

1 HOUSE BILL NO. 156

2 INTRODUCED BY E. BUTTREY

3 BY REQUEST OF THE ECONOMIC AFFAIRS INTERIM COMMITTEE
4

5 A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING LAWS UNDER THE SUPERVISION OF
6 THE STATE AUDITOR; REVISING SECURITIES LAWS RELATING TO DISCLOSURE OF FINANCIAL
7 EXPLOITATION OF AN OLDER PERSON; AUTHORIZING THE SECURITIES ASSISTANCE RESTITUTION
8 FUND TO ASSERT CERTAIN CLAIMS FOR RESTITUTION; REVISING LAWS RELATING TO
9 COMMISSIONER ACCESS TO INSURANCE RECORDS; REVISING INSURANCE LAWS TO REMOVE
10 CERTAIN SERVICE OF PROCESS FEES; REVISING INSURANCE SERVICE OF PROCESS LAWS;
11 REVISING INSURANCE CERTIFICATE OF AUTHORITY LAWS; REQUIRING THE COMMISSIONER TO
12 MAKE AN APPROVED RISK LIST; REVISING THE PENALTY RELATING TO CERTAIN SURPLUS LINES
13 FILINGS; DEFINING "PHARMACY SERVICES ADMINISTRATIVE ORGANIZATION"; REVISING LAWS
14 RELATING TO PHARMACY SERVICES ADMINISTRATIVE ORGANIZATIONS; REVISING LAWS RELATING
15 TO FILINGS OF POLICY FORMS; REVISING LAWS RELATING TO THE APPOINTMENT OF FOREIGN OR
16 ALIEN SOCIETIES; REVISING LAWS RELATING TO THE BOARD OF DIRECTORS OF THE MONTANA
17 LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION BOARD; REVISING LAWS RELATING TO
18 COMMERCIAL LINES POLICIES; REVISING LAWS RELATING TO THE FILING OF VARIABLE LIFE
19 INSURANCE CONTRACTS; REVISING PHARMACY SERVICES ADMINISTRATIVE ORGANIZATION LAWS;
20 REVISING DEFINITIONS; REVISING LAWS RELATING TO THE MONTANA REINSURANCE ASSOCIATION
21 ACT; ALLOWING THE COMMISSIONER TO PERFORM DUTIES OF THE ASSOCIATION ADMINISTRATOR;
22 REVISING MONTANA REINSURANCE ASSOCIATION BOARD POWERS AND COMMISSIONER DUTIES;
23 REVISING LAWS RELATED TO REINSURANCE ASSOCIATION REIMBURSEMENT, PAYMENT, AND
24 EXPENSES; DEFINING "TITLE GUARANTEE"; AUTHORIZING THE COMMISSIONER TO ORDER
25 RESTITUTION RELATED TO TITLE INSURANCE; REVISING LAWS RELATING TO IN-NETWORK AND
26 OUT-OF-NETWORK EMERGENCY SERVICES; REVISING LAWS RELATED TO UTILIZATION REVIEW
27 ORGANIZATIONS; REVISING LAWS RELATED TO STANDARDS FOR PROPERTY AND CASUALTY
28 INSURERS; PROVIDING FOR COVERAGE OF CERTAIN ORAL THERAPY PRESCRIPTIONS RELATED TO

1 OPIOID USE DISORDERS; TRANSFERRING STATUTORY DUTIES FROM THE DEPARTMENT OF PUBLIC
 2 HEALTH AND HUMAN SERVICES TO THE COMMISSIONER OF SECURITIES AND INSURANCE
 3 RELATING TO THE MANAGED CARE PLAN NETWORK ADEQUACY AND QUALITY ASSURANCE ACT;
 4 AUTHORIZING THE COMMISSIONER TO TRANSFER EXISTING RULES RELATING TO THE ACT;
 5 EXTENDING RULEMAKING AUTHORITY; AMENDING SECTIONS 15-31-114, 30-10-341, 30-10-1004, 33-1-
 6 408, 33-1-605, 33-2-116, 33-2-312, 33-2-2402, 33-2-2404, 33-4-509, 33-7-531, 33-10-204, 33-15-336, 33-17-
 7 1101, 33-20-606, 33-20-1316, 33-22-156, 33-22-170, 33-22-172, 33-22-173, 33-22-177, 33-22-1128, 33-22-
 8 1303, 33-22-1307, 33-22-1308, 33-22-1309, 33-22-1313, 33-22-1314, 33-22-1315, 33-22-1316, 33-22-1317,
 9 33-22-1321, 33-23-310, 33-25-105, 33-25-301, 33-32-215, 33-33-201, 33-33-202, 33-36-102, 33-36-103, 33-
 10 36-105, 33-36-201, 33-36-203, 33-36-209, 33-36-210, 33-36-211, 33-36-212, 33-36-213, 33-36-301, 33-36-
 11 302, 33-36-303, 33-36-304, 33-36-305, AND 33-36-401, MCA; REPEALING SECTIONS 33-2-322, 33-7-123,
 12 AND 33-17-405, MCA; AND PROVIDING EFFECTIVE DATES.”

13

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

15

16 **Section 1.** Section 15-31-114, MCA, is amended to read:

17 **"15-31-114. Deductions allowed in computing income.** (1) In computing the net income, the
 18 following deductions are allowed from the gross income received by the corporation within the year from all
 19 sources:

20 (a) all the ordinary and necessary expenses paid or incurred during the taxable year in the
 21 maintenance and operation of its business and properties, including reasonable allowance for salaries for
 22 personal services actually rendered, subject to the limitation contained in this section, and rentals or other
 23 payments required to be made as a condition to the continued use or possession of property to which the
 24 corporation has not taken or is not taking title or in which it has no equity. A deduction is not allowed for salaries
 25 paid upon which the recipient has not paid Montana state income tax. However, when domestic corporations
 26 are taxed on income derived from outside the state, salaries of officers paid in connection with securing the
 27 income are deductible.

28 (b) (i) all losses actually sustained and charged off within the year and not compensated by

1 insurance or otherwise, including a reasonable allowance for the wear and tear and obsolescence of property
2 used in the trade or business. The allowance is determined according to the provisions of section 167 of the
3 Internal Revenue Code in effect with respect to the taxable year. All elections for depreciation must be the
4 same as the elections made for federal income tax purposes. A deduction is not allowed for any amount paid
5 out for any buildings, permanent improvements, or betterments made to increase the value of any property or
6 estate, and a deduction may not be made for any amount of expense of restoring property or making good the
7 exhaustion of property for which an allowance is or has been made. A depreciation or amortization deduction is
8 not allowed on a title plant as defined in 33-25-105~~(45)~~.

9 (ii) There is allowed as a deduction for the taxable period a net operating loss deduction
10 determined according to the provisions of 15-31-119.

11 (c) in the case of mines, other natural deposits, oil and gas wells, and timber, a reasonable
12 allowance for depletion and for depreciation of improvements. The reasonable allowance must be determined
13 according to the provisions of the Internal Revenue Code in effect for the taxable year. All elections made under
14 the Internal Revenue Code with respect to capitalizing or expensing exploration and development costs and
15 intangible drilling expenses for corporate income tax purposes must be the same as the elections made for
16 federal income tax purposes.

17 (d) the amount of interest paid within the year on its indebtedness incurred in the operation of the
18 business from which its income is derived. Interest may not be allowed as a deduction if paid on an
19 indebtedness created for the purchase, maintenance, or improvement of property or for the conduct of business
20 unless the income from the property or business would be taxable under this part.

21 (e) (i) taxes paid within the year, except the following:

22 (A) taxes imposed by this part;

23 (B) taxes assessed against local benefits of a kind tending to increase the value of the property
24 assessed;

25 (C) taxes on or according to or measured by net income or profits imposed by authority of the
26 government of the United States;

27 (D) taxes imposed by any other state or country upon or measured by net income or profits.

28 (ii) Taxes deductible under this part must be construed to include taxes imposed by any county,

1 school district, or municipality of this state.

2 (f) that portion of an energy-related investment allowed as a deduction under 15-32-103;

3 (g) (i) except as provided in subsection (1)(g)(ii) or (1)(g)(iii), charitable contributions and gifts that
4 qualify for deduction under section 170 of the Internal Revenue Code, 26 U.S.C. 170, as amended.

5 (ii) The public service commission may not allow in the rate base of a regulated corporation the
6 inclusion of contributions made under this subsection.

7 (iii) A deduction is not allowed for a charitable contribution using a charitable gift annuity unless the
8 annuity is a qualified charitable gift annuity as defined in 33-20-701.

9 (h) per capita livestock fees imposed pursuant to 15-24-921, 15-24-922, 81-6-104, 81-6-204, 81-6-
10 209, 81-7-118, or 81-7-201.

11 (2) In lieu of the deduction allowed under subsection (1)(g), the taxpayer may deduct the fair
12 market value, not to exceed 30% of the taxpayer's net income, of a computer or other sophisticated
13 technological equipment or apparatus intended for use with the computer donated to an elementary, secondary,
14 or accredited postsecondary school located in Montana if:

15 (a) the contribution is made no later than 5 years after the manufacture of the donated property is
16 substantially completed;

17 (b) the property is not transferred by the donee in exchange for money, other property, or services;
18 and

19 (c) the taxpayer receives a written statement from the donee in which the donee agrees to accept
20 the property and representing that the use and disposition of the property will be in accordance with the
21 provisions of subsection (2)(b).

22 (3) In the case of a regulated investment company or a fund of a regulated investment company,
23 as defined in section 851(a) or 851(g) of the Internal Revenue Code of 1986, 26 U.S.C. 851(a) or 851(g), as
24 that section may be amended or renumbered, there is allowed a deduction for dividends paid, as defined in
25 section 561 of the Internal Revenue Code of 1986, 26 U.S.C. 561, as that section may be amended or
26 renumbered, except that the deduction for dividends is not allowed with respect to dividends attributable to any
27 income that is not subject to tax under this chapter when earned by the regulated investment company. For the
28 purposes of computing the deduction for dividends paid, the provisions of sections 852(b)(7) and 855 of the

1 Internal Revenue Code of 1986, 26 U.S.C. 852(b)(7) and 855, as those sections may be amended or
 2 renumbered, apply. A regulated investment company is not allowed a deduction for dividends received as
 3 defined in sections 243 through 245 of the Internal Revenue Code of 1986, 26 U.S.C. 243 through 245, as
 4 those sections may be amended or renumbered."

5

6 **Section 2.** Section 30-10-341, MCA, is amended to read:

7 **"30-10-341. Third-party disclosure -- immunity.** (1) ~~If a qualified individual, investment adviser,~~
 8 ~~investment adviser representative, or salesperson reasonably believes that financial exploitation of a vulnerable~~
 9 ~~person may have occurred, may have been attempted, or is being attempted, the qualified individual,~~
 10 ~~investment adviser, investment adviser representative, or salesperson may notify any third party closely~~
 11 ~~connected to the vulnerable person. Disclosure may not be made to a third party who is suspected of financial~~
 12 ~~exploitation or other abuse of the vulnerable person~~ A qualified individual, investment adviser, investment
 13 adviser representative, or salesperson may:

14 (a) notify a covered agency if the covered person believes that the financial exploitation of an older
 15 person or a person with a developmental disability is occurring, has or may have occurred, is being attempted,
 16 or has been or may have been attempted;

17 (b) notify any third party reasonably associated with an older person or a person with a
 18 developmental disability if the covered person believes that the financial exploitation of an older person or a
 19 person with a developmental disability is occurring, has or may have occurred, is being attempted, or has been
 20 or may have been attempted. A third party reasonably associated with an older person or a person with a
 21 developmental disability includes but is not limited to the following:

22 (i) a parent, spouse, adult child, sibling, or other known family member or close associate of an
 23 older person or a person with a developmental disability;

24 (ii) an authorized contact provided by an older person or a person with a developmental disability
 25 to the covered financial institution;

26 (iii) a co-owner, additional authorized signatory, or beneficiary of an older person or a person with
 27 a developmental disability's account; and

28 (iv) an attorney-in-fact, trustee, conservator, guardian, or other fiduciary who has been selected by

1 an older person, a person with a developmental disability, a court, a government agency, or a third party to
 2 manage some or all of the financial affairs of the older person or the person with a developmental disability;
 3 (c) choose not to notify any third party reasonably associated with an older person or a person
 4 with a developmental disability of suspected financial exploitation of the older person or the person with a
 5 developmental disability if the covered person believes the third party is, may be, or may have been engaged in
 6 the financial exploitation of the older person or the person with a developmental disability.

7 (2) A qualified individual, investment adviser, investment adviser representative, or salesperson
 8 who, in good faith and exercising reasonable care, complies with this section is immune from administrative or
 9 civil liability that might otherwise arise from the disclosure."
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11 **Section 3.** Section 30-10-1004, MCA, is amended to read:

12 **"30-10-1004. (Temporary) Creation of securities restitution assistance fund.** (1) There is an
 13 account in the state special revenue fund to the credit of the commissioner for use only for securities restitution
 14 assistance. This account may be referred to as the "securities restitution assistance fund" or "fund". The money
 15 in the fund is statutorily appropriated, as provided in 17-7-502, to the commissioner for the purposes provided in
 16 subsection (4) of this section.

17 (2) (a) The fund consists of amounts received by the commissioner from:

18 (i) persons who have violated any provision of parts 1 through 3 of this chapter;

19 (ii) persons who have voluntarily contributed to the fund; and

20 (iii) a portion of fees collected under 30-10-209(1)(b) as provided in 30-10-209(6)(b).

21 (b) Amounts received by the commissioner for deposit in the fund do not include administrative
 22 penalties or fines imposed under this chapter and as referenced under the Montana Administrative Procedure
 23 Act, Title 2, chapter 4, part 6.

24 (c) The amounts received for the fund may not be placed in the general fund.

25 (3) Amounts received by the commissioner for deposit in the fund must be promptly turned over to
 26 the state treasurer for deposit in the fund created under subsection (1).

27 (4) The fund may be used by the commissioner only to pay awards of restitution assistance under
 28 this part.

1 (5) Whenever a claimant is paid from the securities restitution assistance fund pursuant to this
 2 section, the securities restitution assistance fund is subrogated, to the extent of the payment to the claimant, to
 3 the rights of the claimant to any restitution ordered by the court. The commissioner may, on behalf of the
 4 securities restitution assistance fund, file any document in a court of competent jurisdiction to enforce this right.
 5 (Terminates June 30, 2027--secs. 3, 4, Ch. 404, L. 2021.)"

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7 **Section 4.** Section 33-1-408, MCA, is amended to read:

8 **"33-1-408. Conduct of examinations -- records -- correction of accounts -- appraisals.** (1) Upon
 9 determining that an examination should be conducted, the commissioner or the commissioner's designee shall
 10 issue an examination warrant appointing one or more examiners to perform the examination and instructing
 11 them as to the scope of the examination. In conducting the examination, an examiner shall observe the
 12 guidelines and procedures set forth in the examiners' handbook adopted by the NAIC. The commissioner may
 13 also employ other guidelines or procedures as the commissioner considers appropriate.

14 (2) Every company or person from whom information is sought and its officers, directors,
 15 employees, and agents shall provide to the examiners appointed under subsection (1) timely, convenient, and
 16 free access at all reasonable hours ~~at its offices~~ to all books, records, accounts, papers, documents, and any or
 17 all computer or other recordings relating to the property, assets, business, and affairs of the company being
 18 examined, including but not limited to access at its offices. The officers, directors, employees, and agents of the
 19 company or person shall facilitate the examination and aid in the examination so far as it is in their power to do
 20 so. The refusal of any company, by its officers, directors, employees, or agents, to submit to examination or to
 21 comply with any reasonable written request of the examiners is grounds for suspension, refusal, or nonrenewal
 22 of any license or authority held by the company to engage in an insurance or other business subject to the
 23 commissioner's jurisdiction. A proceeding for suspension, revocation, or refusal of any license or authority must
 24 be conducted pursuant to 33-1-318 and 33-1-701.

25 (3) The commissioner or any examiner has the power to issue subpoenas, administer oaths, and
 26 examine under oath any person concerning any matter pertinent to the examination. Upon the failure or refusal
 27 of a person to obey a subpoena, the commissioner may petition a court of competent jurisdiction and, upon
 28 proper showing, the court may enter an order compelling the witness to appear and testify or to produce

1 documentary evidence. Failure to obey the court order is punishable as contempt of court.

2 (4) When making an examination under this part, the commissioner may retain attorneys,
3 appraisers, independent actuaries, independent certified public accountants, or other professionals and
4 specialists as examiners. The cost of retaining the personnel must be borne by the company that is the subject
5 of the examination.

6 (5) This part may not be construed to limit the commissioner's authority to terminate or suspend
7 any examination in order to pursue other legal or regulatory action pursuant to this title. Findings of fact and
8 conclusions made pursuant to an examination are prima facie evidence in any legal or regulatory action.

9 (6) This part may not be construed to limit the commissioner's authority to use and, if appropriate,
10 to make public any final or preliminary examination report, any examiner or company workpapers or other
11 documents, or any other information discovered or developed during the course of any examination in the
12 furtherance of any legal or regulatory action that the commissioner may consider appropriate."
13

14 **Section 5.** Section 33-1-605, MCA, is amended to read:

15 **"33-1-605. Service of process -- foreign or alien insurer -- appointment of registered agent. (1)**

16 A foreign or alien insurer that transacts any business in this state must have a registered agent upon whom any
17 legal process, notice, or demand required or permitted by law to be served upon a company must be served.

18 The agent must be a person who either resides or maintains a business address in this state.

19 (2) The written appointment of an agent must be provided to the commissioner in a form
20 prescribed by the commissioner, and must, at minimum, include a consent to service of process and the official
21 name and address of the agent and the insurer represented.

22 (3) The commissioner shall keep a record of the foreign and alien insurers transacting business in
23 Montana and the name and address of their registered agents. This record must be made public in a readily
24 accessible form prescribed by the commissioner.

25 (4) Service by certified mail to a registered agent listed for an insurer constitutes service of legal
26 process upon that insurer.

27 (5) An insurer may revoke the appointment of an agent by filing with the commissioner a written
28 appointment of another agent and a statement that the appointment of the former agent is revoked. The

1 authority of the agent whose appointment has been revoked terminates 30 days after the notice is received by
2 the commissioner.

3 (6) When a foreign or alien insurer ceases to do business in this state, the agent last designated
4 by or acting for the insurer is deemed to continue as agent for it unless a new agent is appointed. Service by
5 certified mail upon any such agent constitutes service of legal process upon the insurer.

6 ~~(7) Each insurer shall include a fee of \$10 with any initial appointment, change of agent appointment,~~
7 ~~or change of address. The fee is waived for an insurer filing an agent appointment with an original application~~
8 ~~for a certificate of authority or an annual renewal.~~

9 ~~(8)(7)~~ This section does not limit or affect the right to serve any process, notice, or demand upon an
10 insurer in any other manner permitted by law.

11 ~~(9)(8)~~ When legal process is served pursuant to this section, the insurer must appear, answer, or
12 plead within 30 days, exclusive of the date of mailing, after the date of the certified mailing or be subject to the
13 laws of this state regarding default judgment.

14 ~~(10)(9)~~ For the purposes of this section:

15 (a) "certified mail" means a method of sending by common carrier with tracking capability; and

16 (b) "legal process" means a summons and complaint.

17

18 **Section 6.** Section 33-2-116, MCA, is amended to read:

19 **"33-2-116. Issuance or refusal of certificate of authority -- state ownership of certificate.** (1) If
20 upon completion of an insurer's application for a certificate of authority the commissioner finds that the insurer
21 has met the requirements for a certificate of authority under this code, the commissioner shall issue to the
22 insurer a proper certificate of authority. If the commissioner does not find that the insurer is entitled to a
23 certificate of authority, the commissioner shall issue an order refusing to issue a certificate. The commissioner
24 shall act upon an application for a certificate of authority within 180 days after its completion.

25 (2) The certificate, if issued, must specify the kind or kinds of insurance the insurer is authorized to
26 transact in Montana. At the insurer's request, the commissioner may issue a certificate of authority limited to
27 particular types of insurance or insurance coverages within the scope of a kind of insurance as defined in 33-1-
28 205 through 33-1-212.

1 (3) Although issued to the insurer, the certificate of authority is at all times the property of the state
2 of Montana. Upon any expiration or termination of the certificate of authority, the insurer shall promptly ~~deliver~~
3 destroy the certificate of authority to the commissioner."
4

5 NEW SECTION. Section 7. Insurance presumed unobtainable from authorized insurers. (1) At
6 least annually, the commissioner shall make available a list of the kinds of insurance that are presumed to be
7 unobtainable from authorized insurers, known as the approved risk list.

8 (2) When approved, the list constitutes a conclusive presumption within the meaning of 33-2-302
9 that any kind of insurance appearing on the list cannot be obtained from authorized insurers and does not
10 require a diligent search by a licensed surplus lines insurance producer.
11

12 **Section 8.** Section 33-2-312, MCA, is amended to read:

13 **"33-2-312. Penalty for failure to file statement, pay tax, or pay stamping fee.** (1) A surplus lines
14 insurance producer or an insured that independently procured insurance that fails to file the tax and fee
15 statement as required under 33-2-310 or to pay the taxes as required under 33-2-311 is liable for a penalty of
16 up to \$25 for each day of delinquency, commencing 30 calendar days after the due date established by the
17 commissioner by rule. The tax and penalty may be recovered in an action instituted by the commissioner in the
18 name of the state in any court of competent jurisdiction with the attorney general representing the
19 commissioner. The penalty when collected, unless collected by a justice's court, must be paid to the
20 commissioner, forwarded to the state treasurer, and placed to the credit of the general fund. The surplus lines
21 insurance producer's license is also subject to revocation as provided in 33-2-313.

22 (2) If a surplus lines insurance producer or an insured that independently procured insurance does
23 not pay the stamping fee provided for in 33-2-321, the commissioner may impose a penalty of 25% of the
24 stamping fee due plus 1.5% a month from the time of delinquency until the stamping fee is paid."
25

26 **Section 9.** Section 33-2-2402, MCA, is amended to read:

27 **"33-2-2402. Definitions.** As used in this part, the following definitions apply:

28 (1) "Claims processing services" means the administrative services performed in connection with

1 the processing and adjudicating of claims relating to pharmacist services that include either or both of the
2 following:

3 (a) receiving payments for pharmacist services; and

4 (b) making payments to pharmacists or pharmacies.

5 (2) "Enrollee" means a member, policyholder, subscriber, covered person, beneficiary, dependent,
6 or other individual participating in a health benefit plan.

7 (3) "Federally certified health entity" means a 340B covered entity as described in 42 U.S.C.
8 256b(a)(4).

9 (4) "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered, or
10 issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care
11 services.

12 (5) (a) "Health carrier" means an entity that is subject to the insurance laws and regulations of this
13 state or to the jurisdiction of the commissioner and that contracts or offers to contract or enters into an
14 agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

15 (b) The term includes:

16 (i) self-funded multiple employer welfare arrangements as defined in 33-35-103; and

17 (ii) any other entity providing a plan of health insurance, health benefits, or health care services.

18 (6) "Manufacturer" has the meaning provided in 37-7-602.

19 (7) "Other prescription drug or device services" means services other than claims processing
20 services that are provided directly or indirectly, whether in connection with or separate from claims processing
21 services, including but not limited to:

22 (a) negotiating rebates, discounts, or other financial incentives and arrangements with
23 manufacturers, wholesale distributors, or other third parties;

24 (b) disbursing or distributing rebates;

25 (c) managing or participating in incentive programs or arrangements for pharmacist services;

26 (d) negotiating or entering into contractual arrangements with pharmacists, pharmacies, or both;

27 (e) developing and maintaining formularies;

28 (f) designing prescription drug benefit programs;

1 (g) advertising or promoting services; or

2 (h) administering prior authorization, step therapy, case management, or other utilization review
3 programs.

4 (8) "Pharmacist" has the meaning provided in 33-22-170.

5 (9) "Pharmacist services" means products, goods, and services or any combination of products,
6 goods, and services provided as part of the practice of pharmacy.

7 (10) "Pharmacy" means an established location, either physical or electronic, that is licensed by the
8 board of pharmacy pursuant to Title 37, chapter 7.

9 (11) (a) "Pharmacy benefit manager" means a person, including a wholly or partially owned or
10 controlled subsidiary of a pharmacy benefit manager, that provides claims processing services or other
11 prescription drug or device services, or both, to:

12 (i) enrollees who are residents of this state, for health benefit plans; or

13 (ii) injured workers of workers' compensation insurance carriers.

14 (b) The term does not include:

15 (i) a health care facility as defined in 50-5-101 that is licensed in this state;

16 (ii) a health care professional licensed under Title 37;

17 (iii) a consultant who provides advice only as to the selection or performance of a pharmacy benefit
18 manager; or

19 (iv) a health carrier or workers' compensation insurance carrier to the extent that the carrier
20 performs any claims processing and other prescription drug or device services exclusively for its enrollees or
21 injured workers.

22 (12) "Pharmacy services administrative organization" means an entity that acts as a contracting
23 agent or provides contracting and other administrative services to pharmacies to assist them in their
24 interactions with third-party payers, pharmacy benefit managers, drug wholesalers, and other entities.

25 ~~(12)~~(13) "Plan sponsor" has the meaning provided in 33-10-202.

26 ~~(13)~~(14) (a) "Rebates" means all price concessions, however characterized, paid by a manufacturer to
27 a pharmacy benefit manager, including discounts and other remuneration or price concessions, that are based
28 on the actual or estimated utilization of a prescription drug.

1 (b) The term includes price concessions based on the effectiveness of a prescription drug as in a
2 value-based or performance-based contract.

3 ~~(14)~~(15) "Wholesale acquisition cost" has the meaning provided in 42 U.S.C. 1395w-3a.

4 ~~(15)~~(16) "Wholesale distributor" or "distributor" has the meaning provided in 37-7-602.

5 ~~(16)~~(17) "Workers' compensation insurance carrier" means:

6 (a) an insurance company transacting business under compensation plan No. 2; or

7 (b) the state fund compensation plan No. 3 under Title 39, chapter 71."

8

9 **Section 10.** Section 33-2-2404, MCA, is amended to read:

10 **"33-2-2404. Pharmacy benefit manager prohibited practices.** (1) In any participation contracts
11 between a pharmacy benefit manager and pharmacies, ~~or pharmacists,~~ or a pharmacy services administrative
12 organization providing prescription drug coverage, a pharmacy or pharmacist may not be prohibited, restricted,
13 or penalized in any way from disclosing to any enrollee or injured worker any information the pharmacy or
14 pharmacist considers appropriate regarding:

15 (a) the decision of utilization reviewers or similar persons to authorize or deny drug coverage or
16 benefits; and

17 (b) the process that is used to authorize or deny drug coverage or benefits.

18 (2) (a) A pharmacy benefit manager contract with a participating pharmacy, ~~or pharmacist,~~ or a
19 pharmacy services administrative organization in this state may not prohibit, restrict, or limit disclosure of
20 information to the commissioner when the commissioner is investigating or examining a complaint or
21 conducting a review of a pharmacy benefit manager's compliance with the requirements of this part.

22 (b) A pharmacy benefit manager may not terminate the contract of or penalize a pharmacy, ~~or~~
23 pharmacist, or a pharmacy services administrative organization for sharing any portion of the pharmacy benefit
24 manager contract with the commissioner for investigation of a complaint or a question regarding whether the
25 contract complies with this part.

26 (c) Any examination or review under this section must follow the examination procedures and
27 requirements applicable to insurers under Title 33, chapter 1, part 4, including but not limited to the
28 confidentiality provisions of 33-1-409."

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Section 11. Section 33-4-509, MCA, is amended to read:

"33-4-509. Application and policy forms filed with commissioner. All forms of application for insurance and of policies proposed to be used by an insurer must be filed with and approved by the commissioner prior to the issuance, delivery, or use in this state~~at least 30 days in advance of any use~~. The commissioner shall disapprove any form found by the commissioner to be unlawful, illegible, or misleading. An insurer may not use any form after it has received the commissioner's notice of disapproval setting forth the reasons for disapproval."

NEW SECTION. **Section 12. Service of process.** Service of process against a society authorized to do business in this state must be made pursuant to 35-7-113 or in any other manner permitted by law.

Section 13. Section 33-7-531, MCA, is amended to read:

"33-7-531. Foreign or alien society -- admission. (1) A foreign or alien society may not transact business in this state without a license issued by the commissioner of insurance. A foreign or alien society desiring admission to this state shall comply substantially with the requirements and limitations of this chapter applicable to domestic societies. A society may be licensed to transact business in this state upon filing with the commissioner:

(a) a certified copy of its articles of incorporation;

(b) a copy of its bylaws, certified by its secretary or corresponding officer;

~~(c) a written appointment of the commissioner to be the society's agent, as prescribed in 33-7-123 ;~~

~~(d)~~(c) a statement of its business, under oath of its president and secretary or corresponding officers, in a form prescribed by the commissioner, verified by an examination made by the supervising insurance official of its home state or other state, district, territory, province, or country satisfactory to the commissioner of this state;

~~(e)~~(d) certification from the proper official of its home state, district, territory, province, or country that the society is legally incorporated and licensed to transact business in that jurisdiction;

~~(f)~~(e) copies of its certificate forms; and

1 ~~(g)~~(f) other information the commissioner considers necessary.

2 (2) A foreign or alien society applying for authority to transact business in this state must have the
3 qualifications required of domestic societies organized under this chapter."

4

5 **Section 14.** Section 33-10-204, MCA, is amended to read:

6 **"33-10-204. Board of directors -- commissioner approval -- compensation.** (1) The board of
7 directors of the association consists of not less than seven or more than nine members serving terms as
8 established in the plan of operation. Two of the members must be appointed from the public at large by the
9 commissioner. The other members of the board must be selected by member insurers subject to the approval
10 of the commissioner. Vacancies on the board must be filled for the remaining period of the term in the manner
11 described in the plan of operation. In approving selections or in appointing members to the board, the
12 commissioner shall consider, among other things, whether all member insurers are fairly represented.

13 (2) Members of the board may be reimbursed from the assets of the association for expenses
14 incurred by them as members of the board of directors, but members of the board may not otherwise be
15 compensated by the association for their services. However, any designated representatives of members of the
16 board who are not full-time employees of the member insurers that designated them may receive reasonable
17 compensation for their services on the board of directors upon annual approval by the members of the
18 association."

19

20 **Section 15.** Section 33-15-336, MCA, is amended to read:

21 **"33-15-336. Applicability.** (1) Other statutes of this state setting simplification standards for language
22 or format do not apply to property and casualty policies.

23 (2) Sections 33-15-333 through 33-15-340 do not apply to policies in manuscript form or to the
24 following kinds of insurance:

25 (a) ocean marine;

26 (b) surety and financial institution bonds;

27 (c) reinsurance; or

28 (d) ~~commercial aviation~~ commercial lines policies, including but not limited to commercial aviation;

1 or

2 ~~(e) large commercial risks whose aggregate annual premiums for insurance on all risks totals at least~~
3 ~~\$100,000.~~

4 (3) A non-English policy is considered in compliance with 33-15-337 if it was translated from an
5 English policy that complies with 33-15-337."

6

7 NEW SECTION. Section 16. Service of process. Service of process against a nonresident
8 insurance producer must be made pursuant to 35-7-113 or in any other manner permitted by law.

9

10 **Section 17.** Section 33-17-1101, MCA, is amended to read:

11 **"33-17-1101. Place of business -- display of license -- records.** (1) A resident insurance producer
12 shall maintain a place or places of business in this state accessible to the public. A nonresident insurance
13 producer may maintain a place or places of business in this state. An insurance producer's place or places of
14 business must be a place in which transactions are conducted under the insurance producer's license. The
15 address of the primary place of business must appear on the license. This section does not prohibit the
16 maintenance of a place of business in a licensee's place of residence.

17 (2) The license or, if the insurance producer has more than one place of business, a copy of the
18 license must be conspicuously displayed in a part of the place of business customarily open to the public.

19 (3) On request, resident and nonresident insurance producers are required to identify themselves
20 and provide their license number to persons with whom they sell, solicit, or negotiate insurance.

21 ~~(3)(4)~~ The insurance producer shall keep at a place of business complete records pertaining to
22 transactions under the license for a period of at least 3 years after completion of the respective transactions,
23 except that a title insurance producer, as defined in 33-25-105, shall retain records as provided in 33-25-214
24 and 33-25-216."

25

26 **Section 18.** Section 33-20-606, MCA, is amended to read:

27 **"33-20-606. Variable contracts to meet insurance contract requirements.** (1) Except for 33-15-
28 321 through 33-15-329, 33-20-302, and 33-20-307 for variable annuity contracts and 33-20-104, 33-20-110, 33-

1 20-111, 33-20-112, and 33-20-201 through 33-20-213 for variable life insurance policies and as otherwise
 2 provided in this part, all pertinent provisions of Title 33 and other laws relating to insurance apply to separate
 3 accounts and their related policies and contracts.

4 (2) Any individual variable life insurance contract or any individual variable annuity contract
 5 delivered or issued for delivery in this state must contain grace and reinstatement provisions appropriate to the
 6 contract. Any individual variable life insurance contract must contain nonforfeiture provisions appropriate to that
 7 contract.

8 (3) ~~An insurer shall file with the commissioner a copy of a~~ A final prospectus, must be dated and
 9 effective, before ~~it~~ an insurer issues or delivers an individual variable life insurance contract or an individual
 10 variable annuity contract in this state. The prospectus must be made available to the commissioner on request.

11 (4) The reserve liability for any variable contract must be established in accordance with actuarial
 12 procedures that recognize the variable nature of benefits provided and mortality guarantees."
 13

14 **Section 19.** Section 33-20-1316, MCA, is amended to read:

15 **"33-20-1316. Service of process.** (1) For viatical settlement providers, the provisions of Title 33,
 16 chapter 1, part 6, apply.

17 (2) For viatical settlement brokers, ~~the provisions of 33-17-405 apply~~ service of process must be
 18 made pursuant to 35-7-113 or in any other manner permitted by law."
 19

20 **Section 20.** Section 33-22-156, MCA, is amended to read:

21 **"33-22-156. Health insurance rates -- filing required -- use.** (1) Each health insurance issuer that
 22 issues, delivers, or renews individual or small employer group health insurance coverage in the individual or
 23 small employer group market shall, at least 60 days before the rate goes into effect, file with the commissioner
 24 its rates, fees, dues, and other charges for each product form intended for use in Montana, together with
 25 sufficient information to support the premium to be charged as described in 33-22-156 through 33-22-159. This
 26 filing may be made simultaneously with a notice of premium increase to policyholders and certificate holders
 27 required by 33-22-107.

28 (2) A health insurance issuer may submit a single combined justification for rate increases subject

1 to review affecting multiple products if the claims experience of all products has been aggregated to calculate
2 the rate increases and the rate increases are the same for all products. Rate increases are determined by
3 combining the total amount of increases taken on a single product form or market segment, if the rate increase
4 is the same for all products, over a 12-month period. A market segment means the individual or small group
5 market.

6 (3) The commissioner may waive the 60-day filing requirement under subsection (1) if the rate
7 increase is implemented pursuant to 33-22-107(1)(b). However, the rates and justifications for the rate increase
8 still must be filed.

9 (4) The health insurance issuer shall submit a new filing to reflect any material change to the
10 previous rate filing. For all other changes, the insurer shall submit an amendment to a previous rate filing. The
11 insurer may file an actuarial trend to phase in rate increases over a 12-month period. The insurer may file
12 amendments to that trend within the 12-month period.

13 (5) The filing of rates for health plans must include:

14 (a) the product form number or numbers and approval date of the product form or forms to which
15 the rate applies;

16 (b) a statement of actuarial justification; and

17 (c) information sufficient to support the rate as described in 33-22-157.

18 (6) The commissioner shall prescribe the form and content of the information required under this
19 section.

20 (7) A rate filing required under this section must be submitted by a qualified actuary representing
21 the health insurance issuer. The qualified actuary shall certify in a form prescribed by the commissioner that, to
22 the best of the actuary's knowledge and belief, the rates are not excessive, inadequate, unjustified, or unfairly
23 discriminatory, as described in 33-22-157, and comply with the applicable provisions of Title 33 and rules
24 adopted pursuant to Title 33.

25 (8) The rate filing must be delivered by the national association of insurance commissioners'
26 system for electronic rate and form filing.

27 (9) ~~An~~ Subject to 33-22-157(4), an insurer may use a rate filing under this section 60 days after the
28 ~~date of filing with the commissioner unless the health insurance issuer fails to provide the minimum~~

1 ~~documentation required in 33-22-157.~~

2 (10) Sections 33-22-156 through 33-22-159 do not apply to coverage consisting solely of excepted
3 benefits as defined in 33-22-140."

4

5 **Section 21.** Section 33-22-170, MCA, is amended to read:

6 **"33-22-170. Definitions.** As used in 33-22-170 through 33-22-177 and 33-22-180, the following
7 definitions apply:

8 (1) "Contract pharmacy" means a pharmacy operating under contract with a federally certified
9 health entity to provide dispensing services to the federally certified health entity.

10 (2) "Federally certified health entity" means a 340B covered entity as described in 42 U.S.C.
11 256b(a)(4).

12 (3) "Maximum allowable cost list" means the list of drugs used by a pharmacy benefit manager that
13 sets the maximum cost on which reimbursement to a network pharmacy or pharmacist is based.

14 (4) "Pharmacist" means a person licensed by the state to engage in the practice of pharmacy
15 pursuant to Title 37, chapter 7.

16 (5) "Pharmacy" means an established location, either physical or electronic, that is licensed by the
17 board of pharmacy pursuant to Title 37, chapter 7, and that has entered into a network contract with a
18 pharmacy benefit manager, health insurance issuer, or plan sponsor.

19 (6) "Pharmacy benefit manager" means a person who contracts with pharmacies on behalf of a
20 health insurance issuer, third-party administrator, or plan sponsor to process claims for prescription drugs,
21 provide retail network management for pharmacies or pharmacists, pay pharmacies or pharmacists for
22 prescription drugs, or provide other prescription drug or device services.

23 (7) "Pharmacy performance measurement entity" means:

24 (a) the electronic quality improvement platform for plans and pharmacies; or

25 (b) an entity approved by the board of pharmacy provided for in 2-15-1733 as a nationally
26 recognized and unbiased entity that assists pharmacies in improving performance measures.

27 (8) "Pharmacy services administrative organization" means an entity that acts as a contracting
28 agent or provides contracting and other administrative services to pharmacies to assist them in their

1 interactions with third-party payers, pharmacy benefit managers, drug wholesalers, and other entities.

2 ~~(8)(9)~~ "Prescription drug" means any drug that is required by federal law or regulation to be
3 dispensed only by a prescription subject to section 353(b) of the Federal Food, Drug, and Cosmetic Act, 21
4 U.S.C. 301 et seq.

5 ~~(9)(10)~~ "Prescription drug order" has the meaning provided in 37-7-101.

6 ~~(10)(11)~~ "Reference pricing" means a calculation for the price of a pharmaceutical that uses the most
7 current nationally recognized reference price or amount to set the reimbursement for prescription drugs and
8 other products, supplies, and services covered by a network contract between a plan sponsor, health insurance
9 issuer, or pharmacy benefit manager and a pharmacy or pharmacist."

10

11 **Section 22.** Section 33-22-172, MCA, is amended to read:

12 **"33-22-172. Maximum allowable cost or reference price list -- price formulation, updating, and**
13 **disclosure -- exceptions.** (1) At the time of entering into a contract with a pharmacy or a pharmacy services
14 administrative organization and subsequently upon request, a plan sponsor, health insurance issuer, or
15 pharmacy benefit manager shall provide the pharmacy or pharmacy services administrative organization with
16 the sources used to determine the pricing for the maximum allowable cost list or the reference used for
17 reference pricing.

18 (2) If using a maximum allowable cost list, a plan sponsor, health insurance issuer, or pharmacy
19 benefit manager shall:

20 (a) review and update the price information for each drug on the maximum allowable cost list at
21 least once every 10 calendar days to reflect any modification of pricing;

22 (b) establish a process for eliminating products from the maximum allowable cost list or modifying
23 the prices in the maximum allowable cost list in a timely manner to remain consistent with pricing changes and
24 product availability in the marketplace; and

25 (c) provide a process for each pharmacy to readily access the maximum allowable cost list specific
26 to the pharmacy in a searchable and usable format.

27 (3) If using reference pricing, a plan sponsor, health insurance issuer, or pharmacy benefit
28 manager shall:

- 1 (a) review and update no less than every 10 business days the price information for each drug,
 2 product, supply, or service for which reference pricing is used; and
- 3 (b) provide a process for each pharmacy to readily access the reference pricing specific to the plan
 4 sponsor or the health insurance issuer's plan.
- 5 (4) A plan sponsor, health insurance issuer, or pharmacy benefit manager may not:
- 6 (a) prohibit a pharmacist from discussing reimbursement criteria with a covered person;
 7 (b) penalize a pharmacy or a pharmacist for disclosing the information described in subsection
 8 (4)(a) to a covered person or for selling a more affordable alternative to a covered person; or
- 9 (c) require a pharmacy to charge or collect a copayment from a covered person that exceeds the
 10 total charges submitted by the network pharmacy."
 11

12 **Section 23.** Section 33-22-173, MCA, is amended to read:

13 **"33-22-173. Maximum allowable cost -- appeals process.** (1) In contracting with a pharmacy, a
 14 pharmacy services administrative organization, a plan sponsor or pharmacy benefit manager shall:

- 15 (a) provide a procedure by which a pharmacy or a pharmacy services administrative organization
 16 may appeal the price of a drug or drugs on the maximum allowable cost list;
- 17 (b) provide a telephone number at which a network pharmacy may contact the pharmacy benefit
 18 manager to discuss the status of the pharmacy's appeal; and
- 19 (c) respond to an appeal no later than 10 calendar days after the date the appeal is made.

20 (2) If the final determination is a denial of the pharmacy's or the pharmacy services administrative
 21 organization's appeal, the pharmacy benefit manager shall state the reason for the denial and provide the
 22 national drug code of an equivalent drug that is available for purchase by pharmacies in this state from national
 23 or regional wholesalers at a price that is equal to or less than the maximum allowable cost for that drug.

24 (3) If a pharmacy's or a pharmacy services administrative organization's appeal is determined to
 25 be valid by the pharmacy benefit manager, the pharmacy benefit manager shall:

- 26 (a) make an adjustment in the drug price effective on the date the appeal is resolved;
 27 (b) make the adjustment applicable to all similarly situated network pharmacy providers as
 28 determined by the plan sponsor or the pharmacy benefit manager, as appropriate; and

1 (c) permit the appealing pharmacy to reverse and rebill the claim in question, using the dates of
2 the original claim or claims.

3 (4) A pharmacy benefit manager shall make price adjustments to all similarly situated pharmacies
4 within 3 days.

5 (5) A pharmacy or a pharmacy services administrative organization shall file its appeal within 10
6 calendar days of its submission of the initial claim for reimbursement."
7

8 **Section 24.** Section 33-22-177, MCA, is amended to read:

9 **"33-22-177. Rights of pharmacies.** (1) A pharmacy benefit manager or third-party payer may not
10 prohibit a pharmacist or pharmacy from:

11 (a) participating in a class-action lawsuit;

12 (b) disclosing to the plan sponsor or to the patient information regarding the adjudicated
13 reimbursement paid to the pharmacy if the pharmacist or pharmacy complies with the requirements of the
14 federal Health Insurance Portability and Accountability Act of 1996, 29 U.S.C. 1181 et seq.;

15 (c) providing relevant information to a patient about the patient's prescription drug order, including
16 but not limited to the cost and clinical efficacy of a more affordable alternative drug if one is available;

17 (d) mailing or delivering a prescription drug to a patient as an ancillary service of a pharmacy if the
18 practice is not prohibited under Title 37, chapter 7; or

19 (e) charging a shipping and handling fee to a patient who has asked that a prescription drug be
20 mailed or delivered if the practice is not prohibited under Title 37, chapter 7.

21 (2) A pharmacy benefit manager or third-party payer may not require pharmacy accreditation
22 standards or recertification requirements inconsistent with, more stringent than, or in addition to federal and
23 state requirements for licensure as a pharmacy in this state.

24 (3) A pharmacist or pharmacy that belongs to a pharmacy services administrative organization
25 may receive a copy of a contract the pharmacy services administrative organization entered into with a
26 pharmacy benefit manager or third-party payer on the pharmacy's or pharmacist's behalf.

27 (4) A pharmacy benefit manager or third-party payer shall provide a pharmacy or pharmacist with
28 the processor control number, bank identification number, and group number for each pharmacy network

1 established or administered by a pharmacy benefit manager or third-party payer to enable the pharmacy to
2 make an informed contracting decision.

3 (5) (a) A pharmacy benefit manager shall:

4 (i) offer a pharmacy or a pharmacy services administrative organization an opportunity to renew
5 an existing contract every 3 years, at a minimum; and

6 (ii) allow a pharmacy or a pharmacy services administrative organization to terminate a contract
7 upon a 90-day notice to the pharmacy benefit manager.

8 (b) An addendum or amendment to an existing contract between a pharmacy benefit manager and
9 a pharmacy or a pharmacy services administrative organization is effective only upon signing of the addendum
10 or amendment by both parties.

11 (6) A pharmacy or a pharmacy services administrative organization has a private right of action to
12 enforce provisions of 33-22-175 through 33-22-177."
13

14 **Section 25.** Section 33-22-1128, MCA, is amended to read:

15 **"33-22-1128. Insurance producer training requirements.** (1) An individual may not sell, solicit, or
16 negotiate long-term care insurance unless the individual is licensed as an insurance producer for disability or
17 life insurance, has completed a one-time training course ~~on or before July 1, 2008~~, and completes ongoing
18 training within every 24-month period ~~following July 1, 2008~~.

19 (2) The training requirements of this section may be approved as continuing education courses
20 under Title 33, chapter 17, part 12.

21 (3) The one-time training course required by this section may not be less than 8 hours, and the
22 ongoing training required by this section may not be less than 4 hours for each 24-month period.

23 (4) (a) The training must consist of topics related to long-term care insurance, long-term care
24 services, and, if applicable, qualified state long-term care insurance partnership programs.

25 (b) The training must address but is not limited to:

26 (i) state and federal regulations and requirements and the relationship between qualified state
27 long-term care insurance partnership programs and other public and private coverage of long-term care
28 services, including medicaid;

- 1 (ii) available long-term care services and providers;
2 (iii) changes or improvements in long-term care services or providers;
3 (iv) alternatives to the purchase of private long-term care insurance;
4 (v) the effect of inflation on benefits and the importance of inflation protection; and
5 (vi) consumer suitability standards and guidelines.

6 (5) The training required by this section may not include training that is specific to the insurer or a
7 company product or that includes any sales or marketing information, materials, or training, other than those
8 required by state or federal law.

9 (6) (a) An insurer subject to this section shall obtain verification that an insurance producer acting
10 on the insurer's behalf receives the training required by this section before the insurance producer is permitted
11 to sell, solicit, or negotiate the insurer's long-term care insurance products.

12 (b) The insurer shall maintain records subject to this state's record retention requirements and
13 make the verification of the insurance producer's compliance with training requirements available to the
14 commissioner upon request.

15 (7) (a) An insurer subject to this section shall maintain records with respect to the training of its
16 insurance producers concerning the distribution of its policies that will allow the commissioner to provide
17 assurance to the department of public health and human services that insurance producers have received the
18 required training and that the insurance producers have demonstrated an understanding of the insurer's policies
19 and the relationship of the policies to public and private coverage of long-term care, including medicaid, in this
20 state.

21 (b) The records must be maintained in accordance with this state's record retention requirements
22 and must be made available to the commissioner upon request.

23 (8) The satisfaction of the training requirements required by this section in any state must be
24 considered to satisfy the training requirements in this state."

25

26 **Section 26.** Section 33-22-1303, MCA, is amended to read:

27 **"33-22-1303. Definitions.** As used in this part, the following definitions apply:

28 (1) "Association" means the Montana reinsurance association provided for in this part.

1 (2) "Attachment point" means the threshold amount for claims costs incurred by an eligible health
2 insurer for an enrolled individual's covered benefits in a benefit year, beyond which the claims costs for benefits
3 are eligible for reinsurance payments.

4 (3) "Benefit year" means the calendar year for which an eligible health insurer provides coverage
5 through an individual health insurance policy.

6 (4) "Board" means the association's board of directors provided for in 33-22-1306.

7 (5) "Coinsurance rate" means the rate at which the association will reimburse an eligible health
8 insurer for claims incurred for an enrolled individual's covered benefits in a benefit year above the attachment
9 point and below the reinsurance cap.

10 (6) "Eligible health insurer" means a health insurer, health service corporation, or health
11 maintenance organization that:

12 (a) offers individual health insurance coverage in the individual market, as defined in 33-22-140;

13 (b) offers a qualified health plan as defined in 42 U.S.C. 18021(a) that does not discriminate on the
14 basis of health status in rating or issuance, covers all essential health benefits, and does not impose lifetime or
15 annual limits or exclude preexisting conditions; and

16 (c) incurs claims costs for an individual enrollee's covered benefits in the applicable benefit year.

17 (7) "Major medical" health insurance includes individual market and employer group health
18 insurance that:

19 (a) is guaranteed available;

20 (b) is guaranteed renewable;

21 (c) does not impose preexisting condition exclusions;

22 (d) (i) offers essential health benefits as defined in 42 U.S.C. 18022; or

23 (ii) for large employer group coverage, meets the federal requirements for minimum value;

24 (e) pays medical claims, with no lifetime or annual limits; and

25 (f) complies with the federal limits for maximum out-of-pocket.

26 (8) "Payment parameters" means the attachment point, reinsurance cap, and coinsurance rate for
27 the Montana reinsurance program.

28 (9) "Program" means the Montana reinsurance program ~~operated by the Montana reinsurance~~

1 ~~association as provided in this part.~~

2 (10) "Reinsurance cap" means the maximum amount of each claim incurred by an eligible health
3 insurer for an enrolled individual's covered benefits in a benefit year, after which the claims costs for benefits
4 are no longer eligible for reinsurance payments.

5 (11) "Reinsurance payments" means an amount paid ~~by the association~~ to an eligible health insurer
6 under the program."

7

8 **Section 27.** Section 33-22-1307, MCA, is amended to read:

9 **"33-22-1307. Duties of commissioner -- rulemaking.** (1) The commissioner shall:

10 (a) oversee the activities of the association and the board;

11 (b) examine the affairs of the board and program;

12 (c) approve the plan of operation and payment parameters set by the board as needed within 30
13 days of receiving the plan and payment parameters ~~or and any~~ amendments to the plan or payment parameters
14 from the board;

15 (d) with the assistance of the association, collect the assessment and the federal funding
16 designated for this program;

17 (e) designate staff to attend meetings of the board and the association as an ex officio member;

18 ~~and~~

19 (f) perform the duties of the association administrator as described in 33-22-1309;

20 (g) establish administrative and accounting procedures for the association and the program;

21 (h) set the budget for the reinsurance program for each policy year, including the assessment
22 levels as provided in 33-22-1313 for the various members of the association; and

23 ~~(i)~~ require all eligible health insurers to calculate the premium amount the eligible health insurer
24 would have charged for the benefit year if the Montana reinsurance program had not been established. The
25 eligible health insurer shall submit this information as part of its rate filing. The commissioner shall consider this
26 information as part of the rate review.

27 (2) The commissioner may adopt rules necessary to implement this part. Any proposed
28 administrative rules must be submitted to the board for review and comment before the proposed rules are

1 submitted to the secretary of state.

2 (3) The commissioner may contract with a third party or parties to perform or assist in performing
3 the functions described in subsection (1).

4 (4) The commissioner may apply for funds or grants from public or private sources."

5

6 **Section 28.** Section 33-22-1308, MCA, is amended to read:

7 **"33-22-1308. Board duties -- powers.** (1) The board shall:

8 ~~(a) adopt a plan of operation and the reinsurance parameters for the following year, no later than~~
9 ~~June 15, 2019, in accordance with the requirements of this part, and update the plan of operation and~~
10 ~~reinsurance parameters, if needed, no later than May 1 of each succeeding year. No later than May 1 of each~~
11 ~~year, the board shall update the plan of operation and the reinsurance parameters, if needed, for the following~~
12 ~~year. The board shall submit its plan of operation and the reinsurance parameters, including any amendments,~~
13 ~~to the commissioner for approval.~~

14 ~~(b) establish administrative and accounting procedures for the association and the program;~~

15 ~~(c) select an association administrator in accordance with 33-22-1309 who will pay reinsurance claims~~
16 ~~in accordance with the plan of operation; and~~

17 ~~(d) set the budget for the reinsurance program for each policy year, including the assessment levels~~
18 ~~as provided in 33-22-1313 for the various members of the association.~~

19 (2) The board may:

20 (a) enter into contracts as necessary to carry out the purposes of this part; and

21 (b) appoint appropriate actuarial or other committees as necessary to provide technical assistance
22 and any other functions within the authority of the association; ~~and~~

23 ~~(c) apply for funds or grants from public or private sources.~~

24 (3) The board and program may be audited by the legislative auditor.

25 (4) An annual review of the association and the program for solvency and compliance must be
26 performed by an independent certified public accountant using generally accepted accounting principles and
27 submitted to the commissioner and the economic affairs committee of the legislature provided for in 5-5-223 as
28 provided in 5-11-210 for review by June 30 of each year, beginning in 2020.

1 (5) ~~The board~~ With the assistance of the board, the commissioner shall prepare an annual report
 2 on operations and finance and send that report to the economic affairs interim committee as provided in 5-11-
 3 210 and the commissioner by June 30 of each year, beginning in 2020."
 4

5 **Section 29.** Section 33-22-1309, MCA, is amended to read:

6 "**33-22-1309. Association administrator.** (1) ~~The board shall select an administrator, who is either~~
 7 ~~an employee of the nonprofit association or an independent contractor, to administer the reinsurance program~~
 8 ~~pursuant to the parameters decided by the board of directors. The board shall establish qualifications and~~
 9 ~~compensation in the plan of operation for the administrator and the length of the contract of an independent~~
 10 ~~contractor.~~ The commissioner shall perform the duties of the association administrator. The commissioner may
 11 contract with a third party or parties to provide some or all of the administrator's services.

12 (2) The administrator shall:

13 (a) perform all administrative functions relating to the association;

14 (b) submit regular reports to the board regarding the operation of the association. The frequency,
 15 content, and form of the reports must be set forth in the plan of operation.

16 (c) pay reinsurance claims as provided for in the plan of operation."
 17

18 **Section 30.** Section 33-22-1313, MCA, is amended to read:

19 "**33-22-1313. Association member assessments.** (1) (a) (i) For 2020 and each year thereafter, the
 20 commissioner shall assess each member insurer 1.2% of its total premium volume covering Montana residents,
 21 from the prior calendar year, regardless of type of license.

22 (ii) For purposes of subsection (1)(a)(i), total premium volume may not include premiums that
 23 member insurers collect on any coverage issued for excepted benefits as defined in 33-22-140.

24 (b) ~~The board~~ commissioner shall determine the timing of the assessment.

25 (c) The commissioner shall consider the board's recommendation when determining the
 26 assessment amounts.

27 (d) The commissioner shall verify the amount of each insurer's assessment based on annual
 28 financial statements and other reports determined to be necessary.

1 (2) The ~~association-commissioner~~ shall determine and report to the ~~commissioner~~ association the
2 ~~association's~~ reinsurance payments and other expenses for the previous calendar year, including administrative
3 expenses and any incurred but not reported claims for the previous calendar year.

4 (a) The report must consider investment income and other appropriate gains.

5 (b) The report must include an estimate of the assessments needed to cover the expected
6 reinsurance claims for the following calendar year.

7 (3) If assessments and other funds collected ~~by the association~~ exceed the actual losses and
8 administrative expenses of the association, the ~~board-commissioner~~ shall use the excess funds to offset future
9 claims or to reduce future assessments.

10 (4) The commissioner may, after notice and hearing:

11 (a) suspend or revoke the certificate of authority to transact insurance in this state of any member
12 insurer that fails to pay an assessment;

13 (b) impose a penalty on any insurer that fails to pay an assessment when due; or

14 (c) use any power granted to the commissioner to collect any unpaid assessment.

15 (5) An eligible health insurer may not submit claims for reinsurance payments unless the insurer
16 has a medical loss ratio of 80% or greater, as defined in 45 CFR 158.232(f)."

17

18 **Section 31.** Section 33-22-1314, MCA, is amended to read:

19 **"33-22-1314. Payment parameters.** (1) The board shall design and adjust the payment parameters
20 to ensure that the payment parameters will:

21 (a) stabilize or reduce premium rates in the individual market;

22 (b) increase or maintain participation in the individual market;

23 (c) mitigate the impact high-cost individuals have on premium rates in the individual market;

24 (d) consider any federal funding available for the plan; and

25 (e) consider the total amount available to fund the plan.

26 (2) The attachment point must be set ~~by the board~~ at \$40,000 or more but may not exceed the
27 reinsurance cap.

28 (3) The coinsurance rate must be set ~~by the board~~ between 50% and 80%.

1 (4) The reinsurance cap must be set ~~by the board~~ at \$1 million or less.

2 (5) The board, with the approval of the commissioner, may adjust the payment parameters
3 annually to the extent necessary to secure federal approval of the state innovation waiver.

4 (6) The payment parameters must be set forth in the plan of operation."

5

6 **Section 32.** Section 33-22-1315, MCA, is amended to read:

7 **"33-22-1315. Calculation of reinsurance payments.** (1) Each reinsurance payment must be
8 calculated with respect to an eligible health insurer's incurred claims costs for an individual enrollee's covered
9 benefits in the applicable benefit year. If the claims costs do not exceed the attachment point, the reinsurance
10 payment is \$0. If the claims costs exceed the attachment point, the reinsurance payment must be calculated as
11 the product of the coinsurance rate and the less of:

12 (a) the claims costs minus the attachment point; or

13 (b) the reinsurance cap minus the attachment point.

14 (2) ~~The board~~ commissioner shall ensure that the reinsurance payments made to ~~the~~ an eligible
15 health insurer do not exceed the total amount paid by ~~the~~ an eligible health insurer for any eligible claim.

16 (3) For purposes of this section, "total amount paid" means the amount paid by ~~the~~ an eligible
17 health insurer based on the allowed amount less any deductible, coinsurance, or copayment."

18

19 **Section 33.** Section 33-22-1316, MCA, is amended to read:

20 **"33-22-1316. Administration of reinsurance payments.** (1) Claims that are incurred during a benefit
21 year and are submitted for reimbursement in the following benefit year by the date established ~~by the board~~ in
22 the plan of operation will be allocated to the benefit year in which they are incurred. ~~Claims submitted after the~~
23 ~~date established by the board following the benefit year in which they were incurred will be allocated to the next~~
24 ~~benefit year in accordance with the board's operating rules, policies, and procedures.~~ Any claims from the
25 preceding benefit year not submitted for reimbursement by the date established in the plan of operation may
26 not be reimbursed.

27 (2) If funds accumulated in the reinsurance program account in the state special revenue fund with
28 respect to a benefit year are expected to be insufficient to pay all program expenses, claims for reimbursement,

1 and other disbursements allocable to that benefit year, all claims for reimbursement allocable to that benefit
 2 year must be reduced proportionately to the extent necessary to prevent a deficiency in the funds for that
 3 benefit year. Any reduction in claims for reimbursement with respect to a benefit year must apply to all claims
 4 that are allocated to that benefit year without regard to when those claims were submitted for reimbursement,
 5 and any reduction must be applied to each claim in the same proportion.

6 (3) If funds accumulated in the reinsurance program account in the state special revenue fund
 7 exceed the actual claims for reimbursement and program expenses of the association in a given benefit year,
 8 the ~~board~~ commissioner shall use ~~such the~~ excess funds to pay reinsurance claims in successive benefit years
 9 and ~~may recommend to the commissioner a reduction in the assessment amount for the following year.~~

10 (4) For each applicable benefit year, the ~~board~~ commissioner shall notify eligible health insurers of
 11 reinsurance payments to be made for the applicable benefit year by the date established ~~by the board~~ in the
 12 plan of operation in the year following the applicable benefit year.

13 (5) By December 31 of the year following the applicable benefit year, the ~~board~~ commissioner shall
 14 disburse all applicable reinsurance payments payable to an eligible health insurer."
 15

16 **Section 34.** Section 33-22-1317, MCA, is amended to read:

17 **"33-22-1317. Eligible health insurer requests for reinsurance payments.** (1) An eligible health
 18 insurer shall:

19 (a) make requests for reinsurance payment in accordance with any requirements established ~~by~~
 20 ~~the board~~ in the plan of operation;

21 (b) provide the ~~association~~ commissioner with access to data according to the rules and timeline
 22 established ~~by the board~~ in the plan of operation or by the commissioner in the administrative rules. The data
 23 environment utilized must be compatible with the federal risk adjustment program.

24 (c) maintain documents and records sufficient to substantiate the requests for reinsurance
 25 payments made pursuant to this part for a period of at least 6 years;

26 (d) apply all managed care, utilization review, case management, preferred provider
 27 arrangements, claims processing, and other methods of operation as appropriate to each claim without regard
 28 to whether that claim is eligible for or may be paid by reinsurance;

1 (e) make records available ~~upon~~on request from the commissioner ~~or the board~~ for purposes of
2 verification, investigation, audit, or other review of reinsurance payment requests; and

3 (f) repay to the reinsurance program account in the state special revenue fund any reinsurance
4 overpayments as determined by the commissioner as a result of an investigation, audit, or other review.

5 (2) Data collected from eligible health insurers under this section is confidential and not subject to
6 public inspection."

7

8 **Section 35.** Section 33-22-1321, MCA, is amended to read:

9 **"33-22-1321. State and federal special revenue accounts -- reinsurance program.** (1) (a) There is
10 a reinsurance program account in the state special revenue fund established by 17-2-102. The account must be
11 administered by the commissioner for the benefit of the program.

12 (b) There must be deposited in the account:

13 (i) all assessments collected under 33-22-1313;

14 (ii) any interest and income earned on the account; and

15 (iii) any other money from any other source accepted for the benefit of the account.

16 (c) The account may be used only to provide funding for the administration, operation, and claims
17 expenses incurred by the program created in ~~33-22-1302~~ this part, including but not limited to expenses
18 incurred by the commissioner and the board.

19 (2) There is an account in the federal special revenue fund to the credit of the board and
20 administered by the commissioner for the benefit of the program. There must be deposited in the account:

21 (a) federal funding allocated as a result of a section 1332 waiver application;

22 (b) any federal or grant funding; and

23 (c) any interest and income earned on the account."

24

25 **Section 36.** Section 33-23-310, MCA, is amended to read:

26 **"33-23-310. Medical malpractice insurance report by insurer.** (1) ~~Each~~ If requested in writing by
27 the commissioner, each insurer engaged in issuing medical malpractice professional liability insurance in this
28 state shall, within 60 days, provide a report to the commissioner containing the following categories of

1 information, as directed by the commissioner, for one or more professions provided in subsection (2)(b) include
2 the following, by profession and based upon the insurer's experience in this state, in its annual statement to the
3 commissioner of insurance:

4 (a) the number of medical malpractice insureds as of December 31 of the preceding calendar year;

5 (b) the amount of direct premiums written and direct premiums paid for medical malpractice
6 insurance during the preceding calendar year;

7 (c) the number of medical malpractice claims made against its insureds during the preceding
8 calendar year;

9 (d) the number of medical malpractice claims that were closed and that had a direct loss paid
10 during the preceding calendar year, together with the total amount of direct losses paid for all closed claims for
11 that year;

12 (e) the number of medical malpractice claims that were still open and had no direct losses paid as
13 of December 31 of the preceding calendar year;

14 (f) the number of claims filed against its insureds in state and federal courts during the preceding
15 calendar year, including the number of claims that were closed:

16 (i) without settlement during the preceding calendar year;

17 (ii) with a settlement during the preceding calendar year and the total amount paid for those
18 claims;

19 (iii) during the preceding calendar year and that went to trial and the number that resulted in a
20 judgment or verdict for the plaintiff, the number that resulted in a judgment or verdict for the insured, and the
21 number that resulted in some other judgment or verdict;

22 (g) the total direct losses paid for claims against its medical malpractice insureds that went to trial
23 and were closed during the preceding year; and

24 (h) other information and statistics that the commissioner of insurance requires.

25 (2) For purposes of this section:

26 (a) "insurer" has the meaning provided in 33-1-201; and

27 (b) "profession" includes the categories of physician, osteopath, podiatrist, dentist, optometrist,
28 registered nurse, licensed practical nurse, or health care facility as defined in 50-5-101."

1

2 **Section 37.** Section 33-25-105, MCA, is amended to read:

3 **"33-25-105. Definitions.** As used in this chapter, the following definitions apply:

4 (1) "Abstract" means a written representation, provided pursuant to a contract and expected to be
5 relied upon by the person who has contracted for the receipt of that representation, listing all recorded
6 conveyances, instruments, or documents which, under the laws of this state, impart constructive notice
7 regarding the chain of title to real property described in the abstract. Abstract includes "abstract of title".

8 (2) "Applicant" means a person, whether or not a prospective insured, who applies to a title insurer
9 or title insurance producer for a title insurance policy, but does not include a title insurance producer.

10 (3) "Approved attorney" means an attorney authorized to practice law in this state, except an agent
11 or employee of a title insurer, whose certification as to the status of the title to real property a title insurer is
12 willing to accept as the basis for issuance of a title insurance policy.

13 (4) "Associate" means a:

14 (a) corporation, partnership, or other business entity organized for profit, of which a producer of
15 title business is a director, officer, partner, employee, or owner of 5% or more of its equity or capital;

16 (b) franchisor or franchisee of a producer of title business;

17 (c) spouse, parent, or child of a producer of title business;

18 (d) corporation, partnership, or other business entity that controls, is controlled by, or is under
19 common control with a producer of title business; or

20 (e) person with whom a producer of title business or an associate has an agreement, arrangement,
21 understanding, or course of conduct having the purpose or substantial effect of evading the provisions of this
22 title.

23 (5) "Controlled business" means that portion of the business of title insurance in this state of a title
24 insurer or title insurance producer that is referred to it by a producer or associate having a financial interest in
25 the title insurer or title insurance producer.

26 (6) "Financial interest" means a legal or beneficial interest that entitles the holder, directly or
27 indirectly, to 1% or more of the net profits or net worth of the entity in which the interest is held.

28 (7) "Preliminary report" means an offer to issue a title insurance policy subject to any exceptions

1 stated in the report or other matters that may be incorporated by reference therein. Preliminary report includes
2 a commitment or binder.

3 (8) "Producer of title business" or "producer" means a person, corporation, partnership, or other
4 business entity, including an officer, director, or owner of 5% or more of the equity or capital thereof, engaged in
5 this state in the trade, business, occupation, or profession of:

6 (a) buying or selling interests in real property;

7 (b) making loans secured by interests in real property; or

8 (c) acting as broker, insurance producer, or representative of a person described in subsection
9 (8)(a) or (8)(b).

10 (9) "Rate" means fees for:

11 (a) issuing a title insurance policy, including any service charge or fee for the issuance;

12 (b) abstracting, searching, and examining title to real property when prepared or issued in
13 contemplation of or in conjunction with the issuance of a title insurance policy; and

14 (c) preparing or issuing preliminary reports, commitments, binders, or similar products prepared or
15 issued in contemplation of or in conjunction with the issuance of a title insurance policy.

16 (10) "Refer" means to direct, cause to be directed, or exercise an influence over the direction of title
17 insurance business, whether or not the consent or approval of another person is sought or obtained with
18 respect to the referral.

19 (11) "Title guarantee" means a contract by which, subject to its stated terms and conditions, a title
20 insurer guarantees the assured against loss sustained by reason of the incorrectness or assurances set forth in
21 the title guarantee with respect to the stated property. The term includes a trustee's sale guarantee, litigation
22 guarantee, lot book guarantee, subdivision guarantee, recorded documents guarantee, or other form of
23 guarantee filed with and approved by the commissioner.

24 ~~(11)~~(12) "Title insurance business" means:

25 (a) issuing or offering to issue a title insurance policy as an insurer;

26 (b) transacting or proposing to transact any of the following as a title insurer or title insurance
27 producer, in contemplation of or in conjunction with the issuance of a title insurance policy:

28 (i) soliciting or negotiating the issuance of a title insurance policy;

- 1 (ii) guaranteeing, warranting, or otherwise insuring the correctness of title searches;
- 2 (iii) handling escrows, settlements, or closings;
- 3 (iv) executing title insurance policies, reports, commitments, binders, and endorsements;
- 4 (v) effecting contracts of reinsurance; or
- 5 (vi) abstracting, searching, or examining titles;
- 6 (c) transacting, as a title insurer or insurance producer, matters subsequent to the issuance of a
- 7 title insurance policy and arising out of the policy; or
- 8 (d) doing or proposing to do business that, in substance, is equivalent to any of the activities
- 9 described in subsections ~~(11)(a) through (11)(e)~~ (12)(a) through (12)(c) in a manner designed to evade the
- 10 provisions of this title.

11 ~~(12)~~(13) "Title insurance policy" means a contract by which, subject to its stated terms and conditions,

12 a title insurer insures or indemnifies the insured against loss or damage sustained by reason of:

- 13 (a) defects in or liens or encumbrances on the title to the stated property;
- 14 (b) unmarketability of the title to the stated property; or
- 15 (c) invalidity or unenforceability of liens or encumbrances on the stated property.

16 ~~(13)~~(14) (a) "Title insurance producer" means a person who holds a valid title insurance producer's

17 license and is authorized in writing by a title insurer to:

- 18 (i) solicit title insurance business;
- 19 (ii) collect rates;
- 20 (iii) determine insurability in accordance with underwriting rules and standards of the insurer; or
- 21 (iv) issue policies of the title insurer.
- 22 (b) Title insurance producer does not include an approved attorney.

23 ~~(14)~~(15) "Title insurer" means an insurer formed and authorized under the laws of this state to transact

24 the business of title insurance in this state or a foreign or alien insurer so authorized.

25 ~~(15)~~(16) "Title plant" means a set of privately maintained records in which entries have been made of

26 documents imparting constructive notice, under the law, of matters affecting title to real property, an interest

27 therein, or an encumbrance thereon, that have been filed or recorded in the jurisdiction for which the title plant

28 is maintained and from which the ownership of real property within the jurisdiction can be ascertained and liens,

1 encumbrances, defects, and clouds on title to the real property can be determined."

2

3 **Section 38.** Section 33-25-301, MCA, is amended to read:

4 **"33-25-301. Refusal, suspension, or revocation of title insurance producer's license.** (1) In
5 addition to the causes provided in 33-17-1001, the commissioner may refuse to license an applicant or renew
6 the license of a person as a title insurance producer or may suspend or revoke a title insurance producer's
7 license or may fine a title insurance producer or applicant, after notice and opportunity for a hearing, if the
8 commissioner finds that the license applicant or licensee has:

9 (a) made a material misstatement in an application for a title insurance producer license;

10 (b) commingled funds belonging to applicants, escrow participants, or others;

11 (c) intentionally misrepresented the terms of a title insurance policy to an applicant or policyholder
12 or has misrepresented material facts to, concealed material facts from, or made false statements to a party to
13 an escrow, settlement, or closing transaction;

14 (d) in conducting affairs as a title insurance producer, used coercive practices or demonstrated
15 financial irresponsibility;

16 (e) aided, abetted, or assisted another person in violating the provisions of this title or a rule
17 adopted by the commissioner.

18 (2) The commissioner may impose any other appropriate penalty provided for in this title.

19 (3) The commissioner may issue an order requiring restitution to injured parties and
20 reimbursement of the commissioner's reasonable costs of bringing an administrative action.

21 ~~(3)(4)~~ The commissioner may refuse, suspend, or revoke the license of a person licensed as a title
22 insurance producer for the actions described in subsection (1) committed by any individual designated in the
23 license."

24

25 **Section 39.** Section 33-32-215, MCA, is amended to read:

26 **"33-32-215. Emergency services.** (1) When conducting a utilization review or making a benefit
27 determination for emergency services, a health insurance issuer that provides benefits for services in an
28 emergency department of a hospital shall follow the provisions of this section.

1 (2) A health insurance issuer shall cover emergency services that screen and stabilize a covered
2 person:

3 (a) without the need for prior authorization of the emergency services if a prudent lay person would
4 have reasonably believed that an emergency medical condition existed even if the emergency services are
5 provided on an out-of-network basis;

6 (b) without regard to whether the health care provider furnishing the services is a participating
7 provider with respect to the emergency services;

8 (c) if the emergency services are provided out-of-network, without imposing any administrative
9 requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to
10 emergency services received from network providers;

11 (d) if the emergency services are provided out-of-network, by complying with the cost-sharing
12 requirements in subsection (4); and

13 (e) without regard to any other term or condition of coverage, other than:

14 (i) the exclusion of or coordination of benefits;

15 (ii) an affiliation or waiting period as permitted under 42 U.S.C. 300gg-19a; or

16 (iii) cost-sharing, as provided in subsection (4)(a) ~~or (4)(b)~~, as applicable.

17 (3) For in-network emergency services, coverage of emergency services is subject to applicable
18 copayments, coinsurance, and deductibles.

19 (4) (a) ~~Except as provided in subsection (4)(b), for out-of-network emergency services, any cost-~~
20 ~~sharing requirement imposed with respect to a covered person may not exceed the cost-sharing requirement~~
21 ~~for a covered person if the services were provided in-network. Only in-network cost sharing amounts may be~~
22 ~~imposed on out-of-network emergency services.~~

23 ~~(b) A covered person may be required to pay, in addition to the in-network cost-sharing expenses, the~~
24 ~~excess amount the out-of-network provider charges that exceeds the amount the health insurance issuer is~~
25 ~~required to pay under this subsection (4).~~

26 ~~(e)(b)~~ A health insurance issuer complies with the requirements of this section by paying for
27 emergency services provided by an out-of-network provider in an amount not less than the greatest of the
28 following and taking into account exceptions in subsections ~~(4)(d)~~ (4)(c) and ~~(4)(e)~~ (4)(d):

1 (i) the amount negotiated with in-network providers for emergency services, excluding any in-
2 network cost-sharing imposed with respect to the covered person;

3 (ii) the amount of the emergency service calculated using the same method the plan uses to
4 determine payments for out-of-network services but using the in-network cost-sharing provisions instead of the
5 out-of-network cost-sharing provisions; or

6 (iii) the amount that would be paid under medicare for the emergency services, excluding any in-
7 network cost-sharing requirements.

8 ~~(d)(c)~~ For capitated or other health plans that do not have a negotiated charge for each service for in-
9 network providers, subsection ~~(4)(c)(i)~~ (4)(b)(i) does not apply.

10 ~~(e)(d)~~ If a health plan has more than one negotiated amount for in-network providers for a particular
11 emergency service, the amount in subsection ~~(4)(c)(i)~~ (4)(b)(i) is the median of those negotiated amounts.

12 ~~(5) Only in-network cost-sharing amounts may be imposed on out-of-network emergency services.~~

13 ~~(6)(5)~~ A health insurance issuer shall allow a covered person, the person's authorized representative,
14 and the person's health care provider at least 24 hours following an emergency admission or the provision of
15 emergency services to notify the health insurance issuer of the admission or provision of emergency services. If
16 the admission or the emergency services occur on a holiday or weekend, a health insurance issuer shall allow
17 notification no later than by the next business day following the admission or provision of emergency services.

18 ~~(7)(6)~~ If prior authorization is required for a postevaluation or poststabilization services review, a
19 health insurance issuer shall provide access to a designated representative 24 hours a day, 7 days a week, to
20 facilitate the review.

21 ~~(8) A health insurance issuer may not impose prior authorization or step therapy requirements for an~~
22 ~~oral therapy prescription used to treat opioid use disorder."~~

23

24 **Section 40.** Section 33-33-201, MCA, is amended to read:

25 **"33-33-201. Standards for utilization review organizations.** (1) A utilization review organization
26 that conducts utilization reviews in this state for property and casualty insurers shall meet the standards set
27 forth in this part ~~register with the commissioner prior to performing utilization reviews. The commissioner shall~~
28 ~~place a utilization review organization on the register when the utilization review organization provides~~

1 ~~information that establishes that the utilization review organization meets the standards set forth in this section.~~
 2 ~~The commissioner shall remove from the register a utilization review organization that fails to meet the~~
 3 ~~standards set forth in this section.~~

4 (2) Utilization review organizations may use only licensed or certified health care professionals to
 5 conduct utilization reviews.

6 (3) Utilization reviews must be conducted by health care professionals who are licensed or certified
 7 in the same specialty as the provider whose treatment is being received by the insured or by a health care
 8 professional who is qualified to render the treatment being reviewed.

9 (4) Utilization review organizations shall comply with all applicable state or federal medical privacy
 10 laws.

11 (5) Utilization review evaluations must use generally accepted standards for treatment of the
 12 illness, injury, or condition that is being reviewed.

13 (6) Utilization review opinions must be signed by the health care professional performing the
 14 review.

15 (7) A utilization review organization may not base its fees or charges on any recommendation for a
 16 reduction in payment under an insurance contract or on a percentage of claim savings."

17

18 **Section 41.** Section 33-33-202, MCA, is amended to read:

19 **"33-33-202. Standards for property and casualty insurers.** (1) Property or casualty insurers
 20 seeking utilization reviews with respect to insurance contracts issued in this state may use only utilization
 21 review organizations that are registered under 33-33-201.

22 (2) A property or casualty insurer is responsible for:

23 (a) monitoring all utilization review activities carried out by or on behalf of the property or casualty
 24 insurer;

25 (b) ensuring that all requirements of this part and rules adopted pursuant to this part are met; and

26 (c) ensuring that appropriate personnel have operational responsibility for and oversight of the
 27 performance of the property or casualty insurer's utilization review program and contracts with utilization review
 28 organizations.

1 ~~(2)~~(3) A property or casualty insurer that denies, in whole or in part, a policyholder's claim after
 2 consideration of a utilization review shall provide the policyholder an opportunity to request reconsideration by
 3 the insurer and the opportunity to submit additional information relating to the claim."
 4

5 NEW SECTION. **Section 42. Coverage of oral therapy -- opioid use disorder.** A health insurance
 6 issuer may not impose prior authorization or step therapy requirements for an oral therapy prescription used to
 7 treat opioid use disorder.
 8

9 **Section 43.** Section 33-36-102, MCA, is amended to read:

10 **"33-36-102. Purpose.** The purpose and intent of this chapter are to:

- 11 (1) establish standards for the creation and maintenance of networks by health carriers offering
 12 managed care plans and to ensure the adequacy, accessibility, and quality of health care services offered
 13 under a managed care plan by establishing requirements for written agreements between health carriers
 14 offering managed care plans and participating providers regarding the standards, terms, and provisions under
 15 which the participating provider will provide services to covered persons;
- 16 (2) provide for the implementation of state network adequacy and quality assurance standards in
 17 administrative rules, provide for monitoring compliance with those standards, and provide a mechanism for
 18 detecting and reporting violations of those standards to the commissioner;
- 19 (3) establish minimum criteria for the quality assessment activities of a health carrier issuing a
 20 closed plan or a combination plan and to require that minimum state quality assessment criteria be adopted by
 21 rule;
- 22 (4) enable health carriers to evaluate, maintain, and improve the quality of health care services
 23 provided to covered persons; and
- 24 (5) provide a streamlined and simplified process by which managed care network adequacy and
 25 quality assurance programs may be monitored for compliance through ~~coordinated efforts of~~ by the
 26 commissioner ~~and the department~~. It is not the purpose or intent of this chapter to apply quality assurance
 27 standards applicable to medicaid or medicare to managed care plans regulated pursuant to this chapter or to
 28 create or require the creation of quality assurance programs that are as comprehensive as quality assurance

1 programs applicable to medicaid or medicare."

2

3 **Section 44.** Section 33-36-103, MCA, is amended to read:

4 **"33-36-103. Definitions.** As used in this chapter, the following definitions apply:

5 (1) "Closed plan" means a managed care plan that requires covered persons to use only
6 participating providers under the terms of the managed care plan.

7 (2) "Combination plan" means an open plan with a closed component.

8 (3) "Covered benefits" means those health care services to which a covered person is entitled
9 under the terms of a health benefit plan.

10 (4) "Covered person" means a policyholder, subscriber, or enrollee or other individual participating
11 in a health benefit plan.

12 ~~(5) "Department" means the department of public health and human services established in 2-15-~~
13 ~~2204.~~

14 ~~(6)~~(5) "Emergency medical condition" means a condition manifesting itself by symptoms of sufficient
15 severity, including severe pain, that the absence of immediate medical attention could reasonably be expected
16 to result in any of the following:

17 (a) the covered person's health would be in serious jeopardy;

18 (b) the covered person's bodily functions would be seriously impaired; or

19 (c) a bodily organ or part would be seriously damaged.

20 ~~(7)~~(6) "Emergency services" means health care items and services furnished or required to evaluate
21 and treat an emergency medical condition.

22 ~~(8)~~(7) "Facility" means an institution providing health care services or a health care setting, including
23 but not limited to a hospital, medical assistance facility, or critical access hospital, as defined in 50-5-101, or
24 other licensed inpatient center, an outpatient center for surgical services, a treatment center, a skilled nursing
25 center, a residential treatment center, a diagnostic laboratory, a diagnostic imaging center, or a rehabilitation or
26 other therapeutic health setting.

27 ~~(9)~~(8) "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered, or
28 issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care

1 services.

2 ~~(10)~~(9) "Health care professional" means a physician or other health care practitioner licensed,
3 accredited, or certified pursuant to the laws of this state to perform specified health care services consistent
4 with state law.

5 ~~(11)~~(10) "Health care provider" or "provider" means a health care professional or a facility.

6 ~~(12)~~(11) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief
7 of a health condition, illness, injury, or disease.

8 ~~(13)~~(12) "Health carrier" means an entity subject to the insurance laws and rules of this state that
9 contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse
10 any of the costs of health care services, including a disability insurer, health maintenance organization, or
11 health service corporation or another entity providing a health benefit plan.

12 ~~(14)~~(13) "Intermediary" means a person authorized to negotiate, execute, and be a party to a contract
13 between a health carrier and a provider or between a health carrier and a network.

14 ~~(15)~~(14) "Managed care plan" means a health benefit plan that either requires or creates incentives,
15 including financial incentives, for a covered person to use health care providers managed, owned, under
16 contract with, or employed by a health carrier, but not preferred provider organizations or other provider
17 networks operated in a fee-for-service indemnity environment.

18 ~~(16)~~(15) "Medically necessary" means services, medicines, or supplies that are necessary and
19 appropriate for the diagnosis or treatment of a covered person's illness, injury, or medical condition according to
20 accepted standards of medical practice and that are not provided only as a convenience.

21 ~~(17)~~(16) "Network" means the group of participating providers that provides health care services to a
22 managed care plan.

23 ~~(18)~~(17) "Open plan" means a managed care plan other than a closed plan that provides incentives,
24 including financial incentives, for covered persons to use participating providers under the terms of the
25 managed care plan.

26 ~~(19)~~(18) "Participating provider" means a provider who, under a contract with a health carrier or with
27 the health carrier's contractor, subcontractor, or intermediary, has agreed to provide health care services to
28 covered persons with an expectation of receiving payment, other than coinsurance, copayments, or

1 deductibles, directly or indirectly from the health carrier.

2 ~~(20)~~(19) "Primary care professional" means a participating health care professional designated by the
3 health carrier to supervise, coordinate, or provide initial care or continuing care to a covered person and who
4 may be required by the health carrier to initiate a referral for specialty care and to maintain supervision of health
5 care services rendered to the covered person.

6 ~~(24)~~(20) "Quality assessment" means the measurement and evaluation of the quality and outcomes of
7 medical care provided to individuals, groups, or populations.

8 ~~(22)~~(21) "Quality assurance" means quality assessment and quality improvement.

9 ~~(23)~~(22) "Quality improvement" means an effort to improve the processes and outcomes related to the
10 provision of health care services within a health plan."
11

12 **Section 45.** Section 33-36-105, MCA, is amended to read:

13 **"33-36-105. ~~Department Commissioner~~ -- general powers and duties -- rulemaking.** (1) The
14 ~~department commissioner~~ shall:

15 (a) adopt rules pursuant to the Montana Administrative Procedure Act establishing minimum state
16 standards for network adequacy and quality assurance and procedures for ensuring compliance with those
17 standards; and

18 (b) recommend action ~~to the commissioner~~ against a health carrier whose managed care plan
19 does not comply with standards for network adequacy and quality assurance adopted by the ~~department~~
20 commissioner.

21 (2) Quality assurance standards adopted by the ~~department commissioner~~ must consist of some
22 but not all of the health plan employer data and information standards. The ~~department commissioner~~ shall
23 select and adopt only standards appropriate for quality assurance in Montana.

24 (3) The state may contract, through a competitive bidding process, for the development of network
25 adequacy and quality assurance standards."
26

27 **Section 46.** Section 33-36-201, MCA, is amended to read:

28 **"33-36-201. Network adequacy -- standards -- access plan required.** (1) A health carrier offering a

1 managed care plan in this state shall maintain a network that is sufficient in numbers and types of providers to
2 ensure that all services to covered persons are accessible without unreasonable delay. Sufficiency in number
3 and type of provider is determined in accordance with the requirements of this section. Covered persons must
4 have access to emergency care 24 hours a day, 7 days a week. A health carrier providing a managed care plan
5 shall use reasonable criteria to determine sufficiency. The criteria may include but are not limited to:

6 (a) a ratio of specialty care providers to covered persons;

7 (b) a ratio of primary care providers to covered persons;

8 (c) geographic accessibility;

9 (d) waiting times for appointments with participating providers;

10 (e) hours of operation; or

11 (f) the volume of technological and specialty services available to serve the needs of covered
12 persons requiring technologically advanced or specialty care.

13 (2) Whenever a health carrier has an insufficient number or type of participating providers to
14 provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered benefit at
15 no greater cost to the covered person than if the covered benefit were obtained from participating providers or
16 shall make other arrangements acceptable to the ~~department~~ commissioner.

17 (3) The health carrier shall establish and maintain adequate provider networks to ensure
18 reasonable proximity of participating providers to the businesses or personal residences of covered persons. In
19 determining whether a health carrier has complied with this requirement, consideration must be given to the
20 relative availability of health care providers in the service area under consideration.

21 (4) A health carrier offering a managed care plan in this state on ~~October 1, 1999~~ January 1, 2024,
22 shall file with the ~~department~~ commissioner on ~~October 1, 1999~~ December 1, 2023, an access plan complying
23 with subsection (6) and the rules of the ~~department~~ commissioner. A health carrier offering a managed care
24 plan in this state for the first time after ~~October 1, 1999~~ January 1, 2024, shall file with the ~~department~~
25 commissioner an access plan meeting the requirements of subsection (6) and the rules of the ~~department~~
26 commissioner at least 60 days before offering the managed care plan. A plan must be filed with the ~~department~~
27 commissioner in a manner and form complying with the rules of the ~~department~~ commissioner. A health carrier
28 shall file any subsequent material changes in its access plan with the ~~department~~ commissioner within at least

1 30 days prior to ~~of~~ implementation of the change.

2 (5) A health carrier may request the ~~department commissioner~~ to designate parts of its access plan
3 as proprietary or competitive information, and when designated, that part may not be made public. For the
4 purposes of this section, information is proprietary or competitive if revealing the information would cause the
5 health carrier's competitors to obtain valuable business information. A health carrier shall make the access
6 plans, absent proprietary information, available on its business premises and shall provide a copy of the plan
7 upon request.

8 (6) An access plan for each managed care plan offered in this state must describe or contain at
9 least the following:

10 (a) a listing of the names and specialties of the health carrier's participating providers;

11 (b) the health carrier's procedures for making referrals within and outside its network;

12 (c) the health carrier's process for monitoring and ensuring on an ongoing basis the sufficiency of
13 the network to meet the health care needs of populations that enroll in the managed care plan;

14 (d) the health carrier's efforts to address the needs of covered persons with limited English
15 proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental
16 disabilities;

17 (e) the health carrier's methods for assessing the health care needs of covered persons and their
18 satisfaction with services;

19 (f) the health carrier's method of informing covered persons of the plan's services and features,
20 including but not limited to the plan's grievance procedures, its process for choosing and changing providers,
21 and its procedures for providing and approving emergency and specialty care;

22 (g) the health carrier's system for ensuring the coordination and continuity of care for covered
23 persons referred to specialty physicians and for covered persons using ancillary services, including social
24 services and other community resources, and for ensuring appropriate discharge planning;

25 (h) the health carrier's process for enabling covered persons to change primary care professionals;

26 (i) the health carrier's proposed plan for providing continuity of care in the event of contract
27 termination between the health carrier and a participating provider or in the event of the health carrier's
28 insolvency or other inability to continue operations. The description must explain how covered persons will be

1 notified of the contract termination or the health carrier's insolvency or other cessation of operations and be
2 transferred to other providers in a timely manner.

3 (j) any other information required by the ~~department~~commissioner to determine compliance with
4 this part and the rules implementing this part.

5 (7) The ~~department~~commissioner shall ensure timely and expedited review and approval of the
6 access plan and other requirements in this section."
7

8 **Section 47.** Section 33-36-203, MCA, is amended to read:

9 **"33-36-203. Selection of providers -- professional credentials standards.** (1) A health carrier shall
10 adopt standards for selecting participating providers who are primary care professionals and for each health
11 care professional specialty within the health carrier's network. The health carrier shall use the standards to
12 select health care professionals, the health carrier's intermediaries, and any provider network with which the
13 health carrier contracts. A health carrier may not adopt selection criteria that allow the health carrier to:

14 (a) avoid high-risk populations by excluding a provider because the provider is located in a
15 geographic area that contains populations or providers presenting a risk of higher than average claims, losses,
16 or use of health care services; or

17 (b) exclude a provider because the provider treats or specializes in treating populations presenting
18 a risk of higher than average claims, losses, or use of health care services.

19 (2) Subsection (1) does not prohibit a health carrier from declining to select a provider who fails to
20 meet the other legitimate selection criteria of the health carrier adopted in compliance with this part and the
21 rules implementing this part.

22 (3) This part does not require a health carrier, its intermediary, or a provider network with which the
23 health carrier or its intermediary contract to employ specific providers or types of providers who may meet their
24 selection criteria or to contract with or retain more providers or types of providers than are necessary to
25 maintain an adequate network.

26 (4) A health carrier may use criteria established in accordance with the provisions of this section to
27 select health care professionals allowed to participate in the health carrier's managed care plan. A health carrier
28 shall make its selection standards for participating providers available for review by the ~~department~~

1 commissioner and by each health care professional who is subject to the selection standards."

2

3 **Section 48.** Section 33-36-209, MCA, is amended to read:

4 **"33-36-209. Use of intermediaries -- responsibilities of health carriers, intermediaries, and**
5 **providers.** (1) A health carrier is responsible for complying with applicable provisions of this chapter, and
6 contracting with an intermediary for all or some of the services for which a health carrier is responsible does not
7 relieve the health carrier of responsibility for compliance.

8 (2) A health carrier may determine whether a subcontracted provider participates in the provider's
9 own network or a contracted network for the purpose of providing covered benefits to the health carrier's
10 covered persons.

11 (3) A health carrier shall maintain copies of all intermediary health care subcontracts at the health
12 carrier's principal place of business in this state or ensure that the health carrier has access to all intermediary
13 subcontracts, including the right to make copies of the contracts, upon 20 days' prior written notice from the
14 health carrier.

15 (4) If required in a contract or otherwise by a health carrier, an intermediary shall transmit
16 utilization documentation and claims-paid documentation to the health carrier. The health carrier shall monitor
17 the timeliness and appropriateness of payments made to providers and health care services received by
18 covered persons. This duty may not be delegated to an intermediary by a health carrier.

19 (5) If required in a contract or otherwise by a health carrier, an intermediary shall maintain the
20 books, records, financial information, and documentation of services provided to covered persons at its
21 principal place of business in the state and preserve them for 5 years in a manner that facilitates regulatory
22 review.

23 (6) An intermediary shall allow the commissioner ~~and the department~~ access to the intermediary's
24 books, records, claim information, billing information, and other documentation of services provided to covered
25 persons that are required by any of those entities to determine compliance with this part and the rules
26 implementing this part.

27 (7) A health carrier may, in the event of the intermediary's insolvency, require the assignment to
28 the health carrier of the provisions of a participating provider's contract addressing the participating provider's

1 obligation to furnish covered benefits."

2

3 **Section 49.** Section 33-36-210, MCA, is amended to read:

4 **"33-36-210. Contract filing requirements -- material changes -- state access to contracts.** (1) A
 5 health carrier offering a managed care plan in this state on January 1, 2024, shall file with the commissioner
 6 on ~~On October 1, 1999~~ December 1, 2023, a health carrier offering a managed care plan shall file with the
 7 department sample contract forms proposed for use with its participating providers and intermediaries. A health
 8 carrier offering a managed care plan in this state for the first time after January 1, 2024, shall file with the
 9 commissioner sample contract forms proposed for use with its participating providers and intermediaries at
 10 least 60 days before offering the managed care plan.

11 (2) A health carrier shall file with the ~~department~~ commissioner a material change to a contract.
 12 The change must be filed with the ~~department~~ commissioner at least 60 days before use of the proposed
 13 change. A change in a participating provider payment rate, coinsurance, copayment, or deductible or other plan
 14 benefit is not considered a material change for the purpose of this subsection.

15 (3) A health carrier shall maintain participating provider and intermediary contracts at its principal
 16 place of business in this state, or the health carrier must have access to all contracts and provide copies to the
 17 ~~department~~ commissioner ~~upon~~ on 20 days' prior written notice from the ~~department~~ commissioner."

18

19 **Section 50.** Section 33-36-211, MCA, is amended to read:

20 **"33-36-211. General contracting requirements.** (1) The execution of a contract for health care
 21 services with an intermediary by a health carrier does not relieve the health carrier of its duty to provide health
 22 care services to a person with whom the health carrier has contracted and does not relieve the health carrier of
 23 its responsibility for compliance with this chapter or the rules implementing this chapter.

24 (2) All contracts by a health carrier for the provision of health care services by a managed care
 25 plan must be in writing and are subject to review by the ~~department and the~~ commissioner."

26

27 **Section 51.** Section 33-36-212, MCA, is amended to read:

28 **"33-36-212. Contract compliance dates.** (1) ~~A~~ contract between a health carrier and a participating

1 provider or intermediary ~~in effect on October 1, 1999~~, must comply with this part and the rules implementing this
 2 part on the date the contract is issued or put into effect by October 1, 1999. ~~The department may extend the~~
 3 ~~October 1 date for an additional period of up to 6 months if the health carrier demonstrates good cause for an~~
 4 ~~extension.~~

5 ~~(2) A contract between a health carrier and a participating provider or intermediary issued or put into~~
 6 ~~effect on or after October 1, 1999, must comply with this part and the rules implementing this part on the day~~
 7 ~~that it is issued or put into effect.~~

8 ~~(3) A contract between a health carrier and a participating provider or intermediary not described in~~
 9 ~~subsection (1) or (2) must comply with this part and the rules implementing this part by October 1, 1999."~~

10

11 **Section 52.** Section 33-36-213, MCA, is amended to read:

12 "**33-36-213. Department rules.** ~~The department~~ commissioner may adopt rules to implement this
 13 part."

14

15 **Section 53.** Section 33-36-301, MCA, is amended to read:

16 "**33-36-301. Quality assurance -- national accreditation.** (1) A health carrier whose managed care
 17 plan has been accredited by a nationally recognized accrediting organization shall annually provide a copy of
 18 the accreditation and the accrediting standards used by the accrediting organization to the ~~department~~
 19 commissioner.

20 (2) If the ~~department~~ commissioner finds that the standards of a nationally recognized accrediting
 21 organization meet or exceed state standards and that the health carrier has been accredited by the nationally
 22 recognized accrediting organization, the ~~department~~ commissioner shall approve the quality assurance
 23 standards of the health carrier.

24 (3) The ~~department~~ commissioner shall maintain a list of accrediting organizations whose
 25 standards have been determined by the ~~department~~ commissioner to meet or exceed state quality assurance
 26 standards.

27 (4) Section 33-36-302 does not apply to a health carrier's managed care plan if the health carrier
 28 maintains current accreditation by a nationally recognized accrediting organization whose standards meet or

1 exceed state quality assurance standards adopted pursuant to this part.

2 (5) This section does not prevent the ~~department~~commissioner from monitoring a health carrier's
3 compliance with this part."
4

5 **Section 54.** Section 33-36-302, MCA, is amended to read:

6 **"33-36-302. Standards for health carrier quality assessment programs.** A health carrier that
7 issues a closed plan or a combination plan shall adopt and use infrastructure and disclosure systems sufficient
8 to accurately measure the quality of health care services provided to covered persons on a regular basis and
9 appropriate to the types of plans offered by the health carrier. To comply with this requirement, a health carrier
10 shall:

11 (1) establish and use a system designed to assess the quality of health care provided to covered
12 persons and appropriate to the types of plans offered by the health carrier. The system must include systematic
13 collection, analysis, and reporting of relevant data.

14 (2) communicate in a timely fashion its findings concerning the quality of health care to regulatory
15 agencies, providers, and consumers as provided in 33-36-304;

16 (3) report to the appropriate professional or occupational licensing board provided in Title 37 any
17 persistent pattern of problematic care provided by a participating provider that is sufficient to cause the health
18 carrier to terminate or suspend a contractual arrangement with the participating provider; and

19 (4) file a written description of the quality assessment program and any subsequent material
20 changes with the ~~department~~commissioner in a format that must be prescribed by rules of the ~~department~~
21 commissioner. The description must include a signed certification by a corporate officer of the health carrier that
22 the health carrier's quality assessment program meets the requirements of this part."
23

24 **Section 55.** Section 33-36-303, MCA, is amended to read:

25 **"33-36-303. Standards for health carrier quality improvement programs.** A health carrier that
26 issues a closed plan or a combination plan shall, in addition to complying with 33-36-302, adopt and use
27 systems and methods necessary to improve the quality of health care provided in the health carrier's managed
28 care plan as indicated by the health carrier's quality assessment program and as required by this section. To

1 comply with this requirement, a health carrier subject to this section shall:

2 (1) establish an internal system capable of identifying opportunities to improve care;

3 (2) use the findings generated by the system required by subsection (1) to work on a continuing
4 basis with participating providers and other staff within the closed plan or closed component to improve the
5 health care delivered to covered persons; and

6 (3) consistent with this part, adopt and use a program for measuring, assessing and improving the
7 outcomes of health care as identified in the health carrier's quality improvement program plan and provide at
8 the commissioner's request a current quality improvement program plan. ~~This quality improvement program~~
9 ~~plan must be filed with the department by October 1, 2000, and must be consistent with this part. A health~~
10 ~~carrier shall file any subsequent material changes to its quality improvement program plan within 30 days of~~
11 ~~implementation of the change.~~ The quality improvement program plan must:

12 (a) implement improvement strategies in response to quality assessment findings that indicate
13 improvement is needed; and

14 (b) evaluate, not less than annually, the effectiveness of the strategies implemented pursuant to
15 subsection (3)(a)."

16

17 **Section 56.** Section 33-36-304, MCA, is amended to read:

18 **"33-36-304. Reporting and disclosure requirements.** (1) A health carrier offering a closed plan or a
19 combination plan shall document and communicate information, as required in this section, about its quality
20 assurance program. The health carrier shall:

21 (a) include a summary of its quality assurance program in marketing materials;

22 (b) include a description of its quality assurance program and a statement of patient rights and
23 responsibilities with respect to that program in the certificate of coverage or handbook provided to newly
24 enrolled covered persons; and

25 (c) make available annually to providers and covered persons a report containing findings from its
26 quality assurance program and information about its progress in meeting internal goals and external standards,
27 when available.

28 (2) A health carrier shall certify to the ~~department~~ commissioner annually that its quality assurance

1 program and the materials provided to providers and consumers in accordance with subsection (1) meet the
2 requirements of this part.

3 (3) A health carrier shall make available, upon request and payment of a reasonable fee, the
4 materials certified pursuant to subsection (2), except for the materials subject to the confidentiality requirements
5 of 33-36-305 and materials that are proprietary to the managed care plan. A health carrier shall retain all
6 certified materials for at least 3 years from the date that the material was certified or until the material has been
7 examined as part of a market conduct examination, whichever is later."

8

9 **Section 57.** Section 33-36-305, MCA, is amended to read:

10 **"33-36-305. Confidentiality of health care and quality assurance records -- disclosure. (1)**

11 Except as provided in subsection (2), the following information held by a health carrier offering a closed plan or
12 a combination plan is confidential and may not be disclosed by the carrier to a person:

13 (a) information pertaining to the diagnosis, treatment, or health of a covered person, regardless of
14 whether the information is in the form of paper, is preserved on microfilm, or is stored in computer-retrievable
15 form;

16 (b) information considered by a quality assurance program and the records of its actions, including
17 testimony of a member of a quality committee, of an officer, director, or other member of a health carrier or its
18 staff engaged in assisting the quality committee or engaged in the health carrier's quality assessment, quality
19 improvement, or quality assurance activities, or of any person assisting or furnishing information to the quality
20 committee.

21 (2) The information specified in subsection (1) may be disclosed:

22 (a) as allowed by Title 33, chapter 19;

23 (b) as required in proceedings before the commissioner, a professional or occupational licensing
24 board provided in Title 37, or the department of public health and human services pursuant to Title 50, chapter
25 5, part 2;

26 (c) in an appeal, if an appeal is permitted, from a quality committee's findings or recommendations;
27 or

28 (d) as otherwise required by law or court order, including a judicial or administrative subpoena.

- 1 (3) Information specified in subsection (1) identifying:
- 2 (a) the provider may also be disclosed upon a written, dated, and signed approval of the provider if
- 3 the information does not identify the covered person;
- 4 (b) the covered person may also be disclosed upon a written, dated, and signed approval of the
- 5 covered person or of the parent or guardian of a covered person if the covered person is a minor and if the
- 6 information does not identify the provider;
- 7 (c) neither the provider nor the covered person may also be disclosed upon request for use for
- 8 statistical purposes only."
- 9

10 **Section 58.** Section 33-36-401, MCA, is amended to read:

11 "**33-36-401. Enforcement.** (1) If the ~~department~~commissioner determines that a health carrier has

12 not complied with this chapter or the rules implementing this chapter, the ~~department~~commissioner may

13 recommend corrective action to the health carrier.

14 (2) ~~At the recommendation of the department the~~ The commissioner may take an enforcement

15 action provided in subsection (3) if:

16 (a) a health carrier fails to implement corrective action recommended by the ~~department~~

17 commissioner;

18 (b) corrective action taken by a health carrier does not result in bringing a health carrier into

19 compliance with this chapter and the rules implementing this chapter within a reasonable period of time;

20 (c) ~~the department demonstrates to the commissioner that~~ a health carrier does not comply with

21 this chapter or the rules implementing this chapter; or

22 (d) the commissioner determines that a health carrier has violated or is violating this chapter or the

23 rules implementing this chapter.

24 (3) The commissioner may take any of the following enforcement actions to require a health carrier

25 to comply with this chapter or the rules implementing this chapter:

26 (a) suspend or revoke the health carrier's certificate of authority or deny the health carrier's

27 application for a certificate of authority; or

28 (b) use any of the commissioner's other enforcement powers provided in Title 33, chapter 1, part

1 3."

2

3 **NEW SECTION. Section 59. Repealer.** The following sections of the Montana Code Annotated are

4 repealed:

5 33-2-322. Surplus lines advisory organization -- consultation with commissioner in developing approved
6 risk list.

7 33-7-123. Commissioner as agent -- service of process -- procedure -- fee.

8 33-17-405. Service of process -- commissioner as agent.

9

10 **NEW SECTION. Section 60. Transition.** The department of public health and human services and
11 the state auditor are authorized to transfer existing rules that implement the Managed Care Plan Network
12 Adequacy and Quality Assurance Act, Title 33, chapter 36, to implement the provisions of [this act].

13

14 **NEW SECTION. Section 61. Codification instruction.** (1) [Section 7] is intended to be codified as
15 an integral part of Title 33, chapter 2, part 3, and the provisions of Title 33, chapter 2, part 3, apply to [section
16 7].

17 (2) [Section 12] is intended to be codified as an integral part of Title 33, chapter 7, part 1, and the
18 provisions of Title 33, chapter 7, part 1, apply to [section 12].

19 (3) [Section 16] is intended to be codified as an integral part of Title 33, chapter 17, part 4, and the
20 provisions of Title 33, chapter 17, part 4, apply to [section 16].

21 (4) [Section 42] is intended to be codified as an integral part of Title 33, chapter 22, part 1, and the
22 provisions of Title 33, chapter 22, part 1, apply to [section 42].

23

24 **NEW SECTION. Section 62. Effective dates.** (1) Except as provided in subsections (2), (3), and (4),
25 [this act] is effective October 1, 2023.

26 (2) [Sections 2, 3, 4, 7, 8, 12, 13, 14, 15, 16, 17, 19, 20, 21, 38, 39, 40, 41, 42, and 59] and this
27 section are effective on passage and approval.

28 (3) [Sections 26 through 35] are effective January 1, 2025.

