that:

1. Under the provisions of chapter 606, 1979 Montana Laws [section 2-6-109, MCA], agencies are prohibited

> from distributing a list of persons only if the intended use of such list is for unsolicited mass mailings, house calls or distributions, or telephone calls.
>
> 2. The prohibition pertains only to lists of natural persons, not businesses, corporations, governmental agencies or other associations.
>
> 3. Agencies are not required to affirmatively ascertain the intended use for which the list is sought; a clear written disclaimer from the agency as to the proscriptions and penalty of chapter 606 is sufficient.

38 Op. Att'y Gen. No. 59 at 207-08. The second holding quoted above was based on the Attorney General's opinion that the right of privacy mentioned in section 2-6-109, MCA, could be consistently construed with the right of privacy provisions of the Montana Constitution if it applied only "to individual human beings," and not to "corporations, associations, governmental bodies and businesses[.]" 38 Op. Att'y Gen. No. 59 at 211 (1979). Since that opinion was issued, the Montana Supreme Court has twice held that the right of privacy exception to the right to know provision of the Montana Constitution (Mont. Const. Art. II, § 9) applies to corporations as well as individuals. Mountain States Telephone and Telegraph v. Department of Public Service Regulation, 38 St. Rptr. 1479, 1486, 634 P.2d 181, 188 (1981); Belth v. Bennett, 227 Mont. 341, 345, 740 P.2d 638, 640-41 (1987). As you have observed, the holdings in these two cases cast doubt on the validity of the second holding in 38 Op. Att'y Gen. No. 59 at 207 (1979).

In Belth, the State Insurance Commissioner withheld from the editor of a monthly insurance publication information on file in the Commissioner's office concerning financial statements of insurance companies. The Commissioner's decision to withhold was based on section 33-1-412(5), MCA:

> The commissioner may withhold from public inspection any examination or investigation report for so long as he deems such withholding to be necessary for the protection of the person examined against unwarranted injury or to be in the public interest.

Finding that the statute protected a privacy interest coextensive with the privacy exception within the right to know provision of the Montana Constitution, Art. II, § 9, the Court held that the exception applied to corporations as well as natural persons. Belth, 227 Mont. at 345, 740 P.2d at 640-41, citing Mountain States, 38 St. Rptr. at 1486, 634 P.2d at 188. The Court also held that the Commissioner had standing to raise the constitutional issue on behalf of the insurance companies since a breach of the privacy rights of those companies could

lead to a lawsuit against the Commissioner. Belth, 227 Mont. at 345, 740 P.2d at 641, citing Montana Human Rights Division v. City of Billings, 199 Mont. 434, 443, 649 P.2d 1283, 1288 (1982). In Mountain States the Court held that the demands of individual privacy of a corporation as well as of a person might clearly exceed the merits of public disclosure and thus come within the privacy exception of the "right to know." Consequently a corporate utility could seek to preserve confidentiality of certain trade secrets required to be disclosed to the Public Service Commission when the utility applied for a rate increase. 634 P.2d at 188-89. It is my opinion that the holdings in these cases are fully applicable to the issue raised here. I therefore hold that the prohibition against public distribution of state agency mailing lists set forth in 38 Op. Att'y Gen. No. 59 at 207 (1979) applies with equal force to lists of both individual persons and corporations.

There are, however, two important caveats which attend my holding. First, the Montana Supreme Court has made it clear that it will construe statutes protecting privacy interests in a manner that does not violate the mandate of the right to know provision of the Montana Constitution. Belth, 227 Mont. at 346, 740 P.2d at 641; Allstate Insurance Co. v. City of Billings, 46 St. Rptr. 1716, 1719-20, 780 P.2d 186, 188-89 (1989). Compliance with the right to know provision requires that a decision to withhold mailing lists pursuant to the statute must be based on a determination that "the demand of individual privacy clearly exceeds the merits of public disclosure." Belth, 227 Mont. at 346, 740 P.2d at 641. In short, the custodian of the information sought must determine whether there is a constitutionally protected privacy interest at stake, and if so, whether that right clearly exceeds the public's right to know. Belth, 227 Mont. at 346-48, 740 P.2d at 641-43; see also Missoulian v. Board of Regents, 207 Mont. at 513, 675 P.2d at 962 (1984); 42 Op. Att'y Gen. No. 119 at 454, 461-62 (1988). If the Secretary of State determines that there is no privacy interest at stake, or that a protected privacy interest does not clearly exceed the public's right to know, the prohibition of the statute does not apply, and the mailing lists at issue may be publicly disseminated. Second, it must be noted that the statute specifically allows an individual to compile "a mailing list by examination of original documents or applications which are otherwise open to public inspection." § 2-6-109(3), MCA. Because you have indicated that the original documents involved here are open to public inspection, a requestor may be permitted in any case to compile his or her own mailing list by examining those original documents.

THEREFORE, IT IS MY OPINION:

The prohibition of section 2-6-109, MCA, against the distribution of mailing lists by state agencies applies to mailing lists of both individual persons and corporations.

38 Op. Att'y Gen. No. 59 at 207 (1979) is overruled insofar as it conflicts with the holding of this opinion.

Very truly yours,

Marc Racicot

MARC RACICOT
Attorney General

NOTICE OF FUNCTIONS OF ADMINISTRATIVE CODE COMMITTEE

The Administrative Code Committee reviews all proposals for adoption of new rules, amendment or repeal of existing rules filed with the Secretary of State, except rules proposed by the Department of Revenue. Proposals of the Department of Revenue are reviewed by the Revenue Oversight Committee.

The Administrative Code Committee has the authority to make recommendations to an agency regarding the adoption, amendment, or repeal of a rule or to request that the agency prepare a statement of the estimated economic impact of a proposal. In addition, the Committee may poll the members of the Legislature to determine if a proposed rule is consistent with the intent of the Legislature or, during a legislative session, introduce a bill repealing a rule, or directing an agency to adopt or amend a rule, or a Joint Resolution recommending that an agency adopt or amend a rule.

The Committee welcomes comments from the public and invites members of the public to appear before it or to send it written statements in order to bring to the Committee's attention any difficulties with the existing or proposed rules. The address is Room 138, Montana State Capitol, Helena, Montana 59620.

HOW TO USE THE ADMINISTRATIVE RULES OF MONTANA AND THE MONTANA ADMINISTRATIVE REGISTER

Definitions: Administrative Rules of Montana (ARM) is a looseleaf compilation by department of all rules of state departments and attached boards presently in effect, except rules adopted up to three months previously.

Montana Administrative Register (MAR) is a soft back, bound publication, issued twice-monthly, containing notices of rules proposed by agencies, notices of rules adopted by agencies, and interpretations of statutes and rules by the attorney general (Attorney General's Opinions) and agencies (Declaratory Rulings) issued since publication of the preceding register.

Use of the Administrative Rules of Montana (ARM):

Known Subject Matter	1. Consult ARM topical index. Update the rule by checking the accumulative table and the table of contents in the last Montana Administrative Register issued.
Statute Number and Department	2. Go to cross reference table at end of each title which lists MCA section numbers and corresponding ARM rule numbers.

ACCUMULATIVE TABLE

The Administrative Rules of Montana (ARM) is a compilation of existing permanent rules of those executive agencies which have been designated by the Montana Administrative Procedure Act for inclusion in the ARM. The ARM is updated through September 30, 1990. This table includes those rules adopted during the period October 1, 1990 through December 31, 1990 and any proposed rule action that is pending during the past 6 month period. (A notice of adoption must be published within 6 months of the published notice of the proposed rule.) This table does not, however, include the contents of this issue of the Montana Administrative Register (MAR).

To be current on proposed and adopted rulemaking, it is necessary to check the ARM updated through September 30, 1990, this table and the table of contents of this issue of the MAR.

This table indicates the department name, title number, rule numbers in ascending order, catchphrase or the subject matter of the rule and the page number at which the action is published in the 1990 Montana Administrative Register.

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