

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, 33-1-1502, 33-2-116, 33-2-312, 33-2-2402, 33-2-2404, 33-4-509, 33-7-531, 33-10-204, 33-15-
 7 336, 33-17-1101, 33-20-606, 33-20-1304, 33-20-1316, 33-22-156, 33-22-170, 33-22-172, 33-22-173, 33-22-
 8 177, 33-22-1128, ~~33-22-1303~~, ~~33-22-1307~~, ~~33-22-1308~~, ~~33-22-1309~~, ~~33-22-1313~~, ~~33-22-1314~~, ~~33-22-1315~~, 33-
 9 22-1316, ~~33-22-1317~~, ~~33-22-1321~~, 33-23-310, 33-25-105, 33-25-301, 33-31-201, 33-32-215, 33-33-102, 33-33-
 10 201, 33-33-202, 33-36-102, 33-36-103, 33-36-105, 33-36-201, 33-36-203, 33-36-209, 33-36-210, 33-36-211,
 11 33-36-212, 33-36-213, 33-36-301, 33-36-302, 33-36-303, 33-36-304, 33-36-305, AND 33-36-401, MCA;
 12 REPEALING SECTIONS 33-2-322, 33-7-123, AND 33-17-405, MCA; AND PROVIDING EFFECTIVE DATES
 13 AND AN APPLICABILITY DATE."

14

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

16

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

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

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

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

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

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

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

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

23 (A) taxes imposed by this part;

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

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

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

1 (ii) Taxes deductible under this part must be construed to include taxes imposed by any county,
2 school district, or municipality of this state.

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

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

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

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

10 (h) per capita livestock fees imposed pursuant to 15-24-921, 15-24-922, 81-6-104, 81-6-204, 81-6-
11 209, 81-7-118, or 81-7-201.

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

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

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

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

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

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

6

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

8 **"30-10-341. Third-party disclosure -- immunity.** (1) ~~If a qualified individual, investment adviser,~~
 9 ~~investment adviser representative, or salesperson reasonably believes that financial exploitation of a vulnerable~~
 10 ~~person may have occurred, may have been attempted, or is being attempted, the qualified individual,~~
 11 ~~investment adviser, investment adviser representative, or salesperson may notify any third party closely~~
 12 ~~connected to the vulnerable person. Disclosure may not be made to a third party who is suspected of financial~~
 13 ~~exploitation or other abuse of the vulnerable person~~ A qualified individual, investment adviser, investment
 14 adviser representative, or salesperson may WHO REASONABLY BELIEVES THAT THE FINANCIAL EXPLOITATION OF A
 15 VULNERABLE PERSON IS OCCURRING, HAS OR MAY HAVE OCCURRED, IS BEING ATTEMPTED, OR HAS BEEN OR MAY HAVE
 16 BEEN ATTEMPTED:

17 (a) MAY notify: a covered agency if the covered person believes that the financial exploitation of an
 18 older person or a person with a developmental disability is occurring, has or may have occurred, is being
 19 attempted, or has been or may have been attempted

20 (i) A FEDERAL, STATE, OR LOCAL LAW ENFORCEMENT AGENCY;

21 (ii) THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES PROVIDED FOR IN 2-15-2201 OR ITS
 22 LOCAL AFFILIATE; OR

23 (iii) THE COMMISSIONER;

24 (b) MAY notify any third party reasonably associated with an older person or a person with a
 25 developmental disability if the covered person believes that the financial exploitation of an older person or a
 26 person with a developmental disability is occurring, has or may have occurred, is being attempted, or has been
 27 or may have been attempted A VULNERABLE PERSON. A third party reasonably associated with ~~an older person or~~
 28 ~~a person with a developmental disability~~ A VULNERABLE PERSON includes but is not limited to the following:

1 (i) ~~a parent, spouse, adult child, sibling, or other known family member or close associate of an~~
2 ~~elder person or a person with a developmental disability~~ A VULNERABLE PERSON;

3 (ii) ~~an authorized contact provided by an elder person or a person with a developmental disability~~
4 ~~to the covered financial institution~~ A VULNERABLE PERSON TO THE QUALIFIED INDIVIDUAL, INVESTMENT ADVISER,
5 INVESTMENT ADVISER REPRESENTATIVE, OR SALESPERSON;

6 (iii) ~~a co-owner, additional authorized signatory, or beneficiary of an elder person or a person with~~
7 ~~a developmental disability's~~ A VULNERABLE PERSON'S account; and

8 (iv) ~~an attorney-in-fact, trustee, conservator, guardian, or other fiduciary who has been selected by~~
9 ~~an elder person, a person with a developmental disability, a VULNERABLE PERSON, a court, a government~~
10 ~~agency, or a third party to manage some or all of the financial affairs of the elder person or the person with a~~
11 ~~developmental disability~~ VULNERABLE PERSON;

12 (c) ~~choose~~ MAY ~~not to~~ notify any third party reasonably associated with ~~an elder person or a person~~
13 ~~with a developmental disability~~ A VULNERABLE PERSON ~~of suspected financial exploitation of the elder person or~~
14 ~~the person with a developmental disability if the covered person~~ IF THE QUALIFIED INDIVIDUAL, INVESTMENT
15 ADVISER, INVESTMENT ADVISER REPRESENTATIVE OR SALESPERSON believes the third party is, may be, or may have
16 been engaged in the financial exploitation of the ~~elder person or the person with a developmental disability~~
17 VULNERABLE PERSON.

18 (2) A qualified individual, investment adviser, investment adviser representative, or salesperson
19 who, in good faith and exercising reasonable care, complies with this section is immune from administrative or
20 civil liability that might otherwise arise from the disclosure."

21

22 **Section 3.** Section 30-10-1004, MCA, is amended to read:

23 **"30-10-1004. (Temporary) Creation of securities restitution assistance fund.** (1) There is an
24 account in the state special revenue fund to the credit of the commissioner for use only for securities restitution
25 assistance. This account may be referred to as the "securities restitution assistance fund" or "fund". The money
26 in the fund is statutorily appropriated, as provided in 17-7-502, to the commissioner for the purposes provided in
27 subsection (4) of this section.

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

- 1 (i) persons who have violated any provision of parts 1 through 3 of this chapter;
- 2 (ii) persons who have voluntarily contributed to the fund; and
- 3 (iii) a portion of fees collected under 30-10-209(1)(b) as provided in 30-10-209(6)(b).
- 4 (b) Amounts received by the commissioner for deposit in the fund do not include administrative
- 5 penalties or fines imposed under this chapter and as referenced under the Montana Administrative Procedure
- 6 Act, Title 2, chapter 4, part 6.
- 7 (c) The amounts received for the fund may not be placed in the general fund.
- 8 (3) Amounts received by the commissioner for deposit in the fund must be promptly turned over to
- 9 the state treasurer for deposit in the fund created under subsection (1).
- 10 (4) The fund may be used by the commissioner only to pay awards of restitution assistance under
- 11 this part.
- 12 (5) Whenever a claimant is paid from the securities restitution assistance fund pursuant to this
- 13 section PART, the securities restitution assistance fund is subrogated, to the extent of the payment to the
- 14 claimant, to the rights of the claimant to any restitution ordered by the court BEYOND THE AMOUNT THAT WOULD
- 15 MAKE THE CLAIMANT WHOLE. The commissioner may, on behalf of the securities restitution assistance fund, file
- 16 any document in a court of competent jurisdiction to enforce this right. (Terminates June 30, 2027--secs. 3, 4,
- 17 Ch. 404, L. 2021.)"

18

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

20 **"33-1-408. Conduct of examinations -- records -- correction of accounts -- appraisals.** (1) Upon

21 determining that an examination should be conducted, the commissioner or the commissioner's designee shall

22 issue an examination warrant appointing one or more examiners to perform the examination and instructing

23 them as to the scope of the examination. In conducting the examination, an examiner shall observe the

24 guidelines and procedures set forth in the examiners' handbook adopted by the NAIC. The commissioner may

25 also employ other guidelines or procedures as the commissioner considers appropriate.

26 (2) Every company or person from whom information is sought and its officers, directors,

27 employees, and agents shall provide to the examiners appointed under subsection (1) timely, convenient, and

28 free access at all reasonable hours ~~at its offices~~ to all books, records, accounts, papers, documents, and any or

1 all computer or other recordings relating to the property, assets, business, and affairs of the company being
2 examined, including but not limited to access at its offices. The officers, directors, employees, and agents of the
3 company or person shall facilitate the examination and aid in the examination so far as it is in their power to do
4 so. The refusal of any company, by its officers, directors, employees, or agents, to submit to examination or to
5 comply with any reasonable written request of the examiners is grounds for suspension, refusal, or nonrenewal
6 of any license or authority held by the company to engage in an insurance or other business subject to the
7 commissioner's jurisdiction. A proceeding for suspension, revocation, or refusal of any license or authority must
8 be conducted pursuant to 33-1-318 and 33-1-701.

9 (3) The commissioner or any examiner has the power to issue subpoenas, administer oaths, and
10 examine under oath any person concerning any matter pertinent to the examination. Upon the failure or refusal
11 of a person to obey a subpoena, the commissioner may petition a court of competent jurisdiction and, upon
12 proper showing, the court may enter an order compelling the witness to appear and testify or to produce
13 documentary evidence. Failure to obey the court order is punishable as contempt of court.

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

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

21 (6) This part may not be construed to limit the commissioner's authority to use and, if appropriate,
22 to make public any final or preliminary examination report, any examiner or company workpapers or other
23 documents, or any other information discovered or developed during the course of any examination in the
24 furtherance of any legal or regulatory action that the commissioner may consider appropriate."
25

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

27 **"33-1-605. Service of process -- foreign or alien insurer -- appointment of registered agent.** (1)
28 A foreign or alien insurer that transacts any business in this state must have a registered agent upon whom any

1 legal process, notice, or demand required or permitted by law to be served upon a company must be served.

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

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

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

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

11 (5) An insurer may revoke the appointment of an agent by filing with the commissioner a written
12 appointment of another agent and a statement that the appointment of the former agent is revoked. The
13 authority of the agent whose appointment has been revoked terminates 30 days after the notice is received by
14 the commissioner.

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

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

21 ~~(8)(7)~~ This section does not limit or affect the right to serve any process, notice, or demand upon an
22 insurer in any other manner permitted by law.

23 ~~(9)(8)~~ When legal process is served pursuant to this section, the insurer must appear, answer, or
24 plead within 30 days, exclusive of the date of mailing, after the date of the certified mailing or be subject to the
25 laws of this state regarding default judgment.

26 ~~(10)(9)~~ For the purposes of this section:

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

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

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SECTION 6. SECTION 33-1-1502, MCA, IS AMENDED TO READ:

"33-1-1502. Application of criminal law and procedure. (1) Unless a rule or statute specifically states otherwise, the provisions of Titles 45 and 46 apply to the enforcement of the offenses provided for in this part.

(2) In any prosecution for the offenses provided for and charged under this part, for the purposes of and in addition to the provisions of 46-2-101 and 46-3-110, offenses are deemed to have been committed in any of the following locations:

(a) the county or judicial district in which the purported loss, damage, or accident occurs;

(b) the county or judicial district in which the insurance policy provides coverage or, in the case of motor vehicle insurance, where the vehicle is garaged; or

(c) the county or judicial district in which money or other insurance proceeds were received for the fraudulent act."

Section 7. Section 33-2-116, MCA, is amended to read:

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

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

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

1

2 **NEW SECTION. Section 8. Insurance presumed unobtainable from authorized insurers.** (4) At
 3 least annually, the commissioner shall make available a list of the kinds of insurance that are presumed to be
 4 unobtainable from authorized insurers, known as the approved risk list.

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

8

9 **Section 9.** Section 33-2-312, MCA, is amended to read:

10 **"33-2-312. Penalty for failure to file statement, pay tax, or pay stamping fee.** (1) A surplus lines
 11 insurance producer or an insured that independently procured insurance that fails to file the tax and fee
 12 statement as required under 33-2-310 or to pay the taxes as required under 33-2-311 is liable for a penalty of
 13 up to \$25 for each day of delinquency, commencing 30 calendar days after the due date established by the
 14 commissioner by rule. The tax and penalty may be recovered in an action instituted by the commissioner in the
 15 name of the state in any court of competent jurisdiction with the attorney general representing the
 16 commissioner. The penalty when collected, unless collected by a justice's court, must be paid to the
 17 commissioner, forwarded to the state treasurer, and placed to the credit of the general fund. The surplus lines
 18 insurance producer's license is also subject to revocation as provided in 33-2-313.

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

22

23 **Section 10.** Section 33-2-2402, MCA, is amended to read:

24 **"33-2-2402. Definitions.** As used in this part, the following definitions apply:

25 (1) "Claims processing services" means the administrative services performed in connection with
 26 the processing and adjudicating of claims relating to pharmacist services that include either or both of the
 27 following:

28 (a) receiving payments for pharmacist services; and

1 (b) making payments to pharmacists or pharmacies.

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

4 (3) "Federally certified health entity" means a 340B covered entity as described in 42 U.S.C.
5 256b(a)(4).

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

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

12 (b) The term includes:

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

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

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

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

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

21 (b) disbursing or distributing rebates;

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

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

24 (e) developing and maintaining formularies;

25 (f) designing prescription drug benefit programs;

26 (g) advertising or promoting services; or

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

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

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

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

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

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

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

11 (b) The term does not include:

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

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

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

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

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

22 ~~(12)~~(13) "Plan sponsor" has the meaning provided in 33-10-202.

23 ~~(13)~~(14) (a) "Rebates" means all price concessions, however characterized, paid by a manufacturer to
24 a pharmacy benefit manager, including discounts and other remuneration or price concessions, that are based
25 on the actual or estimated utilization of a prescription drug.

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

28 ~~(14)~~(15) "Wholesale acquisition cost" has the meaning provided in 42 U.S.C. 1395w-3a.

1 ~~(15)~~(16) "Wholesale distributor" or "distributor" has the meaning provided in 37-7-602.

2 ~~(16)~~(17) "Workers' compensation insurance carrier" means:

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

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

5

6 **Section 11.** Section 33-2-2404, MCA, is amended to read:

7 **"33-2-2404. Pharmacy benefit manager prohibited practices.** (1) In any participation contracts
8 between a pharmacy benefit manager and pharmacies, ~~or pharmacists, or a pharmacy services administrative~~
9 ~~organization~~ ORGANIZATIONS providing prescription drug coverage, a pharmacy or pharmacist may not be
10 prohibited, restricted, or penalized in any way from disclosing to any enrollee or injured worker any information
11 the pharmacy or pharmacist considers appropriate regarding:

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

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

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

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

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

26

27 **Section 12.** Section 33-4-509, MCA, is amended to read:

28 **"33-4-509. Application and policy forms filed with commissioner.** All forms of application for

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

6
 7 **NEW SECTION. Section 13. Service of process.** Service of process against a society authorized to
 8 do business in this state must be made pursuant to 35-7-113 or in any other manner permitted by law.

9

10 **Section 14.** Section 33-7-531, MCA, is amended to read:

11 **"33-7-531. Foreign or alien society -- admission.** (1) A foreign or alien society may not transact
 12 business in this state without a license issued by the commissioner of insurance. A foreign or alien society
 13 desiring admission to this state shall comply substantially with the requirements and limitations of this chapter
 14 applicable to domestic societies. A society may be licensed to transact business in this state upon filing with the
 15 commissioner:

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

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

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

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

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

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

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

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

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Section 15. Section 33-10-204, MCA, is amended to read:

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

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

Section 16. Section 33-15-336, MCA, is amended to read:

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

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

- (a) ocean marine;
- (b) surety and financial institution bonds;
- (c) reinsurance; or
- (d) ~~commercial aviation~~ commercial lines policies, including but not limited to commercial aviation;
- ~~(e) large commercial risks whose aggregate annual premiums for insurance on all risks totals at least \$100,000.~~

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

3

4 NEW SECTION. Section 17. Service of process. Service of process against a nonresident
5 ~~insurance producer~~ PERSON must be made pursuant to 35-7-113 or in any other manner permitted by law.

6

7 **Section 18.** Section 33-17-1101, MCA, is amended to read:

8 **"33-17-1101. Place of business -- display of license -- records.** (1) A resident insurance producer
9 shall maintain a place or places of business in this state accessible to the public. A nonresident insurance
10 producer may maintain a place or places of business in this state. An insurance producer's place or places of
11 business must be a place in which transactions are conducted under the insurance producer's license. The
12 address of the primary place of business must appear on the license. This section does not prohibit the
13 maintenance of a place of business in a licensee's place of residence.

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

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

18 ~~(3)~~(4) The insurance producer shall keep at a place of business complete records pertaining to
19 transactions under the license for a period of at least 3 years after completion of the respective transactions,
20 except that a title insurance producer, as defined in 33-25-105, shall retain records as provided in 33-25-214
21 and 33-25-216."

22

23 **Section 19.** Section 33-20-606, MCA, is amended to read:

24 **"33-20-606. Variable contracts to meet insurance contract requirements.** (1) Except for 33-15-
25 321 through 33-15-329, 33-20-302, and 33-20-307 for variable annuity contracts and 33-20-104, 33-20-110, 33-
26 20-111, 33-20-112, and 33-20-201 through 33-20-213 for variable life insurance policies and as otherwise
27 provided in this part, all pertinent provisions of Title 33 and other laws relating to insurance apply to separate
28 accounts and their related policies and contracts.

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

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

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

10

11 **SECTION 20. SECTION 33-20-1304, MCA, IS AMENDED TO READ:**

12 **"33-20-1304. Issuance of license.** (1) The commissioner may issue a license to the applicant if the
 13 commissioner determines that the applicant:

14 (a) has satisfied all of the requirements for the license for which an application is made;

15 (b) has not engaged in conduct that would authorize the commissioner to refuse to issue a license
 16 under this part; and

17 (c) is financially responsible and has a good business reputation.

18 ~~(2) The commissioner may issue a license to a nonresident applicant only if the nonresident applicant~~
 19 ~~files with the commissioner in writing an appointment of the commissioner to be the agent of the applicant upon~~
 20 ~~whom all legal process in any action or proceeding against the applicant may be served. In the appointment,~~
 21 ~~the applicant shall agree that any lawful process against the applicant that is served upon the commissioner is~~
 22 ~~of the same legal force and validity as if served upon the applicant and that the authority will continue in force~~
 23 ~~as long as any liability remains outstanding in this state. An appointment under this subsection becomes~~
 24 ~~effective on the date that the commissioner issues the license to the applicant.~~

25 (2) If the commissioner denies an application, the commissioner shall inform the applicant and state
 26 the grounds for the denial.

27 (3) An individual may act as a viatical settlement provider or viatical settlement broker under the
 28 authority of the license of a firm or of a corporate viatical settlement provider whether or not the individual holds

1 a license as a viatical settlement provider if:

2 (a) the individual is a member or employee of the firm or is an employee, officer, or director of the
3 corporation; and

4 (b) the individual is designated by the firm or corporation on its license application or on a form that
5 amends or supplements the application as being authorized to act as a viatical settlement provider under the
6 authority of the license."

7

8 **Section 21.** Section 33-20-1316, MCA, is amended to read:

9 **"33-20-1316. Service of process.** (1) For viatical settlement providers, the provisions of Title 33,
10 chapter 1, part 6, apply.

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

13

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

15 **"33-22-156. Health insurance rates -- filing required -- use.** (1) Each health insurance issuer that
16 issues, delivers, or renews individual or small employer group health insurance coverage in the individual or
17 small employer group market shall, at least 60 days before the rate goes into effect, file with the commissioner
18 its rates, fees, dues, and other charges for each product form intended for use in Montana, together with
19 sufficient information to support the premium to be charged as described in 33-22-156 through 33-22-159. This
20 filing may be made simultaneously with a notice of premium increase to policyholders and certificate holders
21 required by 33-22-107.

22 (2) A health insurance issuer may submit a single combined justification for rate increases subject
23 to review affecting multiple products if the claims experience of all products has been aggregated to calculate
24 the rate increases and the rate increases are the same for all products. Rate increases are determined by
25 combining the total amount of increases taken on a single product form or market segment, if the rate increase
26 is the same for all products, over a 12-month period. A market segment means the individual or small group
27 market.

28 (3) The commissioner may waive the 60-day filing requirement under subsection (1) if the rate

1 increase is implemented pursuant to 33-22-107(1)(b). However, the rates and justifications for the rate increase
2 still must be filed.

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

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

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

10 (b) a statement of actuarial justification; and

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

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

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

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

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

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

26

27 **Section 23.** Section 33-22-170, MCA, is amended to read:

28 **"33-22-170. Definitions.** As used in 33-22-170 through 33-22-177 and 33-22-180, the following

1 definitions apply:

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

4 (2) "Federally certified health entity" means a 340B covered entity as described in 42 U.S.C.
5 256b(a)(4).

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

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

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

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

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

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

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

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

24 ~~(8)(9)~~ (9) "Prescription drug" means any drug that is required by federal law or regulation to be
25 dispensed only by a prescription subject to section 353(b) of the Federal Food, Drug, and Cosmetic Act, 21
26 U.S.C. 301 et seq.

27 ~~(9)(10)~~ (10) "Prescription drug order" has the meaning provided in 37-7-101.

28 ~~(10)(11)~~ (11) "Reference pricing" means a calculation for the price of a pharmaceutical that uses the most

1 current nationally recognized reference price or amount to set the reimbursement for prescription drugs and
2 other products, supplies, and services covered by a network contract between a plan sponsor, health insurance
3 issuer, or pharmacy benefit manager and a pharmacy or pharmacist."
4

5 **Section 24.** Section 33-22-172, MCA, is amended to read:

6 **"33-22-172. Maximum allowable cost or reference price list -- price formulation, updating, and**
7 **disclosure -- exceptions.** (1) At the time of entering into a contract with a pharmacy or a pharmacy services
8 administrative organization and subsequently upon request, a plan sponsor, health insurance issuer, or
9 pharmacy benefit manager shall provide the pharmacy or pharmacy services administrative organization with
10 the sources used to determine the pricing for the maximum allowable cost list or the reference used for
11 reference pricing.

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

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

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

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

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

23 (a) review and update no less than every 10 business days the price information for each drug,
24 product, supply, or service for which reference pricing is used; and

25 (b) provide a process for each pharmacy to readily access the reference pricing specific to the plan
26 sponsor or the health insurance issuer's plan.

27 (4) A plan sponsor, health insurance issuer, or pharmacy benefit manager may not:

28 (a) prohibit a pharmacist from discussing reimbursement criteria with a covered person;

- 1 (b) penalize a pharmacy or a pharmacist for disclosing the information described in subsection
 2 (4)(a) to a covered person or for selling a more affordable alternative to a covered person; or
 3 (c) require a pharmacy to charge or collect a copayment from a covered person that exceeds the
 4 total charges submitted by the network pharmacy."

5

6 **Section 25.** Section 33-22-173, MCA, is amended to read:

7 **"33-22-173. Maximum allowable cost -- appeals process.** (1) In contracting with a pharmacy, a
 8 pharmacy services administrative organization, a plan sponsor or pharmacy benefit manager shall:

- 9 (a) provide a procedure by which a pharmacy or a pharmacy services administrative organization
 10 may appeal the price of a drug or drugs on the maximum allowable cost list;
 11 (b) provide a telephone number at which a network pharmacy may contact the pharmacy benefit
 12 manager to discuss the status of the pharmacy's appeal; and
 13 (c) respond to an appeal no later than 10 calendar days after the date the appeal is made.
 14 (2) If the final determination is a denial of the pharmacy's or the pharmacy services administrative
 15 organization's appeal, the pharmacy benefit manager shall state the reason for the denial and provide the
 16 national drug code of an equivalent drug that is available for purchase by pharmacies in this state from national
 17 or regional wholesalers at a price that is equal to or less than the maximum allowable cost for that drug.
 18 (3) If a pharmacy's or a pharmacy services administrative organization's appeal is determined to
 19 be valid by the pharmacy benefit manager, the pharmacy benefit manager shall:
 20 (a) make an adjustment in the drug price effective on the date the appeal is resolved;
 21 (b) make the adjustment applicable to all similarly situated network pharmacy providers as
 22 determined by the plan sponsor or the pharmacy benefit manager, as appropriate; and
 23 (c) permit the appealing pharmacy to reverse and rebill the claim in question, using the dates of
 24 the original claim or claims.
 25 (4) A pharmacy benefit manager shall make price adjustments to all similarly situated pharmacies
 26 within 3 days.
 27 (5) A pharmacy or a pharmacy services administrative organization shall file its appeal within 10
 28 calendar days ~~of its submission of the initial claim for reimbursement~~ FROM THE TIME OF DENIAL BY THE PHARMACY

1 BENEFIT MANAGER."

2

3 **Section 26.** Section 33-22-177, MCA, is amended to read:

4 **"33-22-177. Rights of pharmacies.** (1) A pharmacy benefit manager or third-party payer may not
5 prohibit a pharmacist or pharmacy from:

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

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

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

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

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

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

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

22 (4) A pharmacy benefit manager or third-party payer shall provide a pharmacy or pharmacist with
23 the processor control number, bank identification number, and group number for each pharmacy network
24 established or administered by a pharmacy benefit manager or third-party payer to enable the pharmacy to
25 make an informed contracting decision.

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

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

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

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

6 (6) A pharmacy or a pharmacy services administrative organization has a private right of action to
7 enforce provisions of 33-22-175 through 33-22-177."
8

9 **Section 27.** Section 33-22-1128, MCA, is amended to read:

10 **"33-22-1128. Insurance producer training requirements.** (1) An individual may not sell, solicit, or
11 negotiate long-term care insurance unless the individual is licensed as an insurance producer for disability or
12 life insurance, has completed a one-time training course ~~on or before July 1, 2008~~, and completes ongoing
13 training within every 24-month period ~~following July 1, 2008~~.

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

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

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

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

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

24 (ii) available long-term care services and providers;

25 (iii) changes or improvements in long-term care services or providers;

26 (iv) alternatives to the purchase of private long-term care insurance;

27 (v) the effect of inflation on benefits and the importance of inflation protection; and

28 (vi) consumer suitability standards and guidelines.

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

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

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

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

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

18 (8) The satisfaction of the training requirements required by this section in any state must be
 19 considered to satisfy the training requirements in this state."
 20

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

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

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

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

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

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

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

5 (6) ~~—"Eligible health insurer" means a health insurer, health service corporation, or health~~
 6 ~~maintenance organization that:~~

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

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

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

12 (7) ~~—"Major medical" health insurance includes individual market and employer group health~~
 13 ~~insurance that:~~

14 (a) ~~—is guaranteed available;~~

15 (b) ~~—is guaranteed renewable;~~

16 (c) ~~—does not impose preexisting condition exclusions;~~

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

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

19 (e) ~~—pays medical claims, with no lifetime or annual limits; and~~

20 (f) ~~—complies with the federal limits for maximum out-of-pocket.~~

21 (8) ~~—"Payment parameters" means the attachment point, reinsurance cap, and coinsurance rate for~~
 22 ~~the Montana reinsurance program.~~

23 (9) ~~—"Program" means the Montana reinsurance program operated by the Montana reinsurance~~
 24 ~~association as provided in this part -~~

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

28 (11) ~~—"Reinsurance payments" means an amount paid by the association to an eligible health insurer~~

1 under the program."

2

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

4 ~~"33-22-1307. — Duties of commissioner -- rulemaking. (1) The commissioner shall:~~

5 ~~(a) — oversee the activities of the association and the board;~~

6 ~~(b) — examine the affairs of the board and program;~~

7 ~~(c) — approve the plan of operation and payment parameters set by the board as needed within 30~~

8 ~~days of receiving the plan and payment parameters or and any amendments to the plan or payment parameters~~

9 ~~from the board;~~

10 ~~(d) — with the assistance of the association, collect the assessment and the federal funding~~

11 ~~designated for this program;~~

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

13 ~~and~~

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

15 ~~(g) — establish administrative and accounting procedures for the association and the program;~~

16 ~~(h) — set the budget for the reinsurance program for each policy year, including the assessment~~

17 ~~levels as provided in 33-22-1313 for the various members of the association; and~~

18 ~~(f)(i) — require all eligible health insurers to calculate the premium amount the eligible health insurer~~

19 ~~would have charged for the benefit year if the Montana reinsurance program had not been established. The~~

20 ~~eligible health insurer shall submit this information as part of its rate filing. The commissioner shall consider this~~

21 ~~information as part of the rate review.~~

22 ~~(2) — The commissioner may adopt rules necessary to implement this part. Any proposed~~

23 ~~administrative rules must be submitted to the board for review and comment before the proposed rules are~~

24 ~~submitted to the secretary of state.~~

25 ~~(3) — The commissioner may contract with a third party or parties to perform or assist in performing~~

26 ~~the functions described in subsection (1).~~

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

28

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

2 "~~33-22-1308. Board duties -- powers.~~ (1) The board shall :

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

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

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

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

14 (2) ~~The board may:~~

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

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

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

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

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

24 (5) ~~The board~~ With the assistance of the board, the commissioner shall prepare an annual report
25 on operations and finance and send that report to the economic affairs interim committee as provided in 5-11-
26 210 and the commissioner by June 30 of each year, beginning in 2020. "

27

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

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

7 (2) — The administrator shall:

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

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

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

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

14 ~~"33-22-1313. — Association member assessments. (1) (a) (i) For 2020 and each year thereafter, the~~
 15 ~~commissioner shall assess each member insurer 1.2% of its total premium volume covering Montana residents,~~
 16 ~~from the prior calendar year, regardless of type of license.~~

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

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

20 (c) — The commissioner shall consider the board's recommendation when determining the
 21 assessment amounts.

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

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

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

28 (b) — The report must include an estimate of the assessments needed to cover the expected

1 reinsurance claims for the following calendar year.

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

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

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

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

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

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

12

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

14 **"33-22-1314. — Payment parameters.** (1) ~~The board shall design and adjust the payment parameters~~
 15 ~~to ensure that the payment parameters will:~~

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

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

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

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

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

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

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

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

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

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

28

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

2 ~~"33-22-1315. **Calculation of reinsurance payments.** (1) Each reinsurance payment must be~~
 3 ~~calculated with respect to an eligible health insurer's incurred claims costs for an individual enrollee's covered~~
 4 ~~benefits in the applicable benefit year. If the claims costs do not exceed the attachment point, the reinsurance~~
 5 ~~payment is \$0. If the claims costs exceed the attachment point, the reinsurance payment must be calculated as~~
 6 ~~the product of the coinsurance rate and the less of:~~

7 ~~(a) — the claims costs minus the attachment point; or~~

8 ~~(b) — the reinsurance cap minus the attachment point.~~

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

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

13

14 **Section 28.** Section 33-22-1316, MCA, is amended to read:

15 ~~"33-22-1316. **Administration of reinsurance payments.** (1) Claims that are incurred during a benefit~~
 16 ~~year and are submitted for reimbursement in the following benefit year by the date established by the board BY~~
 17 ~~THE BOARD in the plan of operation will be allocated to the benefit year in which they are incurred. Claims~~
 18 ~~submitted after the date established by the board following the benefit year in which they were incurred will be~~
 19 ~~allocated to the next benefit year in accordance with the board's operating rules, policies, and procedures Any~~
 20 ~~claims from the preceding benefit year not submitted for reimbursement by the date established in the plan of~~
 21 ~~operation may not be reimbursed.~~

22 (2) If funds accumulated in the reinsurance program account in the state special revenue fund with
 23 respect to a benefit year are expected to be insufficient to pay all program expenses, claims for reimbursement,
 24 and other disbursements allocable to that benefit year, all claims for reimbursement allocable to that benefit
 25 year must be reduced proportionately to the extent necessary to prevent a deficiency in the funds for that
 26 benefit year. Any reduction in claims for reimbursement with respect to a benefit year must apply to all claims
 27 that are allocated to that benefit year without regard to when those claims were submitted for reimbursement,
 28 and any reduction must be applied to each claim in the same proportion.

1 (3) If funds accumulated in the reinsurance program account in the state special revenue fund
 2 exceed the actual claims for reimbursement and program expenses of the association in a given benefit year,
 3 the ~~board commissioner~~ BOARD shall use ~~such the~~ excess funds to pay reinsurance claims in successive benefit
 4 years ~~and may recommend to the commissioner a reduction in the assessment amount for the following year~~
 5 AND MAY RECOMMEND TO THE COMMISSIONER A REDUCTION IN THE ASSESSMENT AMOUNT FOR THE FOLLOWING YEAR.

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

9 (5) By December 31 of the year following the applicable benefit year, the ~~board commissioner~~
 10 BOARD shall disburse all applicable reinsurance payments payable to an eligible health insurer."
 11

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

13 ~~"33-22-1317. Eligible health insurer requests for reinsurance payments.~~ (1) An eligible health
 14 insurer shall:

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

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

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

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

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

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

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

3

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

5 ~~"33-22-1321. State and federal special revenue accounts -- reinsurance program. (1) (a) There~~
6 ~~is a reinsurance program account in the state special revenue fund established by 17-2-102 . The account must~~
7 ~~be administered by the commissioner for the benefit of the program.~~

8 ~~(b) — There must be deposited in the account:~~

9 ~~(i) — all assessments collected under 33-22-1313 ;~~

10 ~~(ii) — any interest and income earned on the account; and~~

11 ~~(iii) — any other money from any other source accepted for the benefit of the account.~~

12 ~~(c) — The account may be used only to provide funding for the administration, operation, and claims~~
13 ~~expenses incurred by the program created in 33-22-1302 THIS PART, INCLUDING BUT NOT LIMITED TO EXPENSES~~
14 ~~INCURRED BY THE COMMISSIONER AND THE BOARD .~~

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

17 ~~(a) — federal funding allocated as a result of a section 1332 waiver application;~~

18 ~~(b) — any federal or grant funding; and~~

19 ~~(c) — any interest and income earned on the account."~~

20

21 **Section 29.** Section 33-23-310, MCA, is amended to read:

22 ~~"33-23-310. Medical malpractice insurance report by insurer. (1) Each ~~If requested in writing by~~~~
23 ~~the commissioner, each insurer engaged in issuing medical malpractice professional liability insurance in this~~
24 ~~state shall, within 60 days, provide a report to the commissioner containing the following categories of~~
25 ~~information, as directed by the commissioner, for one or more professions provided in subsection (2)(b) include~~
26 ~~the following, by profession and based upon the insurer's experience in this state, in its annual statement to the~~
27 ~~commissioner of insurance:~~

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

- 1 (b) the amount of direct premiums written and direct premiums paid for medical malpractice
2 insurance during the preceding calendar year;
- 3 (c) the number of medical malpractice claims made against its insureds during the preceding
4 calendar year;
- 5 (d) the number of medical malpractice claims that were closed and that had a direct loss paid
6 during the preceding calendar year, together with the total amount of direct losses paid for all closed claims for
7 that year;
- 8 (e) the number of medical malpractice claims that were still open and had no direct losses paid as
9 of December 31 of the preceding calendar year;
- 10 (f) the number of claims filed against its insureds in state and federal courts during the preceding
11 calendar year, including the number of claims that were closed:
- 12 (i) without settlement during the preceding calendar year;
- 13 (ii) with a settlement during the preceding calendar year and the total amount paid for those
14 claims;
- 15 (iii) during the preceding calendar year and that went to trial and the number that resulted in a
16 judgment or verdict for the plaintiff, the number that resulted in a judgment or verdict for the insured, and the
17 number that resulted in some other judgment or verdict;
- 18 (g) the total direct losses paid for claims against its medical malpractice insureds that went to trial
19 and were closed during the preceding year; and
- 20 (h) other information and statistics that the commissioner of insurance requires.
- 21 (2) For purposes of this section:
- 22 (a) "insurer" has the meaning provided in 33-1-201; and
- 23 (b) "profession" includes the categories of physician, osteopath, podiatrist, dentist, optometrist,
24 registered nurse, licensed practical nurse, or health care facility as defined in 50-5-101."
- 25

26 **Section 30.** Section 33-25-105, MCA, is amended to read:

27 **"33-25-105. Definitions.** As used in this chapter, the following definitions apply:

- 28 (1) "Abstract" means a written representation, provided pursuant to a contract and expected to be

1 relied upon by the person who has contracted for the receipt of that representation, listing all recorded
2 conveyances, instruments, or documents which, under the laws of this state, impart constructive notice
3 regarding the chain of title to real property described in the abstract. Abstract includes "abstract of title".

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

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

9 (4) "Associate" means a:

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

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

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

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

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

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

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

24 (7) "Preliminary report" means an offer to issue a title insurance policy subject to any exceptions
25 stated in the report or other matters that may be incorporated by reference therein. Preliminary report includes
26 a commitment or binder.

27 (8) "Producer of title business" or "producer" means a person, corporation, partnership, or other
28 business entity, including an officer, director, or owner of 5% or more of the equity or capital thereof, engaged in

1 this state in the trade, business, occupation, or profession of:

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

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

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

6 (9) "Rate" means fees for:

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

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

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

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

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

20 ~~(11)~~(12) "Title insurance business" means:

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

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

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

25 (ii) guaranteeing, warranting, or otherwise insuring the correctness of title searches;

26 (iii) handling escrows, settlements, or closings;

27 (iv) executing title insurance policies, reports, commitments, binders, and endorsements;

28 (v) effecting contracts of reinsurance; or

- 1 (vi) abstracting, searching, or examining titles;
- 2 (c) transacting, as a title insurer or insurance producer, matters subsequent to the issuance of a
3 title insurance policy and arising out of the policy; or
- 4 (d) doing or proposing to do business that, in substance, is equivalent to any of the activities
5 described in subsections ~~(11)(a) through (11)(e)~~ (12)(a) through (12)(c) in a manner designed to evade the
6 provisions of this title.

7 ~~(12)~~(13) "Title insurance policy" means a contract by which, subject to its stated terms and conditions,
8 a title insurer insures or indemnifies the insured against loss or damage sustained by reason of:

- 9 (a) defects in or liens or encumbrances on the title to the stated property;
- 10 (b) unmarketability of the title to the stated property; or
- 11 (c) invalidity or unenforceability of liens or encumbrances on the stated property.

12 ~~(13)~~(14) (a) "Title insurance producer" means a person who holds a valid title insurance producer's
13 license and is authorized in writing by a title insurer to:

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

19 ~~(14)~~(15) "Title insurer" means an insurer formed and authorized under the laws of this state to transact
20 the business of title insurance in this state or a foreign or alien insurer so authorized.

21 ~~(15)~~(16) "Title plant" means a set of privately maintained records in which entries have been made of
22 documents imparting constructive notice, under the law, of matters affecting title to real property, an interest
23 therein, or an encumbrance thereon, that have been filed or recorded in the jurisdiction for which the title plant
24 is maintained and from which the ownership of real property within the jurisdiction can be ascertained and liens,
25 encumbrances, defects, and clouds on title to the real property can be determined."

26

27 **Section 31.** Section 33-25-301, MCA, is amended to read:

28 **"33-25-301. Refusal, suspension, or revocation of title insurance producer's license.** (1) In

1 addition to the causes provided in 33-17-1001, the commissioner may refuse to license an applicant or renew
 2 the license of a person as a title insurance producer or may suspend or revoke a title insurance producer's
 3 license or may fine a title insurance producer or applicant, after notice and opportunity for a hearing, if the
 4 commissioner finds that the license applicant or licensee has:

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

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

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

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

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

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

15 (3) The commissioner may issue an order requiring restitution to injured parties and
 16 reimbursement of the commissioner's reasonable costs of bringing an administrative action PURSUANT TO THIS
 17 SECTION.

18 ~~(3)~~(4) The commissioner may refuse, suspend, or revoke the license of a person licensed as a title
 19 insurance producer for the actions described in subsection (1) committed by any individual designated in the
 20 license."

21

22 **SECTION 32. SECTION 33-31-201, MCA, IS AMENDED TO READ:**

23 **"33-31-201. Establishment of health maintenance organizations.** (1) Notwithstanding any law of
 24 this state to the contrary, a person may apply to the commissioner for and obtain a certificate of authority to
 25 establish and operate a health maintenance organization in compliance with this chapter. A person may not
 26 establish or operate a health maintenance organization in this state except as authorized by a subsisting
 27 certificate of authority issued to it by the commissioner. A foreign person may qualify for a certificate of authority
 28 if it first registers with the secretary of state to transact business in this state as a foreign corporation under 35-

1 14-1502.

2 (2) Each application of a health maintenance organization, whether separately licensed or not, for
3 a certificate of authority must:

4 (a) be verified by an officer or authorized representative of the applicant;

5 (b) be in a form prescribed by the commissioner;

6 (c) contain:

7 (i) the applicant's name;

8 (ii) the location of the applicant's home office or principal office in the United States, if a foreign
9 person;

10 (iii) the date of organization or incorporation;

11 (iv) the form of organization, including whether the providers affiliated with the health maintenance
12 organization will be salaried employees or group or individual contractors;

13 (v) the state or country of domicile; and

14 (vi) any additional information that the commissioner may reasonably require; and

15 (d) set forth the following information or be accompanied by the following documents, as
16 applicable:

17 (i) a copy of the applicant's organizational documents, such as its corporate charters or articles of
18 incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents,
19 and all amendments to those documents, certified by the public officer with whom the originals were filed in the
20 state or country of domicile;

21 (ii) a copy of the bylaws, rules, and regulations, or similar document, if any, regulating the conduct
22 of the applicant's internal affairs, certified by its secretary or other officer having custody of the documents;

23 (iii) a list of the names, addresses, and official positions of the persons responsible for the conduct
24 of the applicant's affairs, including all members of the board of directors, board of trustees, executive
25 committee, or other governing board or committee, the principal officers in the case of a corporation, and the
26 partners or members in the case of a partnership or association;

27 (iv) a copy of any contract made or to be made between:

28 (A) any provider and the applicant; or

1 (B) any person listed in subsection (2)(d)(iii) and the applicant. The applicant may file a list of
2 providers executing a standard contract and a copy of the contract instead of copies of each executed contract.

3 (v) the extent to which any of the following will be included in provider contracts and the form of
4 any provisions that:

5 (A) limit a provider's ability to seek reimbursement for basic health care services or health care
6 services from an enrollee;

7 (B) permit or require a provider to assume a financial risk in the health maintenance organization,
8 including any provisions for assessing the provider, adjusting capitation or fee-for-service rates, or sharing in
9 the earnings or losses; and

10 (C) govern amending or terminating an agreement with a provider;

11 (vi) a financial statement showing the applicant's assets, liabilities, and sources of financial
12 support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the
13 applicant's most recent certified financial statement satisfies this requirement unless the commissioner directs
14 that additional or more recent financial information is required for the proper administration of this chapter.

15 (vii) a description of the proposed method of marketing, a financial plan that includes a projection of
16 operating results anticipated until the organization has had net income for at least 1 year, and a statement as to
17 the sources of working capital as well as any other source of funding;

18 ~~(viii) a power of attorney executed by the applicant, on a form prescribed by the commissioner,
19 appointing the commissioner, the commissioner's successors in office, and the commissioner's authorized
20 deputies as the applicant's attorney to receive service of legal process issued against it in this state;~~

21 (viii) a statement reasonably describing the geographic service area or areas to be served, by
22 county, including:

23 (A) a chart showing the number of primary and specialty care providers, with locations and service
24 areas by county;

25 (B) the method of handling emergency care, with the location of each emergency care facility; and

26 (C) the method of handling out-of-area services;

27 (ix) a description of the way in which the health maintenance organization provides services to
28 enrollees in each geographic service area, including the extent to which a provider under contract with the

1 health maintenance organization provides primary care to those enrollees;

2 (x) a description of the complaint procedures to be used as required under 33-31-303;

3 (xi) a description of the mechanism by which enrollees will be afforded an opportunity to participate
4 in matters of policy and operation under 33-31-222;

5 (xii) a summary of the way in which administrative services will be provided, including the size and
6 qualifications of the administrative staff and the projected cost of administration in relation to premium income.

7 If the health maintenance organization delegates management authority for a major corporate function to a
8 person outside the organization, the health maintenance organization shall include a copy of the contract in its
9 application for a certificate of authority. Contracts for delegated management authority must be filed with the
10 commissioner in accordance with the filing provisions of 33-31-301(2). However, this subsection (2)(d)(xii) does
11 not deprive the health maintenance organization of its right to confidentiality of any proprietary information, and
12 the commissioner may not disclose that proprietary information to any other person. All contracts must include:

13 (A) the services to be provided;

14 (B) the standards of performance for the manager;

15 (C) the method of payment, including any provisions for the administrator to participate in the
16 profits or losses of the plan;

17 (D) the duration of the contract; and

18 (E) any provisions for modifying, terminating, or renewing the contract.

19 (xiii) a summary of all financial guaranties by providers, sponsors, affiliates, or parents within a holding
20 company system or any other guaranties that are intended to ensure the financial success of the plan, including
21 hold harmless agreements by providers, insolvency insurance, reinsurance, or other guaranties;

22 (xiv) a summary of benefits to be offered enrollees, including any limitations and exclusions and the
23 renewability of all contracts to be written;

24 (xv) evidence that it can meet the requirement of 33-31-216(10); and

25 (xvi) any other information that the commissioner may reasonably require to make the determinations
26 required in 33-31-202.

27 (3) Each health maintenance organization shall file each substantial change, alteration, or
28 amendment to the information submitted under subsection (2) with the commissioner at least 30 days prior to

1 its effective date, including changes in articles of incorporation and bylaws, organization type, geographic
2 service area, provider contracts, provider availability, plan administration, financial projections and guaranties,
3 and any other change that might affect the financial solvency of the plan. The commissioner may, after notice
4 and hearing, disapprove any proposed change, alteration, or amendment to the business plan. The
5 commissioner may adopt reasonable rules exempting from the filing requirements of this subsection those
6 items that the commissioner considers unnecessary.

7 (4) An applicant or a health maintenance organization holding a certificate of authority shall file
8 with the commissioner all contracts of reinsurance and any modifications to the contracts. An agreement
9 between a health maintenance organization and an insurer is subject to Title 33, chapter 2, part 12. A
10 reinsurance agreement must remain in full force and effect for at least 90 days following written notice of
11 cancellation by either party by certified mail to the commissioner.

12 (5) Each health maintenance organization shall maintain at its administrative office and make
13 available to the commissioner upon request executed copies of all provider contracts.

14 (6) The commissioner may adopt reasonable rules exempting an insurer or health service
15 corporation operating a health maintenance organization as a plan from the filing requirements of this section if
16 information requested in the application has been submitted to the commissioner under other laws and rules
17 administered by the commissioner.

18 (7) (a) The commissioner may waive the requirements of this section for a PACE organization that
19 has entered into a PACE program agreement pursuant to 42 U.S.C. 1396u-4.

20 (b) A request for waiver must be submitted in a form prescribed by the commissioner. The waiver
21 application must be filed and approved annually. The annual renewal process must be completed by June 30 of
22 each year.

23 (c) The factors that the commissioner may take into account when granting a waiver include but
24 are not limited to the financial condition of the PACE organization, any consumer complaints against the PACE
25 organization, and the length of time the PACE organization has been in business.

26 (d) The PACE organization shall submit an audited financial statement for the organization as a
27 whole and a financial statement for the PACE program specifically with the initial waiver application and
28 annually on June 30. The commissioner may request additional information necessary to evaluate the waiver

1 request.

2 (e) The waiver automatically expires if the certification of the PACE organization by the centers for
3 medicare and medicaid services or the department of public health and human services expires or is
4 terminated.

5 (f) The PACE organization shall notify the commissioner within 30 days if the centers for medicare
6 and medicaid services takes adverse action or issues any warnings regarding the continuation of the PACE
7 organization.

8 (8) (a) (i) The commissioner may waive the requirements of this section for an accountable care
9 organization. Upon establishment of a medicare shared savings program pursuant to 42 U.S.C. 1395jjj, an
10 accountable care organization shall demonstrate compliance with the program requirements in a manner
11 determined by the commissioner.

12 (ii) The commissioner shall follow the medicare shared savings program structure in developing
13 compliance criteria needed for obtaining a waiver.

14 (b) A request for waiver must be submitted in a form prescribed by the commissioner. The waiver
15 application must be filed and approved every 3 years. The renewal process must be completed by June 30 of
16 every third year.

17 (c) The factors that the commissioner may take into account when granting a waiver include but
18 are not limited to the financial condition of the accountable care organization, any consumer complaints against
19 the organization, and the length of time the organization has been in business.

20 (d) The accountable care organization shall submit an audited financial statement for the
21 organization as a whole and a financial statement for the accountable care organization program specifically
22 with the initial waiver application and annually by June 30. The commissioner may request additional
23 information necessary to evaluate the waiver request.

24 (e) The waiver automatically expires if certification of the accountable care organization under the
25 medicare shared savings program or the department of public health and human services expires or is
26 terminated."

27

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 ~~(7)~~(6) If prior authorization is required for a postevaluation or poststabilization services review, a
 22 health insurance issuer shall provide access to a designated representative 24 hours a day, 7 days a week, to
 23 facilitate the review.

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

26

27 **SECTION 34. SECTION 33-33-102, MCA, IS AMENDED TO READ:**

28 **"33-33-102. Scope -- rulemaking. (1) This chapter applies to property and casualty insurers seeking**

1 utilization review opinions and to utilization review organizations that provide opinions with respect to property
2 and casualty insurance contracts issued in this state.

3 (2) The commissioner may adopt rules to implement the provisions of this chapter, including but
4 not limited to ~~registration procedures and~~ medical privacy requirements."

5

6 **Section 35.** Section 33-33-201, MCA, is amended to read:

7 **"33-33-201. Standards for utilization review organizations.** (1) A utilization review organization
8 that conducts utilization reviews in this state for property and casualty insurers shall meet the standards set
9 forth in this part~~register with the commissioner prior to performing utilization reviews. The commissioner shall~~
10 ~~place a utilization review organization on the register when the utilization review organization provides~~
11 ~~information that establishes that the utilization review organization meets the standards set forth in this section.~~
12 ~~The commissioner shall remove from the register a utilization review organization that fails to meet the~~
13 ~~standards set forth in this section.~~

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

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

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

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

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

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

27

28 **Section 36.** Section 33-33-202, MCA, is amended to read:

1 **"33-33-202. Standards for property and casualty insurers.** (1) Property or casualty insurers
 2 seeking utilization reviews with respect to insurance contracts issued in this state may use only utilization
 3 review organizations that ~~are registered under 33-33-204~~ MEET THE REQUIREMENTS OF THIS PART AND ANY RULES
 4 ADOPTED PURSUANT TO THIS PART.

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

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

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

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

12 ~~(2)~~(3) A property or casualty insurer that denies, in whole or in part, a policyholder's claim after
 13 consideration of a utilization review shall provide the policyholder an opportunity to request reconsideration by
 14 the insurer and the opportunity to submit additional information relating to the claim."

15
 16 NEW SECTION. Section 37. Coverage of oral therapy -- opioid use disorder. A health insurance
 17 issuer may not impose prior authorization or step therapy requirements for an oral therapy prescription used to
 18 treat opioid use disorder.

19

20 **Section 38.** Section 33-36-102, MCA, is amended to read:

21 **"33-36-102. Purpose.** The purpose and intent of this chapter are to:

22 (1) establish standards for the creation and maintenance of networks by health carriers offering
 23 managed care plans and to ensure the adequacy, accessibility, and quality of health care services offered
 24 under a managed care plan by establishing requirements for written agreements between health carriers
 25 offering managed care plans and participating providers regarding the standards, terms, and provisions under
 26 which the participating provider will provide services to covered persons;

27 (2) provide for the implementation of state network adequacy and quality assurance standards in
 28 administrative rules, provide for monitoring compliance with those standards, and provide a mechanism for

1 detecting and reporting violations of those standards to the commissioner;

2 (3) establish minimum criteria for the quality assessment activities of a health carrier issuing a
3 closed plan or a combination plan and to require that minimum state quality assessment criteria be adopted by
4 rule;

5 (4) enable health carriers to evaluate, maintain, and improve the quality of health care services
6 provided to covered persons; and

7 (5) provide a streamlined and simplified process by which managed care network adequacy and
8 quality assurance programs may be monitored for compliance through ~~coordinated efforts of~~ by the
9 commissioner ~~and the department~~. It is not the purpose or intent of this chapter to apply quality assurance
10 standards applicable to medicaid or medicare to managed care plans regulated pursuant to this chapter or to
11 create or require the creation of quality assurance programs that are as comprehensive as quality assurance
12 programs applicable to medicaid or medicare."
13

14 **Section 39.** Section 33-36-103, MCA, is amended to read:

15 **"33-36-103. Definitions.** As used in this chapter, the following definitions apply:

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

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

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

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

23 ~~(5) "Department" means the department of public health and human services established in 2-15-~~
24 ~~2201.~~

25 ~~(6)~~(5) "Emergency medical condition" means a condition manifesting itself by symptoms of sufficient
26 severity, including severe pain, that the absence of immediate medical attention could reasonably be expected
27 to result in any of the following:

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

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

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

3 ~~(7)~~(6) "Emergency services" means health care items and services furnished or required to evaluate
4 and treat an emergency medical condition.

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

10 ~~(9)~~(8) "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered, or
11 issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care
12 services.

13 ~~(10)~~(9) "Health care professional" means a physician or other health care practitioner licensed,
14 accredited, or certified pursuant to the laws of this state to perform specified health care services consistent
15 with state law.

16 ~~(11)~~(10) "Health care provider" or "provider" means a health care professional or a facility.

17 ~~(12)~~(11) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief
18 of a health condition, illness, injury, or disease.

19 ~~(13)~~(12) "Health carrier" means an entity subject to the insurance laws and rules of this state that
20 contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse
21 any of the costs of health care services, including a disability insurer, health maintenance organization, or
22 health service corporation or another entity providing a health benefit plan.

23 ~~(14)~~(13) "Intermediary" means a person authorized to negotiate, execute, and be a party to a contract
24 between a health carrier and a provider or between a health carrier and a network.

25 ~~(15)~~(14) "Managed care plan" means a health benefit plan that either requires or creates incentives,
26 including financial incentives, for a covered person to use health care providers managed, owned, under
27 contract with, or employed by a health carrier, but not preferred provider organizations or other provider
28 networks operated in a fee-for-service indemnity environment.

1 ~~(16)~~(15) "Medically necessary" means services, medicines, or supplies that are necessary and
 2 appropriate for the diagnosis or treatment of a covered person's illness, injury, or medical condition according to
 3 accepted standards of medical practice and that are not provided only as a convenience.

4 ~~(17)~~(16) "Network" means the group of participating providers that provides health care services to a
 5 managed care plan.

6 ~~(18)~~(17) "Open plan" means a managed care plan other than a closed plan that provides incentives,
 7 including financial incentives, for covered persons to use participating providers under the terms of the
 8 managed care plan.

9 ~~(19)~~(18) "Participating provider" means a provider who, under a contract with a health carrier or with
 10 the health carrier's contractor, subcontractor, or intermediary, has agreed to provide health care services to
 11 covered persons with an expectation of receiving payment, other than coinsurance, copayments, or
 12 deductibles, directly or indirectly from the health carrier.

13 ~~(20)~~(19) "Primary care professional" means a participating health care professional designated by the
 14 health carrier to supervise, coordinate, or provide initial care or continuing care to a covered person and who
 15 may be required by the health carrier to initiate a referral for specialty care and to maintain supervision of health
 16 care services rendered to the covered person.

17 ~~(21)~~(20) "Quality assessment" means the measurement and evaluation of the quality and outcomes of
 18 medical care provided to individuals, groups, or populations.

19 ~~(22)~~(21) "Quality assurance" means quality assessment and quality improvement.

20 ~~(23)~~(22) "Quality improvement" means an effort to improve the processes and outcomes related to the
 21 provision of health care services within a health plan."

22

23 **Section 40.** Section 33-36-105, MCA, is amended to read:

24 "**33-36-105. ~~Department Commissioner~~ -- general powers and duties -- rulemaking.** (1) The
 25 ~~department commissioner~~ shall:

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

1 (b) ~~recommend action to the commissioner~~ IF APPROPRIATE, INITIATE ACTION against a health carrier
 2 whose managed care plan does not comply with standards for network adequacy and quality assurance
 3 adopted by the ~~department~~ commissioner.

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

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

9

10 **Section 41.** Section 33-36-201, MCA, is amended to read:

11 **"33-36-201. Network adequacy -- standards -- access plan required.** (1) A health carrier offering a
 12 managed care plan in this state shall maintain a network that is sufficient in numbers and types of providers to
 13 ensure that all services to covered persons are accessible without unreasonable delay. Sufficiency in number
 14 and type of provider is determined in accordance with the requirements of this section. Covered persons must
 15 have access to emergency care 24 hours a day, 7 days a week. A health carrier providing a managed care plan
 16 shall use reasonable criteria to determine sufficiency. The criteria may include but are not limited to:

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

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

19 (c) geographic accessibility;

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

21 (e) hours of operation; or

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

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

28 (3) The health carrier shall establish and maintain adequate provider networks to ensure

1 reasonable proximity of participating providers to the businesses or personal residences of covered persons. In
 2 determining whether a health carrier has complied with this requirement, consideration must be given to the
 3 relative availability of health care providers in the service area under consideration.

4 (4) A health carrier offering a managed care plan in this state on ~~October 1, 1999~~ January 1, 2024,
 5 shall file with the ~~department commissioner~~ on ~~October 1, 1999~~ December 1, 2023, an access plan complying
 6 with subsection (6) and the rules of the ~~department commissioner~~. A health carrier offering a managed care
 7 plan in this state for the first time after ~~October 1, 1999~~ January 1, 2024, shall file with the ~~department~~
 8 commissioner an access plan meeting the requirements of subsection (6) and the rules of the ~~department~~
 9 commissioner at least 60 days before offering the managed care plan. A plan must be filed with the ~~department~~
 10 commissioner in a manner and form complying with the rules of the ~~department commissioner~~. A health carrier
 11 shall file any subsequent material changes in its access plan with the ~~department commissioner~~ within at least
 12 30 days prior to ~~of~~ implementation of the change.

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

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

- 21 (a) a listing of the names and specialties of the health carrier's participating providers;
- 22 (b) the health carrier's procedures for making referrals within and outside its network;
- 23 (c) the health carrier's process for monitoring and ensuring on an ongoing basis the sufficiency of
 24 the network to meet the health care needs of populations that enroll in the managed care plan;
- 25 (d) the health carrier's efforts to address the needs of covered persons with limited English
 26 proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental
 27 disabilities;
- 28 (e) the health carrier's methods for assessing the health care needs of covered persons and their

1 satisfaction with services;

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

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

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

9 (i) the health carrier's proposed plan for providing continuity of care in the event of contract
10 termination between the health carrier and a participating provider or in the event of the health carrier's
11 insolvency or other inability to continue operations. The description must explain how covered persons will be
12 notified of the contract termination or the health carrier's insolvency or other cessation of operations and be
13 transferred to other providers in a timely manner.

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

16 (7) The ~~department~~ commissioner shall ensure timely and expedited review and approval of the
17 access plan and other requirements in this section."
18

19 **Section 42.** Section 33-36-203, MCA, is amended to read:

20 **"33-36-203. Selection of providers -- professional credentials standards.** (1) A health carrier shall
21 adopt standards for selecting participating providers who are primary care professionals and for each health
22 care professional specialty within the health carrier's network. The health carrier shall use the standards to
23 select health care professionals, the health carrier's intermediaries, and any provider network with which the
24 health carrier contracts. A health carrier may not adopt selection criteria that allow the health carrier to:

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

28 (b) exclude a provider because the provider treats or specializes in treating populations presenting

1 a risk of higher than average claims, losses, or use of health care services.

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

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

9 (4) A health carrier may use criteria established in accordance with the provisions of this section to
10 select health care professionals allowed to participate in the health carrier's managed care plan. A health carrier
11 shall make its selection standards for participating providers available for review by the ~~department~~
12 commissioner and by each health care professional who is subject to the selection standards."
13

14 **Section 43.** Section 33-36-209, MCA, is amended to read:

15 **"33-36-209. Use of intermediaries -- responsibilities of health carriers, intermediaries, and**
16 **providers.** (1) A health carrier is responsible for complying with applicable provisions of this chapter, and
17 contracting with an intermediary for all or some of the services for which a health carrier is responsible does not
18 relieve the health carrier of responsibility for compliance.

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

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

26 (4) If required in a contract or otherwise by a health carrier, an intermediary shall transmit
27 utilization documentation and claims-paid documentation to the health carrier. The health carrier shall monitor
28 the timeliness and appropriateness of payments made to providers and health care services received by

1 covered persons. This duty may not be delegated to an intermediary by a health carrier.

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

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

10 (7) A health carrier may, in the event of the intermediary's insolvency, require the assignment to
11 the health carrier of the provisions of a participating provider's contract addressing the participating provider's
12 obligation to furnish covered benefits."

13

14 **Section 44.** Section 33-36-210, MCA, is amended to read:

15 **"33-36-210. Contract filing requirements -- material changes -- state access to contracts.** (1) A
16 health carrier offering a managed care plan in this state on January 1, 2024, shall file with the commissioner
17 on ~~On October 1, 1999~~ December 1, 2023, a health carrier offering a managed care plan shall file with the
18 department sample contract forms proposed for use with its participating providers and intermediaries. A health
19 carrier offering a managed care plan in this state for the first time after January 1, 2024, shall file with the
20 commissioner sample contract forms proposed for use with its participating providers and intermediaries at
21 least 60 days before offering the managed care plan.

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

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

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Section 45. Section 33-36-211, MCA, is amended to read:

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

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

Section 46. Section 33-36-212, MCA, is amended to read:

"33-36-212. Contract compliance dates. ~~(1) A contract between a health carrier and a participating provider or intermediary in effect on October 1, 1999, must comply with this part and the rules implementing this part on the date the contract is issued or put into effect by October 1, 1999. The department may extend the October 1 date for an additional period of up to 6 months if the health carrier demonstrates good cause for an extension.~~

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

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

Section 47. Section 33-36-213, MCA, is amended to read:

"33-36-213. Department rules RULEMAKING AUTHORITY. The ~~department~~ commissioner may adopt rules to implement this part."

Section 48. Section 33-36-301, MCA, is amended to read:

"33-36-301. Quality assurance -- national accreditation. (1) A health carrier whose managed care plan has been accredited by a nationally recognized accrediting organization shall annually provide a copy of

1 the accreditation and the accrediting standards used by the accrediting organization to the ~~department~~
2 commissioner.

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

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

10 (4) Section 33-36-302 does not apply to a health carrier's managed care plan if the health carrier
11 maintains current accreditation by a nationally recognized accrediting organization whose standards meet or
12 exceed state quality assurance standards adopted pursuant to this part.

13 (5) This section does not prevent the ~~department~~ commissioner from monitoring a health carrier's
14 compliance with this part."
15

16 **Section 49.** Section 33-36-302, MCA, is amended to read:

17 **"33-36-302. Standards for health carrier quality assessment programs.** A health carrier that
18 issues a closed plan or a combination plan shall adopt and use infrastructure and disclosure systems sufficient
19 to accurately measure the quality of health care services provided to covered persons on a regular basis and
20 appropriate to the types of plans offered by the health carrier. To comply with this requirement, a health carrier
21 shall:

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

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

27 (3) report to the appropriate professional or occupational licensing board provided in Title 37 any
28 persistent pattern of problematic care provided by a participating provider that is sufficient to cause the health

1 carrier to terminate or suspend a contractual arrangement with the participating provider; and
 2 (4) file a written description of the quality assessment program and any subsequent material
 3 changes with the ~~department~~ commissioner in a format that must be prescribed by rules of the ~~department~~
 4 commissioner. The description must include a signed certification by a corporate officer of the health carrier that
 5 the health carrier's quality assessment program meets the requirements of this part."
 6

7 **Section 50.** Section 33-36-303, MCA, is amended to read:

8 **"33-36-303. Standards for health carrier quality improvement programs.** A health carrier that
 9 issues a closed plan or a combination plan shall, in addition to complying with 33-36-302, adopt and use
 10 systems and methods necessary to improve the quality of health care provided in the health carrier's managed
 11 care plan as indicated by the health carrier's quality assessment program and as required by this section. To
 12 comply with this requirement, a health carrier subject to this section shall:

13 (1) establish an internal system capable of identifying opportunities to improve care;
 14 (2) use the findings generated by the system required by subsection (1) to work on a continuing
 15 basis with participating providers and other staff within the closed plan or closed component to improve the
 16 health care delivered to covered persons; and
 17 (3) consistent with this part, adopt and use a program for measuring, assessing and improving the
 18 outcomes of health care as identified in the health carrier's quality improvement program plan and provide at
 19 the commissioner's request a current quality improvement program plan. ~~This quality improvement program~~
 20 ~~plan must be filed with the department by October 1, 2000, and must be consistent with this part.~~ A health
 21 carrier shall file any subsequent material changes to its quality improvement program plan within 30 days of
 22 ~~implementation of the change.~~ The quality improvement program plan must:

23 (a) implement improvement strategies in response to quality assessment findings that indicate
 24 improvement is needed; and
 25 (b) evaluate, not less than annually, the effectiveness of the strategies implemented pursuant to
 26 subsection (3)(a)."
 27

28 **Section 51.** Section 33-36-304, MCA, is amended to read:

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

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

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

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

11 (2) A health carrier shall certify to the ~~department~~ commissioner annually that its quality assurance
12 program and the materials provided to providers and consumers in accordance with subsection (1) meet the
13 requirements of this part.

14 (3) A health carrier shall make available, upon request and payment of a reasonable fee, the
15 materials certified pursuant to subsection (2), except for the materials subject to the confidentiality requirements
16 of 33-36-305 and materials that are proprietary to the managed care plan. A health carrier shall retain all
17 certified materials for at least 3 years from the date that the material was certified or until the material has been
18 examined as part of a market conduct examination, whichever is later."
19

20 **Section 52.** Section 33-36-305, MCA, is amended to read:

21 **"33-36-305. Confidentiality of health care and quality assurance records -- disclosure.** (1)

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

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

27 (b) information considered by a quality assurance program and the records of its actions, including
28 testimony of a member of a quality committee, of an officer, director, or other member of a health carrier or its

1 staff engaged in assisting the quality committee or engaged in the health carrier's quality assessment, quality
 2 improvement, or quality assurance activities, or of any person assisting or furnishing information to the quality
 3 committee.

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

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

6 (b) as required in proceedings before the commissioner, a professional or occupational licensing
 7 board provided in Title 37, or the department of public health and human services pursuant to Title 50, chapter
 8 5, part 2;

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

10 or

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

12 (3) Information specified in subsection (1) identifying:

13 (a) the provider may also be disclosed upon a written, dated, and signed approval of the provider if
 14 the information does not identify the covered person;

15 (b) the covered person may also be disclosed upon a written, dated, and signed approval of the
 16 covered person or of the parent or guardian of a covered person if the covered person is a minor and if the
 17 information does not identify the provider;

18 (c) neither the provider nor the covered person may also be disclosed upon request for use for
 19 statistical purposes only."

20

21 **Section 53.** Section 33-36-401, MCA, is amended to read:

22 **"33-36-401. Enforcement.** (1) If the ~~department commissioner~~ determines that a health carrier has
 23 not complied with this chapter or the rules implementing this chapter, the ~~department commissioner~~ may
 24 recommend corrective action to the health carrier.

25 (2) ~~At the recommendation of the department the~~ The commissioner may take an enforcement
 26 action provided in subsection (3) if:

27 (a) a health carrier fails to implement corrective action recommended by the ~~department~~
 28 commissioner;

1 (b) corrective action taken by a health carrier does not result in bringing a health carrier into
2 compliance with this chapter and the rules implementing this chapter within a reasonable period of time;

3 (c) ~~the department demonstrates to the commissioner that~~ a health carrier does not comply with
4 this chapter or the rules implementing this chapter; or

5 (d) the commissioner determines that a health carrier has violated or is violating this chapter or the
6 rules implementing this chapter.

7 (3) The commissioner may take any of the following enforcement actions to require a health carrier
8 to comply with this chapter or the rules implementing this chapter:

9 (a) suspend or revoke the health carrier's certificate of authority or deny the health carrier's
10 application for a certificate of authority; or

11 (b) use any of the commissioner's other enforcement powers provided in Title 33, chapter 1, part
12 3."

13
14 **NEW SECTION. Section 54. Repealer.** The following sections of the Montana Code Annotated are
15 repealed:

16 33-2-322. Surplus lines advisory organization -- consultation with commissioner in developing approved
17 risk list.

18 33-7-123. Commissioner as agent -- service of process -- procedure -- fee.

19 33-17-405. Service of process -- commissioner as agent.

20
21 **NEW SECTION. Section 55. Transition.** The department of public health and human services and
22 the state auditor are authorized to transfer existing rules that implement the Managed Care Plan Network
23 Adequacy and Quality Assurance Act, Title 33, chapter 36, to implement the provisions of [this act].

24
25 **NEW SECTION. Section 56. Codification instruction.** (1) [Section ~~7~~ 8] is intended to be codified as
26 an integral part of Title 33, chapter 2, part 3, and the provisions of Title 33, chapter 2, part 3, apply to [section 7
27 8].

28 (2) [Section ~~42~~ 13] is intended to be codified as an integral part of Title 33, chapter 7, part 1, and

1 the provisions of Title 33, chapter 7, part 1, apply to [section ~~42~~ 13].

2 (3) [Section ~~46~~ 17] is intended to be codified as an integral part of Title 33, chapter 17, part 4, and
3 the provisions of Title 33, chapter 17, part 4, apply to [section ~~46~~ 17].

4 (4) [Section ~~42~~ 37] is intended to be codified as an integral part of Title 33, chapter 22, part 1, and
5 the provisions of Title 33, chapter 22, part 1, apply to [section ~~42~~ 37].

6
7 **NEW SECTION. SECTION 57. Effective dates.** (1) Except as provided in subsections (2), (3), and (4),
8 [this act] is effective October 1, 2023.

9 (2) [Sections 2, 3, 4, ~~7~~ 6, 8, ~~9~~, ~~42~~-13, 14, 15, 16, 17, ~~18~~, ~~49~~, 20, 21, ~~22~~, ~~31~~, ~~35~~, ~~36~~, ~~37~~, ~~38~~, ~~39~~, ~~40~~,
10 41, ~~42~~, and ~~59~~ AND 43] and this section are effective on passage and approval.

11 (3) [~~Sections 26 through 35~~] are [SECTION 33] IS effective January 1, 2025.

12 (4) [Sections ~~43-38~~ THROUGH 40 AND SECTIONS 42 through ~~58~~ 53] are effective January 1, 2024.

13

14 **NEW SECTION. SECTION 58. APPLICABILITY. [SECTION 6] APPLIES TO OFFENSES THAT OCCUR ON OR**
15 **AFTER [THE EFFECTIVE DATE OF THIS ACT].**

16

- END -