MONTANA ADMINISTRATIVE REGISTER

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The Montana Administrative Register (MAR), a twice-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 The notice section contains state agencies' proposed new, amended or repealed rules; the rationale for the change; date and address of public hearing; and where written comments may be submitted.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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NOTICE SECTION

BEFORE THE BOARD
OF THE STATE COMPENSATION INSURANCE FUND
OF THE STATE OF MONTANA

In the matter of the proposed amendment of rule 2.55.324 pertaining to premium ratesetting.	) NOTICE OF PUBLIC HEARING) FOR PROPOSED AMENDMENT OF) RULE 2.55.324)

TO: All Interested Persons:

1. On June 29, 1994, the State Compensation Insurance Fund will hold a public hearing at 2:00 p.m., in Room 303 of the State Compensation Insurance Fund Building, 5 South Last Chance Gulch, Helena, Montana, to consider the amendment of rule 2.55.324.

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

2.55.324 PREMIUM RATESETTING (1) - (2)(a) remain the same.

(b) Payrolls for horse racing activities conducted at licensed Montana race tracks and hauling of horses between those race tracks from March 1 through September 30 of each year have been determined not to be sufficiently verifiable ~~for the horse racing industry~~ and a fee basis shall be used. The fee for each March 1 through September 30 period shall be based on the aggregate revenue requirements of this classification and allocated among the projected number of industry participants. ~~The policy period and premium rates for this industry may be placed on a calendar year basis.~~ The percentage increase or decrease limits in subsection (4) apply to payroll-based rates and do not apply to fee-based coverage. However, the board may approve limits on the revenue requirement for fee-based coverage. This subsection will become effective October 1, 1994.

(3) - (7) remain the same.

AUTH: Sec. 39-71-2315 and 39-71-2316 MCA.
IMP: Sec. 39-71-2211, 39-71-2311 and 39-71-2316 MCA.

3. Amendment of rule 2.55.324(2)(b) is necessary because the Montana board of horse racing (MBHR) entered into premium fee collection agreements with the State Fund for calendar years 1989, 1990, 1991, 1992, and 1994; however, MBHR has regulatory authority at Montana race tracks only during the "racing season" which MBHR defines as March 1 through September 30 of each year.

The purpose of this rule amendment is to limit coverage based on the "fee basis" premium collection method to "on and between tracks during the racing season," as requested by the MBHR. Payroll-based policies would be required for this industry for all activities from October 1 through the end of the following February and for all offtrack activities, with the exception of hauling between tracks, from March 1 through

September 30 each year. The exception to subsection (4) and the allowance of limits on the revenue requirement is to clarify the board's discretion in applying limits to fee-based coverage.

4. The State Compensation Insurance Fund makes reasonable accommodations for persons with disabilities who wish to participate in this public hearing. Persons needing accommodations must contact the State Fund, Attn: Ms. Dwan Ford, P.O. Box 4759, Helena, MT 59604; telephone (406) 444-6480; TDD (406) 444-5971; fax (406) 444-6555, no later than 5:00 p.m., June 22, 1994, to advise as to the nature of the accommodation needed and to allow adequate time to make arrangements.

5. Interested persons 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 state fund attorney Nancy Butler, Legal Department, State Compensation Insurance Fund, 5 South Last Chance Gulch, Helena, Montana 59604-4759, and must be received no later than July 7, 1994.

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

Dal Smilie, Chief Legal Counsel
Rule Reviewer

Rick Hill
Chairman of the Board

Nancy Butler, General Counsel
Rule Reviewer

Certified to the Secretary of State May 31, 1994.

DEPARTMENT OF AGRICULTURE
STATE OF MONTANA

In the matter of the proposed repeal of rules relating to fees and mediation scheduling and agreement procedures	NOTICE OF PROPOSED REPEAL OF RULES 4.15.101 AND 4.15.201 NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons

1. On July 9, 1994, the Department of Agriculture proposes to repeal the above stated rules in their entirety.

2. The rules proposed to be repealed, are located on 4-653 and 4-655 of the Administrative Rules of Montana. The rules as proposed to be repealed are as follows:

4.15.101 FEES (IS HEREBY REPEALED) AUTH: Sec. 80-13-104 MCA; IMP, Sec. 80-13-111 MCA

4.15.201 MEDIATION SCHEDULING AND AGREEMENT PROCEDURES (IS HEREBY REPEALED) AUTH: Sec. 80-13-104, MCA; IMP, 80-13-201, 202, 203, MCA

REASON: Effective July 1, 1993, the Agricultural Assistance and Counseling Program Title 80, ch. 13, MCA was repealed. These rules, which had been adopted to implement that program, are no longer necessary.

3. Interested persons may submit their written data, views, or arguments concerning the proposed repeal to Ralph Peck, Department of Agriculture, Agricultural Development Division, P.O. Box 200201, Helena, MT 59620-0201, no later than July 7, 1994.

4. If a party who is directly affected by the proposed repeal 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 Ralph Peck, Department of Agriculture, P.O. Box 200201, Helena, MT 59620-0201, no later than July 7, 1994.

5. If the department receives requests for a public hearing under section 2-4-315, MCA, on the proposed repeal, from either 10% or 25%, whichever is less, of the persons who are directly affected by the proposed repeal from the

Administrative Code Committee of the legislature; from a governmental subdivision or agency; or from an association having not fewer 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 151, based on the number of pesticide applicators in the state.

W. Ralph Peck, Administrator
DEPARTMENT OF AGRICULTURE

Timothy J. Meloy, Attorney
Rule Reviewer
Department of Agriculture

Certified to the Secretary of State Office May 24, 1994

DEPARTMENT OF AGRICULTURE
STATE OF MONTANA

In the matter of the proposed repeal and amendment for agricultural exceptions and additions	)	NOTICE OF PROPOSED REPEAL OF ARM 4.2.103 AND PROPOSED AMENDMENT OF ARM 4.2.102

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons

1. On July 10, 1994, the Department of Agriculture proposes to repeal and amend the above stated rules.

2. The rules proposed to be repealed and amended are on page 4-15 of the Administrative Rules of Montana. The rule as proposed to be amended is as follows:

4.2.102 EXCEPTIONS AND ADDITIONS FOR ~~AGRICULTURAL AND BIOLOGICAL SCIENCES DIVISION~~ AGRICULTURAL SCIENCES DIVISION

(1) ARM 1.3.201 (1)(a) requirements are modified by section 80-8-105(1) MCA.

(2) ARM 1.3.218 is amended by sections 80-6-102(7) and 80-6-104(2) MCA.

AUTH: Sec. 2-4-201, MCA IMP: 2-4-201, MCA

The rule proposed to be repealed is as follows:

4.2.103 EXCEPTIONS AND ADDITIONS FOR PLANT INDUSTRY DIVISION (IS HEREBY REPEALED)

AUTH: Sec. 2-4-201, MCA IMP: 2-4-201, MCA

REASON: Reorganization has merged Plant Industry Division under Agricultural Sciences Division.

3. Interested persons may submit their written data, views, or arguments concerning these amendments to Gary Gingery, Department of Agriculture, Agricultural Sciences Division, P.O. Box 200201, Helena, MT 59620-0201, no later than July 8, 1994.

4. If a party who is directly affected by the proposed amendment 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 Gary Gingery, Department of Agriculture, P.O. Box 200201, Helena, MT 59620-0201, no later than July 8, 1994.

5. If the department receives requests for a public hearing under section 2-4-315, MCA, 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 fewer 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 151, based on the number of pesticide applicators in the state.

W. Ralph Peck 5/27/94

W. Ralph Peck, Administrator
DEPARTMENT OF AGRICULTURE

Timothy J. Meloy 5/27/94

Timothy J. Meloy, Attorney
Rule Reviewer
Department of Agriculture

Certified to the Secretary of State, May 31, 1994.

BEFORE THE BOARD OF CHIROPRACTORS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed amendment of rules pertaining to applications, reciprocity, and reinstatement and the adoption of a new rule pertaining to interns and preceptors	NOTICE OF PROPOSED AMENDMENT AND ADOPTION OF RULES PERTAINING TO THE PRACTICE OF CHIROPRACTIC NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On July 9, 1994, the Board of Chiropractors proposes to amend rules pertaining to the practice of chiropractic.

2. The proposed amendments will read as follows: (new matter underlined, deleted matter interlined)

"8.12.601 APPLICATIONS, EDUCATIONAL REQUIREMENTS

(1) through (4) will remain the same.

(5) Applicants must furnish official verification from all states in which they are currently licensed. Verification must be sent directly to the board office from the other state."

Auth: Sec. 37-1-131, ~~37-1-134,~~ 37-12-201, MCA; IMP, Sec. 37-1-131, ~~37-1-134,~~ 37-12-302, 37-12-304, ~~37-12-307,~~ MCA

REASON: This amendment is being proposed to provide for verification of licensure status from states in which the applicant is currently licensed. The verification would provide the Board with notice of any disciplinary actions sanctioned or pending against an applicant in another state.

"8.12.605 RECIPROCITY (1) will remain the same.

(2) The board shall require the applicant to have passed the Special Purposes Examination for Chiropractic (SPEC) administered by the national board of chiropractic examiners. The board will accept the passing score established by the national board of chiropractic examiners."

Auth: Sec. 37-12-201, 37-12-304, MCA; IMP, Sec. 37-12-304, 37-12-305, MCA

REASON: Greater use of the SPEC exam would allow the Board to administer examinations in conjunction with other states and would make it easier to implement such aspects of examinations as reciprocity. The SPEC examination would not be used for initial licensure purposes and would not replace the National Board Parts I, II and III, but would allow applicants licensed in another state the opportunity to take the SPEC examination for reciprocity. SPEC examinations are designed for applicants who have been in practice for some time, for reciprocity/endorsement consideration, and for individuals who have a suspended or revoked license and are seeking reinstatement. The SPEC examination may also be used for other special uses, such as impairment evaluation.

"8.12.609 REINSTATEMENT (1) through (3)(g) will remain the same.

(4) All applicants for reinstatement of license shall pass the Special Purposes Examination for Chiropractic (SPEC) administered by the national board of chiropractic examiners."

Auth: Sec. 37-12-201, 37-12-304, MCA; IMP, Sec. 37-12-304, 37-12-323,MCA

REASON: The SPEC examination is designed, in part, to test those individuals who have had license privileges suspended or revoked.

"8.12.615 FEE SCHEDULE (1) through (9) will remain the same.

(10) Application fee for student/interns 25.00

(11) Application fee for practitioners proposing to serve as preceptors 25.00"

Auth: Sec. 37-12-201, MCA; IMP, Sec. 37-12-201, MCA

REASON: This fee schedule is being amended to allow the Board to assess fees for the intern/preceptorship program recently enacted by the Legislature. The fees are commensurate with program area costs.

3. The proposed new rule will read as follows:

"I INTERNS AND PRECEPTORS (1) No student intern will be allowed to practice under the direction and supervision of a licensed chiropractor (the "preceptor") in the state of Montana unless the student has provided a letter from the chiropractic college the student is attending, listing the student's date of matriculation and expected graduation.

(2) A student intern must complete an application form provided by the board and furnish current transcripts from the chiropractic college attended.

(3) Student interns may not sign insurance claims, workers' compensation claims, medicare claims, birth or death certificates, or other documents that require the signature of a licensed chiropractor.

(4) The student intern shall follow the laws and rules of the board, the same as if he or she were licensed as a chiropractor.

(5) The sponsoring preceptor and the student intern must submit a signed conditions statement, along with the application.

(6) The preceptor must be in good standing with the board.

(7) The preceptor must provide malpractice insurance, if coverage over and above that which is provided by the chiropractic college is required.

(8) The preceptor must have a minimum of five years of practice in the state of Montana.

(9) The preceptor must be present within the practice environment at all times when an intern is seeing patients.

(10) The preceptor must comply with the guidelines on involving an intern in the care of patients of the field doctor as required by the chiropractic college.

(11) All applications for intern/preceptor programs must be approved by the board prior to starting the program."

Auth: Sec. 37-12-304, MCA; IMP, Sec. 37-12-304, MCA

4. Interested persons may submit their data, views or arguments concerning the proposed amendment in writing to the Board of Chiropractors, Lower Level, Arcade Building, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513, to be received no later than 5:00 p.m., July 9, 1994.

5. If a person who is directly affected by the proposed amendment wishes to present his data, views or arguments orally or in writing at a public hearing, he must make written request for a hearing and submit the request along with any comments he has to the Board of Chiropractors, Lower Level, Arcade Building, 111 North Jackson, P.O. Box 200513, Helena, Montana 59620-0513, to be received no later than 5:00 p.m., July 9, 1994.

6. If the Board receives requests for a public hearing on the proposed amendment from either 10 percent or 25, whichever is less, of those persons who are directly affected by the proposed amendment, from the Administrative Code Committee of the legislature, from a governmental agency or subdivision 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 38 based on the 378 licensees in Montana.

BOARD OF CHIROPRACTORS
CHRIS BUZAN, D.C., CHAIRMAN

BY: Annie M. Bartos
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

Annie M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, May 31, 1994.

BEFORE THE BOARD OF DENTISTRY
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed amendment of rules pertaining to continuing education and requirements and restrictions	))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF 8.16.1002 AND 8.16.1003 PERTAINING TO DENTISTS AND DENTAL HYGIENISTS

TO: All Interested Persons:

1. The notice of proposed board action published in the Montana Administrative Register on April 28, 1994, issue number 8, at page 988, is amended as follows due to a number of individuals requesting an opportunity to present data, views or arguments to the Board in person. In response to the requests, the Board has scheduled a hearing on the proposed rules and will open the rulemaking record to the date set forth below in order to receive additional comments.

2. On July 7, 1994, at 11:00 a.m., a public hearing will be held in the conference room of the Professional and Occupational Licensing Bureau, Arcade Building, 111 N. Jackson, Helena, Montana, to consider the proposed amendment of rules pertaining to continuing education.

3. The language of the proposed amendments designated above, the reason for the proposed amendments and the authority of the Board to propose the amendments are the same as cited in the original notice.

4. Interested persons may present their data, views or arguments either orally or in writing at the hearing. Written data, views or arguments may also be submitted to the Board of Dentistry, Professional and Occupational Licensing Bureau, Arcade Building, 111 N. Jackson, P.O. Box 200513, Helena, Montana, to be received no later than 5:00 p.m., July 7, 1994.

5. Robert P. Verdon, attorney, has been designated to preside over and conduct the hearing.

BOARD OF DENTISTRY
SCOTT ERLER, DDS, PRESIDENT

BY: Annie M. Bartos
ANNIE M. BARTOS, CHIEF COUNSEL

Annie M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, May 31, 1994.

BEFORE THE BOARD OF HORSE RACING
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the proposed amendment of a rule pertaining to permissible medication and trifecta wagering	))))	NOTICE OF PROPOSED AMENDMENT OF 8.22.1402 PERMISSIBLE MEDICATION AND 8.22.1802 REQUIREMENTS FOR LICENSEE

NO PUBLIC HEARING CONTEMPLATED

TO: All Interested Persons:

1. On July 9, 1994, the Board of Horse Racing proposes to amend the above-stated rule.

2. The proposed amendment will read as follows: (new matter underlined, deleted matter interlined)

"8.22.1402 PERMISSIBLE MEDICATION (1) and (2) will remain the same.

(3) The only substances permitted to be administered to a horse by this rule ~~is~~ are phenylbutazone (butazoladin) or derivatives thereof and furosemide (lasix).

~~(4) The state veterinarian shall approved phenylbutazone drug requests only if, in the exercise of the veterinarian's professional judgment, a need for the use of the drug for the treatment of the particular horse's injury or disease has been satisfactorily demonstrated. In arriving at the decision, the state veterinarian may take into account, and rely upon, a written professional diagnosis made by a qualified veterinarian duly licensed by the board.~~

~~(5)~~ (4)(a) Furosemide may be discontinued with written permission of the state veterinarian on a medication request form after a minimum of 30 days from the time that permission to medicate was initially granted. Otherwise, approval will expire on December 31 of the year in which it is approved.

(b) ~~Approved medication~~ Phenylbutazone may be discontinued ~~with written permission of the state veterinarian~~ by the trainer with written permission of the state steward on a medication request form after a minimum of ~~thirty~~ (30) days from the time that permission to medicate was initially granted. Otherwise, approval will expire on December 31 of the year in which it is approved.

(6) and (7) will remain the same but will be renumbered (5) and (6).

~~(8)~~ (7) A horse which, during a race or following a race, or which, during exercise or following exercise, is found to be hemorrhaging from one or both nostrils or is found to have bled into its trachea is eligible to be placed on a bleeder list and treated on race day to prevent bleeding during its race. In order to obtain authorization for race day treatment of the bleeder, the horse's trainer must obtain a certificate of examination from the state veterinarian and have the horse placed on the official bleeder list. The state veterinarian must, by examination, and/or in consultation with

the stewards, establish that the horse did in fact hemorrhage from one or both nostrils or that an ~~edoscopic~~ endoscopic examination in the test barn or receiving barn showed observable amounts of free blood in the horse's respiratory tract. When confirmed by the state veterinarian, the horse shall be placed on the bleeder list which is maintained by the state veterinarian. Once on the list, a horse may be removed from the bleeder list only upon the direction of the state veterinarian, who must certify in writing to the board his recommendation for removal of the horse from the list. Bleeder lists will apply to horses listed at all tracks on a statewide basis.

(9) and (10) will remain the same, but will be renumbered (8) and (9).

~~(11)~~ (10) No horses may be entered into races under the influence of ~~phenylbutazone or~~ furosemide unless the trainer and veterinarian of the horse submits to the state veterinarian a drug request form and obtain written approval from the state veterinarian. The board shall publish and supply the appropriate drug request form ~~and a copy of the established procedures shall be posted in the office of the racing secretary~~. The drug request form shall include provision for the following:

(a) through (e) will remain the same.

(11) No horses may be entered into races under the influence of phenylbutazone unless the trainer of the horse submits to the state steward a drug request form. The board shall publish and supply the appropriate drug request form. The drug request form shall include provision for the following:

(a) the name, age, sex and breed of the horse;

(b) the name of the licensed trainer and veterinarian;

(c) the nature of the horse's injury or disease;

(d) a place for request by the trainer to discontinue medication;

(e) a place for the signature of trainer and state steward.

(12) through (21) will remain the same."

Auth: Sec. 23-4-104, 23-4-202, MCA IMP, Sec. 23-4-104, MCA

REASON: The proposed amendments will make the procedures for use of bute easier, and more in keeping with actual practice at the tracks, as bute is used routinely without the impact of other, more dangerous drugs. The proposed amendments will remove the duty imposed on state veterinarians currently to check each horse on bute, as this is unnecessary and a poor use of the veterinarian's time.

"8.22.1802 REQUIREMENTS FOR LICENSEE (1) through (2)(a) will remain the same.

(3) No licensee shall offer trifecta wagering on any race when there are less than six horses scheduled to start, at draw time. In no event will trifecta wagering be permitted on a race in which less than six horses ~~go to the post~~ start.

(4) will remain the same."

Auth: Sec. 23-4-104, MCA; IMP, Sec. 23-4-104, MCA

REASON: The proposed amendment will clarify that the required six or more horses must actually start in a race, not just go to the post, to preserve the proper number of betting interests necessary for trifecta wagering.

3. Interested persons may submit their data, views or arguments concerning the proposed amendment in writing to the Board of Horse Racing, 1520 East Sixth, Room 50, P.O. Box 200512, Helena, Montana 59620-0512, to be received no later than 5:00 p.m., July 7, 1994.

4. If a person who is directly affected by the proposed amendment wishes to present his data, views or arguments orally or in writing at a public hearing, he must make written request for a hearing and submit the request along with any comments he has to the Board of Horse Racing, 1520 East Sixth Avenue, Room 50, P.O. Box 200512, Helena, Montana 59620-0512, to be received no later than 5:00 p.m., July 7, 1994.

5. If the Board receives requests for a public hearing on the proposed amendment from either 10 percent or 25, whichever is less, of those persons who are directly affected by the proposed amendment, from the Administrative Code Committee of the legislature, from a governmental agency or subdivision 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 70 based on the 700 licensees in Montana.

BOARD OF HORSE RACING
MALCOLM ADAMS, CHAIRMAN

BY: Annie M. Bartos
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

Annie M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, May 31, 1994.

BEFORE THE BOARD OF HEALTH AND ENVIRONMENTAL SCIENCES
OF THE STATE OF MONTANA

In the matter of the proposed final Integrated Solid Waste Management Plan) NOTICE OF PUBLIC HEARING)

(Solid Waste)

To: All Interested Persons

1. On July 15, 1994, the Board of Health and Environmental Sciences will hold a public hearing at 9:30 a.m. or as soon thereafter as may be heard, in Room C209 of the Cogswell Building, 1400 Broadway, Helena, Montana, to consider the adoption of the final Integrated Solid Waste Management Plan.

2. The Department is required to formulate an Integrated Solid Waste Management Plan for submission to the Board of Health and Environmental Sciences for the Board's adoption pursuant to the Montana Integrated Waste Management Act, Title 75, Chapter 10, Part 8, MCA. The Plan proposes policy and provides guidance for the State of Montana as it seeks to improve its landfills to better protect the public health, and as it moves toward a more integrated approach to waste management.

AUTH: 75-10-111, MCA; IMP: 75-10-111, 75-10-807, MCA

3. A copy of the proposed final Plan is available to all interested persons upon request from the Department of Health and Environmental Sciences, Solid Waste Program, PO Box 200901, Helena, Montana, 59620-0901.

4. Interested persons may submit their data, views, or comments, either orally or in writing, at the hearing. Written data, views, or comments may also be submitted to Jon Dilliard, Solid Waste Program Manager, Department of Health and Environmental Sciences, PO Box 200901, Helena, Montana, 59620-0901, and must be received no later than 5:00 p.m., July 8, 1994.

5. Several public hearings were held around the State on the draft plan and comments have been received and responded to in the proposed final plan. The Department therefore asks that interested persons that have already submitted comments on the draft plan refrain from submitting identical comments on the final plan.

ROBERT J. ROBINSON, Director

Certified to the Secretary of State May 31, 1994.

Reviewed by:
Eleanor J. Parker
Eleanor Parker, DHES Attorney

BEFORE THE BOARD OF HEALTH AND ENVIRONMENTAL SCIENCES
OF THE STATE OF MONTANA

In the matter of the amendment of rule 16.8.1907 dealing with the fees for the smoke management program.	))))	NOTICE OF PUBLIC HEARING FOR PROPOSED AMENDMENT OF RULE

(Air Quality)

To: All Interested Persons

1. On July 15, 1994, at 11:00 a.m., or as soon thereafter as it may be heard, the board will hold a public hearing in Room C209 of the Cogswell Building, 1400 Broadway, Helena, Montana, to consider the amendment of the above-captioned rule.

2. The rule, as proposed to be amended, appears as follows (new material is underlined; material to be deleted is interlined):

16.8.1907 AIR QUALITY OPEN BURNING FEES (1)-(3) Remain the same.

(4)(a) The major open burning air quality permit application fee shall be based on the actual or estimated actual amount of air pollutants emitted by the applicant in the last calendar year during which the applicant conducted open burning pursuant to an air quality open burning permit for major open burning sources, as required under ARM 16.8.1304 (Major Open Burning Source Restrictions). The fee shall be the greater of the following, as adjusted by any amount determined pursuant to (b), below:

(i) a fee calculated using the following formula:
tons of total particulate emitted in the previous appropriate calendar year,
multiplied by ~~$5.78~~ 9.09; plus
tons of oxides of nitrogen emitted in the previous appropriate calendar year,
multiplied by ~~$1.64~~ 2.27; plus
tons of volatile organic compounds emitted in the ~~appropriate~~ previous appropriate calendar year,
multiplied by ~~$1.64~~ 2.27; or

(ii) a minimum fee of $250.

(b) Remains the same.

AUTH: 75-2-111, MCA; IMP: 75-2-211, 75-2-220, MCA

3. The board is proposing these amendments to the rule because they are necessary to meet the requirements of 75-2-220, MCA, enacted by Ch. 502 of the 1993 Legislature, that permit application fees be set annually to cover the DHES's reasonable direct and indirect costs of operating the permit program. The amendments produce the fees calculated by the department's Air

Quality Bureau as necessary to produce the budget it needs to operate a smoke management/open burning permit program adequate to protect the public from the impacts due to smoke from prescribed burning. In addition, the deletion of "appropriate" in subsection (4)(a)(i) was necessary to delete a redundancy and was strictly editorial.

4. Interested persons may submit their data, views, or arguments concerning the proposed amendment, either orally or in writing, at the hearing. Written data, views, or arguments may also be submitted to Yolanda Fitzsimmons, Department of Health and Environmental Sciences, Cogswell Building, Capitol Station, Helena, Montana 59620, no later than 5:00 p.m. on July 8, 1994.

5. Will Hutchison has been designated to preside over and conduct the hearing.

ROBERT J. ROBINSON, Director

Certified to the Secretary of State May 31, 1994.

Reviewed by:

Eleanor Parker, DHES Attorney

BEFORE THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES
OF THE STATE OF MONTANA

In the matter of the amendment of rules 16.10.1311 and 16.10.1529 dealing with swimming pool inspections	))))	NOTICE OF PROPOSED AMENDMENT OF RULES NO PUBLIC HEARING CONTEMPLATED (Swimming Pool Inspections)

To: All Interested Persons

1. On July 11, 1994, the department proposes to amend ARM 16.10.1311 and 16.10.1529 to indicate what constitutes a full facility inspection and a critical point inspection of a public bathing place or swimming pool.

2. The rules, as proposed to be amended, appear as follows (new material is underlined; material to be deleted is interlined):

16.10.1311 INSPECTIONS (1) Remains the same.

(2) A full facility inspection requires an inspection for compliance with all the requirements of this subchapter.

(3) A critical point inspection requires an inspection for compliance with 50-53-107, MCA, and ARM 16.10.1304 and 16.10.1308.

AUTH: 50-53-103, MCA; IMP: 50-53-103, 50-53-209, MCA

16.10.1529 INSPECTIONS (1)-(2) Remain the same.

(3) A full facility inspection requires an inspection for compliance with all the requirements of this subchapter.

(4) A critical point inspection requires an inspection for compliance with 50-53-107, MCA, and ARM 16.10.1513, 16.10.1519(2), 16.10.1522, and 16.10.1525.

AUTH: 50-53-103, MCA; IMP: 50-53-103, 50-53-106, 50-53-107, 50-53-209, MCA

3. The department is proposing these rules in order to clarify what constitutes a full facility inspection and a critical point inspection of a swimming pool and public bathing place. Section 50-53-209 requires both full facility and critical point inspections to be carried out, but does not define what they are, nor are there any rules defining what constitutes such an inspection. Therefore, these rule amendments are necessary in order to define what inspectors must check for during each type of inspection.

4. Interested persons may submit their data, views, or arguments concerning the proposed amendments, in writing, to Mitzi Schwab, Department of Health and Environmental Sciences, Cogswell Building, Capitol Station, Helena, MT 59620, and must

submit them in sufficient time so that they are received no later than 5:00 p.m., July 8, 1994.

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, he/she must make written request for a hearing and submit this request along with any written comments he/she has to Mitzi Schwab, Department of Health and Environmental Sciences, Cogswell Building, Capitol Station, Helena, Montana 59620. A written request for hearing must be received no later than 5:00 p.m., July 8, 1994.

7. If the agency receives requests for a public hearing on the proposed amendments from either 10% or 25, whichever is less, of the persons who are directly affected by the proposed action; 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, 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 in excess of 25 persons, based on the number of swimming pools and bathing places within the state of Montana and the number of members of the public using them.

ROBERT J. ROBINSON, Director

Certified to the Secretary of State May 31, 1994.

Reviewed by:

Eleanor Parker, DHES Attorney

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

In the matter of the amendment of rules 46.10.803, 46.10.805, 46.10.807, 46.10.811, 46.10.819, 46.10.825, 46.10.841 and 46.10.843 pertaining to AFDC JOBS program	)))))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULES 46.10.803, 46.10.805, 46.10.807, 46.10.811, 46.10.819, 46.10.825, 46.10.841 AND 46.10.843 PERTAINING TO AFDC JOBS PROGRAM

TO: All Interested Persons

1. On June 29, 1994, at 9:30 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 46.10.803, 46.10.805, 46.10.807, 46.10.811, 46.10.819, 46.10.825, 46.10.841 and 46.10.843 pertaining to AFDC JOBS program.

The Department of Social and Rehabilitation Services will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing. If you request an accommodation, contact the department no later than 5:00 p.m. on June 20, 1994, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970.

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

46.10.803 DEFINITIONS Subsections (1) through (8) remain the same.

~~(9) "Community work experience" means a program to improve the employability of a participant through the development in nonprofit employment of the person's skills, experience and confidence.~~

Subsections (10) through (21) remain the same in text but are renumbered (9) through (20). Subsections (22) and (23) remain the same in text but are renumbered (24) and (25).

(26) "JOBS operator" is the entity with whom the department contracts to provide JOBS services to AFDC recipients.

Subsections (24) through (26) remain the same in text but are renumbered (21) through (23). Subsections (27) through (35) remain the same.

(36) "Work activities" means job search, on-the-job training, work supplementation and ~~community~~ alternative work experience.

AUTH: Sec. 53-4-212 and 53-4-719 MCA
IMP: Sec. 53-2-201, 53-4-211, 53-4-215, 53-4-702, 53-4-703, 53-4-704, 53-4-705, 53-4-706, 53-4-707, 53-4-708, 53-4-715, 53-4-716, 53-4-717 and 53-4-718 MCA

46.10.805 ELIGIBILITY, EXEMPT STATUS Subsections (1) through (1)(c) remain the same.

(2) ~~The community work experience program and t~~The alternative work experience program ~~are~~ is a components of the JOBS program designed to improve the employability of participants by assigning the participant to work in a non-profit organization. The department will determine which component or components of the JOBS program are most appropriate for the AFDC recipient.

Subsections (3) through (3)(f) remain the same. Subsections (3)(g) remains the same in text but is renumbered (3)(h).

(~~h~~g) a parent or other caretaker relative who personally provides care for a child under the age of ~~3~~ 1 years, unless the parent or caretaker relative is age 16 through 19, has not completed high school or its equivalency, and there is full-time child care available;

(i) In an unemployed parent assistance unit, the family may decide which parent will be exempted to care for the child~~,~~, except as provided in subsection (3)(g)(ii). This decision cannot be changed more often than once every ~~six (6)~~ 6 months.

(ii) If one parent in an unemployed parent assistance unit is exempt from participation because of pregnancy, incapacity, or because that parent is caring for an incapacitated household member, as provided in subsections (3)(e), (3)(f), and (3)(h), or is currently sanctioned pursuant to ARM 46.10.839 for failure to participate, only the parent who is already exempt or under sanction will be exempted to care for the child, unless a licensed physician, nurse midwife, psychologist, licensed professional counselor or licensed social worker verifies that said parent is physically or mentally unable to care for the child.

Subsections (3)(i) and (3)(j) remain the same.

(k) a person working an average of 30 hours or more per week in unsubsidized employment and receiving minimum wage or more ~~or though not receiving minimum wage is working through an employability plan for self employment~~;

Subsections (3)(l) through (10) remain the same.

AUTH: Sec. 53-4-212 and 53-4-719 MCA
IMP: Sec. 53-2-201, 53-4-211, 53-4-215, 53-4-703, 53-4-706, 53-4-707, 53-4-708, 53-4-715, 53-4-717 and 53-4-720 MCA

46.10.807 JOBS ACTIVITIES Subsections (1) through (2)(h)(i) remain the same.

(ii) post-secondary education only if the recipient is enrolled in the course or program of study under a Job Training

Partnership Act (JTPA), Vocational Rehabilitation, Trade Adjustment Act or refugee assistance center program, or if the recipient was in a self-initiated course or program approved by the recipient's case manager prior to July 1, 1991, and ~~have~~ has received AFDC-UP benefits continuously since July 1, 1991, and has continuously attended the course or program except for school vacations, in which case the recipient may complete the course or program approved in the recipient's employability plan.

AUTH: Sec. 53-4-212 and 53-4-719 MCA
IMP: Sec. 53-2-201, 53-4-211, 53-4-215, 53-4-703, 53-4-705, 53-4-715 and 53-4-720 MCA

46.10.811 UNEMPLOYED PARENTS TRACK PARTICIPATION AND OTHER REQUIREMENTS (1) In an unemployed parent assistance unit, each ~~spouse~~ parent must attend JOBS-UP orientation, assessment, and employability planning unless that ~~spouse~~ parent is specifically exempt under ARM 46.10.805. Failure to attend orientation or assessment by a ~~spouse~~ parent who is not exempt will result in the sanction of that ~~spouse~~ parent as provided in ARM 46.10.839.

Subsection (2) remains the same.

(a) In an assistance unit with a child under the age of ~~three~~ 1, the family may decide whether the primary wage earner or the other ~~spouse~~ parent will be exempted to care for the child~~,~~, except as provided in subsection (2)(b). This decision cannot be changed more often than once every ~~six (6)~~ 6 months.

(b) If one parent is exempt because of incapacity or pregnancy or because that parent is caring for an incapacitated household member, as provided in ARM 46.10.805, or if one parent is currently sanctioned pursuant to ARM 46.10.839 for failure to participate, only the parent who is already exempt or under sanction will be exempted to care for the child, unless a licensed physician, midwife, psychologist, licensed professional counselor or licensed social worker verifies that said parent is physically or mentally unable to care for the child.

(3) If the primary wage earner in an unemployed parent assistance unit is specifically exempt under one of the exemptions set forth in ARM 46.10.805, or is required to participate but fails or refuses to do so, then the other ~~spouse~~ parent will be required to participate in the unemployed parent track of the JOBS program unless specifically exempt under one of the exemptions set forth in ARM 46.10.805~~,~~, other than the exemption for a caretaker of a child under 1.

(4) The ~~spouse~~ parent who is not the primary wage earner in an unemployed parent assistance unit may elect to participate in the unemployed parent track of the JOBS program.

(a) If such a ~~spouse~~ parent who is not specifically exempt under ARM 46.10.805 after electing to participate fails or refuses without good cause to participate or to accept or

maintain employment, that ~~spouse~~ parent shall be sanctioned according to the terms of ARM 46.10.839.

(b) If such a ~~spouse~~ parent who is exempt under ARM 46.10.805 after electing to participate fails or refuses without good cause to participate or to accept or maintain employment, that ~~spouse~~ parent shall not be sanctioned but shall lose priority for participation in the program in the future.

Subsections (5) through (6)(a) remain the same.

(b) of the total hours required in subsection (~~5~~6)(a), a minimum of 16 hours per week must be spent by at least one parent in the AFDC-UP household in the alternative work experience program, on-the-job training ~~or work supplementation. Actual gainful employment other than on-the-job training or work supplementation does not count toward the required 16 hours.~~ employment, and/or Job Training Partnership Act work experience or limited internship.

(i) A parent under the age of 25 who has not completed high school or an equivalent course of education may in the JOBS case manager's discretion substitute educational activities for part or all of the 16 hour requirement, so long as the parent is making satisfactory progress in the educational activity.

Subsections (7) through (9)(b) remain the same.

AUTH: Sec. 53-4-212 and 53-4-719 MCA
IMP: Sec. 53-2-201, 53-4-211, 53-4-215, 53-4-703, 53-4-705, 53-4-706, 53-4-707 and 53-4-720 MCA

46.10.819 TRAINING SERVICES--POST SECONDARY (1) A regular JOBS participant may be allowed to participate in a post-secondary education program if:

Subsection (1)(a) and (1)(b) remain the same.

(c) the participant, by the institution's standards, is making satisfactory progress; ~~and~~

(d) the participant's coursework will lead to a degree or certificate in the approved program; and

Subsection (1)(d) remains the same in text but is renumbered (1)(e). Subsections (2) through (3) remain the same.

AUTH: Sec. 53-4-212 and 53-4-719 MCA
IMP: Sec. 53-2-201, 53-4-211, 53-4-215, 53-4-703, 53-4-705, 53-4-708, 53-4-715 and 53-4-720 MCA

46.10.825 SUPPORTIVE SERVICES AND ONE TIME WORK-RELATED EXPENSES AVAILABILITY Subsections (1) through (1)(a)(i) remain the same.

(A) the cost of public transportation or, if unavailable, reimbursement for private vehicle at ~~17.5~~ 25 cents per mile, up to ~~$75.00~~ 100.00 per week;

(B) liability insurance for necessary private transport not to exceed ~~$110.00~~ 150.00 during the period of 12 consecutive months following enrollment in the program and ~~any 12 months of~~

~~any successive 12 month~~ during each successive period of 12 consecutive months following the anniversary of enrollment ~~period~~ in the program; and

(C) auto repairs for necessary private transport not to exceed $500.00 during the period of 12 consecutive months following enrollment in the program and ~~any 12 months of any successive 12 month~~ during each successive period of 12 consecutive months following the anniversary of enrollment ~~period~~ in the program.

(b) tools for specific job or training needs not to exceed $300.00 during the period of 12 consecutive months following enrollment in the program and ~~any 12 months of any successive 12 month~~ during each successive period of 12 consecutive months following the anniversary of enrollment ~~period~~ in the program;

(c) clothing and personal grooming and hygiene needs not to exceed a total cost of ~~$100.00~~ 125.00 during the period of 12 consecutive months following enrollment in the program and ~~any 12 months of any successive 12 month~~ during each successive period of 12 consecutive months following the anniversary of enrollment ~~period~~ in the program;

(d) fees including transcripts, applications, birth certificates, GED or equivalency not to exceed a total cost of ~~$50.00 per month~~ $200.00 during the period of 12 consecutive months following enrollment in the program and during each successive period of 12 consecutive months following the anniversary of enrollment in the program;

Subsections (1)(e) through (1)(g)(i) remain the same.

(ii) consistent with the employability plan and not to exceed $300.00 during the period of 12 consecutive months following enrollment in the program and ~~any 12 months of any successive 12 month~~ during each successive period of 12 consecutive months following the anniversary of enrollment ~~period~~ in the program.

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

(b) liability insurance for necessary private transportation not to exceed ~~$110.00~~ 150.00 per job;

Subsections (2)(c) and (2)(d) remain the same.

(e) clothing, personal grooming and hygiene needs not to exceed ~~$100.00~~ 125.00 per job;

Subsections (2)(f) through (8) remain the same.

AUTH: Sec. 53-4-212 and 53-4-719 MCA
IMP: Sec. 53-2-201, 53-4-211, 53-4-215, 53-4-703, 53-4-715, 53-4-716 and 53-4-720 MCA

46.10.841 CONCILIATION (1) When there is a dispute between the JOBS ~~provider~~ operator and a participant regarding a required JOBS activity, conciliation must be provided to resolve the dispute. A matter may not be referred by a provider to the department for consideration and pursuit of a sanction unless that matter cannot be resolved through conciliation.

(2) The following procedures and requirements apply in cases where the participant is a regular JOBS participant rather than a JOBS-UP participant:

(~~2~~a) Either the participant or the ~~provider~~ JOBS operator may request conciliation.

Subsection (3) remains the same in text but is renumbered (2)(b).

(~~4~~c) Conciliation begins with a scheduled ~~appointment~~ meeting between the participant and the provider.

Subsections (5) and (6) remain the same in text but are renumbered (2)(d) and (2)(e).

~~(7) The conciliation process will not exceed 30 days in duration.~~

(f) The time for the JOBS operator and the participant to meet and attempt to reach an agreement shall not exceed 30 days from the date of the originally scheduled conciliation meeting.

(~~8~~g) If it becomes apparent to either the ~~provider~~ JOBS operator or the participant that the dispute cannot be resolved through conciliation, the process may be terminated ~~earlier~~ prior to the expiration of 30 days from the date of the originally scheduled conciliation meeting, upon written notification, by either ~~by~~ the participant or the ~~provider~~ JOBS operator.

(~~9~~h) If it is the ~~provider~~ JOBS operator who initiates the conciliation process, after reasonable efforts have been made to conduct the meeting and the participant has failed to appear, the ~~provider~~ operator shall terminate the conciliation process.

Subsections (10) and (11) remain the same in text but are renumbered (2)(i) and (2)(j).

(~~12~~k) When ~~the conciliation period has terminated or~~ the dispute remains unresolved after 30 days from the date of the originally scheduled conciliation meeting, the ~~provider~~ JOBS operator will recommend in writing to the eligibility technician that a sanction be imposed.

(l) If the JOBS operator and the participant agree on a resolution of the dispute, they shall each sign a conciliation form specifying the terms of the agreement they have reached. The conciliation agreement period begins when the conciliation form has been signed by both the operator and the participant and shall be 30 days unless a longer period of time is specified in the conciliation form.

(i) If the participant fails to meet the requirements of the agreement during the conciliation agreement period, the operator shall recommend in writing to the eligibility specialist that a sanction be imposed.

(ii) If the participant satisfactorily complies with the requirements of the agreement for the entire conciliation agreement period, the dispute shall be considered conclusively resolved and no sanction shall be recommended against the participant.

(3) The same conciliation procedures and requirements set forth in subsections (2)(a) through (2)(l)(ii) apply to AFDC-UP participants, except that the time for the JOBS operator and the participant to meet and attempt to reach an agreement shall not exceed 10 days from the date of the request for conciliation.

AUTH: Sec. 53-4-212 and 53-4-719 MCA
IMP: Sec. 53-2-201, 53-4-211, 53-4-215, 53-4-703 and 53-4-720 MCA

46.10.843 FAIR HEARING PROCEDURE (1) A recipient participating in any work-related program or activity under the JOBS program, including on-the-job training and ~~community~~ alternative work experience programs, is entitled to a fair hearing and appeal provided for in ARM 46.2.201 et seq. with respect to the following issues:

(a) a sanction that has not been resolved by the conciliation process provided for in ARM 46.10.841; and

(b) on-the-job working conditions~~; and~~.

~~(c) wage rates used in calculating the hours of participation required of persons in community work experience programs.~~

Subsection (2) remains the same.

(3) A recipient who is dissatisfied with the decision of the fair hearing officer with regard to any of the matters set forth in subsections (1)(b) through (1)(d) may appeal to the office of administrative law judges of the U.S. department of labor, as provided in 45 CFR Part 251.5(b) through (g) as amended through ~~January 23, 1991~~ October 1, 1993, which the department hereby adopts and incorporates by reference. A copy of 45 CFR Part 251.5(b) through (g) as amended through January ~~23, 1991~~ October 1, 1993, may be obtained from the Department of Social and Rehabilitation Services, Office of Legal Affairs, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

(a) An appeal under this subsection must be filed within ~~twenty (20)~~ 20 days of receipt by the recipient of the fair hearing officer's written decision.

Subsection (2)(b) remains the same.

AUTH: Sec. 53-4-212 and 53-4-719 MCA
IMP: Sec. 53-2-201, 53-2-606, 53-4-211, 53-4-215, 53-4-703 and 53-4-720 MCA

3. These rules pertaining to the Job Opportunity and Basic Skills (JOBS) program for recipients of Aid to Families with Dependent Children (AFDC) are being amended in part to clarify the department's policies and ensure that the rules accurately reflect the JOBS program as it currently is administered rather than to change departmental policy. For example, the community work experience program (CWEP), a component of the JOBS program, was replaced by the alternative work experience

program (AWEP) several years ago, but several references to CWEP still remain in the JOBS rules. References to CWEP in ARM 46.10.803, 46.10.805 and 46.10.843 are therefore being deleted and/or changed to AWEP.

ARM 46.10.805 describes the situations in which a recipient may be exempted from participation in JOBS. Currently the rule is somewhat ambiguous about the availability of the exemption for a parent providing care for a young child in AFDC-UP households. The rule is therefore being amended to state more clearly that in AFDC-UP cases where one parent is already exempt or under sanction for failure to participate in JOBS, only that parent may take the child care exemption unless that parent is physically or mentally unable to care for the child.

Also in ARM 46.10.805, the subsections currently numbered (g) and (h) are being switched, that is subsection (g) is being renumbered (h) and (h) is being renumbered (g). The purpose of this renumbering is to avoid confusion, as the subsections currently numbered (h) in turn have subsections designated by the lowercase Roman numerals (i) and (ii). It is not apparent at first glance that (i) is a subsection of (h) rather than being the subsection following (h) designated with the letter "i".

In ARM 46.10.805(2)(k) the provision exempting a self-employed person who is not earning the equivalent of minimum wage has been eliminated because the department has determined that such a person needs assistance to achieve self-sufficiency and therefore should not be exempted from participation in JOBS.

ARM 46.10.807(2) describes acceptable activities for participants of the unemployed parent track of JOBS. At this time, post-secondary education is not an approved activity except under a Job Training Partnership Act (JTPA), Vocational Rehabilitation, Trade Adjustment Act or Refugee Assistance Center program. However, subsection (2)(h)(ii) contains a grandfather provision which allows AFDC recipients enrolled in a post-secondary education program which was self-initiated by the recipient and approved by the recipient's case manager prior to July 1, 1991 to complete the program. This subsection is now being amended to clarify that the grandfather provision applies only if the recipient has continuously attended the program since July 1, 1991.

In ARM 46.10.811 pertaining to participation requirements for the unemployed parent track of JOBS, the word "parent" has been substituted for the word "spouse" throughout the rule, because the parents do not have to be married to be classified as an unemployed parent household. The reference in subsection (6)(b) to work supplementation as an acceptable work-related activity

is being deleted because work supplementation is not currently a component of the department's JOBS program. Subsection (2)(b) is being added to clarify availability of the caretaker exemption in JOBS-UP households. Subsection (6)(b)(i) is being added to specify in the rule that parents under age 25 without a high school diploma may in some cases be allowed to substitute educational activities for work-related activities. This is not a change in policy but merely a clarification.

Post-secondary education requirements for regular JOBS participants in ARM 46.10.819 are being clarified by the addition of a provision requiring that the participant's coursework lead to a degree or certificate.

In ARM 46.10.843, federal regulations pertaining to review of fair hearing decisions by administrative law judges are incorporated by reference. This rule is being amended to incorporate the most recent edition of the code of federal regulations to keep the references up to date, although the section of the regulations which is incorporated in the rule has not changed since its incorporation.

Additionally, some rules are also being amended to implement policy changes required by directives of the legislature and new federal regulations. Thus ARM 46.10.805(3)(h), now (3)(g) is being changed to state that a parent or caretaker relative may be exempted to care for a child under 1 year of age, rather than under 3 years of age. This amendment is necessary to implement the mandate of the November, 1993 Special Session of the 53rd Montana Legislature in House Bill 2 that only recipients with children under the age of 1 year be exempted from participation in JOBS.

ARM 46.10.811 contains participation requirements for the unemployed parent track of JOBS. Subsection (6)(b) currently provides that gainful employment does not count toward the 16 hours per week which the JOBS-UP participant must spend in work-related activities. This provision is being deleted due to a change in the federal interpretation of 45 CFR Part 250.33(a), allowing the states to count gainful employment toward the 16 hours of work-related activities.

In ARM 46.10.825 the maximum amounts which may be spent on certain supportive activities and one-time work-related expenses for JOBS participants are being increased because increases in the cost of living have necessitated expenditures of higher amounts than in the past. Changes in the wording of ARM 46.10.825 have also been made to express more clearly that limits on the amounts which can be spent for supportive services and one-time work-related expenses apply to each 12 month period

that the participant is enrolled in JOBS. The latter change is a clarification, not a change in policy.

ARM 46.10.841 describes the conciliation process available to resolve disputes between JOBS participants and the JOBS operator regarding JOBS activities. Departmental policy currently allows the participant and the operator a 30 day period to resolve the dispute before sanctions can be imposed on the participant if necessary, although the 30 day period is not specified in the rule. With the advent of the pay after performance requirement for JOBS-UP track participants as set forth in ARM 46.10.811(9)(a), it becomes necessary to shorten the conciliation period for JOBS-UP participants, so that it can be determined whether a sanction for failure to participate is appropriate before the AFDC grant is issued without delaying payment to the AFDC assistance unit.

As amended, ARM 46.10.841 will specify for that the conciliation period is 30 days for regular JOBS participants and 10 days for JOBS-UP participants. Other details of the conciliation process which were not previously spelled out in the rule have been added for clarity. Finally, the term "JOBS operator" has been substituted for "provider" throughout the rule, because "operator" is the term commonly used to refer to the entity providing JOBS services to participants. A definition of "JOBS operator" has also been added to ARM 46.10.803, the JOBS definitions rule.

4. The amendment of ARM 46.10.805(3)(g) will be effective on July 1, 1994, because the legislature mandated that this change be made by that date. The amendments to ARM 46.10.825 will be effective on October 1, 1994, to coincide with the effective date of the same amendments to the department's state plan governing the AFDC program.

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 Russell E. Cater, Chief Legal Counsel, Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, MT 59604-4210, no later than July 7, 1994.

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

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State May 31, 1994.

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

In the matter of the amendment of rule 46.12.702 pertaining to medicaid outpatient drugs	)))))	NOTICE OF PUBLIC HEARING ON THE PROPOSED AMENDMENT OF RULE 46.12.702 PERTAINING TO MEDICAID OUTPATIENT DRUGS

TO: All Interested Persons

1. On June 29, 1994, 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 rule 46.12.702 pertaining to medicaid outpatient drugs.

The Department of Social and Rehabilitation Services will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing. If you request an accommodation, contact the department no later than 5:00 p.m. on June 20, 1994, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970.

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

46.12.702 OUTPATIENT DRUGS, REQUIREMENTS Subsections (1) and (2) remain the same.

(3) The department will participate only in the payment of drugs which require a prescription and those over-the-counter drugs which are included in the department drug formulary. Over-the-counter drugs include, but are not limited to insulin, antacids or laxatives.

Subsections (4) through (6) remain the same.

(a) which the secretary of HHS has determined, the prescription drug or its generic equivalent, to be less than effective for all conditions of use prescribed, recommended or suggested in the drug's labeling; and

~~(b) any other prescription drug products which are considered generically equivalent.~~

Subsection (6)(c) remains the same in text but is renumbered (6)(b).

(c) subject to prior authorization as determined by the medicaid drug formulary committee, established in accordance with the Federal Omnibus Budget Reconciliation Act of 1993, without the existence of a prior authorization request approved by the department or its designated representative. A copy of drugs subject to prior authorization will be provided to

interested medicaid providers. A copy of this listing may be obtained by writing to the Department of Social and Rehabilitation Services, Medicaid Services Division, P.O. Box 4210, Helena, Montana 59604-4210.

~~(7) Effective January 1, 1991, the department will not deny reimbursement, based upon lack of a rebate agreement between the manufacturer and the secretary of HHS, for the first six months following approval of a new drug by the FDA. However, if the manufacturer has not entered into a rebate agreement as required by subsection (6)(e) within six months of approval of the new drug by the FDA, the department will not reimburse for the drug.~~

AUTH: Sec. 53-6-113 MCA
IMP: Sec. 53-6-113, 53-6-101 and 53-6-141 MCA

3. The 1994 Legislative Special Session adopted a medicaid recommendation to reduce the rate of growth in the Medicaid Pharmacy program by up to 5% over the coming biennium (FY95 and FY96) by implementing a drug formulary.

The department's intent is to achieve growth reduction through the implementation of a medicaid drug formulary. The School of Pharmacy and Allied Health Sciences will perform literature research and evaluation to recommend drugs for inclusion or exclusion from the Montana medicaid's drug formulary.

A formulary is a listing of products eligible for coverage under a particular reimbursement program. Formularies are established for various reasons however the majority are established to define coverage for those drugs which provide the most therapeutically sound treatment while maintaining costs.

As a condition of the Omnibus Budget Reconciliation Act of 1990, § 4401 Reimbursement for Prescribed Drugs, and in order to maintain any type of formulary, state medicaid programs may not limit coverage of a manufacturer's product other than requiring that prior-authorization be obtained prior to a covered outpatient drug being dispensed if the manufacturer has entered into a rebate agreement with the Department of Health and Human Services.

To prior authorize a drug, a prior authorization program will be established to provide a response by telephone or other telecommunication device within 24 hours of receipt of a request for prior authorization. A provision will also be incorporated to allow for the dispensing of at least a 72-hour supply of a prior authorized prescription drug in an emergency situation.

The Department plans to begin implementation of the drug formulary and prior authorization programs October 1, 1994. The

implementation of these programs will require modification of ARM 46.12.702 regarding product coverage under the Montana Medicaid program.

The estimated financial and budgetary impacts are as follows: (Reductions)

Fund	FY94	FY95	Biennium
State General Fund	$125,996	$ 489,120	$ 615,116
Federal Fund	$306,534	$1,168,914	$1,475,448
Total*	$432,530	$1,658,034	$2,090,564

*(Figures are based on 15% growth factor. FY95 total is assuming a 2% reduction in growth. FY96 total is assuming a 5% growth reduction.)

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 Russell E. Cater, Chief Legal Counsel, Office of Legal Affairs, Department of Social and Rehabilitation Services, P.O. Box 4210, Helena, MT 59604-4210, no later than July 7, 1994.

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

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State May 31, 1994.

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

In the matter of the adoption of new rules regarding small employer health benefit plans	)))	NOTICE OF ADOPTION

TO: All Interested Persons.

On March 17, 1994, the state auditor and commissioner of insurance of the state of Montana published notice of public hearing regarding basic and standard health benefit plans under the Small Employer Health Insurance Availability Act. The notice was published at page 511 of the 1994 Montana Administrative Register, issue number 5.

1. The agency has adopted the new rules XII (6.6.5050), XIII (6.6.5040), XVII (6.6.5070), XVIII (6.6.5074), XX (6.6.5082), XXI (6.6.5086), and XXII (6.6.5090) as proposed.

2. The agency has adopted new rule XXV (6.6.5028) as an additional new rule.

3. The agency has adopted new rules I (6.6.5001), II (6.6.5004), III (6.6.5008), IV (6.6.5012), V (6.6.5016), VI (6.6.5020), VII (6.6.5024), VIII (6.6.5032), IX (6.6.5036), X (6.6.5040), XI (6.6.5044), XIV (6.6.5058), XV (6.6.5058), XVI (6.6.5066), XIX (6.6.5078), XXIII (6.6.5094), and XXIV (6.6.5098) with the following changes (material stricken is interlined; new matter added is underlined):

NEW RULE I (6.6.5001) DEFINITIONS For the purposes of this sub-chapter, the following terms have the following definitions:

(1) through (3) remain the same.

(a) An individual (or the ~~beneficiary~~eligible dependent of such individual) who is employed by a participating employer within a bargaining unit covered by at least one of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained; or

(b) An individual who is a present or former employee (or an ~~beneficiary~~eligible dependent of such employee) of the sponsoring employee organization, of an employer who is or was a party to at least one of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained, or of the employee benefit plan, or of a related plan.

(4) "Case management" means the process of planning and coordinating care and services to meet the individual needs of ~~a client~~eligible employees and eligible dependents. Case management includes assessment, care coordination and referral, case planning, and monitoring.

(5) "Coinsurance" means the percentage of eligible charges which the insurer must pay, after the deductible is met ~~and up to the maximum annual out-of-pocket~~.

(6) "Copayment" means ~~the dollar amount of eligible charges which the insured must pay~~a fixed dollar amount or percentage of eligible charges which the insured must pay for each service after a deductible, if any, is met.

(7) "Deductible" means the dollar amount of eligible charges which the insured must pay in an annual benefit period before any benefits are payable by the insured.

(8) "Eligible Dependent" means any dependent defined in 33-22-1803, MCA, ~~and the eligible employee's lawful spouse, including declared common law spouse, and unmarried children who are under the age of 19 or full-time students under the age of 23. Dependent children include natural or legally adopted children of the eligible employee or the employee's spouse or any other child who qualifies as a dependent under the Internal Revenue Code, and each newborn infant of any insured, as contemplated by 33-22-301 and 33-22-504, MCA,~~ including a common law spouse, or any child who qualifies as a dependent under the Internal Revenue Code.

(9) through (9)(e) remain the same.

(10) "Lifetime maximum benefit" means maximum total benefits paid by the insurer ~~excluding amounts for deductible, coinsurance, and copayment~~ throughout the life of the policy.

(11) "Maximum annual out-of-pocket" means the total amount of eligible charges paid by the insured ~~through the deductible, the insured's share of the coinsurance, or copayment~~as copayments and deductible.

(12) remains the same.

(13) "Risk characteristic" means the health status, claims experience, duration of coverage, or any similar characteristic related to the health status or experience of a small employer group or of any member of a small employer group.

(14) remains the same.

AUTH: 33-1-313 and 33-22-1822, MCA
IMP: 33-22-1802, 33-22-1803, and 33-22-1812, MCA

NEW RULE II (6.6.5004) APPLICABILITY, SCOPE, AND TRANSITION (1) through (2) remain the same.

(3) A carrier that provides individual health insurance policies to one or more of the employees of a small employer must be considered a small employer carrier and must be subject to the provisions of these rules with respect to such policies if the small employer contributes directly or indirectly to the premiums for the policies and the carrier is aware or should have been aware of such contribution. An indirect contribution is any contribution which benefits the employee monetarily. For the purpose of this rule, payroll deductions, list billed premium payments, and employer contributions to premiums paid through cafeteria plans, as defined in section 125 of the Internal Revenue Code, must be regarded as employer contributions.

(a) Any carrier that has a list billed premium payment arrangement with a small employer after ~~January 1, 1994, shall~~

~~either renew coverage or withdraw from the market, in accordance with the procedures in 33-22-1810, MCA. If a carrier chooses to renew coverage, then that carrier must be treated as a small employer carrier and shall thereafter comply with all provisions of the act and these rules.~~the effective date of these rules shall do one of the following:

(i) cease using a list billing to bill individuals;

(ii) renew coverage; or

(iii) withdraw from the market, in accordance with the procedures in 33-22-1810, MCA.

(4) through (4)(c) remain the same.

(5) These rules apply to all health benefit plans provided to small employers or to the employees of small employers, without regard to whether the health benefit plans are offered under, or provided through, a group policy or trust arrangement of any size sponsored by an association or employer contributions to premiums paid through cafeteria plans, as defined in section 125 of the Internal Revenue Code, unless excepted by 33-22-1803(25), MCA, or unless the plan constitutes both a multiple employer welfare arrangement as defined by section 29 USCS 1002(40)(A) and an employee welfare benefit plan under section 29 USCS 1002(1).

(6) remains the same.

(7) If the small employer is issued a health benefit plan under the terms of the act, these rules must continue to apply to the health benefit plan in the case that the small employer subsequently employs more than 25 eligible employees. ~~(8)~~ A carrier providing coverage to such an employer shall, within 60 days of becoming aware that the employer has more than 25 eligible employees, but no later than the anniversary date of the employer's health benefit plan, notify the employer that the protections provided under the act and these rules must cease to apply to the employer if such employer fails to renew its current health benefit plan or elects to enroll in a different health benefit plan.

(9~~8~~) If a health benefit plan is issued to an employer that is not a small employer as defined in the act, but subsequently the employer becomes a small employer, these rules must not apply to the existing health benefit plan. The carrier providing a health benefit plan to such an employer must not become a small employer carrier under these rules solely because the carrier continues to provide coverage under the existing health benefit plan to the employer.

(~~10~~9) A carrier providing coverage to an employer described in (~~8~~7) shall, within 60 days of becoming aware that the employer has 3 to 25 eligible employees, notify the employer of the options and protections available to the employer under the act, including the employer's option to purchase a small employer health benefit plan from any small employer carrier.

(~~11~~0) If a small employer has employees in more than one state, these rules must apply to any health benefit plans issued to the small employer if:

(a) The majority of eligible employees of such small employer are employed in this state~~,~~ or

(b) If no state contains a majority of the eligible employees of the small employer, the primary business location of the small employer is in this state.

(c) In determining whether the laws of this state or another state apply to a health benefit plan issued to a small employer described in (~~1~~2), the provisions of (~~1~~2) apply as of the date the health benefit plan was issued to the small employer for the period that the health benefit plan remains in effect.

(d) If a health benefit plan is subject to these rules, these rules must apply to all individuals covered under the health benefit plan, whether they reside in this state or in another state.

(1~~2~~1) A carrier that is not operating as a small employer carrier in this state is not subject to the provisions of these rules solely because a small employer that was issued a health benefit plan in another state by that carrier moves to this state, until coverage is renewed, extended or modified. However, such a carrier shall, within 60 days of becoming aware that the employer has moved to this state, notify the employer of the options and protections available to the employer under the act, including the employer's option to purchase a small employer health benefit plan from any small employer carrier authorized to do business in this state.

AUTH: 33-1-313 and 33-22-1822, MCA
IMP: 33-22-1802, 33-22-1808, and 33-22-1812, MCA

NEW RULE III (6.6.5008) COVERED SERVICES OF POLICIES UNDER STANDARD PLAN (1) through (1)(b) remain the same.

(c) Coverage for hospital emergency room, services, subject to a $75 copayment, if the insured is not admitted to the hospital. This copayment may not be applied toward the deductible or ~~coinsurance limit~~the maximum annual out-of-pocket.

(d) Coverage for obstetrical care, including services of physicians, certified nurse midwives and other nurse specialists, any provider licensed to give obstetrical care, costs of delivery room, and other medically necessary services directly associated with the delivery.

(e) Coverage for services of physicians and other health care professionals, subject to the freedom of choice protections of 33-22-111, MCA, except as provided in section 33-30-102(1), MCA.

(1)(e)(i) through (1)(g) remain the same.

(h) Coverage for chiropractic services not exceeding 24 treatments aper year, unless an additional 11 visits are approved by the insurer, provided that the maximum covered charge must not exceed $25 per treatment.

(i) Coverage for the following mental health services in accordance with 33-22-703, MCA:

(i) ~~Coverage for outpatient mental health services may be limited to no less than $1,000 a year, including expenses for outpatient substance abuse treatment.~~mental illness;

(ii) ~~Coverage for inpatient services may be limited to no less than 30 days for treatment of mental illness.~~alcoholism; and

(iii) drug abuse.

~~(j) Coverage for the following substance abuse treatment:~~

~~(i) The maximum benefit for inpatient substance abuse services may be limited to no less than $4,000 in any 24-month period and $8,000 in lifetime benefits.~~

~~(ii) The maximum benefit for outpatient services may be limited to $1,000 a year, including expenses for outpatient mental health care.~~

(~~iii~~j) ~~Only s~~Services for alcoholism and drug abuse ~~within the American Society of Addictive Medicine criteria may~~ will be covered if they meet the criteria set forth in the American Society of Addictive Medicine.

(k) Coverage of only ~~prescription~~ drugs available by a prescription, which includes formularies and generic brand prescription drugs and contraceptives prescribed for the treatment of a medical problem and not solely for contraceptive purposes.

(1)(l) through (1)(p) remain the same.

(~~q~~2) Coverage for all usual, customary, and reasonable charges related to medically necessary services rendered, as defined ~~in the contract~~by the small employer carrier includes as follows:~~.~~

(a) Charges in excess of this standard are not required to be included in the calculations under 6.6.5004 and 6.6.5008, unless otherwise excepted in section 33-30-102(1), MCA.

(b) The benefits provided shall be coordinated pursuant to ARM 6.6.2401 through 6.6.2405.

(~~r~~c) Coverage for all statutory mandated benefits, including, but not limited to those mandated by 33-22-114, MCA, (services of physician's assistants - certified); 33-22-125, MCA (independent chiropractic examination and review); 33-22-130, MCA (treatment of adopted children); 33-22-131, MCA (phenylketonuria treatment); ~~33-22-303, 33-22-512, and 33-30-1014, MCA (well-child treatment); 33-22-703, MCA (treatment of mental illness, alcoholism and drug abuse); 33-22-1001 and 33-22-1002, MCA (home health care);~~ 33-22-301, 33-22-504, and 33-30-1001, MCA (newborns); 33-22-304, 33-22-506, and 33-30-1004, MCA (continuation of coverage for the handicapped); 33-22-305 through 311, MCA (the Individual Family Disability Insurance Continuation of Coverage Act); 33-22-503, MCA (regarding continuation of benefits to dependents); 33-22-507, MCA (regarding continuing group coverage after reduction of work schedule); 33-22-508, MCA (regarding conversion on termination of eligibility); 33-22-509, MCA (regarding imposition of pre-existing conditions to a converted policy covered by a

group contract); and 33-22-510, MCA (insured family-conversion entitlement).

AUTH: 33-1-313 and 33-22-1822, MCA
IMP: 33-22-1802 and 33-22-1812, MCA

NEW RULE IV (6.6.5012) COVERED PREVENTIVE CARE AND HEALTH MAINTENANCE SERVICES OF POLICIES UNDER STANDARD PLAN

(1) remains the same.

(a) The following ~~low risk~~ preventive care for low risk, asymptomatic adults:

(i) Coverage for one health examination and related counseling every 1-5 years, ~~as determined by a licensed MD, DO, or other provider if within the scope of practice as determined by the provider's licensing board and practice act,~~ including current health history and counseling for tobacco and substance abuse, nutrition, exercise, sexual behavior, injury prevention, and dental care.

(ii) Coverage of age-appropriate physical examinations, including, for ages 19-39, 1 exam every 5 years; for ages 40-49, 1 exam every 3 years; and for ages 50 and above, 1 exam every 1 to 2 years~~, as determined by an MD, DO, or other provider if within the scope of practice as determined by the provider's licensing board and practice act~~.

(iii) Coverage for mammography examinations as contemplated by 33-22-132, MCA.

(iv) Coverage for 3 consecutive normal pap smear tests following the onset of sexual activity, and subsequent tests every 3 years until age 65.

(v) Coverage of 1 cholesterol test every 5 years beginning at age 35.

(vi) Coverage of 1 stool test for occult blood (colon cancer) every 1 to 2 years beginning at age 50~~, as determined by an MD, DO, or nurse specialist~~.

(vii) Coverage for 1 flexible sigmoidoscopy every 5 years beginning at age 50.

(viii) Coverage for annual flu shots after age 65.

(ix) Coverage for 1 pneumococcal vaccine after age 65.

(x) Coverage for 1 diphtheria/tetanus booster shot every 10 years following the initial series of shots.

(b) The following preventive care for children from birth to age ~~20~~18:

(i) From birth through 2 years of age, coverage for well child care should follow the mandated benefits set forth in 33-22-303, 33-22-512, and 33-30-1014, MCA.

(ii) From age 3 through 18 years of age, cCoverage for interval health history and physical examinations conducted or performed by an MD, DO, or other provider if within the scope of practice as determined by the provider's licensing board and practice act, at intervals recommended by the American Academy of Pediatrics (AAP).

(iii) Coverage for immunizations of eligible dependents following schedules recommended by the AAP.

(c) The following reproductive health care:

(i) ~~Coverage for outpatient mental health services may be limited to no less than $1,000 a year, including expenses for outpatient substance abuse treatment.~~mental illness;

(ii) ~~Coverage for inpatient services may be limited to no less than 30 days for treatment of mental illness.~~alcoholism; and

(iii) drug abuse.

~~(j) Coverage for the following substance abuse treatment:~~

~~(i) The maximum benefit for inpatient substance abuse services may be limited to no less than $4,000 in any 24-month period and $8,000 in lifetime benefits.~~

~~(ii) The maximum benefit for outpatient services may be limited to $1,000 a year, including expenses for outpatient mental health care.~~

(~~iii~~j) ~~Only s~~Services for alcoholism and drug abuse ~~within the American Society of Addictive Medicine criteria may~~ will be covered if they meet the criteria set forth in the American Society of Addictive Medicine.

(k) Coverage of only ~~prescription~~ drugs available by a prescription, which includes formularies and generic brand prescription drugs and contraceptives prescribed for the treatment of a medical problem and not solely for contraceptive purposes.

(1)(1) through (1)(p) remain the same.

(~~q~~2) Coverage for all usual, customary, and reasonable charges related to medically necessary services rendered, as defined ~~in the contract~~by the small employer carrier includes as follows:~~:~~

(a) Charges in excess of this standard are not required to be included in the calculations under 6.6.5004 and 6.6.5008, unless otherwise excepted in section 33-30-102(1), MCA.

(b) The benefits provided shall be coordinated pursuant to ARM 6.6.2401 through 6.6.2405.

(~~r~~c) Coverage for all statutory mandated benefits, including, but not limited to those mandated by 33-22-114, MCA, (services of physician's assistants - certified); 33-22-125, MCA (independent chiropractic examination and review); 33-22-130, MCA (treatment of adopted children); 33-22-131, MCA (phenylketonuria treatment); ~~33-22-303, 33-22-512, and 33-30-1014, MCA (well child treatment); 33-22-703, MCA (treatment of mental illness, alcoholism and drug abuse); 33-22-1001 and 33-22-1002, MCA (home health care);~~ 33-22-301, 33-22-504, and 33-30-1001, MCA (newborns); 33-22-304, 33-22-506, and 33-30-1004, MCA (continuation of coverage for the handicapped); 33-22-305 through 311, MCA (the Individual Family Disability Insurance Continuation of Coverage Act); 33-22-503, MCA (regarding continuation of benefits to dependents); 33-22-507, MCA (regarding continuing group coverage after reduction of work schedule); 33-22-508, MCA (regarding conversion on termination of eligibility); 33-22-509, MCA (regarding imposition of pre-existing conditions to a converted policy covered by a

group contract); and 33-22-510, MCA (insured family-conversion entitlement).

AUTH: 33-1-313 and 33-22-1822, MCA
IMP: 33-22-1802 and 33-22-1812, MCA

NEW RULE IV (6.6.5012) COVERED PREVENTIVE CARE AND HEALTH MAINTENANCE SERVICES OF POLICIES UNDER STANDARD PLAN

(1) remains the same.

(a) The following ~~low risk~~ preventive care for low risk, asymptomatic adults:

(i) Coverage for one health examination and related counseling every 1-5 years, ~~as determined by a licensed MD, DO, or other provider if within the scope of practice as determined by the provider's licensing board and practice act,~~ including current health history and counseling for tobacco and substance abuse, nutrition, exercise, sexual behavior, injury prevention, and dental care.

(ii) Coverage of age-appropriate physical examinations, including, for ages 19-39, 1 exam every 5 years; for ages 40-49, 1 exam every 3 years; and for ages 50 and above, 1 exam every 1 to 2 years~~, as determined by an MD, DO, or other provider if within the scope of practice as determined by the provider's licensing board and practice act~~.

(iii) Coverage for mammography examinations as contemplated by 33-22-132, MCA.

(iv) Coverage for 3 consecutive normal pap smear tests following the onset of sexual activity, and subsequent tests every 3 years until age 65.

(v) Coverage of 1 cholesterol test every 5 years beginning at age 35.

(vi) Coverage of 1 stool test for occult blood (colon cancer) every 1 to 2 years beginning at age 50~~, as determined by an MD, DO, or nurse specialist~~.

(vii) Coverage for 1 flexible sigmoidoscopy every 5 years beginning at age 50.

(viii) Coverage for annual flu shots after age 65.

(ix) Coverage for 1 pneumococcal vaccine after age 65.

(x) Coverage for 1 diphtheria/tetanus booster shot every 10 years following the initial series of shots.

(b) The following preventive care for children from birth to age ~~2018~~:

(i) From birth through 2 years of age, coverage for well child care should follow the mandated benefits set forth in 33-22-303, 33-22-512, and 33-30-1014, MCA.

(ii) From age 3 through 18 years of age, cCoverage for interval health history and physical examinations conducted or performed by an MD, DO, or other provider if within the scope of practice as determined by the provider's licensing board and practice act, at intervals recommended by the American Academy of Pediatrics (AAP).

(iii) Coverage for immunizations of eligible dependents following schedules recommended by the AAP.

(c) The following reproductive health care:

(i) Family planning services, including contraception planning;

(ii) Pregnancy related services; and

(iii) "Risk appropriate" prenatal care following medicaid guidelines. Risk appropriate prenatal care includes payment for case management for high risk pregnant individuals.

(d) Policies of insurance offered under the standard health benefit plan contemplated by 33-22-1812, MCA, must provide full coverage for 4 visits per year to health care providers as listed under 33-22-111 and 33-22-114, MCA, of the patient's choice. This coverage must not be subject to deductible ~~and coinsurance~~or to maximum out-of-pocket, but must be subject to a copayment of $25 per consultation and be applied toward meeting the out-of-pocket limit. This benefit must cover professional service fees only, and not the cost of tests, medications, or other items.

(2) In the event an individual's coverage changes from one benefit plan to another or from one carrier to another, the new benefit plan or the new carrier may count preventive care services paid for by prior carriers and benefit plans in determining whether a particular service or visit is covered.

AUTH: 33-1-313 and 33-22-1822, MCA
IMP: 33-22-1802 and 33-22-1812, MCA

NEW RULE V (6.6.5016) SERVICES THAT MAY BE EXCLUDED FROM COVERAGE UNDER THE STANDARD PLAN (1) through (1)(c) remain the same.

(d) Eyeglasses, contact lenses, hearing aids, or any examination or fitting related to these devices except that such health care services must be offered as optional coverage;

(1)(e) through (1)(i) remain the same.

(j) ~~Medical expenses for work-related injuries or occupational disease covered by a worker's compensation insurer, unless the worker's compensation insurer has~~ denied ~~benefits and the claimant is pursuing redress through mediation, a contested case hearing, or a court and no decision has been made on the case;~~All services and supplies resulting from any illness or injury which occurs in the course of employment when the employer has elected or is required by law to obtain coverage for such under state or federal Workers' Compensation laws, occupational disease laws, or similar legislation, including employees' compensation or liability laws of the United States and applies to all services and supplies resulting from a work-related illness or injury even though:

(i) Coverage under the government legislation provides benefits for only a portion of the services incurred;

(ii) Your employer has failed to obtain such coverage required by law;

(iii) The member waives his or her rights to such coverage or benefits;

(iv) The member fails to file a claim within the filing period allowed by law for such benefits;

(v) The member fails to comply with any other provision of the law to obtain such coverage or benefits; or

(vi) The member was permitted to elect not to be covered by the Workers' Compensation Act but failed to properly make such election effective.

(A) This exclusion will not apply if an employer was not required and did not elect to be covered under any Workers' Compensation, occupational disease laws, or employer's liability acts of any state, country, or the United States.

(B) This exclusion will not apply if the workers' compensation insurer has denied benefits and claimant is pursuing redress through mediation, a contested case hearing, or a court, and no decision has been made on the case. If the workers' compensation coverage agrees to pay the claim, then the small employer carrier will be reimbursed for all expenses paid on the claim.

(1)(k) through (1)(n) remain the same.

(o) Dental services, except for tumors or injury to the natural teeth and gums, except that such service shall be offered as optional coverage;

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

AUTH: 33-1-313 and 33-12 1822, MCA
IMP: 33-22-1802 and 33-22-1812, MCA

NEW RULE VI (6.6.5020) DEDUCTIBLE CHARGES, COINSURANCE, MAXIMUM ALLOWABLE OUT-OF-POCKET CHARGES, AND LIFETIME MAXIMUM BENEFIT LEVEL UNDER THE STANDARD PLAN (1) and (2) remain the same.

(3) Policies of insurance offered under the standard health benefit plan contemplated by 33-22-1812, MCA, must provide maximum annual out-of-pocket charges of $1,250 per person and $2,500 per family. Such policies must also provide that, after the annual out-of-pocket limit is met, the insurer will pay 100% of all medically necessary charges up to the lifetime maximum benefit level.

(4) remains the same.

AUTH: 33-1-313 and 33-22-1822, MCA
IMP: 33-22-1802 and 33-22-1812, MCA

NEW RULE VII (6.6.5024) HMO COST SHARING SCHEDULE AND EXCEPTION TO STANDARD PLAN PROVISIONS (1) remains the same.

(2) Standard plans offered by HMOs are exempt from the deductible charges, and coinsurance provisions of 6.6.5020, but must comply with the maximum annual out-of-pocket and lifetime maximum requirements of ARM 6.6.5020. HMO plans must include the following cost sharing schedule:

INPATIENT HOSPITAL SERVICES

Semi-Private Room and Board Charges:

(i) Family planning services, including contraception planning;

(ii) Pregnancy related services; and

(iii) "Risk appropriate" prenatal care following medicaid guidelines. Risk appropriate prenatal care includes payment for case management for high risk pregnant individuals.

(d) Policies of insurance offered under the standard health benefit plan contemplated by 33-22-1812, MCA, must provide full coverage for 4 visits per year to health care providers as listed under 33-22-111 and 33-22-114, MCA, of the patient's choice. This coverage must not be subject to deductible ~~and coinsurance~~or to maximum out-of-pocket, but must be subject to a copayment of $25 per consultation and be applied toward meeting the out-of-pocket limit. This benefit must cover professional service fees only, and not the cost of tests, medications, or other items.

(2) In the event an individual's coverage changes from one benefit plan to another or from one carrier to another, the new benefit plan or the new carrier may count preventive care services paid for by prior carriers and benefit plans in determining whether a particular service or visit is covered.

AUTH: 33-1-313 and 33-22-1822, MCA
IMP: 33-22-1802 and 33-22-1812, MCA

NEW RULE V (6.6.5016) SERVICES THAT MAY BE EXCLUDED FROM COVERAGE UNDER THE STANDARD PLAN (1) through (1)(c) remain the same.

(d) Eyeglasses, contact lenses, hearing aids, or any examination or fitting related to these devices except that such health care services must be offered as optional coverage;

(1)(e) through (1)(i) remain the same.

(j) ~~Medical expenses for work-related injuries or occupational disease covered by a worker's compensation insurer, unless the worker's compensation insurer has denied benefits and the claimant is pursuing redress through mediation, a contested case hearing, or a court and no decision has been made on the case;~~All services and supplies resulting from any illness or injury which occurs in the course of employment when the employer has elected or is required by law to obtain coverage for such under state or federal Workers' Compensation laws, occupational disease laws, or similar legislation, including employees' compensation or liability laws of the United States and applies to all services and supplies resulting from a work-related illness or injury even though:

(i) Coverage under the government legislation provides benefits for only a portion of the services incurred;

(ii) Your employer has failed to obtain such coverage required by law;

(iii) The member waives his or her rights to such coverage or benefits;

(iv) The member fails to file a claim within the filing period allowed by law for such benefits;

(v) The member fails to comply with any other provision of the law to obtain such coverage or benefits; or

(vi) The member was permitted to elect not to be covered by the Workers' Compensation Act but failed to properly make such election effective.

(A) This exclusion will not apply if an employer was not required and did not elect to be covered under any Workers' Compensation, occupational disease laws, or employer's liability acts of any state, country, or the United States.

(B) This exclusion will not apply if the workers' compensation insurer has denied benefits and claimant is pursuing redress through mediation, a contested case hearing, or a court, and no decision has been made on the case. If the workers' compensation coverage agrees to pay the claim, then the small employer carrier will be reimbursed for all expenses paid on the claim.

(1)(k) through (1)(n) remain the same.

(o) Dental services, except for tumors or injury to the natural teeth and gums, except that such service shall be offered as optional coverage;

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

AUTH: 33-1-313 and 33-12 1822, MCA
IMP: 33-22-1802 and 33-22-1812, MCA

NEW RULE VI (6.6.5020) DEDUCTIBLE CHARGES, COINSURANCE, MAXIMUM ALLOWABLE OUT-OF-POCKET CHARGES, AND LIFETIME MAXIMUM BENEFIT LEVEL UNDER THE STANDARD PLAN (1) and (2) remain the same.

(3) Policies of insurance offered under the standard health benefit plan contemplated by 33-22-1812, MCA, must provide maximum annual out-of-pocket charges of $1,250 per person and $2,500 per family. Such policies must also provide that, after the annual out-of-pocket limit is met, the insurer will pay 100% of all medically necessary charges up to the lifetime maximum benefit level.

(4) remains the same.

AUTH: 33-1-313 and 33-22-1822, MCA
IMP: 33-22-1802 and 33-22-1812, MCA

NEW RULE VII (6.6.5024) HMO COST SHARING SCHEDULE AND EXCEPTION TO STANDARD PLAN PROVISIONS (1) remains the same.

(2) Standard plans offered by HMOs are exempt from the deductible charges, and coinsurance provisions of 6.6.5020, but must comply with the maximum annual out-of-pocket and lifetime maximum requirements of ARM 6.6.5020. HMO plans must include the following cost sharing schedule:

INPATIENT HOSPITAL SERVICES

Semi-Private Room and Board Charges:

Copayment Per Admission	$500
Other Medically Necessary Hospital Charges	No copayment
OUTPATIENT HOSPITAL SERVICES	
Outpatient Therapy	$15 copayment
Other Non-emergency	No copayment
HOSPITAL EMERGENCY ROOM	
If admitted to the hospital	No copayment for emergency room; inpatient copayment applies
If not admitted to the hospital	$50 copayment
OBSTETRICAL CARE	
Professional services only	$150 copayment per delivery
PHYSICIANS AND OTHER MEDICAL PROFESSIONALS	
Hospital inpatient visits	No copayment
Physician office or home visits	$10 copayment
After hours visits (in- or outpatient)	$10 copayment
Referred Services	$15 copayment
MEDICAL NUTRITION SERVICES	$15 copayment
HOME HEALTH CARE	No copayment
CHIROPRACTIC SERVICES	
Copayment	$10 per visit
Maximum covered charge	$25 per visit
Covered treatments per year	24 visits, plus an additional 11 visits with the HMO's approval
MENTAL HEALTH SERVICES	
Inpatient	
Copayment	$200 per day
Days of covered treatment	30 days per year combined with substance abuse treatment
Outpatient	
Copayment	$25 per visit

Maximum covered charge	$1,000 combined with substance abuse treatment
SUBSTANCE ABUSE TREATMENT	
Inpatient	
Copayment	$150 per day
Maximum covered charge	$4,000 per 24-month period
Lifetime maximum	$8,000
Outpatient	
Copayment	$25 per visit
Maximum covered charge	$1,000 combined with mental health service
PRESCRIPTION DRUGS	
Generic	$5 copayment
Brand name at patient's request	Copayment = brand name price minus the generic price
DIAGNOSTIC X-RAY AND LABORATORY	No copayment
AMBULANCE	
Ground ambulance	$50 copayment
Air ambulance	$250 copayment
DURABLE MEDICAL EQUIPMENT	20% ~~co~~~~insurance~~payment
RADIATION THERAPY AND CHEMOTHERAPY	20% ~~co~~~~insurance~~payment
HOSPICE SERVICE	~~$150~~ No copayment ~~per week~~
OFFICE VISITS	
Adult preventative care visits	$10 copayment
Children preventative care visits	$10 copayment
Reproductive health care visits	$10 copayment

AUTH: 33-1-313 and 33-22-1822, MCA
IMP: 33-22-1802 and 33-22-1812, MCA

NEW RULE VIII (6.6.5032) CRITERIA OF POLICIES OFFERED UNDER BASIC PLAN (1) Any health benefit plan offered to a small employer group that has a benefit value, as calculated in 6.6.5036, of less than the benefit value of the insurer's standard plan will qualify as a basic health benefit plan contemplated by 33-22-1812, MCA.

(2) Any HMO plan offered to a small employer carrier that offers fewer benefits than the insurer's standard HMO plan is subject to the commissioner's final determination, as contemplated by 33-22-1812, MCA.

(~~2~~3) All basic health benefit plans and basic HMO plans contemplated by 33-22-1812, MCA, must include all benefits mandated by statute, including, but not limited to, maternity benefits contemplated by court interpretations of statutes.

AUTH: 33-1-313 and 33-22-1822, MCA
IMP: 33-22-1802 and 33-22-1812, MCA

NEW RULE IX (6.6.5036) CALCULATION OF BENEFIT VALUES (1) through (1)(e) remain the same.

(2) In instances wherein some benefits under the proposed basic health care plan are of significantly higher value than those offered under the small ~~group~~employer carrier's standard health benefit plan, and increase the overall value of the basic plan above the overall value of the carrier's standard plan, the carrier must file complete documentation justifying the plan's proposed classification with the commissioner.

AUTH: 33-1-313 and 33-22-1822, MCA
IMP: 33-22-1802, 33-22-1809, and 33-22-1812, MCA

NEW RULE X (6.6.5040) COST CONTAINMENT FEATURES OF BASIC AND STANDARD PLANS (1) through (1)(a) remain the same.

(b) A program for management of acute~~,~~ and long-term care to determine appropriate cost-effective treatment, which must include an agreement to the treatment plan by the patient, family or authorized representative, the treating health care provider, and the insurer;

(c) A program for primary care ~~physicians~~providers and referrals, such as a health maintenance organization style of delivery of care, in which each patient has a primary care provider who makes all referrals to other providers;

(d) A program for review of health care services for patients to determine the medical necessity or appropriateness of service, consistent with 33-32-102(4), MCA~~; or~~;

(e) A preferred provider agreement between health care providers and the insurer, which may limit the amount a provider may charge an insured for service, as well as the amount a provider may be reimbursed~~;~~; or

(f) The selective contracting with hospitals, physicians, and other health care providers as defined in 33-22-1701 through 33-22-1707, MCA.

AUTH: 33-1-313 and 33-22-1822, MCA
IMP: 33-22-1802 and 33-22-1812, MCA

NEW RULE XI (6.6.5044) FILING AND APPROVAL OF BASIC AND STANDARD PLANS (1) All small employer carriers shall file all of the standard health benefit plans that they market or

intend to market in this state ~~with~~ which have not been previously filed with the commissioner ~~for prior approval~~. Each such plan must be filed with the commissioner for prior approval as a standard health benefit plan. Each filing shall include a statement that the policy has not previously been filed and approved in this state.

(2) All small employer carriers which already market health benefit plans previously filed with the commissioner which qualify as standard plans according to the requirements of ARM 6.6.5008 through 6.6.5024 shall file ~~all of the basic health benefit each plans that they intend to market in this state~~ with the commissioner for prior approval as a standard health benefit plan. Each filing shall include a statement that the policy has previously been filed and approved in this state, and shall provide the date of approval.

(3) The commissioner shall review each filing described in (1) and (2) and grant either tentative approval, final approval, or disapproval as a standard plan to each filing within thirty days of receipt of the filing. If the commissioner grants tentative approval to the plan as a standard plan, the small employer carrier may market the plan as a standard plan, subject to (9), pending final approval or disapproval. After 30 days but no later than 120 days, the commissioner shall review each filing which had been granted tentative approval for a final decision regarding approval or disapproval of the plan as a standard health benefit plan. If a plan is disapproved as a standard health benefit plan, the commissioner shall notify the small employer carrier, in writing, of the reasons for the disapproval.

(4) All small employer carriers shall file all of the basic health benefit plans that they market or intend to market in this state which have not been previously filed with the commissioner. Each such plan must be filed with the commissioner for prior approval as a basic health benefit plan. Each filing shall include a demonstration of, and the result of, the benefit value calculation for that plan in compliance with ARM 6.6.5036. Each filing shall include a statement that the policy has not previously been filed and approved in this state.

(5) All small employer carriers which already market health benefit plans previously filed with the commissioner which qualify as basic plans according to ARM 6.6.5032 shall file each plan with the commissioner as a health benefit plan which meets the requirements of a basic health benefit plan according to the test in ARM 6.6.5036. Each filing shall include a demonstration of, and the result of, the benefit value calculation for that plan in compliance with ARM 6.6.5036. Each filing shall include a statement that the policy has previously been filed and approved in this state and shall provide the date of approval. The small employer carriers shall further state for each of these plans that either:

(a) The plan is being filed as a basic plan; or

(2) Any HMO plan offered to a small employer carrier that offers fewer benefits than the insurer's standard HMO plan is subject to the commissioner's final determination, as contemplated by 33-22-1812, MCA.

(~~2~~3) All basic health benefit plans and basic HMO plans contemplated by 33-22-1812, MCA, must include all benefits mandated by statute, including, but not limited to, maternity benefits contemplated by court interpretations of statutes.

AUTH: 33-1-313 and 33-22-1822, MCA
IMP: 33-22-1802 and 33-22-1812, MCA

NEW RULE IX (6.6.5036) CALCULATION OF BENEFIT VALUES (1) through (1)(e) remain the same.

(2) In instances wherein some benefits under the proposed basic health care plan are of significantly higher value than those offered under the small ~~group~~employer carrier's standard health benefit plan, and increase the overall value of the basic plan above the overall value of the carrier's standard plan, the carrier must file complete documentation justifying the plan's proposed classification with the commissioner.

AUTH: 33-1-313 and 33-22-1822, MCA
IMP: 33-22-1802, 33-22-1809, and 33-22-1812, MCA

NEW RULE X (6.6.5040) COST CONTAINMENT FEATURES OF BASIC AND STANDARD PLANS (1) through (1)(a) remain the same.

(b) A program for management of acute~~,~~ and long-term care to determine appropriate cost-effective treatment, which must include an agreement to the treatment plan by the patient, family or authorized representative, the treating health care provider, and the insurer;

(c) A program for primary care ~~physicians~~providers and referrals, such as a health maintenance organization style of delivery of care, in which each patient has a primary care provider who makes all referrals to other providers;

(d) A program for review of health care services for patients to determine the medical necessity or appropriateness of service, consistent with 33-32-102(4), MCA~~, or~~;

(e) A preferred provider agreement between health care providers and the insurer, which may limit the amount a provider may charge an insured for service, as well as the amount a provider may be reimbursed~~,~~; or

(f) The selective contracting with hospitals, physicians, and other health care providers as defined in 33-22-1701 through 33-22-1707, MCA.

AUTH: 33-1-313 and 33-22-1822, MCA
IMP: 33-22-1802 and 33-22-1812, MCA

NEW RULE XI (6.6.5044) FILING AND APPROVAL OF BASIC AND STANDARD PLANS (1) All small employer carriers shall file all of the standard health benefit plans that they market or

intend to market in this state ~~with~~ which have not been previously filed with the commissioner ~~for prior approval~~. Each such plan must be filed with the commissioner for prior approval as a standard health benefit plan. Each filing shall include a statement that the policy has not previously been filed and approved in this state.

(2) All small employer carriers which already market health benefit plans previously filed with the commissioner which qualify as standard plans according to the requirements of ARM 6.6.5008 through 6.6.5024 shall file ~~all of the basic health benefit each~~ plans ~~that they intend to market in this state~~ with the commissioner for prior approval as a standard health benefit plan. Each filing shall include a statement that the policy has previously been filed and approved in this state, and shall provide the date of approval.

(3) The commissioner shall review each filing described in (1) and (2) and grant either tentative approval, final approval, or disapproval as a standard plan to each filing within thirty days of receipt of the filing. If the commissioner grants tentative approval to the plan as a standard plan, the small employer carrier may market the plan as a standard plan, subject to (9), pending final approval or disapproval. After 30 days but no later than 120 days, the commissioner shall review each filing which had been granted tentative approval for a final decision regarding approval or disapproval of the plan as a standard health benefit plan. If a plan is disapproved as a standard health benefit plan, the commissioner shall notify the small employer carrier, in writing, of the reasons for the disapproval.

(4) All small employer carriers shall file all of the basic health benefit plans that they market or intend to market in this state which have not been previously filed with the commissioner. Each such plan must be filed with the commissioner for prior approval as a basic health benefit plan. Each filing shall include a demonstration of, and the result of, the benefit value calculation for that plan in compliance with ARM 6.6.5036. Each filing shall include a statement that the policy has not previously been filed and approved in this state.

(5) All small employer carriers which already market health benefit plans previously filed with the commissioner which qualify as basic plans according to ARM 6.6.5032 shall file each plan with the commissioner as a health benefit plan which meets the requirements of a basic health benefit plan according to the test in ARM 6.6.5036. Each filing shall include a demonstration of, and the result of, the benefit value calculation for that plan in compliance with ARM 6.6.5036. Each filing shall include a statement that the policy has previously been filed and approved in this state and shall provide the date of approval. The small employer carriers shall further state for each of these plans that either:

(a) The plan is being filed as a basic plan; or

(b) The plan is being filed as a health benefit plan which is neither a standard nor a basic plan. The filing must include complete documentation which supports this classification.

(6) All health benefit plans which are filed as basic plans as described in (4) and (5)(a) shall be reviewed by the commissioner and granted either tentative approval, final approval, or disapproval as a basic plan within thirty days of receipt of the filing. If the commissioner tentatively approves a plan as a basic plan, the small employer carrier may market the plan as such, subject to (9), pending final approval or disapproval. After 30 days but no later than 120 days, the commissioner shall review each filing which had been granted tentative approval for a final decision regarding approval or disapproval of the plan as a basic health benefit plan. If a plan is disapproved as a basic health benefit plan, the commissioner shall notify the small employer carrier, in writing, of the reasons for the disapproval.

(7) All health benefit plans which are filed as plans which qualify as basic plans according to the test in ARM 6.6.5036, but which the small employer carriers state in compliance with (5)(b) do not qualify as basic plans, shall be reviewed by the commissioner and granted tentative status either as a basic health benefit plan, a standard health benefit plan, or a health benefit plan which is neither standard nor basic, within 30 days of receipt of the filing. The small employer carrier may then market the plan as a basic plan, a standard plan, or neither a standard nor a basic plan, according to the status granted by the commissioner and subject to (9), pending a final decision by the commissioner. After 30 days but no later than 120 days the commissioner shall review each filing which had been granted tentative status for a final decision regarding approval of the plan as a basic health benefit plan, a standard health benefit plan, or a health benefit plan which is neither standard nor basic. If such plan is approved as a basic or a standard health benefit plan, the commissioner shall notify the small employer carrier, in writing, of the reasons for its classification.

(8) All small employer carriers shall refile all of the health benefit plans that they market or intend to market in this state which have been previously filed with the commissioner and which exceed the value of the standard plan according to the benefit value calculation. Each filing shall include a demonstration of, and the result of, the benefit value calculation for that plan in compliance with ARM 6.6.5036. Each filing shall include a statement that the policy has been previously filed in this state and shall inform the commissioner as to whether the plan was approved, disapproved, or filed for informational purposes only. The commissioner shall review each filing and, if the benefit value calculation verifies that the plan is neither standard nor basic, grant approval to the filing within thirty days of receipt of the filing. If the benefit value calculation shows that the plan is actually a standard or a basic plan, the

commissioner shall so notify the small employer carrier, in writing. The small employer carrier must then refile the plan as a standard or a basic health benefit plan, as classified by the commissioner.

(39) No small employer carrier may market any health benefit plans in this state, unless and until one of its basic health benefit plans and one of its standard health benefit plans haeve been approved by the commissioner.

(10) All small employer carriers which intend to market one or more HMO plans shall file all of the HMO plans that they intend to market in this state which have not been previously filed with the commissioner. Each such plan must be filed with the commissioner as either a standard HMO plan, a basic HMO plan, or an HMO plan that qualifies as neither a standard nor a basic HMO plan, according to ARM 6.6.5028. Each filing shall include complete documentation which justifies the small employer carrier's classification of the HMO plan. Each filing shall include a statement that the policy has not previously been filed and approved in this state.

(11) All small employer carriers which already market HMO plans previously filed with the commissioner shall again file each plan with the commissioner for approval as either a standard HMO plan, a basic HMO plan, or an HMO plan that qualifies as neither a standard nor a basic HMO plan, according to ARM 6.6.5032. Each filing shall include complete documentation which justifies the small employer carrier's classification of the HMO plan as a standard HMO plan, a basic HMO plan, or neither. Each filing shall include a statement that the policy has previously been filed and approved in this state, and shall provide the date of approval.

(12) The commissioner shall review each filing described in (10) and (11) and grant either tentative approval, final approval, or disapproval to each filing within thirty days of receipt of the filing. If the commissioner tentatively approves the small employer's designation of the plan, the small employer carrier may market the plan on that basis pending final approval or disapproval, subject to (14). After 30 days but no later than 120 days, the commissioner shall review each filing which had been granted a tentative approval and grant a final decision regarding approval or disapproval of the plan as a standard, basic, or neither standard nor basic HMO plan.

(13) If the commissioner's determination as to whether an HMO plan is standard, basic, or neither standard nor basic is different from the small employer carrier's determination in (10) or (11), the commissioner shall notify the small employer carrier, in writing, of the reasons for giving it a different classification. The small employer carrier shall immediately comply with the requirements of the HMO plan as classified by the commissioner.

(14) No small employer carrier may market any HMO plans in this state, unless and until one of its basic HMO plans and

one of its standard HMO plans has been approved by the commissioner.

AUTH: 33-1-313, 33-1-501 and 33-22-1822, MCA
IMP: 33-22-1802, 33-22-1811, and 33-22-1812, MCA

NEW RULE XII (6.6.5050) STATUS OF CARRIERS AS SMALL EMPLOYER CARRIERS This rule remains the same.

AUTH: 33-1-313 and 33-22-1822, MCA
IMP: 33-22-1802, 33-22-1812, and 33-22-1814, MCA

NEW RULE XIII (6.6.5054) APPLICATION TO REENTER STATE This rule remains the same.

AUTH: 33-1-313 and 33-22-1822, MCA
IMP: 33-22-1802, 33-22-1810, and 33-22-1812, MCA

NEW RULE XIV (6.6.5058) REQUIREMENT TO INSURE ENTIRE GROUPS (1) remains the same.

(2) Small employer carriers may offer the employees of a small employer the option of choosing among ~~one or more health benefit plans, provided that each employee may choose any of the offered plans~~any health plans which have been chosen by the employer. Except as provided in 33-22-1811(3), MCA, with respect to exclusions for pre-existing conditions, the choice among benefit plans may not be limited, restricted, or conditioned based upon the risk characteristics of the employees or their dependents.

(3) and (4) remain the same.

(a) The excluded individuals have coverage under health benefit plans or other health benefit arrangement that provide benefits equal to or greater than the benefits provided under the health benefit plan offered by the employer as determined by the eligible employee or dependent;

(4)(b) remains the same.

(c) The premium contribution to be paid by the eligible employee would have exceeded 7.5% of the adjusted gross income of the eligible employee and the employee decides not to be covered. The decision not to be covered for this reason is exclusively that of the employee; or

~~(d) An excluded individual states in a signed waiver that the individual has had coverage under a health benefit plan or other health benefit arrangement within the previous 6 months and expects to have coverage within the succeeding 6 months under a health benefit plan or other health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan offered by the employer; or~~

(ed) An employee shows that, in changing policies, the 12-month waiting period in pre-existing conditions would be unduly burdensome to the employee. Whether the waiting period imposes such a burden is a decision that only the employee may

make. Employers shall refrain from influencing their employees' decisions.

(5) through (7)(b) remain the same.

(8) New entrants to a small employer group must be offered an opportunity to enroll in the health benefit plan currently held by such group. Any new entrant that does not exercise the opportunity to enroll in the health benefit plan within the period provided by the small employer carrier may be treated as a late enrollee by the carrier, provided that the time within which to enroll in the health benefit plan extends at least 30 days after the date the new entrant is notified of his or her opportunity to enroll. If a small employer carrier has offered more than one health benefit plan to a small employer group pursuant to (2), the new entrant must be offered the same choice of health benefit plans as the other members of the group.

(8)(a) remains the same.

(b) Small employer carriers may assess a risk load to the new entrants' premium rate ~~associated with new entrants~~, consistent with the requirements of 33-22-1809, MCA. The risk loads must be the same risk load charged to the small employer group immediately prior to acceptance of the new entrant into the group.

(9) through (9)(b)(iv) remain the same.

AUTH: 33-1-313 and 33-22-1822, MCA
IMP: 33-22-1802, 33-22-1811, and 33-22-1812, MCA

NEW RULE XV (6.6.5062) RESTORATION OF COVERAGE

(1) through (3)(d) remain the same.

(e) The premium rate for the health benefit plan must be no more than the premium rate charged to the small employer on the date the health benefit plan was terminated or nonrenewed; provided that, if the number or case characteristics of the eligible employees, or their dependents, of the small employer has changed between the date the health benefit plan was terminated or nonrenewed and the date that it is restored, the carrier may adjust the premium rates to reflect any changes in case characteristics of the small employer. If the carrier has increased premium rates for other similar groups with similar coverage to reflect general increases in health care costs and utilization, the premium rate may further be adjusted to reflect the lowest such increase given to a similar group. The premium rate for the health benefit plan may not be increased to reflect any changes in risk characteristics of the small employer group until one year after the date ~~of~~the health benefit plan is restored. Any such increase must be subject to the provisions of 33-22-1809, MCA.

(4) remains the same.

AUTH: 33-1-313 and 33-22-1822, MCA
IMP: 33-22-1802, 33-22-1809, 33-22-1812, 33-22-1814, and 33-22-1814, MCA

NEW RULE XVI (6.6.5066) QUALIFYING PREVIOUS AND QUALIFYING EXISTING COVERAGES (1) For the purposes of 33-22-1811(3)(b), MCA, an individual must be considered to have qualifying previous coverage with respect to a particular service if the previous policy, certificate, or other benefit arrangement covering such individual met the definition of qualifying previous coverage contained in 33-22-1803(21), MCA, if such previous coverage retained essentially the same benefits or provided increased benefits and provided benefits with respect to the service.

(2) and (3) remain the same.

AUTH: 33-1-313 and 33-22-1822, MCA
IMP: 33-22-1802, 33-22-1810, 33-22-1811, and 33-22-1812, MCA

NEW RULE XVII (6.6.5070) CONSIDERATION OF TRADE, OCCUPATION, OR INDUSTRY IN DECIDING WHETHER TO OFFER COVERAGE This rule remains the same.

AUTH: 33-1-313 and 33-22-1822, MCA
IMP: 33-22-1802, 33-22-1809, 33-22-1811, and 33-22-1812, MCA

NEW RULE XVIII (6.6.5074) RESTRICTIVE RIDERS
This rule remains the same.

AUTH: 33-1-313 and 33-22-1822, MCA
IMP: 33-22-1802, 33-22-1811, and 33-22-1812, MCA

NEW RULE XIX (6.6.5078) FAIR MARKETING STANDARDS
(1) through (3)(b) remain the same.

(4) Small employer carriers shall provide price quotes to small employers, either directly or through authorized producers, within ~~10~~5 working days of receiving a request for a quote. Price quotes must include such information as is necessary to understand the quotes. If a small employer carrier needs additional information to provide price quotes, it must request such information from the employer within 5 working days of receiving the request for the price quotes.

(5) through (9)(f) remain the same.

AUTH: 33-1-313 and 33-22-1822, MCA
IMP: 33-22-1802, 33-22-1812, and 33-22-1813, MCA

NEW RULE XX (6.6.5082) ESTABLISHMENT OF CLASSES OF BUSINESS This rule remains the same.

AUTH: 33-1-313 and 33-22-1822
IMP: 33-22-1802, 33-22-1808, and 33-22-1812, MCA

NEW RULE XXI (6.6.5086) TRANSITION FOR ASSUMPTIONS OF BUSINESS FROM ANOTHER CARRIER This rule remains the same.

AUTH: 33-1-313 and 33-22-1822, MCA
IMP: 33-22-1802, 33-22-1808, 33-22-1809, and 33-22-1812, MCA

NEW RULE XXII (6.6.5090) RATE MANUAL AND RATE RESTRICTION GUIDELINES This rule remains the same.

NEW RULE XXIII (6.6.5094) CALCULATIONS RELATING TO PREMIUM RATE RESTRICTIONS (1) through (2)(a) remain the same.

(b) For each small employer within a given class of business, the small ~~group~~employer carrier shall calculate the ratio of the premium rate charged the small employer during the rating period to the index rate for the census, the plan of business, and the class of business of that small employer for which an index rate was calculated in under (a).

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

(a) Using the small ~~group~~employer carrier's rate manual, the small ~~group~~employer carrier shall calculate the new base premium rate for the new rating period, the actual census, and the plan of benefits for the small employer at the beginning of the new rating period.

(b) Using the rate manual, the small ~~group~~employer carrier shall calculate the base premium rate for the prior rating period, the actual census, and the plan of benefits for the small employer at the beginning of the prior rating period.

(3)(c) through (4) remain the same.

(a) A small ~~group~~employer carrier which charges different premium rates for different industries shall include in each class's rate manual a schedule of factors which reflect the rate differential by industry.

(b) Within each class, the small ~~group~~employer carrier shall calculate the average of all factors which are used, or which could be used, to vary rates by industry within that class.

(4)(c) remains the same.

AUTH: 33-1-313 and 33-22-1822, MCA
IMP: 33-22-1802, 33-22-1809, and 33-22-1812, MCA

NEW RULE XXIV (6.6.5098) ANNUAL FILING OF ACTUARIAL CERTIFICATION (1) On or before March 15 of each year after the effective date of these rules, each small ~~group~~employer carrier shall file with the commissioner annually an actuarial certification which complies with 33-22-1809(5)(b), MCA. The certification must include the following effect:

(1)(a) through (1)(d) remain the same.

(e) A written description of the derivation of the representative actuarially equivalent plan of benefits developed pursuant to ARM 6.6.5090 and a statement that the representative ~~census and~~ actuarially equivalent plan of benefits has either changed or not changed during the period between annual filings.

(f) A statement that the tests developed in ARM 6.6.5090 have been performed on the representative census and on the representative and actuarially equivalent plan of benefits. If ~~such definitions~~ the representative census, the representative and actuarially equivalent plan of benefits, or

both the representative census and the representative and actuarially equivalent plan of benefits have changed, the ~~definitions of the representative census and the actuarially equivalent plan of benefits have changed. The statement must state that the tests have been performed on both the previous and the new definitions~~statement must confirm that the tests have been performed on both the previous and the new definitions of the representative census and of the representative and actuarially equivalent plan of benefits.

(g) A written description of the results of each of the tests referred to in (e) and an explanation addressing the reason for changing either the definition of the representative census, the representative and actuarially equivalent plan of benefits, or ~~the representative actuarially equivalent plan of benefits~~both.

(2) On or before March 15 of each year after the effective date of these rules, every small ~~group~~employer carrier shall file with the commissioner all rates intended for use for its small employer health benefit plans within this state. Each filing must include a schedule of rates for each plan of benefits within each class of business; and each schedule of rates must contain a reference to the plan of benefits and the class of business for which the rates are charged.

AUTH: 33-1-313 and 33-22-1822, MCA
IMP: 33-22-1802, 33-22-1808, 33-22-1809, and 33-22-1812, MCA

NEW RULE XXV (6.6.5028) CONTRACT LANGUAGE

(1) Development of contract language for policies of insurance offered under the standard health benefit plan contemplated by 33-22-1812, MCA, is the responsibility of the small employer carrier. ARM 6.6.5008, 6.6.5012, 6.6.5016, 6.6.5020, and 6.6.5024 do not define actual policy of insurance contract language.
AUTH: 33-1-313 and 33-22-1822, MCA
IMP: 33-22-1802 and 33-22-1812, MCA

4. A public hearing on the proposed rules was held. 52 interested persons attended the hearing. At the hearing on the proposed rules, there were representatives of the health insurance industry including insurers, insurance organizations, nonprofit health insurers, health maintenance organizations, health care providers and users of health insurance, other public officials and agencies, employers and employees, trade associations, and concerned persons particularly those concerned with the reproductive provisions.

The agency has fully considered all written and oral submissions respecting the proposed rules and responds as follows:

Rule I. DEFINITIONS

COMMENTS:
A question as to why a definition for "adjusted gross income" has been included in the rules.

RESPONSE:
The term "adjusted gross income" is used in Rule XIV (4)(c). A definition of the term helps clarify the calculation of the term.

COMMENT:
A suggestion was made that using wages paid by an employer would be more easily verified regarding the definition of adjusted gross income.

RESPONSE:
Adjusted gross income was defined because of the reference in 33-22-1804(3), MCA, to Internal Revenue Code sections 106, 125, 162. The definition for adjusted gross income seems more meaningful than an IRS code number.

COMMENT:
Several comments were received on the definition of association member and why it was included in the definitions.

RESPONSE: The term "associate member of an employee organization" is used in RULE XXII (14)(b) which is why a definition is provided. The other concerns raised are addressed in the change to rule II(5).

COMMENT:
A question was asked as to why the undefined term "beneficiary" is used, instead of "eligible dependent." The same party asks why "former employee" and "related plans" are included in the definition.

RESPONSE: The Commissioner agrees that the defined term "eligible dependent" should be used and makes the appropriate changes in the final rules.

COMMENT:
The confusing use of the word "client" in the definition was pointed out with the recommendation that more specific language be adopted.

RESPONSE:
The Commissioner agrees with the recommendation for more specific language. The adopted rule refers to "eligible employees and eligible dependents" instead of "clients."

COMMENT:
It was noted that the definition of "coinsurance" differs from its use throughout the rules. It was recommended that

the definition of coinsurance and copayment be combined into one definition.

RESPONSE:
The Commissioner finds that the term coinsurance is most commonly used to refer to the portion of a payment made by the insurer. The adopted rules include changes to ensure consistent use of the term coinsurance.

COMMENT;
It was pointed out that "copayment" as used would include deductibles.

RESPONSE:
The Commissioner agrees that term copayment needs clarification and adopts the following definition, " Copayment" means a fixed dollar amount or percentage of eligible charges which the insured must pay for each service after a deductible, if any, is met." The intent of this definition change is to clarify that copayments are separate from payments made toward the deductible, if any. The adopted definition differentiates copayments as the insured's responsibility from coinsurance, the insurer's responsibility.

COMMENT:
The definition of "eligible dependent" was objected to because it expands the definition of "dependent" in code. It was recommended that the definition in the statute should remain.

RESPONSE:
The Commissioner agrees that as proposed the definition expands the applicability of the term some. The definition is revised to allow for only provisions that clarify the statute.
[ADOPT DEF: "Eligible dependent" means any dependent defined in 33-22-103, MCA, including a common law spouse, or any child who qualifies as a dependent under the Internal Revenue Code.]

COMMENT:
Problems were noted with the definition of "lifetime maximum benefit" and "maximum annual out-of-pocket" as they relate to the definitions of copayment or coinsurance.

RESPONSE:
The Commissioner agrees and has made changes that are consistent with the comments and with the changes made in response to comments on copayment.

COMMENT:
A definition was suggested for "Carrier Allowances."

RESPONSE:

The committee declined to include a definition of "Carrier Allowances" and the Commissioner agrees with the committee and declines to adopt a definition of "Carrier Allowances."

COMMENT:
A request was made that stated exclusions in Section 33-22-1803(14) be reiterated in the rules.

RESPONSE:
It is unnecessary and generally preferred that you don't repeat statute in the rules.

Rule II, APPLICABILITY, SCOPE, AND TRANSITION

COMMENT:
A request was made for clarification of indirect employer contributions and what standard will be applied to a carrier to prove that the carrier should have been aware of that contribution.

RESPONSE:
The Commissioner clarifies in the adopted rules what is meant as an indirect employer contribution as a contribution which benefits the employee monetarily. The Commissioner believes that establishing a standard to evaluate whether a carrier should have been aware of an indirect contribution is impossible. The Commissioner prefers to examine each situation on a case by case basis.

COMMENT:
A suggestion was made that carriers who are list billing be given the option to cease list billing. It was pointed out the retroactive effective date of January 1, 1994, would pose legal difficulties and variances in the definition concerning a small employer.

RESPONSE:
The Commissioner agrees that a third option to cease list billing is reasonable and that the proposed effective date is not reasonable. The suggested language by commenter is adopted.

COMMENT:
Definitions were requested for "indirect contribution" and "should have been aware."

RESPONSE:
The Commissioner has clarified the rules in response to the comment on indirect employer contributions and the same would apply to this comment.

COMMENT:

It is asserted that paragraph (5) makes all section 125 flex plans subject to small group reform which is not the intent of the act. They argue that people should be allowed to use before tax dollars to pay for their insurance premiums without being subject to the act.

RESPONSE:
The intent of the proposed rule is to say that all 125 flex plans offered through a small employer would be subject to the act. Flex plans offered through employers not qualifying a "small employers" would not be subject to the act. Characteristics of the employer, not the method of payment, determine compliance. Section 33-22-1804, MCA, of the act specifically includes plans marketed through a small employer that are part of section 125 of the Internal Revenue Code, i.e. flex plans.

COMMENT:
It is recommended that paragraph (8) be a subsection of (7). It was also objected to allowing renewal of small group policies, and the protections provided, when a group has become larger than 25 eligible employees.

RESPONSE:
The Commissioner agrees that proposed subsection (8) should be a subsection of (7) and renumbers the rules accordingly in the adopted version. In addition, subsections of (11) will be renumbered for similar reasons. This rule originates in the NAIC model. The Commissioner believes that it is an important rule to maintain continuity of coverage for groups. Groups that vary in size near the 3 to 25 eligible employee limits need protection from loss of coverage and waiting periods with new policies. The proposed language is adopted.

COMMENT:
A comment was made that 11(d) appears to export Montana law to other states and persons insured in those states and that this provision was not contained in the NAIC Model Regulations.

RESPONSE:
The provision is contained in the NAIC model regulations (119) on page 4, section (3)(F)(2). The Commissioner adopts the provision as it does not export Montana law, in his opinion.

COMMENT:
It was pointed out that the last sentence of paragraph (12) is not in the model rules.

RESPONSE:
The Commissioner has the ability to adopt rules that are not part of a model and does so in this instance.

COMMENT:
A suggestion was made that paragraph (2) should be deleted as it was not part of the model National Association of Insurance Commissioners (NAIC) law.

RESPONSE:
Section 33-22-1804 MCA applies to a health benefit plan marketed through a small employer that provides coverage to the employees of a small employer in this state if any of the listed conditions are met. This section of code would need to be repealed in order to delete Rule II(2).

COMMENT:
It was suggested that if paragraph (3) be retained that the commissioner should change the effective date from January 1, 1994 to August 1, 1994.

RESPONSE:
Section 33-22-1810 is effective January, 1, 1994, as passed by the Legislature.

COMMENT:
It was commented on that paragraph (12) states that a carrier not authorized to do business in Montana does not have to comply with the law because a covered employer moves to Montana. However, the insurer, upon becoming aware of the move, is to notify the employer of the option to purchase a small group plan. It was suggested eliminating this notice requirement.

RESPONSE:
If the risk resides in Montana, the insurer will have to make the appropriate contractual changes anyway. This asks insurers to notify the employer of his options.

COMMENT:
Paragraph (5) includes policies sold outside Montana which subsequently issue certificates of insurance to Montana employers and their employees and was concerned how this would apply to their group.

RESPONSE:
This does not include ERISA exempt groups and was modified to clarify such.

COMMENT:
A concern was raised that under paragraph (3) that individuals and employers who use list billing, payroll deductions, and pretax dollar deductions for insurance will have to comply with small group insurance laws.

RESPONSE:
The law applies to employer groups with 3 to 25 employees. 33-22-1804(3). The law requires inclusion of this

rule. The risk clarifies what is meant by the IRS code sections 106, 125, or 162.

COMMENT:
A criticism was that paragraph (4) requires that agents and companies have to determine who qualifies as a small employer since it includes as small employers if they have 3 to 25 employers who work 30 or more hours per week, and he/she contributes to the premium.

RESPONSE: Agents and companies have always been required to make determinations of eligibility for various products.

COMMENT:
A concern was raised that paragraph (5) would apply to trust agreements.

RESPONSE:
See the change to help clarify what is exempt.

COMMENT:
Paragraph (9) limits the application of the law as an employer's group may change to become a small employer group as defined. The criticism is that this rule conflicts with paragraphs (8)(9)&(10). The comment was that (8) and (9) indicated that a plan sold to an employer that is not a small employer as defined does not have to comply with the law while paragraph (10) requests that an insurer notify an employer who subsequently qualifies as small employer of his right to have a standard or basic plan and that there is a potential that employers will discriminate in hiring employees on the basis of their health.

RESPONSE:
The purpose of the law is to make guaranteed issue policies available to small employers, not to regulate employment practices.

COMMENT:
Colonial Life & Accident Ins. Co. was concerned about the rule in general as to the applicability to "individual health insurance policies" when there is payroll deduction or list billing of premium. They requested that paragraph (3) be amended to reference "individual health benefit plans" and not "individual health insurance policies" in order to be consistent with the act.

RESPONSE:
As long as a company continues to write only coverage for specified disease, accident only and disability income insurance, they will continue to be exempt under this rule and provision of the law.

Rule III. COVERED SERVICES OF POLICIES UNDER THE STANDARD PLAN

COMMENT:
It was requested that services through Certified Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) be specified as covered benefits in the standard plan.

RESPONSE:
The Commissioner has determined that most if not all services provided through these clinics and centers are well covered by the standard plan. The Montana Primary Care Association(MPCA) in its follow-up correspondence dated 4/29/94 notes that "most, if not all, of the service 'providers'... are covered in your proposed rules". MPCA advocates that "in order to protect this fragile health care structure [of RHCs and FQHCs], special recognition is required in any health reform measure to ensure that private insurers adequately cover services provided to these challenging populations." While the Commissioner recognizes the importance of these facilities, he believes that standard plan will more than adequately cover services of the clinics and centers. No other specific kinds of facilities are given special recognition in the standard plan. At this point the Commissioner does not have enough information to justify giving "special recognition" in the standard plan to these facilities and, therefore, adopts the proposed rules without this recommendation.

COMMENT:
It was requested that a provision to clarify that these rules require certain insurance contract benefits, but do not propose actual contract language.

RESPONSE:
The Commissioner agrees that the provision suggested helps clarify the purpose of the rules. The suggested provision is adopted with slight modification so that it applies more broadly.

COMMENT:
A revised cost estimate of the Standard Plan was requested.

RESPONSE: This request is not relevant to the rules.

COMMENT:
A question was raised as to how many standard plans must a small group carrier offer.

RESPONSE:
Proposed Rule XII (3) requires that small employer carriers offer at least one standard plan approved by the

Commissioner. The standard plan must be available guaranteed issue to all small employer groups.

COMMENT:
It was requested that "coverage to medically necessary services" needs to apply to proposed Rule IV and Rule V, as it does to Proposed Rule III. It was asked that the reference in proposed Rule III to "coverage of medically necessary services" be stated only once in the introductory provision and deleted in internal references.

RESPONSE:
Proposed Rule IV addresses preventive health care and health maintenance services. Requiring coverage of only medically necessary services is awkward with relation to services like immunizations, mammograms, family planning, and physical examinations. Rule V addresses optional exclusions. Some of these exclusions are medically necessary services, other are not. It is unclear how to apply the term in an introduction to this rule. As for extra internal references to coverage of medically necessary services in Rule III, the Commissioner ["agrees to delete them" OR "feels that the repetition helps to emphasize the point."]

COMMENT:
In paragraph (1)(a) a deletion was requested of the phrase "...but not limited to,..." because it is redundant with the ending phrase "...and all other related hospital services."

RESPONSE:
This suggestion is adopted.

COMMENT:
In paragraph (1)(c) it was asked if what is meant by "coinsurance limit" at the end of the section is intended to be "maximum annual out-of-pocket."

RESPONSE:
The Commissioner agrees that the term maximum annual out-of-pocket should be used and adopts it in the final rules.

COMMENT:
It was requested that under paragraph (1)(d) that licensed physician assistants be included as a covered provider for obstetrical care.

RESPONSE:
The Commissioner agrees that because obstetrical care is within the scope of practice of physician assistants, these practitioners should be included as covered providers. The Commissioner prefers to broaden coverage to any provider

licensed to give obstetrical care. The rule provision is amended to reflect these changes.

COMMENT:
A request was made that the phrase "medically necessary" be deleted as redundant of the phrase in the introductory provision of the definitions.

RESPONSE:
The Commissioner agrees that the introductory provision of Rule III applies requirements for "coverage of medically necessary services" to the entire rule. Repetition of this requirement internally is for emphasis and is retained in the adopted language.

COMMENT:
Under paragraph (1)(e) Blue Cross and Blue Shield of Montana argues that they are exempt from this "Freedom of Choice" provision.

RESPONSE:
The Commissioner agrees with the position of Blue Cross and Blue Shield.

COMMENT:
It was recommended that paragraph (1)(e)(i) be reworded to say, "Speech, occupational, and physical therapy must be covered within policy limits." It was suggested that the reference to nutritionists be deleted here because it is addressed in the next provision.

RESPONSE:
The purpose of this subsection of the "freedom of choice" provision (1)(e) is to list additional services of certain practitioners to be covered if referred by other practitioners. Services of nutritionists need this referral for coverage. As for the request to allow coverage within policy limits, this would result in a lack of uniformity of standard plans as insurers chose different limits. Cost containment features of the plan should help to eliminate unnecessary expenses.

COMMENT:
Under paragraph (f) a request was made for the deletion of the term medically necessary as repetitive. Suggested language was made to clarify the inclusion of nutritionists because of their suggestion to delete references to nutritionist in (1)(e)(i). Also a question was asked if the nutrition services are subject to the deductibles and copayments, and requested that these services be so.

RESPONSE:
As with the previous requests, the term medically necessary is retained for emphasis of its importance. The

suggested language is not adopted because the suggestion for paragraph (e)(i) was not adopted. Nutritional services are subject to the deductible, coinsurance and copayment requirements as is everything in this rule unless specifically exempted. The introductory provision in paragraph (1) states this.

COMMENT:

Under paragraph (j)(i) it was noted that the 30 day mandated limit for inpatient substance abuse treatment has been cut. They suggest referring to the statutory requirement and adding the ASAM requirement.

RESPONSE:

The Commissioner agrees that it would be simpler to refer to the statutory requirement. The 30 day inpatient limit was not purposely cut from the proposed rules, but omitted by mistake. In addition, (i) is modified to refer to the statute.

COMMENT:

Under paragraph (1)(k) a recommendation was made that formularies and/or generic brand prescription drugs be specifically allowed as a cost containment measure.

RESPONSE:

The Commissioner agrees with this recommendation and adopts language to include formularies and generic brand prescription drugs.

COMMENT:

It was requested that the use of the phrase "only drugs available by a prescription" because nonprescription drugs can be prescribed and whether this includes birth control pills.

RESPONSE:

The Commissioner adopts the clarified term "only drugs available by a prescription." He adds language to specify that contraceptives are not covered, if prescribed solely for contraceptive purposes. Contraceptives are covered if prescribed for the treatment of medical problems.

COMMENT:

Under paragraph (1)(q) it was pointed out that Blue Cross and Blue Shield does not define "usual, customary and reasonable" in their existing contracts. They refer to their comment about each insurer determining final contract language.

RESPONSE:

The Commissioner agrees that it is up to the insurer to determine what is "usual, customary, and reasonable" and whether to state it in the contract. The adopted language

deletes reference to the contract and make it clear that the insurer defines what is "usual, customary and reasonable."

COMMENT:
Under paragraph (1)(r) it was recommended adding appropriate Chapter 30 provisions so mandated benefits clearly apply to health service corporations. It was suggested that reference to any mandated coverage or offering previously addressed in the rules be deleted from this listing.

RESPONSES:
The Commissioner agrees with both suggestions and they are included in the adopted rules.

COMMENT:
A request is made for clarification under paragraph (1)(f) for coverage for nutrition counseling for stated disease conditions up to $240 per benefit period.

RESPONSE:
Nutrition counseling is reimbursable only if one of the stated conditions is present. The maximum amount payable by the insurer is $240 in a benefit period per insured member. Coverage for nutrition services deemed medically necessary for one or more of the following disease conditions . . . The maximum payable by a carrier is $240 per benefit period for a covered individual.

COMMENT:
A suggestion was made that paragraph (1)(g) which refers to usual and customary charges be made paragraph (2) and adding coordination of benefits.

RESPONSE:
The commissioner agrees with this suggestion and it is made in the rules as adopted.

COMMENT:
A criticism was made that with the described benefits of the standard plan that the plan will be more expensive than plans in the current market.

RESPONSE:
Section 33-22-1802(2) MCA is not intended to provide comprehensive solution to the problem of affordability.

Rule IV. - COVERED PREVENTIVE CARE

COMMENT:
Under paragraph (1) clarification was asked of the phrase "...must provide full coverage of all costs of the following...". Can a carrier apply reasonable allowances or usual, customary, and reasonable limitations.

RESPONSE:
The introductory provisions says that the insurer will pay 100% of the cost or charges for the preventive care services in this rule. The deductible and copayment requirements can not be applied to these services. The Commissioner agrees with addition of language to assure that coverage is for usual, customary, and reasonable charges as defined by the insurer.

COMMENT:
A request was made under paragraph (1)(a)(i) & (ii) that there not be a distinction between a health exam and a physical exam. Further how often is an individual entitled to a preventative exam, every one to five years or according to the age appropriate schedule. Also what "other providers" are allowed to provide this service.

RESPONSE:
The Commissioner agrees that having individual provisions for health and physical exams may led to an excessive number of preventive exams if conducted separately. In the adopted rule the services are combined into one provision so that health exams, the screen and counseling on health habits, and physical exams, medical evaluation of a person's health status, can be conducted at the same time. The age appropriate schedule is adopted for these exams. The Commissioner feels that any licensed provider can perform this service if it is within the scope of their practice as determined by their licensing board. Allowing coverage for other practitioners, such as physician assistants or nurse practitioners, provides greater access to services for especially rural policyholders, and is often less expensive than if conducted by a Physician.

COMMENT:
Under paragraph (1)(a)(iv) it was proposed that pap smear tests be covered annually as recommended by the American Cancer Society.

RESPONSE:
The proposed rule is based on recommendations from the American College of Physicians, the US Preventive Services Task Force, the Canadian Task Force on Periodic Health Examination, and the American Cancer Society as listed in a 1991 chart on "Preventive Care Guidelines for Asymptomatic, Low-Risk Adults". Based on these recommendations, the Commissioner adopts the proposed rule with a three year schedule for asymptomatic women.

COMMENT:
Under paragraph (1)(a)(vi) it was asked why a more limited list of providers can order this test. It was suggested that the broader referral of any provider if with the scope of their practice as determined by their licensing board be used and apply to all the tests and services in (a).

RESPONSE:
The Commissioner agrees with this recommendation and incorporates it into the final rules.

COMMENT:
A question was raised as to how the benefit in paragraph (a)(viii) and (ix) interact with Medicare's flu shot program and Medicare benefits.

RESPONSE:
The standard plan would serve as primary coverage and Medicare as secondary coverage for seniors who have both. Therefore, these services would be paid under the standard plan.

COMMENT:
Under paragraph (b) it was an overlap was pointed out in adult and children preventive care services and ask how the well child care mandate enacts with this care.

RESPONSE:
The Commissioner adopts provisions which eliminates the overlap and clarifies that the well child care mandate is the schedule for care from birth through age 2.

COMMENT:
An objection was voiced under paragraph (c) as to coverage of contraceptives and contraceptive planning.

RESPONSE:
The provision only covers charges related to contraceptive planning and not the contraceptives. The adopted version of paragraph (k) clarifies that contraceptives are not covered. The Commissioner adopts this provision to cover contraceptive planning.

COMMENT:
Under paragraph(1)(c)(ii) there were several objections to the provision for coverage of pregnancy related services, which includes coverage for abortion procedures. Clarification was requested on whether employers and employees will be forced to buy abortion coverage. Also there were several groups voicing their support for coverage of pregnancy related services.

RESPONSE:
Current Montana law is silent on the issue of abortion coverage in insurance, therefore the coverage is permissible in any plan. Neither does the act prohibit coverage in the standard plan. Purchase of a standard plan is completely voluntary for employers. Employees are not compelled to accept health care coverage under the standard plan if they have comparable or better coverage under another policy or meet other criteria in Rule XIV (4). Because the standard

plan is meant to include coverage standard in the market, as is the case with abortion coverage, and purchase of a standard plan is completely voluntary, the Commissioner adopts this rule provision as proposed.

COMMENT:

An objection was made to paragraph (1)(c)(iii) as including coverage for case management for high risk pregnancies on the grounds that it would promote abortions of high risk pregnancies and ration services. Support was also expressed in support of the provision as proposed.

RESPONSE:

The purpose of case management for high risk pregnancies is to provide women with assistance through a healthy pregnancy and avoid problems which will endanger the life and health of the mother and child. The Commissioner finds no basis to fear that this case management will promote or increase abortions of high risk pregnancies. The Commissioner adopts the proposed rule provision as is.

COMMENT:

Under paragraph (1)(d) it was wanted to know what is meant by "health care provider" in this section. It was suggested that this service be provided by physicians only.

RESPONSE:

The purpose of this benefit is to allow policyholders four visits a year to a health care provider without the burden of having met the deductible. The incentive is to encourage people to address health care problems in early stages before more critical and expensive care is needed. The suggestion that this benefit be provided by physicians only potentially make it more expensive by excluding providers like nurse practitioners, physician assistants. The Commissioner agrees that the provision needs clarification and adds language that the health care providers listed under Section 33-22-111 and 33-22-114 MCA can provide the service. This allows for coverage of variety of practitioners and is more cost effective than if restricted to only physicians.

COMMENT:

A request was made that credit be given for services already provided in a benefit period by a previous carrier

RESPONSE:

The Commissioner has no objection to the addition but that there be no requirement for carriers to check with other carriers on these items. Also, benefit periods may not be the same on all plans.

COMMENT:

A concern was raised under paragraph (1)(viii) which addresses coverage for those over 65. Since the majority of

groups represented will not be TEFRA eligible, should coverage be addressed to them when Medicare will be primary in most circumstances?

RESPONSE:
The committee discussed this issue and felt it of a high enough priority to be included and the Commissioner agrees with the conclusions of the committee.

COMMENT:
A request was made that dependent maternity care be addressed as a covered benefit. Many companies do this now, however, many do not write them into benefit outlines.

RESPONSE:
The rules are not designed to change or restrict coverage which is already a part of what is being offered.

Rule V. SERVICES THAT MAY BE EXCLUDED FROM COVERAGE UNDER THE STANDARD PLAN

COMMENT:
Under paragraph (1)(d) it is recommended that eyeglasses and hearing aids be covered for children up to age 18.

RESPONSE:
The Commissioner concludes that services will be offered as optional coverage.

COMMENT:
A complaint was raised under paragraph (1)(j) complain that the work-related exclusion does not conform to generally accepted exclusion language.

RESPONSE:
As with the rest of the contract language, final language used in exclusions is up to the insurer. The Commissioner agrees to include more details in the adopted language for this exemption.

COMMENT:
Does paragraph (1)(k) allow for subrogation?

RESPONSE:
As it is clear that if another carrier agrees to pay the claim, the small group carrier will be reimbursed reaffirms the right of subrogation, the Commission agrees that subrogation is permitted.

COMMENT:
An objection was raised as to the inclusion of dental coverage for oral tumors under paragraph (1)(o).

RESPONSE:
The Commissioner allows for dental coverage of oral tumors in the adopted rules. Oral tumors should be covered like any other tumors.

COMMENT:
Under paragraph (1)(o) it was recommended that dental coverage be provided for children up to the age of 18.

RESPONSE:
The Commissioner feels that such coverage should be provided as optional coverage.

COMMENT:
Paragraph (c) was criticized for the lack of "medical necessity" wording throughout the plan.

RESPONSE:
See adopted rule III(2)

Rule VI - DEDUCTIBLE CHARGES, COINSURANCE, MAXIMUM ALLOWABLE OUT-OF-POCKET CHARGES AND LIFETIME MAXIMUM BENEFIT

COMMENT:
Under paragraph (3) it was stated that it is not clear that the out-of-pocket expense applies annually to the lifetime maximum benefit level. Language changes were requested so that an insurer can review charges for medical appropriateness.

RESPONSE:
The Commissioner adopts language proposed to clarify the concerns raised.

COMMENT:
A suggestion was made that under paragraph (3) that covered should be added to explain charges.

RESPONSE:
The Commissioner Agrees.

COMMENT:
The rules were criticized because of the low level of deductible and copayment.

RESPONSE:
The plan is as designed by committee as required by the Legislature.

COMMENT:

Paragraph (3) limits the out-of-pocket maximum amount paid by the insured to $1250 per year and it was suggested using usual and customary language to indicate company is not responsible for payment of amounts in excess of usual and customary charges.

RESPONSE:
The Commissioner agrees.

Rule VII. - HMO COST SHARING SCHEDULE

COMMENT:
It was stated that paragraph (1) under a carrier need not have a standard plan for HMO as long as they have one with traditional benefits. Furthermore, the that the rules should describe minimum benefits for a standard plan.

RESPONSE:
At this point, Commissioner believes that the standard plan should be a uniform package of benefits, rather than a minimum level of benefits.

COMMENT:
Under paragraph (2) it was asked that the 30 day limit for inpatient mental health and substance abuse treatment combined be stipulated in the HMO cost sharing schedule. A prescription drug benefit was suggested that isn't as difficult to administer.

RESPONSE:
The Commissioner agrees and a stipulation for a 30 day limit on inpatient coverage for mental health and substance abuse treatment combined is included in the adopted language. The Commissioner agrees to change the prescription drug cost sharing schedule to be fixed amounts of $5 for generic brand drugs and $10 for brand name drugs.

COMMENT:
A comment was made that proposed Rule VII is sometimes inconsistent with Rules III, IV, V, VI but there was not specific discussion.

RESPONSE:
Since there were no specific inconsistencies listed it is difficult to comment.

COMMENT:
The rule was criticized because of the lack of cost containment language in the HMO schedule of cost sharing.

RESPONSE:
An HMO controls services to be provided by requiring an HMO physician. This physician has to make all referrals to

hospital or other providers. This gives the HMO more control over the services, and thereby the costs incurred.

Rule VIII - CRITERIA OF POLICIES UNDER THE BASIC PLAN

COMMENT:
The multipolicy approach to the basic plans was questioned.

RESPONSE:
Under section 33-22-1811(1)(b)(ii) MCA a carrier shall maintain and offer to eligible small employers AT LEAST one basic . . . and AT LEAST one standard - if the legislature only intended one basic and one standard plan, why this reference?

Rule IX - CALCULATION OF BENEFIT VALUES

COMMENT:
There were several comments raised concerning the formula in proposed Rule IX.

RESPONSE: Response to Blue Cross/Blue Shield's comments on Rule IX:

The formula in Rule IX is intended to accomplish two things:

(1) Act as a means for small group employers to determine whether or not each of their plans is a basic plan; and

(2) Make this determination consistent among small group employers.

Most health insurance plans have a deductible and coinsurance. After that benefits may vary from plan to plan. There could be different deductibles or no deductibles for some types of benefits, inside limits on others, and first-dollar coverage or indemnified benefits for others.

The formula in Rule IX is meant to be a starting point. After that their are so many possible variations by plan, it is impossible to cover them all in the Rule. That is why the provision at the end of Rule IX is included. A plan which would be classified as a basic plan if the formula was the only determining factor may be filed as a plan which is neither standard nor basic, as long as complete documentation supporting this classification is included.
Often it will be obvious whether or not the plan is richer than the standard plan. For instance, in the case of the Blue Cross/Blue Shield "security product", if the deductible and coinsurance for the hospital portion are the same as what the Standard Plan has for all its benefits (that is, $250 deductible, 80/20 coinsurance for the next $5,000, and the

company pays 100% thereafter), but the deductible does not apply to physician services, it would probably be richer than the Standard Plan (assuming there aren't too many other benefits required by the Standard Plan that are lower or missing in the "security product").

On the other hand, if the hospital portion has a higher deductible, or perhaps higher cost-sharing on the policyholder's part through the coinsurance provision, it would be harder to tell whether or not it is a basic plan. The benefit value that was calculated would be a clue. If it is close but slightly below the Standard Plan's benefit value, it may in fact qualify as a non-basic, non-standard plan. If it is $10 or more below, it is probably a basic plan, but the insurer still has the right to file it as a non-basic, non-standard plan if he or she can justify it.

Rule XI has been expanded to describe the policy form filing process. It clearly outlines a procedure for filing all policies, including those which qualify as basic plans according to the formula but which the insurer believes are neither basic nor standard. The burden would then be on the Insurance Department to determine whether or not it is in fact a basic plan.

Merely requiring each small employer carrier to file a certification listing all the plans it markets and identifying them as standard, basic or neither, as suggested by Blue Cross & Blue Shield of Montana, would give the insurers no guidance as to how a plan should be classified, and there would be no consistency between insurers' methods of classifying their plans. The formula solves both these problems to a certain extent; and the Insurance Department will act as a referee in cases where the formula does not go far enough.

Rule X - COST CONTAINMENT FEATURES

COMMENT:
Under paragraph (1) it is noted that an option for a cost containment feature listed in the statute is selective contracting with hospitals, physicians and other health care providers. The adoption of this option is urged.

RESPONSE:
The proposed options include HMO and PPO arrangements which covers the said option stated in statute. The Commissioner adopts the proposed language with this understanding.

COMMENT:
Under paragraph (1)(a) it is argued that patient education and assistance telephone programs are not significant cost containment features and should not be included in the list.

RESPONSE:
The savings of an education and assistance program is difficult to measure. Because the rules require insurers to adopt at least two cost containment features, the Commissioner feels that the merits and potential cost savings of an educational and assistance service make it worth keeping on the list. Insurers are not compelled to offer this option.

COMMENT:
Under paragraph (1)(b) it was pointed out that the use of the wording "acute, long term care" is imprecise.

RESPONSE:
The adopted language attempts to clarify the meaning of this cost containment option as management of acute and long term care.

COMMENT:
Under paragraph (1)(c) it was suggested that the phrase "A program for primary care physicians and referrals" be changed to "A program for primary care providers and referrals".

RESPONSE:
The Commissioner agrees with the suggested phrasing since not all primary care providers are physicians. The suggested change is adopted.

COMMENT:
Under paragraph **(1)(e)** language was suggested regarding HMOs and health service corporations that more closely reflect statutory language. They would also like to see an option for selective contracting with providers.

RESPONSE:
The suggested language is confusing because option (c) deals with HMOs and option (e) concerns PPOs. The suggested additional option would be repetitive. The Commissioner adopts the proposed language and options.

COMMENT:
A concern was raised that the requirement of two cost containment features will lead to medical care rationing.

RESPONSE:
The intent of the cost containment section is in compliance with the request by the legislature that the Health Benefit Plan committee make recommendations designed to reduce costs of medical care. The specific cost containment measures listed comply with current Montana law and are already being used in the market.

COMMENT:
A concern was raised that paragraph (b)argues for large case management. These patients generally would be

hospitalized at great costs to the plan and whether a physician will be required to outline a plan for every patient.

RESPONSE:
Physician will only be asked to cooperate by writing care plans for patients who will otherwise be hospitalized for indefinite periods of time. The cost of patient care can be reduced significantly if home health care is a possible care solution. The insurer will only make this change from hospitalization to home health care or nursing home care if the doctor and patient/family agree.

COMMENT:
Under paragraph (c), since specialists are covered upon referral of the primary care specialist, this is a gatekeeper mechanism for rationing.

RESPONSE:
Section 31 of SB285 specifically requires the Health Benefit plan Committee to: 3(a) design plans consistent with the operation of Health Maintenance Organizations which 3(b) must include cost containment features:
The Committee and the Commissioner are complying with the terms of SB285 by including cost containment features in the health benefit plans.

COMMENT:
A fear was raised that a clerk with a high school diploma will conduct reviews concerning the medical necessity of a procedure.

RESPONSE:
Section 33-32-201(5)(a) MCA requires that the person conducting the review must be trained in the field of the provider. This precludes the scenario listed in the comment.

Rule XI - FILING AND APPROVAL OF BASIC AND STANDARD PLANS

COMMENT:
Does an exempt carrier need to file notice with the Commissioner under paragraph (1) indicating to the commissioner if they intend to be a small employer carrier.

RESPONSE:
A notice would need to be filed of their anticipated exemption and their compliance with guaranteed issue. There is no need to file as a small employer carrier if they are exempt by law.

Rule XIV - REQUIREMENT TO INSURE ENTIRE GROUPS

COMMENT:

A requested clarification was made concerning paragraph (2) to explain that an employee may select from any plan purchased by the employer, rather than from all plans sold by the insurer.

RESPONSE:
The Commissioner adopted this suggestion.

COMMENT:
An objection was made as to the restrictive nature of the provisions of paragraph (3) & (4). It is argued that by requiring coverage of all eligible employees and dependents, unless the eligible meet four specific exclusions, will prohibit some groups from getting coverage. Alternative one of the NAIC model regulations be considered instead of the alternative two model rules that were put in the proposed rules.

RESPONSE:
The Commissioner prefers to adopt alternative two. Employees are provided with four ways to exempt out of coverage: have comparable or better coverage, have a good health record, be unable to afford the employee share of the premium, or have comparable or better coverage for the next six months. These criteria are not overly restrictive in the Commissioner's opinion. Having specified exemptions prevents unhealthy people from opting out of insurance. Uninsured people only add a burden to the Medicaid system or result in unpaid medical costs passed on as higher charges to the insured. This option will encourage more coverage, but still allow for reasonable ways to opt out of an employer plan.

COMMENT:
It is pointed out that in paragraph (4)(a) there is no criteria to determine what benefits are "equal to or greater than."

RESPONSE:
The Commissioner agrees that criteria easy to administer is needed. Therefore, language is added so that the eligible employee or dependent decides for their circumstances and to the best of their judgement which option for coverage provides better benefits.

COMMENT:
It is suggested that paragraphs (6) & (7) vary significantly from the NAIC model.

RESPONSE:
The proposed language is almost verbatim from the model. The waiver for this option is to be related to the four exemptions. The proposed language is adopted.

COMMENT:
A request was made that there should be a provision to allow for probationary periods for new entrants such are found in the model rules.

RESPONSE:
The Commissioner adopts the model rule provision.

COMMENT:
A complaint was raised that paragraph (9) requires an open enrollment period and notice of opportunity to enroll to begin before the rules take effect.

RESPONSE:
This provision has been incorrectly read as to the proposed effective date in the rules. As proposed and adopted an enrollment period will begin on the effective date of 33-22-1811 MCA, i.e. 180 days after the Commissioner has approved the standard and basic plan or when the reinsurance program is operative, whichever is later. The rules will be effective long before either the notice or enrollment period begins. The Commissioner prefers a six month enrollment period for these cases and adopts the proposed language.

Rule XVI - QUALIFYING PREVIOUS AND QUALIFYING EXISTING COVERAGES

COMMENT:
A concerned was voiced that paragraph (1) requires small employer carriers to offer coverage to the entire group.

RESPONSE:
This provision has been wrongly interpreted to mean employees have no participation requirement. Wrongly assumes that only the unhealthy members of a group will choose insurance; and that this will drive up the employer's rate.

COMMENT:
An objection was raised to being required to offer coverage to employees/dependents who were previously denied coverage, without the reinsurance option until 1/97.

RESPONSE:
Actually Rule XV(3)(b) provides that coverage be no loss/no gain for such pre-existing conditions. However, specifically excluded conditions must be covered.

COMMENT:
The provisions of (4)(d) place a requirement to insured entire group while paragraph (4)(d) provides an exception if the excluded individual signs a waiver stating they already have coverage and expect that coverage to continue. The suggestion is that (d) could be eliminated to avoid confusion concerning the time frame listed.

RESPONSE:
This does repeat 4(a) with the addition of the 6 months time frame. The Commissioner does not object to deleting this subsection.

COMMENT:
These rules require small employer carriers not to issue coverage to a small employer if the carrier knows or believes an employee has been pressured to sign a waiver excluding coverage. It was suggested that this is overly burdensome to agents to obtain this information.

RESPONSE:
To accomplish guaranteed issue there will be new responsibilities in the market. Agents may be the only possible source of information concerning the exclusion of employees. Agents collect all types of confidential information. We are confident agents can handle this additional burden.

COMMENT:
Paragraph (8)requires that eligible new employees be allowed to enroll in the group's health benefit plan. The suggestion is to allow employers to determine eligibility requirements for new employees.

RESPONSE:
This section of the rules is designed to make insurance portable for new employees. If employers are allowed to determine eligibility preexisting conditions will not be covered and coverage will not be portable.

COMMENT:
Requested an interpretation of (8)(b) referring to the ability of carriers to charge for the addition of new entrants to the plan.

RESPONSE:
The carriers are not allowed to charge for the addition of new entrants to the plan. The rule allows an insurer to assess a risk load to a new entrant's premium-and if it does, the risk load must be the same as the risk load that was applied to the group in their most recent premium structure. The Commissioner does feel that it can be made clearer and does so.

COMMENT:
Proposed rules XV and XVI were criticized concerning the reinstatement of coverage terminated after July 1, 1993, especially the lack of pre-existing condition exclusions and waivers or riders.

RESPONSE:

Actually proposed Rule XV(3)(b) provides that coverage be no loss/no gain for such pre-existing conditions. However, specifically excluded conditions must be covered.

COMMENT:
It was noted that under proposed Rule XV(2)(b), if a health benefit plan was nonrenewed because the employer voluntarily elected coverage under another health benefit plan, this section addresses the restoration of coverage. It was suggested "voluntarily elects coverage" needs clarification. It is asked if an employer changes plans due to a large premium increase if this constitutes voluntary change.

RESPONSE:
Since premium increases are restricted, under Section 33-22-1809(1)(c)(i)(ii)(iii) MCA, we would have to consider such a change voluntary.

COMMENT:
It was suggested that (3)(e) is unfair and could financially impair carriers since on restoration of coverage a small employer carrier must give the employer the same rate that was in effect on termination unless there are more employees/dependents or case characteristics have changed, or if similar groups have received a premium increase.

RESPONSE:
Sections 33-22-1810(2)(g)(ii) and 33-22-1811(4)(b) MCA provide that if a carrier will be financially impaired they are not required to comply with these sections.

COMMENT:
Proposed Rules XV and XVI were criticized because of the reinstatement of coverage terminated after July 1, 1993, especially the lack of pre-existing condition exclusions and waivers or riders.

RESPONSE:
Actually Rule XV(3)(b) provides that coverage be no loss/no gain for such pre-existing conditions. However, specifically excluded conditions must be covered.

COMMENT:
A concern was raised about an employer deciding to change coverage from carrier to another in order to obtain coverage for known conditions. It was recommended that the pre-existing condition should be reduced to the situation that benefits remained the same or were reduced.

RESPONSE:
The commissioner accepts this recommendation.

Rule XVIII - RESTRICTIVE RIDERS

COMMENT:
A concern was raised on the removal of riders on anniversary date following the effective date of the rules.

RESPONSE:
The Commissioner adopts the rule without any changes since this will allow for all policies to come into compliance within the time indicated in statute.

Rule XIX - FAIR MARKETING STANDARDS

COMMENT:
A question was raised as to what other plans will be offered other than standard and basic plans.

RESPONSE:
Any plan currently approved for use and any new plan which exceeds the standard plan benefits may be offered upon approval by the Commissioner.

COMMENT:
Under paragraph (4) it was suggested that small employer carriers be granted 15 working days to respond with BC/BS's suggesting 10 working days to seek additional information.

RESPONSE:
The commissioner agrees that 15 working days should be allowed but feels that with this change, 5 days is sufficient to seek additional information.

COMMENT:
Under paragraph (6)(c) a question was raised as why the availability of other plans must be discounted in the price quotes since it is not in the model rules.

RESPONSE:
The rules as adopted contemplate the potential of multiple basic plans.

COMMENT:
Under paragraph (9)(c) the need for reporting upon number of plans in force in each county is questioned.

RESPONSE:
The Commissioner feels this information is important to judge effectiveness of program.

Rule XXIV - ANNUAL FILING OF ACTUARIAL CERTIFICATION

COMMENT:
A question was raised as whether the actuaries will themselves be tested or certified in some manner to eliminate any collusion between carriers and for-hire actuaries?

RESPONSE:
Actuaries are certified and operate under a professional code of ethics.

COMMENT:
A concern was raised under paragraph (2) requiring the filing of rates for all small employer health benefit plans:

RESPONSE:
The commissioner is granted the authority to require rate filing for small employer health benefit plans by 33-1-311(2), MCA, in conjunction with 33-22-1809(1)(i), MCA.

33-1-311(2), MCA, states "The commissioner shall have the powers and authority expressly conferred upon the commissioner by or reasonably implied from the provisions of this code."

This authority is reasonably implied from 33-22-1809(1)(i), MCA: "The commissioner shall adopt rules...to ensure that rating practices used by small employer carriers are consistent with the purposes of this part,..." It would not be possible to "ensure" this if the department never sees the rates.

GENERAL COMMENTS

COMMENT:
A concern was raised as to the inclusion of mandated benefits in the basic plan since it would affect affordability of plans. A request was made to the Commissioner not adopt rules until Coopers and Lybrand price the benefits.

RESPONSE:
Delay for pricing purposes will cause an extensive postponement of reform. Further Section 33-22-1821 MCA allows for the waiver of mandated benefits but does not require that such benefits be waived. It is discretionary in nature.

COMMENT:
A concerned was raised about the act increasing premiums.

RESPONSE:
The companies that have estimated the highest percentage of premium increase are those that have traditionally used the most stringent underwriting rules - "the cherrypickers." The estimates by insurers of the cost of guaranteed issue range from 2% to 48%. In practice, none of the states who have already implemented the reform have had this large a premium increase.

COMMENT:
It is alleged that Blue Cross/Blue Shield will become single payor.

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The Commissioner adopts the rule without any changes since this will allow for all policies to come into compliance within the time indicated in statute.

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RESPONSE:
We don't know if a single payor system will be acceptable to the people of Montana or their Legislative Representatives. We are to implement insurance reform as passed by the 1993 Legislature.

COMMENT:
It was alleged that small group reform could break Montana Medical Benefit Plan within one year.

RESPONSE:
Since MMBP has provided the commissioner with formal written notice of their intent NOT to be a small employer carrier. If they are not a small employer carrier, how will this law financially impair their company?

COMMENT:
Alleges if MMBP goes broke Blue Cross/Blue Shield will be able to get a large rate increase.

RESPONSE:
It is difficult to speculate as to what could happen which it is very unlikely that it will happen.

COMMENT:
Alleges this premium increase will end up as a "Canadian Style Plan."

RESPONSE:
Again, we can only implement the insurance reform passed by the Legislature.

COMMENT:
An objection was raised to the $150 hospice copay per week.

RESPONSE:
The Commissioner agrees and such is deleted.

COMMENT:
A clarification is requested concerning the association exemption contained in Section 33-22-1803(25)(c)(ii)(iii) MCA.

RESPONSE:
Again, a clarification for a specific association can be handled by the office in the regulation of the Act. This question is not pertinent to the overall consideration of specific rules.

COMMENT:
An error was noted in the numbering of rules. Page 34, last paragraph of the proposed rules should be changed from Rule XI to New Rule XXIII.

RESPONSE:
This is an error which can be corrected without objection.

COMMENT:
It was suggested that implementation of SB 285 should be postponed, that the mandated benefits should be deleted and that small employer are being adversely affected by the law with the last section of SB285 being discriminatory against small employers. The conclusion is that the reinsurance mechanism established pursuant to this bill "will create another state run re-insurance fund like the badly run worker's compensation fund.

RESPONSE:
SB285 as codified at 33-22-1801-1822 does not allow the option of postponing implementation unless the Reinsurance Board is unable to submit a suitable plan of operation within 180 days of appointment. See Section 33-22-1819(2)MCA. The mandated benefit issue was reviewed by the Health Benefit Committee and was not found to impact premium enough to warrant exclusion of this coverage. The last section of SB285 is Section 47. This section states the effective dates for various sections of the bill. There is no explanation as to why the last section is most problematic for small employers nor is there an explanation as how this discriminates against small employers.

COMMENT:
It was that certain government employee groups will be eligible to buy reinsurance, yet their plans do not offer guaranteed issue.

RESPONSE:
The exact groups in question are not listed. We know of no government group which does not allow all employers and dependents to enroll at the time they become eligible. As MMBP has indicted they do not plan to participate as a small employer carrier, Rule XII(4) will require that they terminate existing plans by January 1, 1997. This represents the first date transitional (existing group business) plans will be allowed to reinsure individuals or groups.

COMMENT:
A concern was raised that if an insurer becomes insolvent the group would be left without insurance with the taxpayers paying the claims.

RESPONSE:
In an insurer is insolvent, claims are paid by the Montana Life and Health Insurance Guaranty Fund. These funds for claim payments are funded by assessments of the insurers in the market. Perhaps the reference is to 33-10-230(2) which allows the insurer to offset the amount of the assessment

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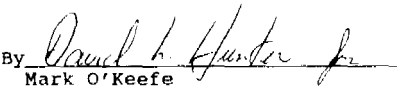
against premium taxes due which are deposited into the State General Fund. This is not a direct payment of claims by taxpayers.

State Auditor and
Commissioner of Insurance

By 
Mark O'Keefe


Gary L. Spaeth
Rules Reviewer

Certified to the Secretary of State this 31st day of May, 1994.

BEFORE THE BOARD OF ARCHITECTS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of a rule pertaining to reciprocity) NOTICE OF AMENDMENT OF 8.6.405 RECIPROCITY

TO: All Interested Persons:

1. On April 14, 1994, the Board of Architects published a notice of proposed amendment of the above-stated rule at page 715, 1994 Montana Administrative Register, issue number 7.

2. The Board has amended the rule exactly as proposed.

3. No comments or testimony were received.

BOARD OF ARCHITECTS
KEITH RUPERT, PRESIDENT

BY: Annie M. Bartos
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

Annie M Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, May 31, 1994.

BEFORE THE BOARD OF CHIROPRACTORS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of rules pertaining to applications, renewals and unprofessional conduct	))))))	NOTICE OF AMENDMENT OF 8.12.601 APPLICATIONS, EDUCATIONAL REQUIREMENTS, 8.12.606 RENEWALS - CONTINUING EDUCATION REQUIREMENTS, 8.12.607 UNPROFESSIONAL CONDUCT

TO: All Interested Persons:

1. On February 10, 1994, the Board of Chiropractors published a notice of proposed amendment of the above-stated rules, at page 222, 1994 Montana Administrative Register, issue number 3.

2. The Board has amended the rules exactly as proposed.

3. The Board has thoroughly considered all comments and testimony received. Those comments and the Board's responses to those comments follow:

COMMENT: The Board received a comment from Timothy Heaps, D.C., who felt the requirement to attend a school approved by the Council on Chiropractic Education was overly stringent.

RESPONSE: According to 37-12-302, MCA, the statutes allow the Board to approve the various schools of chiropractic. The Board, in its discretion, has determined that an acceptable school of chiropractic is one that has been accredited by the Council on Chiropractic Education throughout the student's tenure at that school.

BOARD OF CHIROPRACTORS
CHRIS BUZAN, D.C., PRESIDENT

BY: Annie M. Bartos
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

Annie M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, May 31, 1994.

BEFORE THE BOARD OF LANDSCAPE ARCHITECTS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of rules pertaining to fees and renewals	)))	NOTICE OF AMENDMENT OF 8.24.409 FEE SCHEDULE AND 8.24.406 RENEWALS

TO: All Interested Persons:

1. On April 28, 1994, the Board of Landscape Architects published a notice of proposed amendment of the above-stated rules, at page 991, 1994 Montana Administrative Register, issue number 8.

2. The Board has amended the rules exactly as proposed.

3. The Board has thoroughly considered all comments and testimony received. Those comments, and the responses thereto, follow:

Comment 1: The Board received two written comments, one from Jim Martin, and one from Richard Boston, in opposition to the proposed fee increase provided in the notice of proposed rule-making. The comments state that the increase is too large, and that a reasonable alternative fee should be considered. Mr. Boston states that the fee increase, if approved, would make Montana's license fee one of the highest in the country. Mr. Boston suggests that the Board is doing more than is necessary to accommodate certain interest groups, and that raising the fees as proposed will reduce the number of licensees.

RESPONSE: The Board has no choice but to raise the license fees for landscape architects. The current fund balance of the Board is approximately one thousand six hundred dollars. The annual budget for the board is fifteen thousand, one hundred dollars. Under the current fee structure, only fourteen thousand dollars can be raised. In addition, such money cannot be raised until June 30, 1994, the renewal date for licensure. Without the fee change, the licensure program for landscape architects would have to be immediately shut down for lack of funds.

BOARD OF LANDSCAPE ARCHITECTS
TED WIRTH, CHAIRMAN

BY: _____
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

_____
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, May 31, 1994.

BEFORE THE BOARD OF CHIROPRACTORS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of rules pertaining to applications, renewals and unprofessional conduct	NOTICE OF AMENDMENT OF 8.12.601 APPLICATIONS, EDUCATIONAL REQUIREMENTS, 8.12.606 RENEWALS - CONTINUING EDUCATION REQUIREMENTS, 8.12.607 UNPROFESSIONAL CONDUCT

TO: All Interested Persons:

1. On February 10, 1994, the Board of Chiropractors published a notice of proposed amendment of the above-stated rules, at page 222, 1994 Montana Administrative Register, issue number 3.

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RESPONSE: According to 37-12-302, MCA, the statutes allow the Board to approve the various schools of chiropractic. The Board, in its discretion, has determined that an acceptable school of chiropractic is one that has been accredited by the Council on Chiropractic Education throughout the student's tenure at that school.

BOARD OF CHIROPRACTORS
CHRIS BUZAN, D.C., PRESIDENT

BY: Annie M. Bartos
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

Annie M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, May 31, 1994.

BEFORE THE BOARD OF LANDSCAPE ARCHITECTS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of rules pertaining to fees and renewals	)))	NOTICE OF AMENDMENT OF 8.24.409 FEE SCHEDULE AND 8.24.406 RENEWALS

TO: All Interested Persons:

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BOARD OF LANDSCAPE ARCHITECTS
TED WIRTH, CHAIRMAN

BY: _____
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

_____
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, May 31, 1994.

BEFORE THE BOARD OF MEDICAL EXAMINERS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of rules pertaining to licensure and unprofessional conduct	NOTICE OF AMENDMENT TO 8.28.502 REQUIREMENTS FOR LICENSURE AND 8.28.508 UNPROFESSIONAL CONDUCT AND THE ADOPTION OF A NEW RULE PERTAINING TO DEFINITIONS WITH REGARD TO THE PRACTICE OF ACUPUNCTURE

TO: All Interested Persons:

1. On March 31, 1994, the Board of Medical Examiners published a notice of proposed amendment and adoption of the above-states rules at page 613, 1994 Montana Administrative Register, No.6.

2. The Board has amended ARM 8.28.503 and 8.28.508, and adopted new rule I (8.28.509) as proposed, but with the following changes: (the authority and implementing sections will remain the same as proposed in the original notice)

"8.28.502 REQUIREMENTS FOR LICENSURE (1) will remain the same as proposed.

(2) Applicants for licensure must pass all three components of the examination in ~~clean~~ sterile needle technique administered by the national commission for the certification of acupuncturists, or its successor."

"8.28.508 UNPROFESSIONAL CONDUCT (1) through (3) will remain the same as proposed.

(4) Failure to utilize ~~clean~~ sterile needle technique, as articulated by the national commission for the certification of acupuncturists, or its successor."

"8.28.509 DEFINITIONS (1) will remain the same.

(a) failure to utilize ~~clean~~ sterile needle technique, as articulated by the national commission for the certification of acupuncturists, or its successor."

3. The board is amending the rules as shown above to indicate that the needles used by acupuncturists should not only be clean but should be sterilized before use.

4. The Board has thoroughly considered all comments and testimony received. Those comments and the Board's responses thereto, are as follows:

COMMENT: A comment was received that the rules should be drafted without reference to the National Commission for the Certification of Acupuncturists.

RESPONSE: The National Commission for Certification of Acupuncturists is the entity which administers the national acupuncturist examination accepted by the state of Montana as part of the qualification for licensure in this state. The NCCA has a publication entitled "Clean Needle Technique for Acupuncturists, A Manual, Guidelines and Standards for the

Clean & Safe Clinical Practice of Acupuncture, Third Edition," which the Board has reviewed and discussed with representatives of the Montana Association of Acupuncture and Oriental Medicine. The Board agrees that the sterile techniques described in said publication provide an acceptable standard of care for the practice of acupuncture in Montana. The Board has made arrangements to provide copies of said publication to all acupuncturists in this state, so that acupuncturists and the public may be on notice of what is required to meet sterile technique standards.

COMMENT: A Board member suggested that the word "clean" be replaced with the word "sterile." The term "sterile" is a term of art in the practice of medicine, and more accurately describes the condition required of acupuncture needles to be used on patients than merely "clean." While the publication described above is entitled "Clean Needle Technique," in fact, the procedures and conditions set forth in the publication describe sterilization and sterile conditions.

RESPONSE: The Board agreed with the comment and amended the proposed rules to replace the word "clean" with the word "sterile" throughout.

COMMENT: A comment was received that the Board ought to consider allowing acupuncturists to write prescriptions.

RESPONSE: The Board does not have jurisdiction to adopt such a rule. Such a change in the scope of practice of acupuncturists is the prerogative of the state legislature.

BOARD OF MEDICAL EXAMINERS
GORDON L. BELL, M.D., PRESIDENT

BY: _____
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

_____
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, May 31, 1994.

BEFORE THE BOARD OF MEDICAL EXAMINERS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of rules pertaining to definitions, qualifications, applications, fees, utilization plans, protocol, temporary approval, informed consent, termination and transfer, and the adoption of a new rule pertaining to unprofessional conduct	NOTICE OF AMENDMENT AND ADOPTION OF RULES PERTAINING TO PHYSICIAN-ASSISTANTS (8.28.1501, 8.28.1503 through 8.28.1508, 8.28.1510, 8.28.1518 through 8.28.1520)

TO: All Interested Persons:

1. On April 14, 1994, the Board of Medical Examiners published a notice of proposed amendment of rules pertaining to physician-assistants at page 720, 1994 Montana Administrative Register, issue number 7.

2. The Board has amended and adopted the rules exactly as proposed.

3. No comments or testimony were received.

BOARD OF MEDICAL EXAMINERS
GORDON L. BELL,M.D., PRESIDENT

BY: Annie M. Bartos
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

Annie M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, May 31, 1994.

BEFORE THE BOARD OF PHYSICAL THERAPY EXAMINERS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of rules pertaining to examinations, fees, licensure by endorsement and foreign-trained applicants	)))))	NOTICE OF AMENDMENT OF 8.42.402 EXAMINATIONS, 8.42.403 FEES, 8.42.406 LICENSURE BY ENDORSEMENT AND 8.42.410 FOREIGN-TRAINED APPLICANTS

TO: All Interested Persons:

1. On April 28, 1994, the Board of Physical Therapy Examiners published a notice of proposed amendment of the above-stated rules at page 996, 1994 Montana Administrative Register, issue number 8.

2. The Board has amended the rules exactly as proposed.

3. No comments or testimony were received.

BOARD OF PHYSICAL THERAPY EXAMINERS
THOMAS MEAGHER, CHAIRMAN

BY: Annie M. Bartos
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

Annie M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, May 31, 1994.

BEFORE THE BOARD OF REAL ESTATE APPRAISERS
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of rules pertaining to definitions, application requirements, course requirements, continuing education and fees	)	NOTICE OF AMENDMENT OF 8.57.401 DEFINITIONS, 8.57.404 APPLICATION REQUIREMENTS, 8.57.406 COURSE REQUIREMENTS, 8.57.411 CONTINUING EDUCATION AND 8.57.412 FEES

TO: All Interested Persons:

1. On April 14, 1994, the Board of Real Estate Appraisers published a notice of proposed amendment of the above-stated rules at page 727, 1994 Montana Administrative Rules of Montana, issue number 7.

2. The Board has amended the rules exactly as proposed.

3. No comments or testimony were received.

BOARD OF REAL ESTATE APPRAISERS
PAT ASAY, CHAIRMAN

BY: Anne M. Bartos
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

Anne M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, May 31, 1994.

BEFORE THE BOARD OF REALTY REGULATION
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the amendment of rules pertaining to applications and unprofessional conduct	NOTICE OF AMENDMENT OF 8.58.406C APPLICATION FOR EQUIVALENCY - BROKER AND 8.58.419 GROUNDS FOR LICENSE DISCIPLINE - GENERAL PROVISIONS - UNPROFESSIONAL CONDUCT

TO: All Interested Persons:

1. On April 14, 1994, the Board of Realty Regulation published a notice of proposed amendment of the above-stated rules at page 730, 1994 Montana Administrative Register, issue number 7.

2. The Board has amended ARM 8.58.406C exactly as proposed and has amended ARM 8.58.419 as proposed, but with the following changes: (authority and implementing sections will remain the same as proposed in the original notice)

"8.58.419 GROUNDS FOR LICENSE DISCIPLINE - GENERAL PROVISIONS - UNPROFESSIONAL CONDUCT (1) through (2) will remain the same as proposed.

(3)(a) In all transactions, the licensee shall either be full agent of the seller or buyer; dual agent as provided by subsection (3)(b) of this rule; or shall be deemed the limited agent of the buyer as provided by this part. A licensee who enters into a WRITTEN listing agreement with a prospective seller of property shall be considered to be the full agent of the seller and shall owe to the seller full fiduciary obligations. A licensee who accepts an offer of subagency from a listing agent shall be considered to be the sub-agent of the seller and shall owe to the seller full fiduciary obligations. A licensee who enters into an WRITTEN agreement with a prospective buyer of property, giving the licensee or other licensees affiliated with the licensee the exclusive right to represent the buyer for a stated period of time shall be considered to be the full agent of the buyer and shall owe to the buyer full fiduciary obligations. A licensee who shows property to a prospective buyer of property without entering into an exclusive agency agreement with that buyer and further without acting as a listing agent or sub-agent, shall be considered to be the limited agent of the buyer, as to the property shown such buyer. The limited agent shall owe to the buyer the following duties:

(i) through (6) will remain the same as proposed."

3. The Board has thoroughly considered all comments and testimony received. Those comments and the Board's responses thereto, are as follows:

COMMENT: One comment was received suggesting that the word "written" be placed in two different locations in the rule amendment as adopted to clarify that a broker must have a

written agreement with a principal in order to be considered his or her sole agent with full fiduciary responsibility.

RESPONSE: The Board concurred and the rule has been amended as shown above.

COMMENT: Mr. Lane Coulston submitted a comment expressing his concern that the role of a limited buyer diminishes the professional and important role of buyer agency.

RESPONSE: The Board determined that the rule as proposed, with the limited agent duties disclosed and with the buyer having the option of selecting limited or full agency, clearly does not diminish the professionalism of the buyer agent, but gives the buyer an opportunity to select what type of representation he or she desires.

BOARD OF REALTY REGULATION
STEVE CUMMINGS, CHAIRMAN

BY: Annie M. Bartos
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

Annie M. Bartos
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, May 31, 1994.

BEFORE THE LOCAL GOVERNMENT ASSISTANCE DIVISION
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the adoption of a new rule for the administration of the 1994 Federal Community Development Block Grant Program	)))))	NOTICE OF ADOPTION OF NEW RULE I (8.94.3710) PERTAINING TO THE ADMINISTRATION OF THE 1994 FEDERAL COMMUNITY DEVELOPMENT BLOCK GRANT (CDBG) PROGRAM

TO: All Interested Persons:

1. On January 27, 1994, the Local Government Assistance Division published a notice of public hearing on the proposed adoption of the above-stated rule at page 127, 1994 Montana Administrative Register, issue number 2. The hearing was held on February 16, 1994, at 2:30 p.m., in the Department of Commerce building in Helena, Montana.

2. The Division has adopted the rule exactly as proposed.

3. Two members of the public attended the hearing, but did not testify regarding the proposed rule. The Division did receive four written comments during the public comment period provided for by the Administrative Procedure Act. Two of those comments supported the adoption of the rule as proposed. Two requested that the rule be modified. A summary of those two comments and the Division's responses to them follow:

COMMENT: The proposed application guidelines for the economic development component of the CDBG program should include inclusive language in reference to microbusiness development corporations (MBDC) to provide technical assistance for micro-entrepreneurs and to capitalize revolving loan funds. The change would complement capital investments made by the Montana legislature and strengthen an existing state-wide MBDC network. CDBG funds would be used to provide for technical services to individual small business owners and micro-loans for "gap financing" for these small businesses.

RESPONSE: By federal law microbusiness development centers are not, themselves, eligible applicants for CDBG funds. Any microbusiness program using CDBG funds, regardless of the amount of money involved, would have to meet all CDBG, HUD Title 1, requirements. Consequently, the administrative burden for the microbusiness program, the local applicant community, the Department of Commerce, and, most important, the small business being assisted, would be excessive compared to the actual benefits.

Similarly, each applicant for a micro-loan of CDBG funds would have to satisfy all federal requirements such as providing a complete financial analysis, documenting the need for the funds and the existence of a financing gap, and hiring of low and moderate income persons. In addition, the limitations and federal reporting requirements on the use of CDBG funds would make it extremely difficult to meld CDBG funds with less restrictive micro-loan programs. New federal regulations require that even CDBG micro-loan repayments never

lose their federal identity, further complicating CDBG funds used in conjunction with other sources of funds. Furthermore, in order to ensure that economic development projects are financially feasible and meet federal, national objectives and eligibility requirements, the Division must review the application of every assisted business, greatly increasing the Division's administrative burden. Currently, the Division discourages applications involving loans of less than $100,000 due to the high administrative costs associated with the use of CDBG funds.

Other states and entitlement communities throughout the country receive considerably more CDBG funds allocated each year to their programs than those available to the Montana CDBG Program. This usually affords them the opportunity to fund more divergent programming. The demand for CDBG funds for the types of major economic development projects currently being funded has always exceeded the availability of these funds. Given the Division's scarcity of economic development funding, even at a relatively modest increase to the economic development set-aside, the Division is extremely limited in funding other activities.

COMMENT: Based on the recent demand for economic development funds, 50% of the total CDBG allocation of funds should be allocated for economic development projects.

RESPONSE: The Division has received general support for the proposed allocation of one-third of the total allocation to be reserved for economic development projects. The Division considers this to be most appropriate, at this time, in light of the other conflicting demands for housing and public facility financing.

LOCAL GOVERNMENT ASSISTANCE DIVISION

BY: _____
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE

_____
ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, May 31, 1994.

BEFORE THE LOCAL GOVERNMENT ASSISTANCE DIVISION
DEPARTMENT OF COMMERCE
STATE OF MONTANA

In the matter of the adoption of a new rule for the administration of the Treasure State Endowment Program	)))))	NOTICE OF ADOPTION OF NEW RULE I (8.94.3802) INCORPORATION BY REFERENCE OF RULES FOR ADMINISTERING the 1994 TREASURE STATE ENDOWMENT PROGRAM (TSEP)

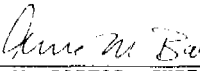
TO: All Interested Persons:

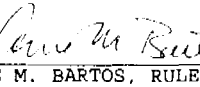
1. On January 27, 1994, the Local Government Assistance Division published a notice of public hearing on the proposed adoption by reference of the above-stated rule at page 125, 1994 Montana Administrative Register, issue number 2. The hearing was held on February 16, 1994, at 2:30 p.m., in the Department of Commerce building in Helena, Montana.

2. The Division has adopted the rule exactly as proposed.

3. Two members of the public attended the hearing, but did not testify regarding the proposed rule. The Department received no comments during the public comment period provided for by the Administrative Procedure Act.

LOCAL GOVERNMENT ASSISTANCE DIVISION

BY: 
ANNIE M. BARTOS, CHIEF COUNSEL
DEPARTMENT OF COMMERCE


ANNIE M. BARTOS, RULE REVIEWER

Certified to the Secretary of State, May 31, 1994.

BEFORE THE DEPARTMENT OF
FAMILY SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of Rules 11.8.304, 11.8.306, 11.8.308, and 11.8.310 pertaining to violations of aftercare agreements.	)))))	NOTICE OF AMENDMENT OF RULES 11.8.304, 11.8.306, 11.8.308, AND 11.8.310 PERTAINING TO VIOLATIONS OF AFTERCARE AGREEMENTS

TO: All Interested Persons.

1. On April 14, 1994, the Department of Family Services published notice of public hearing on the proposed amendment of Rules 11.8.304, 11.8.306, 11.8.308, and 11.8.310 pertaining to violations of aftercare agreements, at page 819 of the 1994 Montana Administrative Register, issue number 7.

2. The department has amended the rules as proposed.

3. On May 10, 1994, a hearing was held in the second floor conference room of the Department of Family Service, 48 North Last Chance Gulch, Helena, Montana, to consider the proposed amendment of the rules. No person appeared to offer testimony at the hearing, and only one written comment was received. The department has thoroughly considered the comment.

COMMENT: (Steve Gibson, Superintendent of Pine Hills School, Jim Hunter, Chief of Developmental Services) The facility chosen should be approved by the Youth Corrections Division Administrator or his/her designee. In addition, the prohibition against placement or return to a youth correctional facility of youth found to be seriously mentally ill or mentally ill pursuant to § 41-5-523, MCA should appear in the rules.

RESPONSE: The request on approval should be referred to the the appropriate Division Administrators and the Director.

This rule-making need not address the prohibition in § 41-5-523, MCA. In fact, rules must not be unduly repetitious of statutes. However, it is useful to mention the prohibition, and for the department to set out herein its intention that the prohibition apply to placement following revocation under these rules.

DEPARTMENT OF FAMILY SERVICES

Hank Hudson, Director

John Melcher, Rule Reviewer

Certified to the Secretary of State, May 31, 1994.

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

In the matter of the rules 46.12.1107, 46.12.1108, 46.12.1109, 46.12.1110, 46.12.1111, 46.12.1112, 46.12.1113 and 46.12.1114 pertaining to medicaid coverage of services provided to recipients age 65 and over in institutions for mental diseases	))))))))	NOTICE OF THE AMENDMENT OF RULES 46.12.1107, 46.12.1108, 46.12.1109, 46.12.1110, 46.12.1111, 46.12.1112, 46.12.1113 AND 46.12.1114 PERTAINING TO MEDICAID COVERAGE OF SERVICES PROVIDED TO RECIPIENTS AGE 65 AND OVER IN INSTITUTIONS FOR MENTAL DISEASES

TO: All Interested Persons

1. On April 14, 1994, the Department of Social and Rehabilitation Services published notice of the proposed amendment of rules 46.12.1107, 46.12.1108, 46.12.1109, 46.12.1110, 46.12.1111, 46.12.1112, 46.12.1113 and 46.12.1114 pertaining to medicaid coverage of services provided to recipients age 65 and over in institutions for mental diseases at page 936 of the 1994 Montana Administrative Register, issue number 7.

2. The Department has amended rules 46.12.1107, 46.12.1109, 46.12.1111, 46.12.1113 and 46.12.1114 as proposed.

3. The Department has amended the following rules as proposed with the following changes:

46.12.1108 INSTITUTIONS FOR MENTAL DISEASES, DEFINITIONS

Subsections (1) through (4)(a) remains as proposed.

(i) In making a determination of whether an institution is an institution for mental diseases, the department shall consider the guidelines set forth in SUBsection B C of section 4390 of the state medicaid manual, but no single guideline or combination of guidelines shall necessarily be determinative. The state medicaid manual is promulgated by the federal health care financing administration to provide guidance to states on administration of the medicaid program. The department hereby adopts and incorporates herein by reference SUBsection B C of section 4390 of the state medicaid manual (19904). A copy of SUBsection B C of section 4390 of the state medicaid manual may be obtained from the Department of Social and Rehabilitation Services, Medicaid Services Division, P.O. Box 4210, Helena, MT 59604-4210.

Subsection (5) remains as proposed.

(~~3~~6) "Mental disease" means a diseases listed as a mental disorders in the ~~ICD-9-CM~~ DSM-III (International Classification

~~of~~ CURRENT EDITION OF THE Diagnostic and Statistical Manual of Mental Diseases~~, Ninth Third Edition)~~, ~~with the exception of~~ but does not include mental retardation, senility and organic brain syndrome.

(~~4~~7) "Nursing facility services" ~~includes the term "long term care facility services" and also the terms "skilled nursing services" and "intermediate care services". Examples of nursing facility services and a listing of items provided by the facility which are defined as routine services and reimbursed though the routine per diem rate are contained in ARM 46.12.1202 (2)(a) through (2)(a)(viii)~~ means services defined in ARM 46.12.1222(14), but not including intermediate care facility services for the mentally retarded.

Subsections (8) through (11) remain as proposed.

AUTH: Sec. 53-2-201 and 53-6-113 MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113 MCA

46.12.1110 ~~SCREENING AND UTILIZATION REVIEW REQUIREMENTS FOR MEDICAID RECIPIENTS~~ INSTITUTIONS FOR MENTAL DISEASES, INDIVIDUAL TREATMENT PLANS (1) Institutions for mental diseases providing services under these rules must provide for and maintain recorded individual plans of treatment and care to ensure that institutional care maintains the recipient at, or restores ~~him~~ THE RECIPIENT to, the greatest possible degree of health and independent functioning. The plans must include:

Subsections (1)(a) through (1)(e) remain as proposed.

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

46.12.1112 INSTITUTIONS FOR MENTAL DISEASES, BILLING AND PAYMENT (1) Providers must bill for all services and supplies in accordance with the provisions of ARM 46.12.303. The department~~'s fiscal agent~~ will pay a provider on a monthly basis the amount determined under these rules upon receipt of an appropriate billing which reports the number of patient days provided to authorized medicaid recipients during the billing period.

AUTH: Sec. 53-2-201 and 53-6-113 MCA
IMP: Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113 MCA

4. The Department has thoroughly considered all commentary received:

COMMENT: In the proposed rule ARM 46.12.1107(3)(a)(i), references to subsection B of section 4390 of the State Medicaid Manual are no longer current because section 4390 was revised in March 1994.

RESPONSE: The department concurs with the comment and will change the reference to subsection C of the March 1994 revision of section 4390. Subsection C, "Guidelines for Determining Whether Institution Is an IMD," is the appropriate section for incorporation in the rule and is comparable to subsection B in the previous version of section 4390.

COMMENT: The impending publication of DSM-IV will make the reference to the DSM-III obsolete in proposed rule ARM 46.12.1107(6).

RESPONSE: The department agrees with the comment and will change the reference to the "current edition of the Diagnostic and Statistical Manual of Mental Diseases".

COMMENT: The reference to ARM 46.12.1222 in proposed rule ARM 46.12.1107(7) includes more than the definition of nursing facility services.

RESPONSE: The department agrees and will amend the reference to specify subsection (14) of ARM 46.12.1222 which defines nursing facility services.

COMMENT: The language in proposed rule ARM 46.12.1110(1) referring to the recipient as "him" and in proposed rule ARM 46.12.1112(1) referring to the "department's fiscal agent" as the payor is inaccurate.

RESPONSE: The department concurs. The department proposes amending proposed rule ARM 46.12.1110(1) to read ". . . maintains the recipient at, or restores the recipient to, . . ." and proposed rule ARM 46.12.1112(1) to read "The department will pay a provider . . ."

5. These rule amendments will take effect on July 1, 1994.

Rule Reviewer

Director, Social and Rehabilitation Services

Certified to the Secretary of State May 31, 1994.

VOLUME NO. 45 OPINION NO. 22

BONDS - Authority of joint solid waste management district to issue bonds to participate in self-insurance fund;
INSURANCE - Joint solid waste management district as political subdivision;
LOCAL GOVERNMENT - Joint solid waste management district as political subdivision;
MUNICIPAL CORPORATIONS - Joint solid waste management district as political subdivision;
SOLID WASTE - Joint solid waste management district as political subdivision able to participate in self-insurance plan;
MONTANA CODE ANNOTATED - Sections 2-9-101, 2-9-211, 2-9-212, 7-11-101, 7-13-241 (1989), 7-13-301 to -311 (1991), 39-71-403, 39-71-2102, 75-10-103, 75-10-112;
MONTANA LAWS OF 1991 - Chapter 770;
OPINIONS OF THE ATTORNEY GENERAL - 44 Op. Att'y Gen. No. 28 (1992), 43 Op. Att'y Gen. No. 68 (1990), 38 Op. Att'y Gen. No. 75 (1980).

HELD: 1. A joint solid waste management district is a political subdivision for purposes of participating in the self-insurance programs authorized by Mont. Code Ann. § 2-9-211.

2. A joint solid waste management district does not have the authority to issue bonds for the purpose of establishing a workers' compensation self-insurance fund.

May 19, 1994

Mr. Seldon Frisbee
Cut Bank City Attorney
113 East Main
Cut Bank, MT 59427

Dear Mr. Frisbee:

You have requested my opinion on two questions which I have rephrased as follows:

1. Is a joint solid waste management district a political subdivision with the statutory power to self-insure under Mont. Code Ann. § 2-9-211?

2. Does a joint solid waste management district have the authority to issue bonds for the purpose of establishing a workers' compensation self-insurance fund?

The City of Cut Bank is a member of the Northern Montana Joint Refuse District [hereinafter "district"] which was formed in 1990 and composed of four municipalities and the portions of three counties which were not within the boundaries of the Blackfeet Indian Reservation. The district was originally formed as a joint refuse disposal district under Mont. Code Ann. § 7-13-241 (1989), but later recognized as a joint solid waste management district under Mont. Code Ann. §§ 7-13-301 to -311 (1991).

The district is considering a number of options for obtaining cost-effective insurance coverage. One option is participation in the insurance programs organized and administered through the Montana Municipal Insurance Authority. The Montana Municipal Insurance Authority [MMIA] is an entity organized pursuant to the Interlocal Cooperation Act, Mont. Code Ann. tit. 7, ch. 11, pt. 1, and currently composed of 85 cities and towns. The MMIA provides two types of self-insurance coverage for its members: liability insurance and workers' compensation insurance. The liability self-insurance plan is authorized by Mont. Code Ann. § 2-9-211, which allows "all political subdivisions of the state to procure insurance separately or jointly with other subdivisions." See 38 Op. Att'y Gen. No. 75 (1980) (counties may participate in self-insurance program pursuant to interlocal agreement). A workers' compensation self-insurance plan for cities and towns and other "public corporations," except state agencies, is authorized by Mont. Code Ann. § 39-71-403(3).

In order to be able to participate in the liability self-insurance program and join the MMIA, the district must be a "political subdivision" as that term is used in Mont. Code Ann. § 2-9-211. Under Mont. Code Ann. § 2-9-101, a "political subdivision" as used in parts 1, 2, and 3 of chapter 9 is broadly defined as any "county, city, municipal corporation, school district, special improvement or taxing district, or any other political subdivision or public corporation." (Emphasis added.) Your first question is whether the district can be considered such a "political subdivision."

Two previous Attorney General's Opinions held that a solid waste management district (then refuse disposal district) was not a political subdivision for purposes of the Municipal Finance Consolidation Act [MFCA]. See 43 Op. Att'y Gen. No. 68 at 256 (1990) (refuse disposal district not political subdivision); 44 Op. Att'y Gen. No. 28 (1992) (solid waste management district not political subdivision). In these opinions, a refuse disposal district was not considered a political subdivision because it did not have an independent governing body which was capable of exercising authority separate from the county commissioners who created it. 44 Op. Att'y Gen. No. 28; 43 Op. Att'y Gen. No. 68 at 259.

In 1991, the legislature significantly amended the laws relating to solid waste management districts. See 1991 Mont. Laws, ch.

770. The legislature expressly stated that a "joint solid waste district is a political subdivision of the state for the purposes of the Municipal Finance Consolidation Act of 1983 as provided in 17-5-1602 and for solid waste management services as provided in 75-10-112." Mont. Code Ann. § 7-13-301. Under this language, joint districts were specifically excluded from the effect of the prior Attorney General's Opinions which held that a refuse district was not a political subdivision for MFCA purposes. The legislature also substantively vested a joint district with plenary powers which could be exercised independent of the governing bodies of the cities or counties that made up the district. See Mont. Code Ann. § 7-13-305(5) (board of joint district unconditionally has all powers listed in Mont. Code Ann. § 75-10-112). Because it has such broad independent authority, a joint district must be considered a political subdivision within the meaning of Mont. Code Ann. § 2-9-211.

Your second question arises from an MMIA requirement that the participating political subdivisions have the statutory authority to issue bonds in order to establish and maintain a workers' compensation self-insurance reserve fund. The MMIA further requires that the bonds must be supported by an annual tax levy. Currently, the MMIA workers' compensation program issues bonds on behalf of each participating entity for the purpose of creating and maintaining a self-insurance reserve fund. The MMIA's authority to issue such bonds is necessarily derived from the authority of each participating member to issue bonds for the purpose of establishing the self-insurance fund. Accordingly, you ask whether the district has the statutory authority to issue bonds for the establishment of a workers' compensation self-insurance fund payable from an annual property tax levied within the boundaries of the joint district.

Under Mont. Code Ann. § 39-71-403(2), a "public corporation," other than a state agency, may elect, separately or jointly with any other public corporation other than a state agency, to participate in workers' compensation plan No. 1, plan No. 2 or plan No. 3. Workers' compensation plan No. 1 describes the procedures and requirements that must be met by an employer who wants to provide self-insured workers' compensation benefits for employees. See Mont. Code Ann. §§ 39-71-2101 to -2108. Under Mont. Code Ann. § 39-71-403(3), a public corporation that elects plan No. 1 may establish a fund to pay its workers' compensation liabilities. Further, the public corporation is given the express authority to "issue and sell its bonds and notes for the purpose of establishing, in whole or in part," a self-insurance workers' compensation fund. Mont. Code Ann. § 39-71-403(3)(b).

The definition of a "public corporation" for purposes of Mont. Code Ann. § 39-71-403 includes "any county, municipal corporation, school district, city, city under commission form of government or special charter, town, or village." Mont. Code Ann. § 39-71-116(22). Conspicuously absent from this definition

is a generic, catch-all phrase which would include "local government units" or "political subdivisions" within the meaning of the term "public corporation." Thus, a political subdivision such as a joint solid waste management district does not have the specific or express authority under this statute to participate in plan No. 1 or to issue bonds to establish a workers' compensation self-insurance fund.

You suggest nonetheless that the bonding authority in Mont. Code Ann. § 2-9-211 could be construed to allow issuance of bonds to establish a workers' compensation self-insurance fund. Mont. Code Ann. § 2-9-211 authorizes a political subdivision to self-insure and issue bonds to establish a self-insurance fund, but proceeds from the self-insurance fund are limited to claims arising under title 2, chapter 9, parts 1 to 3. See Mont. Code Ann. § 2-9-211(3). Thus, the bonding authority in Mont. Code Ann. § 2-9-211 may not be used as a basis for issuance of bonds for establishment of a reserve fund to guarantee payment of workers' compensation claims.

You further suggest that either Mont. Code Ann. § 7-13-308 or Mont. Code Ann. § 7-13-309 contains the requisite authority for establishment of a workers' compensation self-insurance fund through issuance of bonds. Mont. Code Ann. § 7-13-308 allows the joint district to issue revenue bonds. The MMIA has indicated that it requires its members to have the authority to issue bonds payable through tax proceeds and the authority to issue revenue bonds would presumably not meet this requirement. Mont. Code Ann. § 7-13-309 allows a joint solid waste management district to issue bonds supported by tax proceeds, providing in pertinent part:

> Upon approval of the board of directors of the joint district, a joint district may borrow money by the issuance of its bonds to:
>
> (a) provide funds for payment of part or all of the cost of acquisition of property, construction of improvements, and purchase of equipment;
>
> (b) provide an adequate working capital; and
>
> (c) pay costs related to the planning, designing, and financing of a solid waste management system.

This section does not specifically allow issuance of bonds to establish a workers' compensation self-insurance reserve fund. It grants a joint district the authority to issue bonds to provide "working capital" or to pay the costs of "financing" a solid waste system. Neither of these provisions authorizes the issuance of long-term obligations associated with establishing and maintaining a workers' compensation self-insurance fund.

In the accounting context, the term "working capital" means the money necessary to meet current operating expenses: it is "'the excess of a [business's] current assets over its liabilities.'" Blue Cross & Blue Shield of Delaware v. Elliot, 479 A.2d 843, 848 (Del. Super. Ct. 1984), quoting Finney, Principles of Accounting at 55. Working capital essentially means the operating cash necessary to meet current liabilities and indicates a short-term debt. It does not encompass the establishment of a reserve fund which would require incurring a long-term obligation, and which would potentially result in a savings earned by reducing costs to the district.

Nor does the phrase "cost of financing" indicate that the joint district has the bonding authority to create a workers' compensation self-insurance fund. McQuillin has explained how bonding authority for one purpose may not be construed as authorizing issuance of bonds for another purpose:

> The power conferred by a law relating to the issuance of bonds is to be construed as restricted to the bonds authorized. Thus, authority to issue building bonds does not include bonds for hospitals or garbage reduction plants; authority to issue bonds for manufacturing and industrial purposes does not authorize issuance of bonds for service businesses. . . .

McQuillin, Municipal Corporations § 43.22. Similarly, the authority to issue bonds for planning, designing or financing a solid waste management system may not be used as a basis for issuance of bonds to establish and maintain a workers' compensation self-insurance fund.

My conclusion is consistent with the legislative history of how cities, counties, and school districts acquired the authority to issue bonds for a workers' compensation self-insurance fund. The legislative history of Mont. Code Ann. § 39-71-403(2) and (3) indicates that cities, counties and school districts believed, on advice of bond counsel, that specific bonding authority was necessary in order to issue bonds for the creation of a workers' compensation self-insurance fund. Minutes, House Committee on Labor and Employment Relations, Testimony of Gordon Morris on SB 285, Mar. 14, 1989, at 2. Given that specific statutory authority was necessary for cities, counties and school districts to be able to establish a workers' compensation self-insurance fund, joint solid waste management districts must similarly have such authorization.

THEREFORE, IT IS MY OPINION:

1. A joint solid waste management district is a political subdivision for purposes of participating in the self-insurance programs authorized by Mont. Code Ann. § 2-9-211.

2. A joint solid waste management district does not have the authority to issue bonds for the purpose of establishing a workers' compensation self-insurance fund.

Sincerely,

JOSEPH P. MAZUREK
Attorney General

jpm/elg/bjh

VOLUME NO. 45 OPINION NO. 23

COUNTIES - Responsibility of nonassumed counties to pay Department of Family Services administrative costs for protective services;
FAMILY SERVICES, DEPARTMENT OF - Responsibility of nonassumed counties to pay for department's administrative costs for protective services;
MONTANA CODE ANNOTATED - Sections 27-2-209(3), 41-3-1122, 52-1-110, 53-2-322, 53-2-801, 53-2-811;
MONTANA LAWS OF 1987 - Chapter 609, sections 14, 77.

HELD: 1. Mont. Code Ann. § 53-2-322 requires nonassumed counties to pay for their proportionate share of administrative costs for protective services, including rent, adequate equipment and supplies.

2. The responsibility of nonassumed counties to pay for their proportionate share of the administrative costs associated with providing protective services in the county, other than the salaries, travel expenses, and indirect costs of employees, is not capped at the amount paid in fiscal year 1987.

3. If the Department of Family Services has presented claims to the nonassumed counties, any action to recover the disputed claims must be filed within six months of the denial of the Department's claim. Older claims are barred by the statute of limitations.

May 19, 1994

Mr. Hank Hudson
Director
Department of Family Services
P.O. Box 8005
Helena, MT 59604-8005

Dear Mr. Hudson:

You have requested my opinion on three questions I have phrased as follows:

1. Does Mont. Code Ann. § 53-2-322 require nonassumed counties to pay for administrative costs for protective services, including rent, adequate equipment and supplies, in addition to the salaries, travel expenses and indirect costs of protective services employees?

2. If so, is their responsibility capped at the amount paid in fiscal year 1987?

3. If nonassumed counties must pay for the administrative costs associated with providing protective services in the county, are nonassumed counties responsible to repay the Department of Family Services amounts already paid by the Department that were the financial obligation of the nonassumed counties?

At the option and with the express consent of an individual county, the Department of Family Services [DFS] may assume all responsibility for protective services for children in the county. Mont. Code Ann. §§ 53-2-801 and -811. Several Montana counties have not opted to transfer such responsibility to DFS, and remain "nonassumed" by the state. You have informed me that some of these nonassumed counties refuse to reimburse DFS for administrative costs of protective services, and your questions stem from a continuing controversy about whether or not they are obligated to do so.

This presents the second request from DFS for an opinion on these issues. An earlier request in 1991 was declined by Attorney General Racicot, due in large part to the conclusion that the statutes provided no clear answer to the questions and that a legislative solution should be sought. The statutes have not been amended since that time, and the controversy between DFS and the nonassumed counties continues to exist. What follows is my analysis of the construction of the involved statutes. It leaves unanswered a major point of contention between DFS and the nonassumed counties, but provides some guidance about the manner in which the answer to that question should be determined.

DFS and the counties apparently agree that two statutes enacted as part of the bill which created DFS govern the controversy. DFS was established in 1987 through the enactment of House Bill 325, a lengthy and complex rewriting of the statutes governing the administration of public assistance and child protective services in Montana. 1987 Mont. Laws, ch. 609. The bill addressed the allocation of costs for protective services in two sections. One section of the bill amended Mont. Code Ann. § 53-2-322, an existing statute dealing with allocation and reimbursement for costs of public assistance. Id. at § 77. As amended in 1987, section 53-2 322 provides in pertinent part:

> (1) The board of county commissioners in each county shall levy 13.5 mills for the county poor fund as provided by law or so much of that amount as may be necessary. The board may levy up to an additional 12 mills if approved by the voters in the county. A county shall levy sufficient mills to reimburse the state for any administrative or operational costs in excess of the administrative and operational costs for the previous fiscal year. . . .

> (2) The board shall budget and expend so much of the funds in the county poor fund for public assistance and protective services purposes as necessary to reimburse the department [of social and rehabilitation services] and the department of family services for the county's proportionate share of the administrative costs and of all public assistance and protective services and its proportionate share of any other public assistance activity that may be carried on jointly by the state and the county.
>
> (3) The amounts set up in the budget for the reimbursements . . . to the department of family services must be sufficient to make all of these reimbursements in full. The budget must make separate provision for each one of these public assistance and protective services activities, and proper accounts must be established for the funds for all the activities.

(Emphasis added.) Though inartfully worded, this statute in my opinion evidences a legislative intent to require counties to shoulder a "proportionate share" of the "administrative costs" incurred by DFS in providing protective services. The terms "proportionate share" and "administrative costs" are not defined in the statutes, and your letter and memorandum have provided no clear explanation of DFS's interpretation of the terms.

It appears to be common ground that the salaries, travel expenses, and "indirect costs" of DFS protective services employees are among the "administrative costs" for which DFS must be reimbursed. This is clear from the provisions of the second section of HB 325 addressing costs allocation, 1987 Mont. Laws, ch. 609, § 14, codified at Mont. Code Ann. § 52-1-110:

> (1) Upon the transfer of certain functions of the county welfare department to the department of family services as provided in section 12, Chapter 609, Laws of 1987, the salaries and travel expenses . . . of protective services employees must be paid by the department of family services. The board of county commissioners shall reimburse the department of family services from county poor funds in an amount equal to that county's expenditures for salaries, travel expenses, and indirect costs of protective services employees in fiscal year 1987, adjusted for annual inflation.

It must be presumed that if the legislature had intended that these personnel-related costs be the only costs for which the counties were required to reimburse DFS, it would have used the term "salaries, travel expenses, and indirect costs" in both Mont. Code Ann. § 52-1-110 and § 53-2-322. Since it did not, it is my opinion that the costs for which reimbursement is due

under Mont. Code Ann. § 53-2-322 must be read to include more than the personnel costs referred to in Mont. Code Ann. § 52-1-110.

I further conclude that DFS's interpretation that a county's "proportionate share" of "administrative costs" for protective services includes costs for rent, utilities, adequate equipment and supplies is not unreasonable or inappropriate. The legislature did not limit the administrative costs to be reimbursed by nonassumed counties to the salaries, travel expenses, and indirect costs of employees. Mont. Code Ann. § 53-2-322(1) requires that a county levy sufficient mills to reimburse the state for any administrative or operational costs in excess of the "administrative and operational costs" of the previous year. Mont. Code Ann. § 53-2-322(2) requires that the board budget and expend so much of the funds in the county poor fund for public assistance and protective services purposes as necessary to reimburse the Department of Social and Rehabilitation Services and DFS "for the county's proportionate share of the administrative costs and of all public assistance and protective services." Finally, Mont. Code Ann. § 53-2-322(3) requires the county to budget sufficient funds "to make all of these reimbursements in full." Use of such broad and unrestrictive language indicates a legislative intent to require reimbursement for all administrative costs, not just salaries, travel expenses and indirect costs of employees. It is not unreasonable for DFS to conclude that these "administrative" or "operational" costs should include matters such as rent, utilities, adequate equipment and supplies.

Your second question concerns the ceiling amount, if any, on the nonassumed counties' responsibility for payment to DFS for their proportionate share of the administrative costs of child protective services. This question stems from controversy over whether the "proportionate share" of the administrative costs of child protective services to be paid by nonassumed counties is capped at the level paid in fiscal year 1987, adjusted for annual inflation.

A county's expenditure for salaries, travel expenses, and indirect costs for protective services employees is capped at 1987 amounts, adjusted for inflation. Mont. Code Ann. § 52-1-110. County reimbursements for foster care are also expressly limited to a level at or below the level of reimbursements paid in fiscal year 1987. Mont. Code Ann. § 41-3-1122(3), (4). However, nowhere in the statutes expressly limiting reimbursement to the level in fiscal year 1987, adjusted for inflation, is language concerning general administrative costs of protective services. The statute generally referring to administrative costs requires a county to levy sufficient mills to reimburse the state for any administrative or operational costs in excess of the administrative and operational costs for the previous fiscal year. Mont. Code Ann. § 53-2-322(1). That section also requires that the board "budget and expend so much

of the funds in the county poor fund for public assistance and protective services purposes as necessary to reimburse the department [of social and rehabilitation services] and the department of family services for the county's proportionate share of the administrative costs." Mont. Code Ann. § 53-2-322(2). My function in interpreting a statute is merely to ascertain and declare what in terms or substance is contained in a statute; it is not my function to insert what has been omitted. Mont. Code Ann. § 1-2-101. The statutes contain a cap only on the counties' responsibility to pay for salaries, travel expenses, and "indirect costs" for protective services employees, and on foster care. They contain no cap on the responsibility of the nonassumed counties for their proportionate share of other administrative costs of protective services.

The above discussion makes no attempt to define the full extent of the terms "administrative costs" and "indirect costs" in these statutes. DFS is the agency designated by law to apply and enforce the laws dealing with protective services. A court would be obligated to defer to the agency's interpretation of these statutory terms, giving appropriate weight to the agency's experience and expertise in the subject area. See, e.g., Norfolk Holdings v. Montana Dep't of Revenue, 249 Mont. 40, 44, 813 P.2d 460, 462 (1991). Your memorandum has not indicated the full extent of the agency's interpretation of these terms, and I decline to construe them in this opinion in advance of any interpretation and application of the terms by the agency.

Your final question concerns whether nonassumed counties are responsible to repay DFS amounts already paid by DFS that were the financial obligation of the nonassumed counties. Mont. Code Ann. § 27-2-209(3) provides the statute of limitations applicable to any action DFS might bring to recover sums claimed to be due from the counties. It states:

> Actions for claims against a county which have been rejected by the county commissioners must be commenced within 6 months after the first rejection thereof by such board.

If DFS has presented claims to the nonassumed counties, any action to recover the disputed claims must be filed within six months of the denial of the department's claim. Accord Sisters of Charity of Providence of Montana v. Glacier County, 177 Mont. 259, 266, 581 P.2d 830, 834 (1978).

THEREFORE, IT IS MY OPINION:

1. Mont. Code Ann. § 53-2-322 requires nonassumed counties to pay for their proportionate share of administrative costs for protective services, including rent, adequate equipment and supplies.

2. The responsibility of nonassumed counties to pay for their proportionate share of the administrative costs associated with providing protective services in the county, other than the salaries, travel expenses, and indirect costs of employees, is not capped at the amount paid in fiscal year 1987.

3. If the Department of Family Services has presented claims to the nonassumed counties, any action to recover the disputed claims must be filed within six months of the denial of the Department's claim. Older claims are barred by the statute of limitations.

Sincerely,

JOSEPH P. MAZUREK
Attorney General

jpm/kcs/brf

VOLUME NO. 45 OPINION NO. 24

CITIES AND TOWNS - Effect of sale of tax deed land by county on delinquent SID assessments;
COUNTIES - Effect of sale of tax deed land by county on delinquent SID assessments;
SPECIAL IMPROVEMENT DISTRICTS - Effect of sale of tax deed land by county on delinquent SID assessments;
TAXATION AND REVENUE - Effect of sale of tax deed land by county on delinquent SID assessments;
MONTANA CODE ANNOTATED - Sections 7-8-2306, 7-12-4183, 15-18-214;
OPINIONS OF THE ATTORNEY GENERAL - 45 Op. Att'y Gen. No. 2 (1993), 43 Op. Att'y Gen. No. 38 (1989), 41 Op. Att'y Gen. No. 77 (1986).

HELD: Although a county treasurer may not require delinquent SID assessments to be paid in addition to the sale price of tax deed land, the county treasurer must apply the sale proceeds of the land to delinquent SID assessments as provided in Mont. Code Ann. § 7-8-2306.

May 23, 1994

Mr. Gale R. Gustafson
Conrad City Attorney
400 South Main, Suite 101
Conrad, MT 59425

Dear Mr. Gustafson:

You have requested my opinion on the following issue:

> May a county treasurer require a purchaser of tax deed property to pay delinquent SID assessments on the property prior to its transfer?

The property in question was purchased by the county pursuant to Mont. Code Ann. § 15-17-214 and the county commissioners directed the county treasurer to issue the county a tax deed pursuant to Mont. Code Ann. § 15-18-211(3). The city was not assigned any of the county's rights under Mont. Code Ann. § 15-17-317. The county sold the tax deed pursuant to Mont. Code Ann. §§ 7-8-2301 to -2308 which define the procedures for disposing of county tax deed property.

Your request stems from past practices of the county in which the county treasurer has required the purchaser of tax deed property to pay any special improvement district (SID) assessments prior to transferring the property. You have indicated that at a recent sale, the purchaser contended that he is not liable for payment of any special assessments imposed on

the property, relying upon Mont. Code Ann. § 15-18-214. Your situation is complicated by the fact that the SID assessments had been accelerated by the city prior to the taking of the tax deed by the county, thereby making all assessments due and payable prior to issuance of the tax deed. See Mont. Code Ann. § 7-12-4183 (allowing city to adopt a resolution authorizing acceleration of the remaining SID payments when earlier assessments have become delinquent). In addition to your question on the propriety of requiring payment of SIDs prior to transfer of tax deed land, you have asked if the city must "decelerate" the SID assessments in order to prevent them from being extinguished upon issuance of a tax deed.

Mont. Code Ann. § 15-18-214 defines the effect of issuance of a tax deed and provides in pertinent part that when a tax deed is issued, absolute title to the property is conveyed "free and clear of all liens and encumbrances" except when the claim is payable after the execution of the deed and a lien of a special improvement district is levied against the property. Former Attorney General's Opinions have confirmed that this statute operates to extinguish special assessment liens that were due and payable at the time the tax deed was issued, but that the statute does not extinguish any future assessments. 43 Op. Att'y Gen. No. 38 at 125 (1989), 41 Op. Att'y Gen. No. 77 at 344 (1986). Thus, when the county took the tax deed all special assessments that were then due and payable were extinguished. If the city had accelerated the assessments under Mont. Code Ann. § 7-12-4182 or -4183 by making all special assessments due and payable, all such accelerated payments would be extinguished upon issuance of the tax deed. See 41 Op. Att'y Gen. No. 77 at 344 (because of acceleration, all assessment payments were due and payable immediately and were therefore extinguished in their entirety at the time the tax deed was issued). However, if, prior to the county's taking of the tax deed, the city withdraws the acceleration and declares future assessments no longer delinquent, then only the past assessments which were actually due and payable prior to the issuance of the tax deed would be extinguished and any future assessments would remain unaffected. See Mont. Code Ann. § 7-12-4184(3) (withdrawal of declaration of delinquency may be made before tax deed is executed).

Withdrawal of the delinquency or "deceleration" is not the only alternative open to a city. The city could seek assignment of the tax certificate under Mont. Code Ann. § 15-17-318, but would have had to pay the delinquent county taxes. The city then would have the option of either reassigning the property to a third-party purchaser under Mont. Code Ann. § 15-17-317, or, after the redemption period, obtaining a tax deed under Mont. Code Ann. § 15-18-211 and conducting its own sale pursuant to Mont. Code Ann. § 15-17-319.

Even if the city does not "decelerate" the SID payments or take an assignment of the property, the city may still recoup the delinquent assessments from the purchase price paid at the sale

of the tax deed property. Mont. Code Ann. § 7-8-2306 defines how the proceeds from the sale of the tax deed land must be distributed. First, the proceeds are credited to the county general fund for reimbursement of expenditures made from it in connection with the procurement of the tax deed and the holding of the sale. Mont. Code Ann. § 7-8-2306(1)(a). Any remainder of the proceeds is distributed in the manner described in Mont. Code Ann. § 7-8-2306(1)(b)(i) and (ii). If the remainder is:

> (i) in excess of the amount of all taxes and assessments accrued against the property for all funds and purposes, without penalty and interest, then as much of the remaining proceeds must be credited to each fund or purpose as each fund or purpose would have received had the taxes been paid before becoming delinquent, and all excess must be credited to the general fund of the county; or
>
> (ii) less in amount than the aggregate amount of all taxes and assessments accrued against the property for all funds and purposes, without penalty or interest, the proceeds must be prorated between the funds and purposes in the proportion that the amount of taxes and assessments accrued against the property for each fund or purpose bears to the aggregate amount of taxes and assessments accrued against the property for all funds and purposes.

Thus, the sale price of the tax deed land must be applied to all the delinquent taxes and assessments. This interpretation--that assessments must be included in the disbursement of the proceeds - was affirmed in a recent opinion. See 45 Op. Att'y Gen. No. 2 (1993). If there is money left over after the sale price has been credited to the delinquent taxes and assessments, then the excess goes to the county general fund. If there is not sufficient money to cover all the taxes and assessments, the money is prorated among the various funds.

The practice of the county treasurer to require payment of the assessments at the time of sale of tax deed property is, therefore, appropriate as long as the money is taken from the actual sale proceeds. It is not appropriate, however, to require payment of the assessments in addition to the sale price, because absent a statutory provision allowing such practice, the taxes and assessments are otherwise considered extinguished at time of issuance of the tax deed. While this reasoning may seem inconsistent, as I pointed out in 45 Op. Att'y Gen. No. 2, "there is no correlation between the method of distribution outlined in MCA § 7-8-2306 and the effect of a tax deed in MCA § 15-18-214." The sale proceeds of the tax deed land must therefore be distributed to pay off the taxes and assessments to the greatest extent possible, despite the removal of the liens when the tax deed was issued to the county.

THEREFORE, IT IS MY OPINION:

Although a county treasurer may not require delinquent SID assessments to be paid in addition to the sale price of tax deed land, the county treasurer must apply the sale proceeds of the land to delinquent SID assessments as provided in Mont. Code Ann. § 7-8-2306.

Sincerely,

JOSEPH P. MAZUREK
Attorney General

jpm/elg/brf

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 March 31, 1994. This table includes those rules adopted during the period April 1, 1994 through June 30, 1994 and any proposed rule action that was 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 March 31, 1994, 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 1994 Montana Administrative Register.

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