MINUTES

MONTANA SENATE
52nd LEGISLATURE - REGULAR SESSION

COMMITTEE ON BUSINESS & INDUSTRY

Call to Order: By Chairman J.D. Lynch, on February 21, 1991, at 5:00 p.m.

ROLL CALL

Members Present:

J.D. Lynch, Chairman (D)
John Jr. Kennedy, Vice Chairman (D)
Betty Bruski (D)
Eve Franklin (D)
Delwyn Gage (R)
Thomas Hager (R)
Jerry Noble (R)
Gene Thayer (R)
Bob Williams (D)

Members Excused: None

Staff Present: Bart Campbell (Legislative Council).

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

Announcements/Discussion: None

HEARING ON SENATE BILL 131

Presentation and Opening Statement by Sponsor:

Senator Harry Fritz, sponsor of the bill, thanked Senator Lynch for allowing him a rehearing on this bill. This bill would allow insurance companies from other states to transfer or relocate in Montana.

Proponents' Testimony:

Robert Minto, an attorney in Missoula and also the president of attorneys liability protection society (ALPS), stated that the bill was reworded to meet all of the right criteria. The purpose of the bill for small boutique type insurance companies to relocate to the state of Montana. Montana is a good place for insurance companies to exist. He had Senator Fritz introduce the first original bill, and subsequent to that time discovered that the bulk of the companies that he was trying to target were created under captive laws in another jurisdiction. The result,

because Montana didn't have a captive law to create a captive environment in order to facilitate the original purpose of the bill. Although the amendment is rather lengthy, this bill as it's presently written tracks very closely with Senator Thayer's bill of last session with some major changes with regard to capitalization to meet some concerns that the companies be adequately capitalized. He stands here as a citizen of the state of Montana with no particular vested interest in this bill except to say that he believes in Montana's economic entity and he believes Montana ought to try and attract these kinds of businesses, and that is the purpose for this bill.

Opponents' Testimony:

Jacqueline Terrell, representing the American insurance association, stated that the American insurance association supports those provisions of the bill as they were originally introduced. Those portions of the bill that relate to captive insurers, they oppose. They oppose not the concept that only to the extent that captive insurers are not regulated in the same way that other insurance companies are regulated in Montana. Their primary concern is with the insolvency of the insurers, the captive insurers. When a property casualty company becomes insolvent, there is a guaranteed fund to protect the claimant against that company. No is no similar provisions in this bill to protect those claimants against the captive insurer in the event of insolvency. She stated that she believes the amendment as it deals with captive insurers is outside of the scope of the purpose of the bill. She asked the committee to at least give the captive insurer portion of the bill a do not pass.

Questions From Committee Members:

Senator Thayer asked about the difference in this bill compared to the bill that he carried two years ago regarding minimum capital and minimum surplus.

Robert Minto replied that this bill basically tracks within fifty thousand dollars one way or the other. The minimum surplus and capital requirements are mutual for stock companies, except for the case of pure captive. The same definitions that Senator Thayer used before a pure captive is where a company creates an insurance company to insure its own interests. Association captive is where the bar association for example, creates a captive to insure the others.

Susan Witte, chief legal council, state auditor's office, stated that she has the section by section analysis from last years bill.

Senator Thayer asked if they increased this substantially.

Susan Witte replied that each category has been increased by about fifty thousand dollars.

Senator Lynch stated that maybe the committee should pass the bill as it was originally introduced.

Senator Fritz stated if that is the will of the committee, and at this late date that may be the thing to do. That would

undercut some of the opposition of the bill which is not to the original bill, but to the amended bill. The original bill, without the amendments would do the job. The amendment could wait until next session and come back with a clean bill on that subject.

Senator Noble asked what the original purpose was of the bill.

Senator Lynch stated that the original bill's purpose was to bring in new insurers that are now listed as foreign insurers to make them domestic insurers. This goes further and gets into some captive.

Senator Thayer asked in the original bill would they be part of the assigned risk pool.

Robert Minto stated that the original bill will only deal with stock companies that are mutual to their part of the assigned risk pool guarantee fund. That is the difference between the two. They will still be able to use this bill. They will still be able to attract insurers, they are just not going to be able to track as many of the smaller companies as they might be able to with the amended. If the committee doesn't pass the amendment then the only thing that it will cover is stocks and mutuals.

Closing by Sponsor:

Senator Fritz closed.

EXECUTIVE ACTION ON SENATE BILL 232

Motion:

Senator Thayer moved the amendments proposed do pass.
Senator Noble moved to do pass SB 232 as amended.
Senator Noble moved to do not pass SB 232 as amended.

Discussion:

Senator Lynch stated that SB 232 deals with the surrendering of the certificate of ownership. They have had some talk about seventy five dollars is a little harsh to inspect a two hundred dollar vehicle.

Senator Gage stated that the title appears to be the big problem in this area. If somebody could come up with language that says that the junk dealers stamp those things or the insurance companies stamp those things with something that says for a junk vehicle, or something to identify the vehicle.

Peter Funk stated that there are a couple of problems with that. One being, more vehicle titles are secure documents which are produced and designed so that except for their execution. If you have the holders of the titles making those types of changes on them, it really flies in the face of the entire nationwide titling system. They have discussed an option where all of the employees and the costs that are involved with the bill comes on

the VIN inspection site, primarily section two of the bill. They have discussed whether it would be better to have the bill simply require the issuance of the salvage certificate, and then strike all of the VIN inspection portions of the bill. The problem there is, it does not address the problem that they are trying to address because now a crook can go to a salvage yard, buy a piece of salvage for the title and then do the salvage switch that was discussed at the hearing, and come back and use the title. If they don't inspect at that point, after the issuance of the salvage certificate, then the crook just brings the county treasurer's office the salvage certificate gets a new title, and nobody ever goes out and looks at the car. They don't know any other way other than having the register's office do the stamping or do the issuance of the new document that the bill requests. The whole system is designed so that nobody other than the motor vehicle registrar can tinker with the title. The issuance of salvage certificates without a VIN inspection is a meaningless exercise.

Senator Noble stated that it was testified that you don't need to buy a vehicle from a salvage yard, you can go give them a hundred dollars and buy a title of anything that you want. He stated that this bill has a lot of problems.

Senator Lynch stated that somebody said that you can go any place in Montana and buy a title for a hundred dollars. Do they know where they are, can't they go to jail for something like that.

Peter Funk replied that that information comes essentially from some of the salvage people themselves. That they know that there are some of their members that are in the business of selling titles. The thief doesn't care about the junked car except they can take the VIN numbers off of it and put them on the stolen vehicle.

Senator Thayer asked that the department explain the amendments.

Peter Funk stated that paragraph two on the amendment, they have inserted to attempt to alleviate the concerns of the salvage folks that testified, to make it clear that this system is not designed in any way to impact any salvage vehicles which are in that statutes at the time that the bill becomes law. Their intent is just to deal with those vehicles that insurers determine to be total losses after the effective date of the bill. Amendment number one, there is language on the bill that was originally drafted which addresses what happens if an insurer is not involved and a vehicle simply becomes salvage and this particular sentence gives the department the authority to approach someone that has a salvage vehicle that hasn't been told by an insurer, and say you have to get a salvage certificate for that vehicle. In order to simplify the bill, what they are proposing in the first amendment is to say let's take this language out of the bill so the sum total of vehicles which will be involved in the system are only those vehicles that go through an insurers hands, and only those vehicles that are totalled by insurers. Their feeling being that it is far in the way of the majority of vehicles that thieves are interested in doing salvage

switches on. If vehicles are uninsured and they become salvage the point of fact is they are probably not worth enough to keep thieves interests anyway.

Senator Gage pointed out the absurdity of the statement of intent. It gives no intent what so ever of the intent of the legislature.

Amendments, Discussion, and Votes:

Senator Gage stated that it doesn't appear that the second amendments do much for the junk yard folks.

Senator Thayer stated that the new language would be inserted there.

Senator Gage stated that the new language says "if they have complied with this".

Senator Lynch stated it sounds like they are giving it to them and then taking it away again.

Peter Funk stated that section 75-10-513 is existing law. Their feeling is that the salvage operators shouldn't have it both ways. If they are not complying with existing law, which requires them to send in a list of all the vehicles which they possess on a quarterly basis, then why should they be excused from the provisions of this act if they are not following existing law. The amendments say that if they follow the existing law, they will forget about them. If they don't follow existing law, then perhaps their yard needs to be taken a look at.

Senator Thayer stated in defense of the amendment, if they want to send the title in they don't have to worry about a fee. But if they are rebuilding a vehicle they should pay a fee whether it is in the yard currently or if it is a new vehicle that they are going to buy tomorrow. The salvage operator has that option, and this amendment clarifies and answers the concerns of those people.

The amendments proposed passed unanimously.

Recommendation and Vote:

The motion to do pass SB 232 as amended failed 6 to 3 votes.

The motion to do not pass SB 232 as amended passed 6 to 3 votes by way of votes being reversed.

Senator Kennedy asked to have his vote reversed.

Senator Lynch replied without objection that he would allow his vote to be reversed.

The motion to do not pass SB 232 as amended passed 5 to 4 votes.

EXECUTIVE ACTION ON SENATE BILL 169

Motion:

Senator Thayer moved to do pass SB 169.

Discussion:

Senator Thayer asked if SB 232 and SB 169 were companion bills. Would this bill still be beneficial to the department.

Peter Funk replied that it would still be beneficial, this bill embodies the other ideas from the task force that are not late to the issuance of the salvage certificates or the VIN inspection. This bill would accomplish some considerable amount even without the other one.

Amendments, Discussion, and Votes:

None

Recommendation and Vote:

The motion that SB 169 do pass passed unanimously.

EXECUTIVE ACTION ON SENATE BILL 131

Motion:

Senator Noble moved that SB 131 be amended to have an immediate date and a retroactive date.

Senator Noble moved that SB 131 do pass as amended.

Discussion:

Senator Lynch stated that he feels the committee should pass the bill in its first form, it didn't have any opposition. If they want to come back in two years that should be a bill of itself. He feels there should be an amendment on an effective date retroactive.

Amendments, Discussion, and Votes:

Senator Gage stated that his notes recall that the opponents were opposed do to the extensive proposed amendment.

Senator Lynch stated that the opponents are gone now, because the committee didn't put in the extensive amendments.

Recommendation and Vote:

The motion to amend SB 131 passed unanimously.

The motion that SB 131 do pass as amended passed by 8 to 1 votes.

EXECUTIVE ACTION ON SENATE BILL 324

Motion:

Senator Gage moved that SB 324 do not pass.

Discussion:

Senator Williams stated that it was testified to that two states have as of under the 1988 NIC model bill, on the application for rental plus two other states, Utah and Virginia. The 1986 NIC model bill, which he has the information is not hearsay, it's not oral testimony, the facts and figures are right here. The states under the ones in 1986 are California, Indiana, Iowa, Kansas, Louisiana, Maryland, Nevada, South Carolina, Texas, and Wisconsin. We are not breaking trail. He has been trying to get a hold of the gentleman that testified from national car rental and can't get a hold of him. He testified to the fact that one point eight percent of their income was from this program. It is here in black and white, the confusion is much greater than it was. He stated that he did some checking around the state, and understands that there are senators here that have received calls from local rental dealers in the state. There is a lot more involved than just the local dealers. He stated that Dave _____, in Andy Bennett's office stated that each and every auto rental agency must carry at least liability insurance on each car for rent. U-Save auto rental in Butte, Senator Williams stated, read collision damage means if damage happens to our car while in your possession you, the renter, will only be responsible for our U-save insurance deductible which is one thousand dollars. U-save stated that they have to, by law, carry insurance. Hertz, in Belgrade, stated that they have to insure their cars. They also have a new program called PAI, personal accident insurance. For three dollars and ninety five cents a day, it'll protect you, any passenger, and also your belongings in the locked car. The Hertz representative is not able to answer questions pertaining to the limits of the PAI. Hertz has no deductible on any of their programs. The collision damage waiver is twelve dollars a day. Thrifty car rental in Billings, states we have three different programs, we have collision damage, passenger protective coverage (PPC), and personal effects coverage (PEC). There is also no deductible on any program. Collision damage is eight dollars and ninety five cents per day. PPC is three dollars a day, and PEC is one dollar a day. When asked about credit card coverage, if you are in an accident, they immediately charge the full damage amount to your credit card. It states at the bottom of the application that the customer agrees to be bound by both sides of the rental agreement. The application then states "my signature below authorizes all charges to my credit card".

Senator Noble stated that he agrees that there is some confusing business. People learn by and large to deal with this when they travel. The two small companies that he has heard from

say that it is not the one point eight percent of their income, but it's because of the liabilities. If any of these things exist on page three then they should be able to approve it. This bill would make it hard on some small companies.

Senator Thayer stated that we're already paying for our own auto insurance, liability and collision insurance, and we're not going to save anything. We have coverage for our rental cars right now. The worst part about it is is that your going to expect some little car rental agency in Montana to chase some guy back in New York and to sue them, not to mention the fact that we are not held liable or accountable for the cars that we rent. Big companies don't care because they are all self insured anyway and their the only ones that can live with it.

Senator Williams stated that each and every auto rental agency must carry at least liability insurance on each car for rent.

Amendments, Discussion, and Votes:

None

Recommendation and Vote:

The motion to do not pass SB 324 passed 6 to 2 votes.

EXECUTIVE ACTION ON SENATE BILL 394

Motion:

Senator Gage moved that the amendments from SRS do pass.

Senator Gage moved that the amendments that Mr. Hopgood proposed do pass.

Senator Gage moved to pass the amendments excluding sub section one on page six.

Senator Franklin moved that SB 394 do pass as amended.

Senator Thayer moved to table SB 394.

Discussion:

None

Amendments, Discussion, and Votes:

Pat Melby, representing rimrock foundation, submitted some proposed amendments to SB 394 (See attached copy).

Mary Dalton, primary care bureau chief in the medicade department of SRS, stated that originally the reason that medicade asked to be exempt from this bill is because medicade is an unique medical service. Other insurers can limit their benefit by dollar amount or by day amount. Medicade is under federal law mandated to provide medically necessary services. The problem that they have with community standard care is that

if a hospital in Butte decided that the standard of care for psychiatric services in Butte was sixty days, even though they believe that the medical need for services for children is only thirty days, that would automatically become the standard for care. That would set precedence over national standards which is around thirty nine days, and they would then have to pay for sixty days of care even though that care may not be necessary. They don't think they need to be in this bill. All of their rules have to be incorporated through the administrative rules of Montana. If the committee wishes to include them in the amendment that Mr. Melby has suggested it is acceptable to them.

Pat Melby stated that medicade does a substantial amount of utilization review, and should be included in the bill and that's why he proposed an amendment to solve this unique problem that they have.

Senator Thayer asked that Tom Hopgood and Blue Cross respond to the amendments proposed.

Tom Hopgood stated that his main concern appears on page six, in lines four through eight as to who can conduct an adverse review, and who can make an adverse determination. The amendment they have come up with is a person who has to make an adverse finding is a healthcare professional trained in the relevant area of healthcare. The language is a little bit fuzzy, but everyone knows that they have then said that a chiropractic review is adverse to a claim is to be conducted by a chiropractor, etc.

Pat Melby stated that the initial review does not have to be done, if it can be done by a nurse review, which is usually done by most utilization review agencies. The language states, if there is going to be a denial, then the nurse reviews it or some other person reviews it, if they see a problem then they kick at them to appropriate a healthcare professional.

Tom Hopgood stated that is how he understands it. He stated that may be fine for how blue cross blue shield conducts their business, but the companies that he represents do not confine their business just in Montana, they operation nationally and they do not operate in that manner. Montana constitutes a very small share of their market. This bill asked the large companies that operate in fifty states to change their entire way of doing business to fit this particular statute. They have nurse reviewers under the utilization review that is done by the national companies do make final determinations. In the normal course, this can be appealed. When you appeal it up you have somebody that is a healthcare professional in a relevant area, but the initial adverse decision can be made by a nurse reviewer. That is their primary concern. The other concern they have appears on page nine regarding the effective date. The effective date for this bill is July 1, 1991. He has over three hundred companies, some of them conducting business in all fifty states, some of them rather large companies. The compliance by July 1 is going to be very difficult if not impossible for many of those. He asked the committee to consider a normal effective date of October 1, 1991. The amendments proposed are a step in the right direction, but he can't agree with what has been done.

Senator Gage stated that he understands it that they are

bringing the review process done to the professional training area, and requiring before a step earlier as that is what Tom Hopgood's folks are doing.

Tom Hopgood replied that was correct. He suggested that they insert language so that when the review is done by a utilization review agent and they would use standards that are physician determined.

Senator Thayer asked to get a response from a blue cross representative.

Steve Brown, representing blue cross blue shield, stated that they support the amendments as offered by Mr. Melby. They will not object to the bill as amended and passed. They also do not object to changing the effective date. He stated that with the committee's permission he would like Tanya Ask to address the issue of local standards versus the national criteria. The only other point he would like to make is blue cross blue shield would like to respond in detail to the insertion yesterday that they have denied twenty five claims of patients from the rimrock foundation. They have spoken with rimrock, and they are going to provide blue cross blue shield with the names of those patients and they would like permission to file something with the committee that they are willing to respond in detail, because they do not think their testimony was correct.

Senator Thayer asked if it was true that they set up meetings with rimrock on how they were setting this whole thing up.

Steve Brown stated that the pamphlets that the committee was given yesterday was a product of establishing a manage care system in the mental alcohol area. It was his understanding that the criteria that was ultimately adopted by blue cross blue shield were sent to the providers who provide mental alcohol treatment in this state. They were in fact given the opportunity to comment on this criteria.

Tanya Ask, blue cross blue shield, stated that they have no objections to their criteria being available. When they came to the point of adopting chemical dependency and mental illness criteria, they first circulated a draft criteria among all of the providers in the state. They invited them in to work on that criteria, and then sent out copies of their finalized criteria to all of the providers in the state. She submitted copies of all the criteria including a transcript of the meeting (See Exhibit 1, Exhibit 1A, Exhibit 1B, Exhibit 1C). There were some providers who did not agree with all of the criteria that they did put in place. The point is the criteria was available, there was no secret to how they were evaluating claims. Section eight of the bill, page four and page five, because of the concerns raised with the department from SRS and that being these being based on nationally recognized based criteria and reflect community standards of care, and insure quality of care, and insure access to needed healthcare services. All four of those things would go into it, not just specifically looking into the community standards of care. Yesterday, they had raised an objection to a community standard of care and there might be a problem if you are only looking at the standard of care in

perhaps, Butte as opposed to the rest of the state. Maybe they do something different in Butte or in Dillon, then they do in the rest of the state.

Senator Thayer asked if that was in these amendments.

Tanya Ask replied no. They agreed to leave that community standard of care because it is also subject to those other provisions.

Senator Noble asked if this bill as amended is accepted, what would this do to hospital rates.

Pat Melby replied that this bill isn't just directed at blue cross blue shield. Senator Thayer had asked the question on the criteria, and didn't rimrock know about these. Yes, we did, blue cross blue shield had been good about caring for this criteria, and they didn't agree with all of the comments. There are a lot of other insurance agencies out there and a lot of other utilization review agents that do not share their criteria.

Jim Ehrens, president of the Montana hospital association, stated that he didn't see it effecting hospital rates one way or the other.

Senator Noble asked is Larry Akey had anything to say.

Larry Akey, representing the association of life underwriters, stated that they disagree with Jim Ahrens when he stated that hospital rates won't rise. If you wipe out utilization reviews for commercial carriers, utilization rates will rise and the overall amount that is spent on hospital healthcare will go up. If you do that, health insurance premiums will go up.

Senator Franklin asked if Tom Hopgood would describe his amendment.

Tom Hopgood stated that he would strike lines four through eight on page six, and insert the following "any determination by an utilization review agent as to necessity or appropriateness of admission, service, or procedure, shall be reviewed by a physician or determined in accordance with standards or guidelines approved by a physician". He also has a definitional section for a utilization review agent that would go in on page four at lines fourteen in new subsection five "utilization review agents means any person or entity preforming utilization review except an agent of the federal government or an agent acting on behalf of the federal government, that only to the insurance agent is providing services through the federal government". He stated that he doesn't think it would effect Ms. Dalton's amendment.

Pat Melby asked to speak on Tom Hopgood's amendment. It is inappropriate for someone's medical claims be denied even at the first level without the professional healthcare provider, or the healthcare professional that works in that area having review the claim. Most utilization review firms in fact do do it in the way the bill suggests. This language is similar language that is in a lot of other state's legislation regarding utilization review, an these insurance companies are already having to deal with it. The appropriate way to deal with this is to leave the language the way it is. They would agree to a change in the effective date if the language in the bill on a review stays the way it is.

The motion to do pass the proposed amendments from SRS passed unanimously.

The motion to do pass the proposed amendments from Tom Hopgood passed by a 7 to 1 vote.

The motion to do pass the proposed amendments excluding sub section one on page six passed unanimously.

Recommendation and Vote:

The motion to do pass SB 394 as amended failed 5 to 4 vote.

The motion to table SB 394 passed by a reversed vote of 5 to 4.

ADJOURNMENT

Adjournment At: 6:30 p.m.

J.D. LYNCH, Chairman

DARA ANDERSON, Secretary

JDL/dia

ROLL CALL

B & I COMMITTEE

DATE 2/28/91

___ LEGISLATIVE SESSION ___

NAME	PRESENT	ABSENT	EXCUSED
BRUSKI	X		
FRANKLIN	X		
GAGE	X		
HAGER	X		
NOBLE	X		
THAYER	X		
WILLIAMS	X		
KENNEDY	X		
LYNCH	X		

Each day attach to minutes.

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 21 day of Feb, 1991.

Name: Mary Dalton

Address: Medicaid Division
Dept of SRS

Telephone Number: 444-4540

Representing whom?
SRS

Appearing on which proposal?
SB 394

Do you: Support?____ Amend? X Oppose?____

Comments:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY

ROLL CALL VOTE

SENATE COMMITTEE B&I

Date 2/21/91 Bill No. SB 232 Time 5:00

NAME	YES	NO
WILLIAMS		
THAYER	X	
NOBLE	X	
HAGER	X	
GAGE	X	
FRANKLIN		
BRUSKI	X	
KENNEDY	X	
LYNCH	X	

D ANDERSON
Secretary

JD LYNCH
Chairman

Motion: TO AMEND

ROLL CALL VOTE

SENATE COMMITTEE B&I

Date 2/21/91 Bill No. SB 232 Time 5 PM

NAME	YES	NO
WILLIAMS	X	
THAYER	X	
NOBLE		X
HAGER		X
GAGE		X
FRANKLIN		X
BRUSKI		X
KENNEDY		X
LYNCH	X	

D ANDERSON
Secretary

JD LYNCH
Chairman

Motion: DO PASS AS AMENDED

ROLL CALL VOTE

SENATE COMMITTEE B & I

Date 2/21/91 Bill No. SB232 Time 5:00

NAME	YES	NO
WILLIAMS		X
THAYER		X
NOBLE	X	
HAGER	X	
GAGE	X	
FRANKLIN	X	
BRUSKI	X	
KENNEDY - asked to have two more answered	(X) →	
LYNCH		X

D ANDERSON
Secretary

JD LYNCH
Chairman

Motion: DO NOT PASS AS AMENDED

ROLL CALL VOTE

SENATE COMMITTEE B & I

Date 3/21/91 Bill No. SB169 Time 5 PM

NAME	YES	NO
WILLIAMS	X	
THAYER	X	
NOBLE	X	
HAGER	X	
GAGE	X	
FRANKLIN	X	
BRUSKI	X	
KENNEDY	X	
LYNCH	X	

D ANDERSON
Secretary

JD LYNCH
Chairman

Motion: DO PASS

Amendments to Senate Bill No. 131
First Reading Copy

For the Committee on Business and Industry

Prepared by Bart Campbell
February 12, 1991

1. Title, line 4.
Following: "ACT"
Insert: "ADOPTING LAWS TO REGULATE MONTANA CAPTIVE INSURERS;"

2. Title, line 7.
Strike: "AND"

3. Title, line 9.
Following: "DOMICILE"
Insert: "; AND AMENDING SECTION 33-2-708, MCA"

4. Page 1, line 14.
Strike: "3"
Insert: "23"

5. Page 1, line 16.
Strike: "1"
Insert: "21"
Strike: "2"
Insert: "22"

6. Page 1.
Following: line 19
Insert: "NEW SECTION. Section 1. **Short title.** [Sections 1 through 19] may be cited as the "Montana Captive Insurers Act".

NEW SECTION. Section 2. **Definitions.** As used in [sections 1 through 19], the following definitions apply:

(1) "Affiliated company" means a company that, by virtue of common ownership, control, operation, or management, is the same corporate system as a parent company, an industrial insured, or a member organization.

(2) "Association" means a legal association of individuals, corporations, partnerships, or associations that has been in continuous existence for at least 1 year and whose members collectively:

(a) own, control, or hold with power to vote all of the outstanding voting securities of an association captive insurer that is incorporated as a stock insurer; or

(b) have complete voting control over an association captive insurer that is incorporated as a mutual insurer.

(3) "Association captive insurer" means a company that insures risks of the member organizations of the association and their affiliated companies.

(4) "Captive insurer" means a pure captive insurer, association captive insurer, or industrial insured captive insurer formed or authorized under [sections 1 through 19].

(5) "Excess workers' compensation insurance" means, in the case of an employer that has insured or self-insured its workers' compensation risks in accordance with applicable state law, insurance in excess of a specified per-incident or aggregate limit.

(6) "Industrial insured" means an insured:

(a) who procures the insurance of a risk by using the services of a full-time employee acting as an insurance manager or buyer;

(b) whose aggregate annual premiums for insurance on all risks total at least $25,000; and

(c) who has at least 25 full-time employees.

(7) "Industrial insured captive insurer" means a company that insures risks of the industrial insureds that comprise the industrial insured group and the group's affiliated companies.

(8) "Industrial insured group" means either:

(a) a group of industrial insureds that collectively:

(i) own, control, or hold with power to vote all of the outstanding voting securities of an industrial insured captive insurer that is incorporated as a stock insurer; or

(ii) have complete voting control over an industrial insured captive insurer that is incorporated as a mutual insurer; or

(b) a group that is created under the Product Liability Risk Retention Act of 1981 (15 U.S.C. 3901), as amended, as a corporation or other limited liability association taxable as a stock insurer or a mutual insurer under Montana law.

(9) "Member organization" means an individual, corporation, partnership, or association that belongs to an association.

(10) "Parent" means a corporation, partnership, or individual that directly or indirectly owns, controls, or holds with power to vote more than 50% of the outstanding voting securities of a pure captive insurer.

(11) "Pure captive insurer" means a company that insures risks of its parent and affiliated companies.

NEW SECTION. Section 3. **Certificate of authority -- procedure.** (1) A captive insurer, when permitted by its articles of incorporation or charter, may apply to the commissioner for a certificate of authority to transact the kinds of insurance defined in 33-1-206(1)(a), (1)(b), and (1)(d) through (1)(n), 33-1-209, 33-1-210, and 33-1-211, except that:

(a) a pure captive insurer may not insure a risk other than that of its parent and affiliated companies;

(b) an association captive insurer may not insure a risk other than that of the member organizations of its association and their affiliated companies;

(c) an industrial insured captive insurer may not insure a risk other than that of the industrial insureds that comprise the industrial insured group and the group's affiliated companies;

(d) a captive insurer may not provide personal motor vehicle or homeowner's insurance coverage or any component thereof;

(e) a captive insurer may not accept or cede reinsurance except as provided in [section 12]; and

(f) a captive insurer may provide excess workers' compensation insurance to its parent and affiliated companies

unless prohibited by the laws of the state having jurisdiction over the transaction.

(2) A captive insurer may not transact any insurance business in this state unless:

(a) it first obtains from the commissioner a certificate of authority authorizing it to transact insurance business in this state;

(b) its board of directors holds at least one meeting each year in this state;

(c) it maintains its principal place of business in this state; and

(d) it appoints a resident registered agent to accept service of process and to otherwise act on its behalf in this state. If the registered agent cannot with reasonable diligence be found at the registered office of the captive insurer, the secretary of state is the agent of the captive insurer upon whom any process, notice, or demand may be served.

(3) Before receiving a certificate of authority, each applicant captive insurer shall file with the commissioner:

(a) a certified copy of its charter and bylaws, a statement under oath of its president and secretary showing its financial condition, and any other statements or documents required by the commissioner; and

(b) evidence of the following:

(i) the amount and liquidity of its assets relative to the risks to be assumed;

(ii) the adequacy of the expertise, experience, and character of each person who will manage it;

(iii) the overall soundness of its plan of operation;

(iv) the adequacy of the loss prevention programs of its parent, member organizations, or industrial insureds, as applicable; and

(v) other factors considered relevant by the commissioner in ascertaining whether the proposed captive insurer will be able to meet its policy obligations.

(4) Each captive insurer shall pay to the commissioner a nonrefundable fee as provided in 33-2-708 for the examination and investigation and the processing of its application for a certificate of authority. In addition, it shall pay a fee as provided in 33-2-708 for annual continuation of a certificate of authority. The commissioner may retain legal, financial, and examination services from outside the department, the reasonable cost of which may be charged to the applicant.

(5) If the commissioner is satisfied that the documents and statements filed by the captive insurer comply with [sections 1 through 19], he may grant a certificate of authority authorizing it to transact insurance business in this state. A certificate of authority issued under [sections 1 through 19] continues in force until suspended, revoked, or otherwise terminated. The certificate of authority must be continued by the captive insurer each year by payment before March 1 of the renewal fee required in 33-2-708.

NEW SECTION. Section 4. **Name of captive insurer.** A captive insurer may not adopt a name that is the same as, deceptively similar to, or likely to be confused with or mistaken for any

other existing business name registered in the state of Montana.

NEW SECTION. Section 5. **Minimum capital.** The commissioner may not issue a certificate of authority to a pure captive insurer, an association captive insurer that is incorporated as a stock insurer, or an industrial insured captive insurer that is incorporated as a stock insurer unless it possesses and maintains unimpaired, paid-in capital of $400,000.

NEW SECTION. Section 6. **Minimum surplus.** The commissioner may not issue a certificate of authority to a captive insurer unless it possesses and maintains free surplus of:

(1) in the case of a pure captive insurer, not less than $150,000;

(2) in the case of an association captive insurer that is incorporated as a stock insurer, not less than $350,000;

(3) in the case of an industrial insured captive insurer that is incorporated as a stock insurer, not less that $300,000;

(4) in the case of an association captive insurer that is incorporated as a mutual insurer, not less than $750,000; or

(5) in the case of an industrial insured captive insurer that is incorporated as a mutual insurer, not less than $500,000.

NEW SECTION. Section 7. **Formation of captive insurer in this state.** (1) A pure captive insurer must be incorporated in this state as a stock insurer as defined in 33-3-102.

(2) An association captive insurer or an industrial insured captive insurer may be incorporated in this state:

(a) as a stock insurer as defined in 33-3-102; or

(b) as a mutual insurer as defined in 33-3-102.

(3) A captive insurer may not have less than three incorporators, of whom not less than two must be residents of this state.

(4) Before the articles of incorporation are transmitted to the secretary of state, the incorporators shall petition the commissioner to issue a certificate setting forth his finding that the establishment and maintenance of the proposed corporation will promote the general good of the state. To determine whether the corporation will promote the general good of the state, the commissioner shall consider:

(a) the character, reputation, financial standing, and purposes of the incorporators;

(b) the character, reputation, financial responsibility, insurance experience, and business qualifications of the officers and directors; and

(c) other aspects the commissioner considers advisable.

(5) The incorporators shall transmit to the secretary of state the articles of incorporation and the certificate described in subsection (4). The secretary of state shall record the articles of incorporation and the certificate.

(6) The capital stock of a captive insurer incorporated as a stock insurer must be issued at not less than par value.

(7) A least one of the members of the board of directors of a captive insurer incorporated in this state must be a resident

of this state.

(8) A captive insurer formed under [sections 1 through 19] has the privileges of and is subject to Title 35 and the applicable provisions of [sections 1 through 19]. If a provision of Title 35 conflicts with a provision of [sections 1 through 19], [sections 1 through 19] control.

NEW SECTION. Section 8. **Annual statement.** Prior to March 1 of each year, each captive insurer transacting insurance business in this state shall submit to the commissioner a statement of its financial condition, verified by oath of two of its executive officers. Each association captive insurer shall file its statement in the form required by 33-2-701. The commissioner shall by rule propose the form in which a pure captive insurer and an industrial insured captive insurer submit a statement of financial condition.

NEW SECTION. Section 9. **Examinations -- costs.** (1) Except as provided in subsection (2), the commissioner shall, not less than once every 3 years and whenever he considers it advisable, visit each authorized captive insurer and thoroughly inspect and examine its affairs, transactions, accounts, records, and assets to ascertain its financial condition, its ability to fulfill its obligations, and its compliance with [sections 1 through 19].

(2) If the captive insurer is subject to a comprehensive annual audit by independent auditors approved by the commissioner, the commissioner may, in his discretion and upon application by a captive insurer, increase the 3-year period described in subsection (1) to 5 years.

(3) The examined captive insurer shall pay the costs of the examination. The commissioner shall pay to the credit of the general fund all money received by him for an examination or investigation conducted under this section.

NEW SECTION. Section 10. **Grounds and procedures for suspension or revocation of certificate of authority.** (1) The commissioner may suspend or revoke the certificate of authority of a captive insurer to transact insurance in this state for any of the following reasons:

(a) insolvency or impairment of capital or surplus;

(b) failure to meet the requirements of [section 5 or 6];

(c) refusal or failure to submit an annual statement, as required by [section 8], or any other report required by law or by order of the commissioner;

(d) failure to comply with the provisions of [sections 1 through 19] or its own articles of incorporation, charter, or bylaws;

(e) failure to submit to examination, as required by [section 9], or any related legal obligation;

(f) refusal or failure to pay the costs of examination as required by [section 9];

(g) use of methods that, although not otherwise specifically prohibited by law, nevertheless render its operation detrimental to or its condition unsound with respect to the public or its policyholders; or

(h) failure to comply with any other laws of this state.

(2) If, upon examination, hearing, or other evidence, the commissioner finds that a captive insurer has committed any of

the acts specified in subsection (1), he may, notwithstanding any other provision of this code, suspend or revoke the certificate of authority if he finds it in the best interest of the public and the policyholders of the captive insurer.

NEW SECTION. Section 11. **Legal investments.** (1) An association captive insurer shall comply with the investment requirements contained in Title 33, chapter 2, part 8.

(2) A pure captive insurer or industrial insured captive insurer is not subject to any restrictions on allowable investments, including those limitations contained in chapter 2, part 8, except that the commissioner may prohibit or limit any investment that threatens the solvency or liquidity of such an insurer.

NEW SECTION. Section 12. **Reinsurance.** (1) A captive insurer may provide reinsurance on risks ceded by any other insurer.

(2) A captive insurer may take credit for reserves on risks or portions of risks ceded to reinsurers that have complied with 33-2-1205. A captive insurer must receive the prior approval of the commissioner before it may cede risks to or take credit for reserves on risks or portions of risks ceded to reinsurers that have not complied with 33-2-1205.

(3) In addition to credit for reinsurance allowed under 33-2-1205, a captive insurer may take credit for reserves on risks or portions of risks ceded to a pool, exchange, or association acting as a reinsurer that has been authorized by the commissioner. The commissioner may require any documents, financial information, or other evidence that the pool, exchange, or association will be able to provide adequate security for its financial obligations. The commissioner may deny authorization or impose any limitations on the activities of a reinsurance pool, exchange, or association that, in his judgment, are necessary and proper to provide adequate security for the ceding captive insurer and for the protection and benefit of the public.

NEW SECTION. Section 13. **Rating organizations -- membership.** A captive insurer may not be required to join a rating organization.

NEW SECTION. Section 14. **Exemption from compulsory association.** A captive insurer may not join or contribute financially to a plan, pool, association, or guaranty or insolvency fund in this state. A captive insurer, its insured, its parent or any affiliated company, or any member organization of its association may not receive a benefit from any plan, pool, association, or guaranty or insolvency fund for claims arising out of the operations of the captive insurer.

NEW SECTION. Section 15. **Tax on premiums collected.** (1) A captive insurer organized under the provisions of this chapter and doing business in this state shall pay to the commissioner the state tax imposed under chapter 2, part 7, to the same extent and in the same manner as a domestic insurance company.

(2) Domestic captive insurers are subject to the rules adopted under the Montana income tax laws.

(3) The taxes referred to in this section constitute all taxes collectible under the laws of this state from a captive

insurer. No occupation tax or other taxes may be levied or collected from a captive insurer by the state or by a county, city, or municipality within this state, except ad valorem taxes on real and personal property used in the production of income.

NEW SECTION. Section 16. **Rules.** The commissioner may adopt rules relating to captive insurers as are necessary to carry out the provisions of [sections 1 through 19].

NEW SECTION. Section 17. **Other provisions applicable.** (1) Except as provided in subsection (2), the provisions of this code do not apply to a captive insurer.

(2) The following chapters, parts, and sections of this code apply to captive insurers to the extent the provisions are applicable and not in conflict with [sections 1 through 19]: chapter 1; 33-2-701; 33-2-708; chapter 2, part 8; 33-2-1205; chapter 11; and [sections 1 through 19].

NEW SECTION. Section 18. **Penalties.** A captive insurer that violates or causes or induces a violation of [sections 1 through 19] or a rule implementing a provision of [sections 1 through 19] is subject to a penalty as provided in 33-1-317.

NEW SECTION. **Section 19. Subordinated indebtedness.** (1) A captive insurer organized under this chapter may borrow or assume a liability for the repayment of a sum of money upon a written agreement for the loan or advance, with interest at a rate not exceeding the prime rate as reported in the Wall Street Journal on the first business day of the month plus 3% a year. The rate must be fixed on the execution of the loan and may apply only for the term of the loan. The loan and interest must be repaid only out of surplus of the captive insurer in excess of the minimum surplus established in the loan agreement.

(2) The loan agreement must be approved first by a majority of the board of directors of the captive insurer and by the commissioner. Repayment of the principal or interest may be made only if the commissioner is satisfied that the financial condition of the captive insurer warrants the repayment.

(3) A loan or advance, together with the accrued interest, may not constitute part of the legal liabilities of the captive insurer until the commissioner approves repayment of the debt. Until the commissioner authorizes repayment of the debt, all financial statements published by the captive insurer must, at the captive insurer's election, show the debt as a special surplus or capital account.

(4) Nothing in this section may be construed to mean that a company may not otherwise borrow money so long as the amount borrowed is carried by the company as a liability.

Section 20. Section 33-2-708, MCA, is amended to read:

"**33-2-708. Fees and licenses.** (1) Except as provided in 33-17-212(2), the commissioner shall collect in advance and the persons served shall pay to the commissioner the following fees:

(a) certificates of authority:

(i) for filing applications for original certificates of

authority, articles of incorporation (except original articles of incorporation of domestic insurers as provided in subsection (1)(b)) and other charter documents, bylaws, financial statement, examination report, power of attorney to the commissioner, and all other documents and filings required in connection with the application and for issuance of an original certificate of authority, if issued:

(A) domestic insurers ..... $ 600.00

(B) foreign insurers 600.00

(c) captive insurers 600.00

(ii) annual continuation of certificate of authority 600.00

(iii) reinstatement of certificate of authority 25.00

(iv) amendment of certificate of authority 50.00

(b) articles of incorporation:

(i) filing original articles of incorporation of a domestic insurer, exclusive of fees required to be paid by the corporation to the secretary of state 20.00

(ii) filing amendment of articles of incorporation, domestic and foreign insurers, exclusive of fees required to be paid to the secretary of state by a domestic corporation 25.00

(c) filing bylaws or amendment to bylaws where required 10.00

(d) filing annual statement of insurer, other than as part of application for original certificate of authority 25.00

(e) insurance producer's license:

(i) application for original license, including issuance of license, if issued 15.00

(ii) appointment of insurance producer, each insurer 10.00

(iii) temporary license 15.00

(iv) amendment of license (excluding additions to license) or reissuance of master license 15.00

(f) nonresident insurance producer's license:

(i) application for original license, including issuance of license, if issued 100.00

(ii) appointment of insurance producer, each insurer 10.00

(iii) annual renewal of license 10.00

(iv) amendment of license (excluding additions to license) or reissuance of master license 10.00

(g) examination for license as insurance producer, each examination 15.00

(h) surplus lines insurance producer license:

(i) application for original license and for issuance of license, if issued 50.00

(ii) annual renewal of license 50.00

(i) adjuster's license:

(i) application for original license and for issuance of license, if issued 15.00

(ii) annual renewal of license 15.00

(j) insurance vending machine license, each machine, each year 10.00

(k) commissioner's certificate under seal (except when on certificates of authority or licenses) 10.00
(l) copies of documents on file in the commissioner's office, per page ..... .50
(m) policy forms:
(i) filing each policy form 25.00
(ii) filing each application, rider, endorsement, amendment, insert page, schedule of rates, and clarification of risks 10.00
(iii) maximum charge if policy and all forms submitted at one time or resubmitted for approval within 180 days 100.00
(n) applications for approval of prelicensing education courses:
(i) reviewing initial application 150.00
(ii) periodic review 50.00
(2) The commissioner shall promptly deposit with the state treasurer to the credit of the general fund of this state all fines and penalties, those amounts received pursuant to 33-2-311, 33-2-705, and 33-2-706, and any fees and examination and miscellaneous charges that are collected by him pursuant to Title 33 and the rules adopted under Title 33.
(3) All fees are considered fully earned when received. In the event of overpayment, only those amounts in excess of $10 will be refunded.""
Renumber: subsequent sections

7. Page 3, line 13.
Strike: "1"
Insert: "21"
Strike: "2"
Insert: "22"

8. Page 3, line 14.
Following: "instruction"
Insert: "(1) [Sections 1 through 19] are intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to [sections 1 through 19].
(2)"

9. Page 3, lines 15 and 17.
Strike: "1 through 3"
Insert: "21 through 23"

10. Page 3.
Following: line 17
Insert: "NEW SECTION. **Section 25. {standard} Saving clause.** [This act] does not affect rights and duties that matured, penalties that were incurred, or proceedings that were begun before [the effective date of this act].

NEW SECTION. **Section 26. {standard} Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains

in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **Section 1. {standard} Retroactive applicability.** The effective date of [sections 21 through 23] is January 1, 1991."

ROLL CALL VOTE

SENATE COMMITTEE BEI

Date 2/21/91 Bill No. SB131 Time 5 PM

NAME	YES	NO
WILLIAMS	X	
THAYER	X	
NOBLE		X
HAGER	X	
GAGE	X	
FRANKLIN	X	
BRUSKI	X	
KENNEDY	X	
LYNCH	X	

D Anderson
Secretary

JD LYNCH
Chairman

Motion: DO PASS AS AMENDED

ROLL CALL VOTE

SENATE COMMITTEE B&I

Date 2/21/91 Bill No. SB131 Time 5:00

NAME	YES	NO
WILLIAMS	✓	
THAYER	✓	
NOBLE	✓	
HAGER	✓	
GAGE	✓	
FRANKLIN	✓	
BRUSKI	✓	
KENNEDY	✓	
LYNCH	✓	

D. ANDERSON
Secretary

J D LYNCH
Chairman

Motion: TO AMEND IMMEDIATE EFFECTIVE DATE

ROLL CALL VOTE

SENATE COMMITTEE B & I

Date 2/21/91 Bill No. SB324 Time 5 PM

NAME	YES	NO
WILLIAMS		X
THAYER	X	
NOBLE	X	
HAGER	X	
GAGE	X	
FRANKLIN		
BRUSKI	X	
KENNEDY	X	
LYNCH		X

DARA ANDERSON
Secretary

JD LYNCH
Chairman

Motion: DO NOT PASS

DEPARTMENT OF
SOCIAL AND REHABILITATION SERVICES

STAN STEPHENS
GOVERNOR

JULIA E. ROBINSON
DIRECTOR

STATE OF MONTANA

P.O. BOX 4210
HELENA, MONTANA 59604-4210
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TESTIMONY OF THE DEPARTMENT
OF SRS BEFORE THE
SENATE BUSINESS AND INDUSTRY COMMITTEE
(Re: SB 394 Conduct of Utilization Review)

Senator Svrcek has introduced Senate Bill 394 relating to regulating the conduct of utilization reviews by health insurers.

SRS is interested in this bill because of its impact on the Medicaid Division's Utilization Review Programs.

SRS is not opposed to the concept of utilization review (UR) standards or with filing a UR plan with the Insurance Department.

Our concerns with the bill relate to how the UR process is conducted.

Section 4(1) mandates that adverse determinations be approved by a physician. The Medicaid Division contracts with a variety of health care providers to conduct medical necessity determinations. These providers include physicians, dentists, speech therapists, audiologists, etc. that review determinations based on the type of claim involved. This bill should be amended to allow these type of providers to continue to make determinations based on their specialty type.

Section 4(2) mandates the written evaluation of a specialty physician when denial of payment is involved. In Montana, there are many specialty areas including physiatry and psychiatrists where providers are limited.

To require this second level review will increase Medicaid costs to complete the UR process and could delay the time it takes to make determination on individual cases.

Section 5 provides for a presumption of medical necessity if a person is in need of immediate admission to a health care facility. Federal regulations require that medical necessity is determined before Medicaid can pay. In many cases the review is after the fact but the provider is at risk of non-payment if the utilization reviewer determines that the service is not medically necessary. Making payment under a presumption of medical necessity which later is not substantiated could jeopardize federal matching dollars which represents $.72 of every $1.00.

Amendment to Senate Bill #394
(RE: Utilization Reviews)
Introduced Copy

1. Page 9, line 14.
Strike: subsection (iii) in its entirety

2. Page 9.
Following line 19
Insert: "(3) Utilization review for health care services under the general relief medical assistance or medicaid program provided in Title 53 is exempt from the provisions of [this act]."

- End -

Rationale: The proposed amendment exempts persons or entities performing utilization reviews on behalf of state agencies and utilization reviews for health care services under the general relief medical assistance or medicaid program provided in Title 53 from the provisions of the act.

Prepared on February 21, 1991.

Montana Department of Social
& Rehabilitation Services

THIRD DRAFT

Pat Melby
2/21/91

Proposed Amendments to Senate Bill 394

1. Title, line 10.
Strike: "PHYSICIAN"
Insert: "HEALTH CARE PROFESSIONAL TRAINED IN THE RELEVANT AREA OF HEALTH CARE"

2. Title, line 13 through line 15.
Following: "PATIENT" on line 13
Strike: remainder of line 13 through "FACILITY" on line 15

3. Statement of intent, page 1, line 22.
Strike: "requires"
Insert: "authorizes"

4. Page 2, line 5.
Strike: subsections (1) and (2) in their entirety
Renumber: subsequent subsections

5. Page 3, line 22.
Following "counselor;"
Insert: "and"

6. Page 3, line 25.
Strike: "; and"
Insert: "."

7. Page 4, line 1.
Strike: subsection (c) in its entirety

8. Page 5, line 20.
Strike: subsection (7) in its entirety
Renumber: subsequent subsection

9. Page 6, line 8.
Strike: "physician"
Insert: "health care professional trained in the relevant area of health care"

10. Page 6, line 13.
Strike: "physician"
Insert: "health care professional"

11. Page 6, line 14.
Strike: "specialty or subspecialty"
Insert: "area of health care"

12. Page 6, line 19.
Strike: "physician"
Insert: "health care professional"

13. Page 6, line 20.
Strike: "consulted"
Insert: "made a reasonable attempt to consult"

14. Page 6, lines 19 and 20.
Strike: "physician or other"

15. Page 6, line 20.
Strike: ", as the case may be,"

16. Page 6, line 23.
Strike: section 5 in its entirety
Insert: "Section 5. Commissioner not to approve or disapprove plans. Nothing in [sections 1 through 9] may be construed as authorizing the commissioner to approve or disapprove a utilization review plan required in [section 3]."

17. Page 7, line 14.
Strike: "the'
Insert: "all relevant"

18. Page 7, lines 15 through 23
Following: "review" on line 15
Strike: remainder of line 15 through "person" on line 23

19. Page 7, line 24.
Strike: section 7 in its entirety
Renumber: subsequent sections

20. Page 8, line 5.
Strike: "shall"
Insert: "may"

21. Page 8, line 8.
Strike: subsection (1) and (2) in their entirety
Renumber: subsequent subsections

22. Page 8, line 18.
Following: "preempted"
Insert: "or duplicated"

23. Page 8, line 21.
Following: "preempted"
Insert: "or duplicated"

24. Page 8, line 23.
Following: "preemption"
Insert: "or duplication"

25. Page 9, line 16.
Following: "provider"
Insert: ", including in-house utilization review conducted by or for a long-term care facility required by medicare or medicaid regulations,"

26. Page, line 17.
Following: "not"
Insert: "directly"

SENATE BILL NO. 394

INTRODUCED BY Smith, Hoffman, Laughlin, Franklin, Bob Brown, Dorothy Eck, Joe Brown

A BILL FOR AN ACT ENTITLED: "AN ACT TO REGULATE THE CONDUCT OF UTILIZATION REVIEWS BY HEALTH INSURERS AND OTHER THIRD-PARTY PAYORS; TO PROHIBIT A PERSON FROM CONDUCTING UTILIZATION REVIEWS UNLESS THE PERSON MAINTAINS WITH THE COMMISSIONER OF INSURANCE A UTILIZATION REVIEW PLAN; TO PROTECT PATIENTS AND HEALTH CARE PROVIDERS IN THE CONDUCT OF UTILIZATION REVIEWS BY REQUIRING CONCURRENCE OF A HEALTH CARE PROFESSIONAL TRAINED IN THE RELEVANT AREA OF HEALTH CARE IN A DETERMINATION RELATING TO THE NECESSITY OR APPROPRIATENESS OF HEALTH CARE SERVICES RENDERED TO A PATIENT; ~~TO PROVIDE A PRESUMPTION OF MEDICAL NECESSITY OF HEALTH CARE SERVICES IF AN INSURED PERSON IS IN NEED OF IMMEDIATE ADMISSION TO A HEALTH CARE FACILITY;~~ TO PROVIDE FOR THE APPEAL OF AN ADVERSE DECISION RESULTING FROM A UTILIZATION REVIEW; TO AUTHORIZE THE COMMISSIONER OF INSURANCE TO ADOPT RULES; AND PROVIDING AN EFFECTIVE DATE."

STATEMENT OF INTENT

A statement of intent is required for this bill because [section 8] ~~requires~~ authorizes the commissioner of insurance to adopt rules for the purpose of implementing [sections 1 through 10].

It is the intent of the legislature that the commissioner of insurance adopt rules necessary for the regulation of utilization reviews in this state. Rules adopted by the commissioner may include but are not limited to rules providing for:

~~(1) the performance of utilization review activities;~~

~~(2) procedures for reconsideration or appeal of adverse decisions resulting from utilization reviews;~~

~~(3)~~ (1) information to be included in the utilization review plan required in [section 3];

~~(4)~~ (2) utilization review criteria, standards, and procedures; and

~~(5)~~ (3) the protection of the confidentiality of medical records used in the course of utilization reviews.

Rules adopted by the commissioner of insurance must be consistent with the purposes of this bill as stated in [section 1] and must supplement the provisions of [sections 1 through 10].

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

NEW SECTION. **Section 1.** Purpose. The legislature finds and declares that it is the purpose of [sections 1 through 10] to:

(1) promote the delivery of quality health care in a cost-effective manner;

(2) foster greater coordination between health care

INTRODUCED BILL
SB 394

providers, third-party payors, and others who conduct utilization review activities;

(3) ensure access to health care services; and

(4) protect patients, employers, and health care providers by ensuring that utilization review activities result in informed decisions on the appropriateness of medical care made by those best qualified to be involved in the utilization review process.

NEW SECTION. **Section 2.** Definitions. As used in [sections 1 through 10] the following definitions apply:

(1) "Commissioner" means the commissioner of insurance provided for in 2-15-1903.

(2) "Health care provider" means a person, corporation, facility, or institution licensed by the state to provide or otherwise lawfully providing health care services, including but not limited to:

(a) a physician, health care facility as defined in 50-5-101, osteopath, dentist, nurse, optometrist, chiropractor, podiatrist, physical therapist, psychologist, licensed social worker, speech pathologist, audiologist, certified chemical dependency counselor, or licensed professional counselor; and

(b) an officer, employee, or agent of a person described in subsection (2)(a) acting in the course and scope of employment; ~~and~~

~~(c) an agency related to or supportive of health care services.~~

(3) "Health care services" means the health care and services provided by health care providers, including drugs, medicines, ambulance services, and other therapeutic and rehabilitative services and supplies.

(4) "Utilization review" means a system for review of health care services for a patient to determine the necessity or appropriateness of services, whether that review is prospective, concurrent, or retrospective, when the review will be utilized directly or indirectly in order to determine whether the health care services will be paid, covered, or provided.

NEW SECTION. **Section 3.** Utilization review plan. A person may not conduct a utilization review of health care services provided or to be provided to a patient covered under a contract or plan for health care services issued in this state unless that person, at all times, maintains with the commissioner a current utilization review plan that includes:

(1) a description of review criteria, standards, and procedures to be used in evaluating proposed or delivered health care services that, to the extent possible, must:

(a) be based on nationally recognized criteria, standards, and procedures;

Section 5. Commissioner not to approve or disapprove plans. Nothing in [sections 1 through 9] may be construed as authorizing the commissioner to approve or disapprove a utilization review plan required by [section 3]

~~person admitted was in need of immediate care in a health care facility, the certification constitutes a presumption of the medical necessity of the admission. To overcome this presumption, the entity requesting the utilization review or the person conducting the utilization review shall show by clear and convincing evidence that the admitted person was not in need of immediate care in the health care facility.~~

NEW SECTION. **Section 6.** Appeal and assignment of claim. (1) A patient or provider affected by an adverse decision has 30 days in which to appeal or seek reconsideration of the adverse decision by the person conducting the utilization review.

(2) A final decision on appeal or reconsideration must be made within 30 days of receipt of ~~the~~ all relevant medical records by the person conducting the utilization review ~~and not less than 60 days following the request for appeal or reconsideration.~~

~~(3) Notwithstanding any provision to the contrary contained in a contract or plan for health care benefits issued after July 1, 1991, following denial after utilization review and appeal or reconsideration as provided in this section, a claim for health care benefits may be assigned to the health care provider by the covered person.~~

~~NEW SECTION. Section 7. Persons considered engaged in practice of medicine. A physician who reviews health care~~

LC 0921/01

~~services provided or to be provided in this state for utilization review purposes is considered to be engaged in the practice of medicine under Title 37, chapter 3.~~

NEW SECTION. **Section 8.** Commissioner to adopt rules. The commissioner shall adopt rules for the implementation of [sections 1 through 10], including but not limited to rules providing for:

~~(1) the performance of utilization review activities;~~

~~(2) procedures for reconsideration or appeal of adverse decisions resulting from utilization reviews;~~

~~(3)~~ (1) information to be included in the utilization review plan required in [section 3];

~~(4)~~ (2) utilization review criteria, standards, and procedures; and

~~(5)~~ (3) the protection of the confidentiality of medical records used in the course of utilization reviews.

NEW SECTION. **Section 9.** Preemption of federal law. If any provision of [sections 1 through 10] is preempted or duplicated by federal law or regulations as applied to any specific health care service, then the provision of [sections 1 through 10] that is preempted or duplicated by federal law or regulations does not apply to that health care service but only to the extent of the preemption or duplication.

NEW SECTION. **Section 10.** Application of act -- exemptions. (1) The provisions of [sections 1 through 10]

apply to a person or entity performing utilization reviews who is, or is affiliated with, under contract with, or acting on behalf of;

(a) a Montana business entity; or

(b) a third party that provides or administers health care benefits to citizens of this state including:

(i) a health insurer, nonprofit health service plan, health service corporation, employees' health and welfare fund, or preferred provider organization authorized to offer health insurance policies or contracts;

(ii) a health maintenance organization issued a certificate of authority in accordance with Title 33, chapter 31; or

(iii) a state agency.

(2) A general in-house utilization review for a health care provider ^ including in-house utilization review conducted by or for a long-term care facility required by medicare or medicaid regulations. ^ is exempt from the provisions of [sections 1 through 10] as long as the review does not ~~directly~~ ^ result in the approval or denial of payment for health care services for a particular case.

NEW SECTION. **Section 11.** Codification instruction. [Sections 1 through 10] are intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to [sections 1 through 10].

NEW SECTION. **Section 12.** Effective date. [This act] is effective July 1, 1991.

-End-

Blue Cross
Blue Shield
of Montana

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 1
DATE 2/21/91
BILL NO. SB394

Helena Division
404 Fuller Avenue • P.O. Box 4309
Helena, Montana 59604
(406) 444-8200
Fax: (406) 442-6946

Great Falls Division
3360 Tenth Avenue South • P.O. Box 5004
Great Falls, Montana 59403
(406) 791-4000
Fax: (406) 727-9355

October 30, 1990

Mary Huntington-Lehner
Clinical Director
Rocky Mountain Treatment Center
920 Fourth Avenue North
Great Falls, MT 59401-4199

727-8832

RE: Psychiatric and Chemical Dependency Advisory Committee Meetings on November 8 and November 9, 1990

Dear Ms. Lehner:

This letter will confirm our recent telephone conversation regarding the Psychiatric and Chemical Dependency Advisory Committee meetings scheduled for November 8 and November 9, 1990, from 9:30 a.m. to 3:00 p.m. on both days at our Fuller Street office in Helena.

Enclosed are copies of our proposed draft criteria for inpatient psychiatric and chemical dependency treatment. These documents should be considered working drafts for your review and input.

Please indicate Rocky Mountain Treatment Center's participation by completing the bottom portion of the enclosed copy of this letter and returning it to this office, attention: Shelley Ross, Administrative Assistant, Alternative Delivery Systems.

Any questions regarding this meeting should also be directed to Shelley Ross at 444-8258.

We look forward to seeing you November 8 and November 9.

Sincerely,

Shelley Ross
HMO Administrative Assistant

HMOLTR.3
R10060
Enclosure

Representative's Name: _____

Title: _____

Telephone: _____

Reply to Helena Division

CRITERIA FOR INPATIENT CHEMICAL DEPENDENCY TREATMENT

JUSTIFICATION FOR ADMISSION

The patient must have a clearly documented history of excessive use of alcohol and/or other psychoactive chemicals and is currently unable to effectively control this chemical use at the time of admission. An evaluation period to assess the patient's condition in conjunction with these criteria may also be necessary if a diagnosis cannot be determined. In order for coverage to apply, the conditions described in this paragraph, plus one or more of the following must be descriptive of the patient's condition and be documented in the medical records:

1. Significant suicidal or homicidal risk demonstrated by documented behavior.

2. Life-threatening symptomatology related to excessive use of alcohol or drugs (coma, stupor, convulsions, etc.)

3. Seriously impaired social, family or occupational functioning requiring the need for continuous skilled observation/care in a structured inpatient treatment program, i.e., patient is unable to abstain from the use of chemicals, and this condition and its associated behaviors result in the patient's inability to function on the job or in the home, in even a limited capacity.

4. Medical conditions that are not life-threatening but related to the excessive use of alcohol and/or drugs such as metabolic abnormalities and impairment of physiological functioning which must be severe enough to warrant inpatient treatment.

5. Failure of outpatient treatment within the past 12 months as evidenced by documentation in the patient's medical records by one or more of the following:

   a. Intensification of symptoms

   b. Lack of adequate expected therapeutic response

   c. Inadequate involvement of the patient as an active participant in the treatment program

JUSTIFICATION FOR CONTINUED STAY

Documentation of one or more of the following is needed for justification of continued stay:

1. Change of diagnosis or treatment failure which necessitates a change in the treatment plan and continued inpatient treatment.

2. The complications of chemical dependency are exacerbated by a substantive psychiatric problem which is documented by psychological testing by a psychologist or psychiatric evaluation by a psychiatrist. The patient is sufficiently impaired by a psychiatric illness that he/she is unable to benefit from an outpatient program and requires the continued support of an inpatient treatment program.

3. External, destructive factors which jeopardize the health care management of the patient and requires the controlled environment of an inpatient treatment program.

4. The patient's physical, emotional or behavioral condition requires an inpatient environment. Documentation of specific symptoms is necessary.

5. Existence or development of medical complications or side effects of medications which require continued stay.

JUSTIFICATION FOR TERMINATION OF INPATIENT BENEFITS

1. Patient is resistant to treatment to a degree that sufficient progress is not likely to continue in an inpatient treatment program.

2. Continued stay solely for the purpose of waiting for:

   a. Placement in a halfway house, foster home, or outpatient program.
   b. Scheduling of family or employer conference.

NONCOVERED

1. Inpatient treatment for those individuals whose chemical use is not completely out of control, but who are perceived as "slipping" and in need of reinforcement will not be covered.

2. Outpatient treatment is appropriate, but not available.

3. Treatment of chemical dependency for substances other than the following will not be covered: ethyl alcohol, minor tranquillizers, narcotics and narcotic synthetics, sedatives/hypnotics, amphetamines, cocaine, hallucinogens, products containing tetra-hydro-cannabinol, or volatile inhalants.

4. Admission done solely for the presence of the following reasons will not be considered adequate for coverage of services and must be accompanied by one of the covered admission criteria.

   a. Truancy and/or family problems. Example: Nonsupportive environment.

   b. No halfway house, boarding school, or other facility available.

   c. Court-ordered admissions.

DRAFT

CRITERIA FOR INPATIENT PSYCHIATRIC TREATMENT

A. JUSTIFICATION FOR ADMISSION

Services will be covered if one or more of the following describe the patient's current condition.

1. Actual or potential danger to self, others and/or property.

   a. Psychiatric disorder with significant risk of suicidal and/or homicidal behavior.

   b. Psychiatric disorder with dangerous assaultive or other uncontrolled behavior not due to acute intoxication.

2. Evaluation for or treatment with electroshock or electroconvulsive therapy where an inpatient environment is clearly indicated and outpatient treatment of this sort is not appropriate.

3. Failure of an outpatient treatment program evidenced by documentation in the patient's medical records of:

   a. Intensification of symptoms.

   b. Lack of expected therapeutic response to drugs.

   c. Lack of adequate expected therapeutic response and/or inadequate involvement of the patient as an active participant in the treatment program.

4. Acute care setting is necessary because of documented need, in the patient's medical records, for a structured treatment environment. Outpatient treatment is not beneficial due to the patient's psychiatric illness/clinical disorientation or disorganization leading to:

   a. Failure to keep appointments.

   b. Failure to take prescribed medication.

   c. Inadequate involvement of the patient as an active participant in the treatment program.

5. Initiation of medication for the treatment of the psychiatric diagnosis which may be complicated by the presence of a medical condition.

6. Regulation of medication for the psychiatric diagnosis due to complications arising from side effects of medication initiated on an outpatient basis.

7. Need for more observation and evaluation of the patient due to questionable diagnosis so that proper treatment plan can be initiated.

Admission done solely for the presence of the following reasons or diagnoses will not be considered adequate for coverage of services. Admissions done for these reasons must be accompanied by one of the above admission criteria.

1. Court ordered evaluation period. (County involved will be responsible until the date of the hearing.)

2. Truancy and/or family problems. Example: Nonsupportive environment.

3. Admissions for diagnostic evaluations, mental retardation and learning disability.

4. No halfway house, boarding school, or other facility available.

NONCOVERED: Outpatient treatment is feasible, but not available.

B. JUSTIFICATION FOR CONTINUED STAY

Documentation for one or more of the following:

1. Continued evidence of symptoms which would reflect potential danger to self, others and/or property.

2. Continued use of electroshock or electroconvulsive therapy as the prescribed course of treatment.

3. Initiation of medications for the treatment of the psychiatric diagnosis which may be complicated by the presence of medical condition.

4. Continued regulation of medication for the psychiatric diagnosis or treatment of complications arising as side effects of medications.

5. Inability of the patient to perform the activities of daily living or to function in the daily routine due to the mental state of the patient.

6. Intensification of illness or persistence of symptoms/behavior of such severity that it requires continued supervision and hospitalization.

7. Change of diagnosis or treatment failure necessitating a change in the treatment plan.

8. Cited treatment plans have been reviewed and elements that are essential to the successful completion of the program were found to be incomplete.

C. JUSTIFICATION FOR DISCHARGE

1. When the patient has reached the level where further progress cannot be achieved, services will be considered custodial and, therefore, are not covered.

2. Maintenance of patient after stabilization has occurred if outpatient treatment or residential treatment is feasible. Availability of alternate services is not a consideration.

3. Cases waiting placement in a: A. Foster home, B. chemical dependency treatment program, when mental health and/or chemical dependency problems are found to exist.

4. Institutionalization in lieu of detention or correctional placement.

Blue Cross
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of Montana

SENATE BUSINESS & INDUSTRY
EXHIBIT NO. 14
DATE 2/21/91
BILL NO. SB394

Helena Division
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Helena, Montana 59604
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Great Falls Division
3360 Tenth Avenue South • P.O. Box 5004
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Fax: (406) 727-9355

December 31, 1990

Mary Huntington-Lehner
Rocky Mountain Treatment Center
920 Fourth Avenue North
Great Falls, MT 59401-4199

Re: Inpatient Psychiatric and Chemical Dependency Treatment Criteria

Dear Ms. Huntington-Lehner:

We appreciate your attendance and comments at our recent Chemical Dependency and Psychiatric Inpatient Stay Criteria Meetings on November 8 and November 9, 1990. Based on these meetings and follow-up communication from many of those who attended the meetings, we have revised our psychiatric and chemical dependency inpatient stay criteria incorporating many of your suggestions and ideas.

Our staff will be reviewing cases using these revised criteria beginning February 1, 1991. Prior to certification of any length of stay, cases will be required to meet admission criteria at the time of admission. You will note our criteria address severity of illness and intensity of service as we feel both are essential in determining appropriateness of inpatient treatment.

Again, we appreciate your participation in these meetings and look forward to further correspondence with you regarding our psychiatric and chemical dependency inpatient criteria. Should you have any questions or comments regarding our psychiatric and chemical dependency inpatient criteria, please address written correspondence to:

Kristie Wilson, Supervisor
Certification Review
Managed Care Montana
P.O. Box 1165
Helena, MT 59624-1165

Sincerely,

James W. Crichton, M.D.
Medical Director

KW/smp
T201V

Final

CRITERIA FOR INPATIENT CHEMICAL DEPENDENCY TREATMENT

JUSTIFICATION FOR ADMISSION

The patient must have a clearly documented history of excessive use of alcohol and/or other psychoactive chemicals and is currently unable to effectively control this chemical use at the time of admission. In order for medical necessity to apply, the conditions described in this paragraph, plus one or more of the following must be descriptive of the patient's condition and be documented clearly in the medical records:

1. Significant suicidal or homicidal risk demonstrated by documented behavior.

2. Life-threatening symptomatology related to excessive use of alcohol or drugs (coma, stupor, convulsions, etc.)

3. The complications of chemical dependency are exacerbated by a substantive psychiatric problem which is documented by psychiatric evaluation by a psychiatrist. The patient is sufficiently impaired by a psychiatric illness that he/she is unable to benefit from an outpatient program and requires the continuous support of an inpatient treatment program.

4. Seriously impaired social, family or occupational functioning requiring the need for continuous skilled observation/care in a structured inpatient treatment program, i.e., patient is unable to abstain from the use of chemicals, and this condition and its associated behaviors result in the patient's inability to function on the job or in the home.

5. Medical conditions that are not life-threatening but related to the excessive use of alcohol and/or drugs such as metabolic abnormalities and impairment of physiological functioning which must be severe enough to warrant inpatient treatment.

6. Failure of outpatient treatment appropriate to the patient's needs within the past 12 months as evidenced by documentation in the patient's medical records by one or more of the following:

   a. Intensification of symptoms

b. Lack of adequate expected therapeutic response

c. Inadequate involvement of the patient as an active participant in the treatment program

JUSTIFICATION FOR CONTINUED STAY

Documentation of one or more of the following is needed for justification of continued stay:

1. Change of diagnosis or treatment failure which necessitates a change in the treatment plan and continued inpatient treatment.

2. The complications of chemical dependency are exacerbated by a substantive psychiatric problem which is documented by psychological testing by a psychologist or psychiatric evaluation by a psychiatrist or licensed clinical social worker's psychosocial evaluation. The patient is sufficiently impaired by a psychiatric illness that he/she is unable to benefit from an outpatient program and requires the continued support of an inpatient treatment program.

3. External, destructive factors which jeopardize the health care management of the patient and requires the controlled environment of an inpatient treatment program.

4. Existence or development of medical complications or side effects of medications which require continued stay.

JUSTIFICATION FOR DISCHARGE

1. Patient is resistant to treatment to a degree that sufficient progress is not likely to continue in an inpatient treatment program.

2. Continued stay solely for the purpose of waiting for:

   a. Placement in a halfway house, foster home, or outpatient program.
   b. Scheduling of family or employer conference.

NONCOVERED

1. Inpatient treatment for those individuals whose chemical use is not completely out of control, but who are perceived as "slipping" and in need of reinforcement.

2. Outpatient treatment is appropriate, but not available. Availability of existing alternate services is not necessarily a consideration.

3. Treatment of chemical dependency for substances other than the following: ethyl alcohol, minor tranquilizers, narcotics and narcotic synthetics, sedatives/hypnotics, amphetamines, cocaine, hallucinogens, products containing tetra-hydro-cannabinol, or volatile inhalants.

4. Admission done solely for the presence of the following reasons will not be considered adequate for and must be accompanied by one of the admission criteria.

   a. Truancy and/or family problems. Example: Nonsupportive environment.

   b. No halfway house, boarding school, or other facility available.

   c. Court-ordered admissions.

Final

CRITERIA FOR INPATIENT PSYCHIATRIC TREATMENT

A. JUSTIFICATION FOR ADMISSION

Services will be considered as meeting criteria if one or more of the following describe the patient's current condition.

1. Actual or potential danger to self, others and/or property.

   a. Psychiatric disorder with significant risk of suicidal and/or homicidal behavior.

   b. Psychiatric disorder with dangerous assaultive or other uncontrolled behavior.

2. Evaluation for or treatment with electroconvulsive therapy where an inpatient environment is clearly indicated and outpatient treatment of this sort is not appropriate.

3. Failure of an outpatient treatment program evidenced by documentation in the patient's inpatient medical records of:

   a. Intensification of symptoms.

   b. Lack of expected therapeutic response to drugs.

   c. Lack of adequate expected therapeutic response and/or inadequate involvement of the patient as an active participant in the treatment program.

4. Acute care setting is necessary because of documented need, in the patient's inpatient medical records, for a structured treatment environment. Outpatient treatment is not beneficial or expected to be beneficial due to the patient's psychiatric illness/clinical disorientation or disorganization leading to:

   a. Failure to keep appointments.

   b. Failure to take prescribed medication.

   c. Inadequate involvement of the patient as an active participant in the treatment program.

   d. Deterioration of behavioral functioning (e.g. socially, vocationally/academically, and basic self care) of sufficient severity to make outpatient treatment inappropriate.

5. Initiation of medication for the treatment of the psychiatric diagnosis which may be complicated by the presence of a medical condition.

6. Regulation of medication for the psychiatric diagnosis due to complications arising from side effects of medication initiated on an outpatient basis.

Admission done solely for the presence of the following reasons or diagnoses will not be considered adequate. Admissions done for these reasons must be accompanied by one of the above admission criteria.

1. Court ordered evaluation period. (County involved will be responsible until the date of the hearing.)

2. Truancy and/or family problems. Example: Nonsupportive environment.

3. Admissions for diagnostic evaluations, mental retardation and learning disability.

4. No halfway house, boarding school, or other facility available.

5. Admissions for acute intoxication/detoxification.

NONCOVERED: Outpatient treatment is appropriate, but not available.

B. JUSTIFICATION FOR CONTINUED STAY

Documentation for one or more of the following:

1. Continued evidence of symptoms which would reflect potential danger to self, others and/or property.

2. Continued use of electroconvulsive therapy as the prescribed course of treatment.

3. Initiation of medications for the treatment of the psychiatric diagnosis which may be complicated by the presence of medical condition.

4. Continued regulation of medication for the psychiatric diagnosis or treatment of complications arising as side effects of medications (does not include minor dosage adjustments).

5. Inability of the patient to perform the activities of daily living or to function in a less intensive setting due to the mental state of the patient.

6. Intensification of illness or persistence of symptoms/behavior of such severity that it requires continued supervision and hospitalization.

7. Change of diagnosis or treatment failure necessitating a change in the treatment plan.

C. JUSTIFICATION FOR DISCHARGE

1. When the patient has reached the level where further significant progress cannot be achieved, services will be considered custodial and, therefore, are not medically necessary.

2. Maintenance of patient after stabilization has occurred if outpatient treatment or residential treatment is appropriate. Availability of existing alternate services is not necessarily a consideration.

3. Cases waiting placement in facilities including, but not limited to: A. Foster home, B. chemical dependency treatment program, when mental health and/or chemical dependency problems are found to exist, C. Nursing home.

4. Institutionalization in lieu of detention or correctional placement.

OVERVIEW OF PSYCHIATRIC INPATIENT STAY CRITERIA MEETING 11/09/90

The criteria are listed below by heading and number followed by comments and questions from the Advising Committee.

Justification for Admission

Services will be covered if one or more of the following describe the patient's current condition.

1. Actual or potential danger to self, others and/or property.

   a. Psychiatric disorder with significant risk of suicidal and/or homicidal behavior.

   b. Psychiatric disorder with dangerous assaultive or other uncontrolled behavior not due to acute intoxication.

   Comments: The words "significant risk" need to be defined.

   This criterion should be further expanded to include inability to care for self.

   Under 1(b), concern was expressed with noncoverage due to "...acute intoxification."

   Response: To help clarify, it was decided that the chemical dependency criteria would be sent out to everyone present as well. Dr. Scanlan mentioned this would be a clinical judgment and that this point addresses more the police bringing up the drunk off the street.

   Query: What is the definition of psychiatric disorder? Are there certain diagnoses that are being excluded?

   Response: Diagnoses that are covered vary depending upon certification of coverage. While every contract is virtually, we have self-funded groups that we just administer. These self-funded groups are able to choose whatever benefits or exclusions they like.

   Comment: 1(b) should be reworded so that the intent is that the patient may not be admitted solely for detoxification. Interpretation as it exists will create problems down the road.

2. Evaluation for or treatment with electroshock or electroconvulsive therapy where an inpatient environment is clearly indicated and ouptatient treatment of this sort is not appropriate.

   Comment: Electroshock should be eliminated as this treatment is archaic and maintains an old stigma.

3. Failure of an outpatient treatment program evidenced by documentation in the patient's medical records of:

   a. Intensification of symptoms.

   b. Lack of expected therapeutic response to drugs.

   c. Lack of adequate expected therapeutic response and/or inadequate involvement of the patient as an active participant in the treatment program.

   Comment: The term "medical record" should be expanded upon to include "social record." This again should be further defined, or made clear that you are asking for hospital records.

   Response: We expect you to provide us with records to justify your decision for inpatient admission.

   Comment: This set of criteria would be more straight forward if you had a section that states when outpatient treatment would not be the appropriate treatment.

4. Acute care setting is necessary because of documented need, in the patient's medical records, for a structured treatment environment. Outpatient treatment is not beneficial due to the patient's psychiatric illness/clinical disorientation or disorganization leading to:

   a. Failure to keep appointments.

   b. Failure to take prescribed medication.

   c. Inadequate involvement of the patient as an active participant in the treatment program.

   Comment: The treatment of adolescents is not always the same as for adults, and because of that, outpatient treatment may work for an adult but not for an adolescent and some consideration should be given to this.

   Comment: Again, the term "medical record" should be spelled out as hospital "hospital record" if that, indeed, is the type of record being requested.

   Comment: In the case of a minor or adolescent, language should be added to the effect that the caregiver is unable to provide the requirements and not necessarily the child.

   Comment: The opening paragraph of #4 should be further defined by adding "...not beneficial or expected to be beneficial..."

5. Initiation of medication for the treatment of the psychiatric diagnosis which may be complicated by the presence of a medical condition.

6. Regulation of medication for the psychiatric diagnosis due to complications arising from side effects of medication initiated on an outpatient basis.

7. Need for more observation and evaluation of the patient due to questionable diagnosis so that proper treatment plan can be initiated.

Admission done solely for the presence of the following reasons or diagnoses will not be considered adequate for coverage of services. Admissions done for these reasons must be accompanied by one of the above admission criteria.

1. Court ordered evaluation period. (County involved will be responsible until the date of the hearing.)

2. Truancy and/or family problems. Example: Nonsupportive environment.

   Comment: This should be part of the admission criteria.

3. Admissions for diagnostic evaluations, mental retardation and learning disability.

   Comment: This conflicts with #7 above and should be clarified.

   Response: #7 can be reworded.

4. No halfway house, boarding school, or other facility available.

NONCOVERED: Outpatient treatment is feasible, but not available.

Comment: The chemical dependency criteria used the term "appropriate" care, and this criteria uses the word "feasible." Both sets of criteria should be consistent.

Justification for Continued Stay

Documentation for one or more of the following:

1. Continued evidence of symptoms which would reflect potential danger to self, others and/or property.

2. Continued use of electroshock or electroconvulsive therapy as the prescribed course of treatment.

   Comment: Electroshock should be eliminated as this treatment is archaic and maintains old stigma.

3. Initiation of medications for the treatment of the psychiatric diagnosis which may be complicated by the presence of medical condition.

4. Continued regulation of medication for the psychiatric diagnosis or treatment of complications arising as side effects of medications.

Comment: Dr. Scanlan suggested we add that minor changes in medication may be reason enough to keep the person in an acute care facility.

Good criteria, but one of the dangers is that this criteria could be played with to justify inpatient treatment.

5. Inability of the patient to perform the activities of daily living or to function in the daily routine due to the mental state of the patient.

Comment: Concern whether this statement refers to not functioning in hospital or in the real world.

Response: Dr. Scanlan suggested rewording to indicate functioning in a less intensive setting.

Comment: Could Blue Cross and Blue Shield of Montana further add "functioning in a less intensive setting than available"?

6. Intensification of illness or persistence of symptoms/behavior of such severity that it requires continued supervision and hospitalization.

7. Change of diagnosis or treatment failure necessitating a change in the treatment plan.

8. Cited treatment plans have been reviewed and elements that are essential to the successful completion of the program were found to be incomplete.

Comment: Concern expressed that some of the criteria listed for psychiatry are not available for chemical dependency, particularly this criteria.

Justification for Discharge

1. When the patient has reached the level where further progress cannot be achieved, services will be considered custodial and, therefore, are not covered.

Comment: How much progress is considered no progress? This needs to be clarified.

2. Maintenance of patient after stabilization has occurred if outpatient treatment or residential treatment is feasible. Availability of alternate services is not a consideration.

Comment: This criterion should be revised to add "not necessarily a consideration."

Comment: This is the type of criteria that causes ethical problems.

Comment: This criterion should be revised to cover existing, but unavailable facilities.

3. Cases waiting placement in a: A. Foster home, B. chemical dependency treatment program, when mental health and/or chemical dependency problems are found to exist.

   Comment: Nursing homes should be considered.

   Comment: The facilities listed in this criterion should be cited as examples.

   Response: This is a criterion that Blue Cross and Blue Shield of Montana needs to look at and determine how it will be administered.

4. Institutionalization in lieu of detention or correctional placement.

SR/lj
D161R

OVERVIEW OF CHEMICAL DEPENDENCY INPATIENT STAY CRITERIA MEETING
November 8, 1990

The criteria as distributed for the above-referenced meeting are listed below by heading and number followed by questions and comments from the advising committee.

Justification for Admission

The patient must have a clearly documented history of excessive use of alcohol and/or other psychoactive chemicals and is currently unable to effectively control this chemical use at the time of admission. An evaluation period to assess the patient's condition in conjunction with these criteria may also be necessary if a diagnosis cannot be determined. In order for coverage to apply, the conditions described in this paragraph, plus one or more of the following must be descriptive of the patient's condition and be documented in the medical records:

Query: What is the time frame for making an evaluation.

Response: Three days. The three days would include detox, but additional time may be needed if a person is actively detoxing at that time. In addition, the generated problem list required by ICAM should at least be started within those three days.

Query: Does the person have to be currently using to meet criteria in the first paragraph?

Response: Dr. Scanlan advised that this is a clinical issue and each case would be reviewed on the basis of the information submitted.

Justification for Admission

1. Significant suicidal or homicidal risk demonstrated by documented behavior.

Query: What if a facility does not have the ability to treat those at significant suicidal or homicidal risk. Does this rule that facility out?

Response: We realize that not every facility has the ability to treat those who are at significant suicidal or homicidal risk. This is why the first paragraph asks for "one or more of the following . . ." This response would also relate to No. 2.

Comment: It was stated that No. 1 in the criteria is too vague and should be broadened.

2. Life-threatening symptomatology related to excessive use of alcohol or drugs (coma, stupor, convulsions, etc.).

Comment: Criterion No. 2 seems skewed to facilities without detox units.

3. Seriously impaired social, family or occupational functioning requiring the need for continuous skilled observation/care in a structured inpatient treatment program, i.e., patient is unable to abstain from the use of chemicals, and this condition and its associated behaviors result in the patient's inability to function on the job or in the home, in even a limited capacity.

Comment: This criterion is very vague and poorly worded and leaves things too open-ended. Levels of functioning need to be laid out with more specificity. The approach that the NAATP and AASAM use is much clearer.

4. Medical conditions that are not life-threatening but related to the excessive use of alcohol and/or drugs such as metabolic abnormalities and impairment of physiological functioning which must be severe enough to warrant inpatient treatment.

Comment: There are problems getting payment from insurance companies for older patients who are in-stage alcoholics who have been admitted to an acute care facility for metabolic symptoms and then transferred to attached CD facility.

5. Failure of outpatient treatment within the past 12 months as evidenced by documentation in the patient's medical records by one or more of the following:

a. Intensification of symptoms.

b. Lack of adequate expected therapeutic response.

c. Inadequate involvement of the patient as an active participant in the treatment program.

Comment: Point brought up that this criterion has not been used as one of five; it is the criterion for inpatient stay. It appears that regardless of other criteria the patient may have if this doesn't apply, there is no admit. Failure of an outpatient program should not be a prerequisite to inpatient care. It was felt that this criterion is discriminatory, and should speak to clinical condition of patient and security.

Response: The point was stressed about this being one consideration and not the only criterion.)

Comment: Another point made here was that adolescents need special consideration, and that extra latitude needs to be given to kids.

Comment: A definition of outpatient was requested.

Query: Is consideration given to the patient as to whether he/she feels he can be or is successful in outpatient treatment.

Comment: No. 5b. and c. seem to contradict No. 1 under Justification for Termination of inpatient benefits.

Justification for Continued Stay

1. Change of diagnosis or treatment failure which necessitates a change in the treatment plan and continued inpatient treatment.

   No comments.

2. The complications of chemical dependency are exacerbated by a substantive psychiatric problem which is documented by psychological testing by a psychologist or psychiatric evaluation by a psychiatrist. The patient is sufficiently impaired by a psychiatric illness that he/she is unable to benefit from an outpatient program and requires the continued support of an inpatient treatment program.

   Comment: Concern was expressed with dual diagnoses patients, it is felt in the time frame allowed, some facilities are unable to treat the alcoholic schizophrenic for example.

   Query: At what point would the continued stay criterion 2 apply?

   Response: After the initial days assigned end.

   Comment: This criterion should be added under Justification for Admission.

3. External, destructive factors which jeopardize the health care management of the patient and requires the controlled environment of an inpatient treatment program.

   Query: How would halfway house care be treated?

   Response: That is something that is being looked at, but we have to be careful that we don't conflict with mandated benefits.

4. The patient's physical, emotional or behavioral condition requires an inpatient environment. Documentation of specific symptoms is necessary.

   Comment: This criterion seems so objective. What the admitting counselor might see could be totally different than what Blue Cross and Blue Shield of Montana sees.

   Comment: It is felt that Blue Cross and Blue Shield of Montana needs to address the degree of what needs to be present for discharge. JCAH and NAATP require each facility to have level of treatment objectives. There are

three levels the patient needs to see before being discharged, and this is something Blue Cross and Blue Shield of Montana should think about incorporating into their criteria. Need to address degree of resolution of problems.

Comment: This criterion belongs in "Justification for Admission" rather than under this section.

5. Existence or development of medical complications or side effects of medications which require continued stay.

Comment: None.

Justification for Termination of Inpatient Benefits

1. Patient is resistant to treatment to a degree that sufficient progress is not likely to continue in an inpatient treatment program.

Comment: The word "inpatient" should be changed to "residential" when referring to type of treatment program.

Comment: Inpatient hospital and inpatient residential are different and should be defined.

2. Continued stay solely for the purpose of waiting for:

a. Placement in a halfway house, foster home, or outpatient program.
b. Scheduling of family or employer conference.

Comment: None.

Noncovered

1. Inpatient treatment for those individuals whose chemical use is not completely out of control, but who are perceived as "slipping" and in need of reinforcement will not be covered.

Comment: Excludes the binge-drinking alcoholic.

2. Outpatient treatment is appropriate, but not available.

Comment: Much concern expressed about communities where outpatient treatments are not available.

Comment: "Not available" needs further definition.

Response: We have to look at availability of services in our review.

3. Treatment of chemical dependency for substances other than the following will not be covered: ethyl alcohol, minor tranquilizers, narcotics and narcotic synthetics, sedatives/hypnotics, amphetamines, cocaine,

hallucinogens, products containing tetra-hydro-cannabinol, or volatile inhalants.

Comment: Needs to be further defined.

Response: We will revise criterion to add ". . . to such an extent that patient cannot participate in a less intensive treatment setting."

4. Admission done solely for the presence of the following reasons will not be considered adequate for coverage of services and must be accompanied by one of the covered admission criteria.

   a. Truancy and/or family problems. Example: Nonsupportive environment.

   b. No halfway house, boarding school, or other facility available.

   c. Court-ordered admissions.

   Comment: Key word in this criterion is "solely."

SR/sks
D141T

ROLL CALL VOTE

SENATE COMMITTEE B & I

Date 2/21/91 Bill No. SB394 Time 5:00 PM

NAME	YES	NO
WILLIAMS	X	
THAYER	X	
NOBLE	X	
HAGER		X
GAGE	X	
FRANKLIN	X	
BRUSKI	X	
KENNEDY	X	
LYNCH		

D ANDERSON
Secretary

JD LYNCH
Chairman

Motion: THE AMENDMENTS OF TOM HOPGOOD

ROLL CALL VOTE

SENATE COMMITTEE BEI

Date 2/21/91 Bill No. SB394 Time 5 PM

NAME	YES	NO
WILLIAMS	X	
THAYER	X	
NOBLE	X	
HABER	X	
GAGE	X	
FRANKLIN	X	
BRUSICI	X	
KENNEDY	X	
LYNCH		

DARA ANDERSON
Secretary

JD LYNCH
Chairman

Motion: THE AMENDMTS FROM SRS

ROLL CALL VOTE

SENATE COMMITTEE B&I

Date 2/21/91 Bill No. SB394 Time 5 PM

NAME	YES	NO
WILLIAMS		X
THAYER	X	
NOBLE	X	
HAGER	X	
GAGE	X	
FRANKLIN		X
BRUSKI	X	
KENNEDY		X
LYNCH		X

D ANDERSON
Secretary

JD LYNCH
Chairman

Motion: RVS VOTE - TABLE

SENATE STANDING COMMITTEE REPORT

February 22, 1991

MR. PRESIDENT:

We, your committee on Business and Industry having had under consideration Senate Bill No. 169 (first reading copy -- white), respectfully report that Senate Bill No. 169 do pass.

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

2-22-91
Asst. Coord.

2-22 9:40
Sec. of Senate

SENATE STANDING COMMITTEE REPORT

February 22, 1991

MR. PRESIDENT:
We, your committee on Business and Industry having had under consideration Senate Bill No. 131 (first reading copy -- white), respectfully report that Senate Bill No. 131 be amended and as so amended do pass:

1. Title, line 7.
Following: ";"
Strike: "AND"

2. Title, line 9.
Following: "DOMICILE"
Insert: "; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE AND A RETROACTIVE APPLICABILITY DATE"

3. Page 3, line 18.
Insert: "NEW SECTION. Section 5. Effective date -- retroactive applicability. [This act] is effective on passage and approval and applies retroactively, within the meaning of 1-2-109, to January 1, 1991."

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

2-22-91
Amd. Coord.

2-22 9:40
Sec. of Senate

SENATE STANDING COMMITTEE REPORT

February 22, 1991

MR. PRESIDENT:

We, your committee on Business and Industry having had under consideration Senate Bill No. 232 (first reading copy -- white), respectfully report that Senate Bill No. 232 be amended and as so amended do not pass:

1. Page 9, line 21 through page 10, line 1.
Following: "(4)" on page 9, line 21
Strike: remainder of line 21 through "." on page 10, line 1

2. Page 10, line 21.
Following: line 20
Insert: "(7) A salvage vehicle owned by or in the inventory of a motor vehicle wrecking facility on October 1, 1991, is exempt from the provisions of this section if the owner of the facility has complied with the provisions of 75-10-513(2)."

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

2-22-91
Amd. Coord.

2-22 9:40
Sec. of Senate

SENATE STANDING COMMITTEE REPORT

February 22, 1991

MR. PRESIDENT:

We, your committee on Business and Industry having had under consideration Senate Bill No. 324 (first reading copy -- white), respectfully report that Senate Bill No. 324 do not pass.

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

JL 2-22-91
Amd. Coord.

2-22 1:40
Sec. of Senate