

STATE OF MONTANA
MONICA J. LINDEEN
STATE AUDITOR
COMMISSIONER OF INSURANCE & SECURITIES
840 HELENA AVENUE
HELENA, MT 59601

APPLICATION FOR ORIGINAL CERTIFICATE OF AUTHORITY

NAME OF APPLICANT _____
(Health Maintenance Organization)

MAILING ADDRESS _____
(Street or PO Box)

(City)

(State)

(Zip)

*Date Incorporated _____

State of Domicile _____

HEREWITH SUBMITTED ARE THE FOLLOWING DOCUMENTS:

- () *Certified copy of Corporate Charter or Articles of Incorporation, with all amendments.
- () *Certified copy of Bylaws, as amended.
- () Annual Statement as of December 31 preceding (size 9" x 14") or statement of operations if a plan.
- () Certificate of Good Standing from the Montana Secretary of State (foreign corporation).
- () Copy of your Certificate of Authority or Good Standing from your domiciliary state (foreign HMO only).
- () Copy of last examination report (conducted within the last 3 years).
- () Evidence that the deposit requirement outlined in Section 33-31-216, MCA, has been met.
- () Copy of the fidelity bond pursuant to Section 33-31-223(2), MCA.
- () Appointment of Attorney to Accept Service of Process (Form INSURER.SP).
- () Uniform NAIC biographical affidavit for each officer and director of the HMO.
- () A copy of all contracts made with each provider, officer, and director pursuant to Section 33-31-201(3)(d)(iv), MCA.
- () Description of HMO's proposed marketing plan in Montana, including:
 - a) insurance products to be marketed;
 - b) how and by whom insurance products will be marketed;
 - c) advertising methods to be employed.
- () Projection of anticipated Montana premium for each of the next 5 years.
- () Description of your geographic service area in Montana, including:
 - a) chart showing the number of primary and specialty care providers with locations and service areas by county;
 - b) method of handling emergency care, with the location of each emergency care facility;
 - c) method of handling out-of-area services.
- () Description of how service is to be provided enrollees in Montana.
- () A detailed financial plan that includes a projection of operating results for the greater of either three (3) years or when the HMO is projected as profitable.
- () A statement as to the sources of working capital and any other source of funding.
- () Description of your procedure for handling complaints.

*Not required of a plan.

- () Description of your mechanism which allows enrollers an opportunity to participate in matters of policy and operation pursuant to Section 33-31-222(2), MCA.
- () Summary of how administrative services will be provided, including:
 - a) size and qualifications of administrative staff;
 - b) projected cost of administration in relation to premium income
- () If the management authority for a major corporate function is conducted by a person outside the organization, submit a copy of the management contract.
- () Summary of all financial guaranties by providers, sponsors, affiliates or parent within your holding company system or any other guaranties that are intended to ensure the financial success of the HMO.
- () Summary of benefits to be offered enrollers, including limitations, exclusions and renewability of the contract.
- () Evidence demonstrating that if the HMO becomes insolvent:
 - a) Enrollees hospitalized on the date of insolvency will be covered until discharged;
 - b) enrollees will be entitled to similar alternate coverage that does not contain any medical underwriting or preexisting limitation requirements.
- () A copy of each reinsurance contract.

1. Are you operated by an insurer or a health service corporation as a plan?
Yes _____ No _____ If yes, the organization _____
2. Are the medical providers affiliated with the HMO salaried employees?
Yes _____ No _____ If yes, explain on a separate attachment.
3. Does each of your insurance policies for Montana contain a description of your complaint process pursuant to Section 33-31-303(1)(a), MCA.
Yes _____ No _____
4. Has your HMO ever been refused admission to this or any other state prior to the date of application?
Yes _____ No _____ If yes, explain on a separate attachment.
5. Has your license or certificate of authority ever been revoked or suspended by any state?
Yes _____ No _____ If yes, explain on a separate attachment.
6. Has your HMO been fined by any state?
Yes _____ No _____ If yes, explain on a separate attachment.

() Check No. _____ in the amount of \$300 application fee.

Dated _____

Name and Title of Officer

Signature of Officer

Application contact person and telephone number: _____

**APPOINTMENT OF ATTORNEY TO ACCEPT
SERVICE OF PROCESS**

_____ (Name of Company), appoints THE DULY ELECTED STATE AUDITOR AND COMMISSIONER OF INSURANCE OF THE STATE OF MONTANA as its attorney to receive service of legal process issued against it in the State of Montana. The Company authorizes the Commissioner, or, in the Commissioner's absence, an employee of the Commissioner, to acknowledge service of legal process on behalf of the Company in this state. The Company does consent and agree that any lawful process against it that is served upon the Commissioner as appointed attorney shall have the same legal force and validity as if served upon the Company. The Company waives all claim or right of error by reason of acknowledgement of service. This appointment is irrevocable, binds the Company and any successor in interest or to the assets or liabilities of the Company, and remains in effect as long as there is in force in the State of Montana any contract made by the Company or obligations arising from a contract. The Company is duly organized under the laws of the State of _____ and has been admitted or is applying for authority to transact insurance in the State of Montana.

IN WITNESS WHEREOF, the said Company has to these presents affixed its corporate seal and caused the same to be subscribed and attested by its President and Secretary at the City of _____, in the State of _____, on the _____ day of _____, A.D. 20_____.

President

Secretary

Name and address of the person to whom Service of Process is to be forwarded.

BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

(Print or Type)

Full Name, Address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names). _____

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. a. Affiant's Full Name (Initials Not Acceptable). _____
b. Maiden Name (if applicable). _____
2. a. Have you ever had your name changed? _____ If yes, give the reason for the change and provide the full name(s).

- b. Other names used at any time (including aliases).

3. a. Are you a citizen of the United States?
b. Are you a citizen of any other country, if so, what country?
4. Affiant's Occupation or Profession. _____
5. Affiant's business address. _____
Business telephone. _____

Beginning/Ending
Dates (MM/YY) _____ - _____ Employers' Name _____
Address _____ City _____ State/Province _____
Country _____ Postal Code _____ Phone _____ Offices/Positions Held _____
Supervisor / Contact _____

Beginning/Ending
Dates (MM/YY) _____ - _____ Employers' Name _____
Address _____ City _____ State/Province _____
Country _____ Postal Code _____ Phone _____ Offices/Positions Held _____
Supervisor / Contact _____

10. a. Have you ever been in a position which required a fidelity bond? _____ If any claims were made on the bond, give details. _____

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked? If yes, give details. _____

11. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. Attach additional pages if the space provided is insufficient.

Organization/Issuer of License _____ Address _____

City _____ State/Province _____ Country _____ Postal Code _____

License Type _____ License # _____ Date Issued (MM/YY) _____

Date Expired (MM/YY) _____ Reason for Termination _____

Non-insurance Regulatory Phone Number (if known) _____

Organization /Issuer of License _____ Address _____

City _____ State/Province _____ Country _____ Postal Code _____

License Type _____ License # _____ Date Issued (MM/YY) _____

Date Expired (MM/YY) _____ Reason for Termination _____

Non-insurance Regulatory Phone Number (if known) _____

12. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond “no” to the question. Have you ever:
- a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?

 - b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?

 - c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action? _____
 - d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses? _____
 - e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

 - f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses? _____
 - g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking? _____
 - h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute? _____
 - i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government? _____
 - j. Had a lien, or foreclosure action filed against you or any entity while you were associated with that entity?

If the response to any question above is answered “Yes”, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

13. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term “control” (including the terms “controlling,” “controlled by” and “under common control with”) means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person. _____

If any of the stock is pledged or hypothecated in any way, give details. _____

- 14. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified. If the answer is "Yes", please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.

If any of the shares of stock are pledged or hypothecated in any way, give details.

- 15. Have you ever been adjudged a bankrupt? _____

- 16. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity? If yes, please indicate and give details. When responding to questions (b) and (c) affiant should also include any events within twelve (12) months after his or her departure from the entity.

- a. Been refused a permit, license, or certificate of authority by any regulatory authority, or Governmental-licensing agency? _____
- b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)? _____
- c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action? _____

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this _____ day of _____ at _____ I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

(Signature of Affiant) _____
Date

State of _____ County of _____

The foregoing instrument was acknowledged before me this _____ day of _____, 20____ By _____, and:

- who is personally known to me, or
- who produced the following identification: _____

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

BIOGRAPHICAL AFFIDAVIT
Supplemental Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

Full Name, Address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

1. a. Affiant's Full Name (Initials Not Acceptable). _____
b. Maiden Name (if applicable) _____
2. Affiant's Social Security Number _____
3. Government Identification Number if not a U.S. Citizen _____
4. Foreign Student ID# (if applicable) _____
5. Date of Birth: (MM/DD/YY) _____ Place of Birth: City _____
State/Province _____ Country _____
6. Name of Affiant's Spouse (if applicable) _____
7. List your residences for the last ten (10) years starting with your current address, giving:

Beginning/Ending

Dates (MM/YY)	Address	City	State/ Province	Country	Postal Code
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Dated and signed this _____ day of _____ at _____
I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

(Signature of Affiant)

Date

State of _____ County of _____

The foregoing instrument was acknowledged before me this _____ day of _____, 20____ By
_____, and:

- who is personally known to me, or
- who produced the following identification: _____

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS (*All states except California, Minnesota and Oklahoma*)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of _____ **[insert company name]** (“Company”) for licensure or a permit to organize (“Application”) with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) (“Background Reports”) regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative (“Affiant”) of Company or of any business entities affiliated with Company (“Term of Affiliation”) for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency (“CRA”) that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact _____ **[insert company’s designated person, position, or department, address and phone]**.

Attached for your information is a “Summary of Your Rights Under the Fair Credit Reporting Act.”

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) twelve (12) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

(Printed Full Name and Residence Address)

(Signature)

(Date)

State of _____ County of _____

The foregoing instrument was acknowledged before me this _____ day of _____ 20____ By _____, who is personally known to me, or _____ who produced the following identification:

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS (Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of _____ [insert company name] (“Company”) for licensure or a permit to organize (“Application”) with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) (“Background Reports”) regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative (“Affiant”) of Company or of any business entities affiliated with Company (“Term of Affiliation”) for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may request more information about the nature and scope of Background Reports produced by any consumer reporting agency (“CRA”) by submitting a written request to Company. You should submit any such written request for more information, to _____ [insert company’s designated person, position, or department, address and phone].

Attached for your information is a “Summary of Your Rights Under the Fair Credit Reporting Act.” You will be provided with a copy of any Background Report procured by Company if you check the box below.

- By checking this box, I request a copy of any Background Report from any CRA retained by Company, at no extra charge.

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) twelve (12) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

(Printed Full Name and Residence Address)

(Signature)

(Date)

State of _____ County of _____

The foregoing instrument was acknowledged before me this _____ day of _____, 20____ By _____, who is personally known to me, or _____ who produced the following identification:

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS (California)

This Disclosure and Authorization is provided to you in connection with a pending application of _____ **[insert company name]** (“Company”) for licensure or a permit to organize (“Application”) with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both) (“Background Reports”) regarding your background for review by any department of insurance in such states where Company is currently pursuing an Application, because you are either functioning as, or are seeking to function as, an officer, member of the board of directors or other management representative (“Affiant”) of Company or of any business entities affiliated with Company (“Term of Affiliation”) for which a Background Report is required by a department of insurance reviewing any Application. Background Reports will be obtained through _____ **[insert name of CRA, address]** (“CRA”). Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may request more information about the nature and scope of Background Reports produced by any consumer reporting agency (“CRA”) by submitting a written request to Company. You should submit any such written request for more information, to _____ **[insert company’s designated person, position, or department, address and phone]**.

Attached for your information is a “Summary of Your Rights Under the Fair Credit Reporting Act.” You will be provided with a copy of any Background Report procured by Company if you check the box below.

By checking this box, I request a copy of any Background Report from any CRA retained by Company, at no extra charge.

Under section 1786.22 of the California Civil Code, you may view the file maintained on you by the CRA listed above. You may also obtain a copy of this file, upon submitting proper identification and paying the costs of duplication services, by appearing at the CRA in person or by mail; you may also receive a summary of the file by telephone. The CRA is required to have personnel available to explain your file to you and the CRA must explain to you any coded information appearing in your file. If you appear in person, you may be accompanied by one other person of your choosing, provided that person furnishes proper identification.

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. In no event, however, will this authorization remain in effect beyond twelve (12) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

(Printed Full Name and Residence Address)

(Signature)

(Date)

State of _____ County of _____

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____. By _____, who is personally known to me, or _____ who produced the following identification:

[SEAL]

Notary Public

Printed Notary Name

My Commission Expires

CHAPTER 31

HEALTH MAINTENANCE ORGANIZATIONS

Part 1

General Provisions

33-31-101. Short title. This chapter may be cited as the "Montana Health Maintenance Organization Act".
History: En. Sec. 1, Ch. 457, L. 1987.

33-31-102. Definitions. As used in this chapter, unless the context requires otherwise, the following definitions apply:

- (1) "Affiliation period" means a period that, under the terms of the health insurance coverage offered by a health maintenance organization, must expire before the health insurance coverage becomes effective.
- (2) "Basic health care services" means:
 - (a) consultative, diagnostic, therapeutic, and referral services by a provider;
 - (b) inpatient hospital and provider care;
 - (c) outpatient medical services;
 - (d) medical treatment and referral services;
 - (e) accident and sickness services by a provider to each newborn infant of an enrollee pursuant to 33-31-301(3)(e);
 - (f) care and treatment of mental illness, alcoholism, and drug addiction;
 - (g) diagnostic laboratory and diagnostic and therapeutic radiologic services;
 - (h) preventive health services, including:
 - (i) immunizations;
 - (ii) well-child care from birth;
 - (iii) periodic health evaluations for adults;
 - (iv) voluntary family planning services;
 - (v) infertility services; and
 - (vi) children's eye and ear examinations conducted to determine the need for vision and hearing correction;
 - (i) minimum mammography examination, as defined in 33-22-132;
 - (j) outpatient self-management training and education for the treatment of diabetes along with certain diabetic equipment and supplies as provided in 33-22-129; and
 - (k) treatment and medical foods for inborn errors of metabolism. "Medical foods" and "treatment" have the meanings provided for in 33-22-131.
- (3) "Commissioner" means the commissioner of insurance of the state of Montana.
- (4) "Enrollee" means a person:
 - (a) who enrolls in or contracts with a health maintenance organization;
 - (b) on whose behalf a contract is made with a health maintenance organization to receive health care services; or
 - (c) on whose behalf the health maintenance organization contracts to receive health care services.
- (5) "Evidence of coverage" means a certificate, agreement, policy, or contract issued to an enrollee setting forth the coverage to which the enrollee is entitled.
- (6) "Health care services" means:
 - (a) the services included in furnishing medical or dental care to a person;
 - (b) the services included in hospitalizing a person;
 - (c) the services incident to furnishing medical or dental care or hospitalization; or
 - (d) the services included in furnishing to a person other services for the purpose of preventing, alleviating, curing, or healing illness, injury, or physical disability.
- (7) "Health care services agreement" means an agreement for health care services between a health maintenance organization and an enrollee.
- (8) "Health maintenance organization" means a person who provides or arranges for basic health care services to enrollees on a prepaid basis, either directly through provider employees or through contractual or other arrangements with a provider or a group of providers. This subsection does not limit methods of provider payments

made by health maintenance organizations.

(9) "Insurance producer" means an individual, partnership, or corporation appointed or authorized by a health maintenance organization to solicit applications for health care services agreements on its behalf.

(10) "Person" means:

(a) an individual;

(b) a group of individuals;

(c) an insurer, as defined in 33-1-201;

(d) a health service corporation, as defined in 33-30-101;

(e) a corporation, partnership, facility, association, or trust; or

(f) an institution of a governmental unit of any state licensed by that state to provide health care, including but not limited to a physician, hospital, hospital-related facility, or long-term care facility.

(11) "Plan" means a health maintenance organization operated by an insurer or health service corporation as an integral part of the corporation and not as a subsidiary.

(12) "Point-of-service option" means a delivery system that permits an enrollee of a health maintenance organization to receive health care services from a provider who is, under the terms of the enrollee's contract for health care services with the health maintenance organization, not on the provider panel of the health maintenance organization.

(13) "Provider" means a physician, hospital, hospital-related facility, long-term care facility, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, registered pharmacist, or advanced practice registered nurse, as specifically listed in 37-8-202, who treats any illness or injury within the scope and limitations of the provider's practice or any other person who is licensed or otherwise authorized in this state to furnish health care services.

(14) "Provider panel" means those providers with whom a health maintenance organization contracts to provide health care services to the health maintenance organization's enrollees.

(15) "Purchaser" means the individual, employer, or other entity, but not the individual certificate holder in the case of group insurance, that enters into a health care services agreement.

(16) "Uncovered expenditures" mean the costs of health care services that are covered by a health maintenance organization and for which an enrollee is liable if the health maintenance organization becomes insolvent.

History: En. Sec. 2, Ch. 457, L. 1987; amd. Sec. 3, Ch. 34, L. 1989; amd. Sec. 2, Ch. 80, L. 1989; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 1, Ch. 437, L. 1991; amd. Sec. 2, Ch. 663, L. 1991; amd. Sec. 1, Ch. 165, L. 1997; amd. Sec. 3, Ch. 413, L. 1997; amd. Sec. 29, Ch. 416, L. 1997; amd. Sec. 3, Ch. 434, L. 1999; amd. Sec. 3, Ch. 450, L. 2001.

Administrative Rules:

ARM 6.6.2503 Definitions.

ARM 6.6.2508 Services.

33-31-103. Rules. The commissioner may, after notice and hearing, make reasonable rules necessary to effectuate this chapter.

History: En. Sec. 20, Ch. 457, L. 1987; amd. Sec. 2, Ch. 437, L. 1991.

Administrative Rules:

Title 6, chapter 6, subchapter 25, ARM Health maintenance organizations.

Title 6, chapter 6, subchapter 58, ARM Managed Care Community networks.

33-31-104. Repealed. Sec. 10, Ch. 437, L. 1991.

History: En. Sec. 27, Ch. 457, L. 1987.

33-31-105 through 33-31-110 reserved.

33-31-111. (Temporary) Statutory construction and relationship to other laws. (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to a health maintenance organization authorized to transact business under this chapter. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives is not a violation of any law relating to solicitation or advertising by health professionals.

(3) A health maintenance organization authorized under this chapter is not practicing medicine and is exempt from Title 37, chapter 3, relating to the practice of medicine.

(4) This chapter does not exempt a health maintenance organization from the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

(5) This section does not exempt a health maintenance organization from the prohibition of pecuniary interest under 33-3-308 or the material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance organization must be considered an insurer for the purposes of 33-3-308 and 33-3-701 through 33-3-704.

(6) This section does not exempt a health maintenance organization from:

(a) prohibitions against interference with certain communications as provided under chapter 1, part 8;

(b) the provisions of Title 33, chapter 22, part 19;

(c) the requirements of 33-22-134 and 33-22-135;

(d) network adequacy and quality assurance requirements provided under chapter 36, except as provided in 33-22-262; or

(e) the requirements of Title 33, chapter 18, part 9.

(7) Except as provided in 33-22-262, Title 33, chapter 1, parts 12 and 13, Title 33, chapter 2, part 19, 33-2-1114, 33-2-1211, 33-2-1212, 33-3-422, 33-3-431, 33-15-308, Title 33, chapter 19, 33-22-107, 33-22-129, 33-22-131, 33-22-136, 33-22-141, 33-22-142, 33-22-244, 33-22-246, 33-22-247, 33-22-514, 33-22-521, 33-22-523, 33-22-524, 33-22-526, and 33-22-706 apply to health maintenance organizations. (*Terminates June 30, 2009--sec. 14, Ch. 325, L. 2003.*)

33-31-111. (Effective July 1, 2009) Statutory construction and relationship to other laws. (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to a health maintenance organization authorized to transact business under this chapter. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives is not a violation of any law relating to solicitation or advertising by health professionals.

(3) A health maintenance organization authorized under this chapter is not practicing medicine and is exempt from Title 37, chapter 3, relating to the practice of medicine.

(4) This chapter does not exempt a health maintenance organization from the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

(5) This section does not exempt a health maintenance organization from the prohibition of pecuniary interest under 33-3-308 or the material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance organization must be considered an insurer for the purposes of 33-3-308 and 33-3-701 through 33-3-704.

(6) This section does not exempt a health maintenance organization from:

(a) prohibitions against interference with certain communications as provided under chapter 1, part 8;

(b) the provisions of Title 33, chapter 22, part 19;

(c) the requirements of 33-22-134 and 33-22-135;

(d) network adequacy and quality assurance requirements provided under chapter 36; or

(e) the requirements of Title 33, chapter 18, part 9.

(7) Title 33, chapter 1, parts 12 and 13, Title 33, chapter 2, part 19, 33-2-1114, 33-2-1211, 33-2-1212, 33-3-422, 33-3-431, 33-15-308, Title 33, chapter 19, 33-22-107, 33-22-129, 33-22-131, 33-22-136, 33-22-141, 33-22-142, 33-22-244, 33-22-246, 33-22-247, 33-22-514, 33-22-521, 33-22-523, 33-22-524, 33-22-526, and 33-22-706 apply to health maintenance organizations.

History: En. Sec. 24, Ch. 457, L. 1987; amd. Sec. 74, Ch. 379, L. 1995; amd. Sec. 10, Ch. 198, L. 1997; amd. Sec. 6, Ch. 410, L. 1997; amd. Sec. 4, Ch. 413, L. 1997; amd. Sec. 30, Ch. 416, L. 1997; amd. Sec. 1, Ch. 527, L. 1997; amd. Sec. 40, Ch. 531, L. 1997; amd. Sec. 3, Ch. 178, L. 1999; amd. Sec. 2, Ch. 334, L. 1999; amd. Sec. 5, Ch. 348, L. 1999; amd. Sec. 4, Ch. 434, L. 1999; amd. Sec. 56, Ch. 472, L. 1999; amd. Sec. 66, Ch. 227, L. 2001; amd. Sec. 4, Ch. 336, L. 2001; amd. Sec. 4, Ch. 450, L. 2001; amd. Sec. 7, Ch. 325, L. 2003; amd. Sec. 47, Ch. 380, L. 2003; amd. Sec. 7, Ch. 384, L. 2003.

33-31-112. Filings and reports as public documents. All applications, filings, and reports required under this chapter, except those that contain trade secrets or privileged or confidential commercial or financial information (other than an annual financial statement that the commissioner may require under 33-31-211), are public documents.

History: En. Sec. 25, Ch. 457, L. 1987.

33-31-113. Confidentiality of medical information. (1) Any data or information pertaining to the diagnosis, treatment, or health of an enrollee or applicant obtained from the enrollee, applicant, or a provider by a health maintenance organization must be held in confidence and may not be disclosed to any person except:

(a) to the extent that it may be necessary to carry out the purposes of this chapter;

(b) upon the express consent of the enrollee or applicant;

(c) pursuant to statute or court order for the production of evidence or the discovery thereof; or
(d) in the event of claim or litigation between the enrollee or applicant and the health maintenance organization wherein the data or information is pertinent.

(2) A health maintenance organization is entitled to claim the same statutory privileges against disclosure that the provider who furnished the information to the health maintenance organization is entitled to claim.

History: En. Sec. 26, Ch. 457, L. 1987.

33-31-114. Coverage for adopted children from time of placement -- preexisting conditions. (1) Each health maintenance contract regulated under this chapter must provide coverage for an adopted child of the enrollee to the same extent as for natural children of the enrollee.

(2) The coverage required by this section must be effective from the date of placement for the purpose of adoption and must continue unless the placement is disrupted prior to legal adoption and the child is removed from placement. Coverage at the time of placement must include the necessary care and treatment of medical conditions existing prior to the date of placement.

(3) As used in this section, "placement" has the meaning as defined in 33-22-130.

History: En. Sec. 3, Ch. 387, L. 1991; amd. Sec. 163, Ch. 480, L. 1997.

33-31-115. Applicability to managed health care entity. (1) A managed health care entity, as defined in 53-6-702, is governed by the provisions of Title 53, chapter 6, part 7.

(2) The department of public health and human services may limit the amount, scope, and duration of services provided by a managed health care entity under contract for programs established under Title 53. These services may be less than services required by this title.

History: En. Sec. 10, Ch. 502, L. 1995; amd. Sec. 2, Ch. 577, L. 1999; amd. Sec. 1, Ch. 466, L. 2001.

Part 2

Authorization of Health Maintenance Organizations

33-31-201. Establishment of health maintenance organizations. (1) Notwithstanding any law of this state to the contrary, a person may apply to the commissioner for and obtain a certificate of authority to establish and operate a health maintenance organization in compliance with this chapter. A person may not establish or operate a health maintenance organization in this state except as authorized by a subsisting certificate of authority issued to it by the commissioner. A foreign person may qualify for a certificate of authority if it first obtains from the secretary of state a certificate of authority to transact business in this state as a foreign corporation under 35-1-1028.

(2) Each health maintenance organization operating in this state as of October 1, 1987, shall submit an application for a certificate of authority under subsection (3) within 30 days after the effective date of rules adopted by the commissioner as provided in 33-31-103. Each such applicant may continue to operate in this state until the commissioner acts upon the application. If an application is denied under 33-31-202, the applicant must be treated as a health maintenance organization whose certificate of authority has been revoked.

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

- (a) be verified by an officer or authorized representative of the applicant;
- (b) be in a form prescribed by the commissioner;
- (c) contain:
 - (i) the applicant's name;
 - (ii) the location of the applicant's home office or principal office in the United States (if a foreign person);
 - (iii) the date of organization or incorporation;
 - (iv) the form of organization (including whether the providers affiliated with the health maintenance organization will be salaried employees or group or individual contractors);
 - (v) the state or country of domicile; and
 - (vi) any additional information the commissioner may reasonably require; and
- (d) set forth the following information or be accompanied by the following documents, as applicable:
 - (i) a copy of the applicant's organizational documents, such as its corporate charters or articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto, certified by the public officer with whom the originals were filed in the state or country of domicile;
 - (ii) a copy of the bylaws, rules, and regulations, or similar document, if any, regulating the conduct of the

applicant's internal affairs, certified by its secretary or other officer having custody thereof;

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

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

(A) any provider and the applicant; or

(B) any person listed in subsection (3)(d)(iii) and the applicant. The applicant may file a list of providers executing a standard contract and a copy of the contract instead of copies of each executed contract.

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

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

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

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

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

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

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

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

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

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

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

(x) a description of the way in which the health maintenance organization provides services to enrollees in each geographic service area, including the extent to which a provider under contract with the health maintenance organization provides primary care to those enrollees;

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

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

(xiii) a summary of the way in which administrative services will be provided, including the size and qualifications of the administrative staff and the projected cost of administration in relation to premium income. If the health maintenance organization delegates management authority for a major corporate function to a person outside the organization, the health maintenance organization shall include a copy of the contract in its application for a certificate of authority. Contracts for delegated management authority must be filed with the commissioner in accordance with the filing provisions of 33-31-301(2); however, nothing in this subsection deprives the health maintenance organization of its right to confidentiality of any proprietary information, and the commissioner may not disclose that proprietary information to any other person. All contracts must include:

(A) the services to be provided;

(B) the standards of performance for the manager;

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

(D) the duration of the contract; and

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

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

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

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

(xvii) any other information that the commissioner may reasonably require to make the determinations

required in 33-31-202.

(4) Each health maintenance organization shall file each substantial change, alteration, or amendment to the information submitted under subsection (3) with the commissioner at least 30 days prior to its effective date, including changes in articles of incorporation and bylaws, organization type, geographic service area, provider contracts, provider availability, plan administration, financial projections and guaranties, and any other change that might affect the financial solvency of the plan. The commissioner may, after notice and hearing, disapprove any proposed change, alteration, or amendment to the business plan. The commissioner may make reasonable rules exempting from the filing requirements of this subsection those items he considers unnecessary.

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

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

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

History: En. Sec. 3, Ch. 457, L. 1987; amd. Sec. 192, Ch. 368, L. 1991; amd. Sec. 3, Ch. 437, L. 1991.

Administrative Rules:

ARM 6.6.2504 Filing exemption for health maintenance operated by insurer or health service corporation as a plan.

33-31-202. (Temporary) Issuance of certificate of authority. (1) The commissioner shall issue or deny a certificate of authority to any person filing an application pursuant to 33-31-201 within 180 days after receipt of the application. The commissioner shall grant a certificate of authority upon payment of the application fee prescribed in 33-31-212 if the commissioner is satisfied that each of the following conditions is met:

(a) The persons responsible for the conduct of the applicant's affairs are competent and trustworthy.

(b) The health maintenance organization will effectively provide or arrange for the provision of basic health care services, except as provided in 33-22-262, on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments. This requirement does not apply to the physical or mental health care services provided by a health maintenance organization to a person receiving medicaid services under the Montana medicaid program as established in Title 53, chapter 6.

(c) The health maintenance organization is financially responsible and can reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner may consider:

(i) the financial soundness of the arrangements for health care services and the schedule of charges used in connection with the services;

(ii) the adequacy of working capital;

(iii) any agreement with an insurer, a health service corporation, a government, or any other organization for ensuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the health maintenance organization;

(iv) any agreement with providers for the provision of health care services;

(v) any deposit of cash or securities submitted in accordance with 33-31-216; and

(vi) any additional information that the commissioner may reasonably require.

(d) The enrollees must be afforded an opportunity to participate in matters of policy and operation pursuant to 33-31-222.

(e) Nothing in the proposed method of operation, as shown by the information submitted pursuant to 33-31-201 or by independent investigation, violates any provision of this chapter or rules adopted by the commissioner.

(2) The commissioner may deny a certificate of authority only if the requirements of 33-31-404 are complied with.

(3) The commissioner shall examine each health maintenance organization applying for an initial certificate of authority to do business in this state. In lieu of making an examination under this part of any health maintenance organization domiciled in another state, the commissioner may accept an examination report on the organization prepared by the insurance department of the organization's state of domicile. (*Terminates June 30, 2009--sec. 14, Ch. 325, L. 2003.*)

33-31-202. (Effective July 1, 2009) Issuance of certificate of authority. (1) The commissioner shall issue or deny a certificate of authority to any person filing an application pursuant to 33-31-201 within 180 days after receipt of the application. The commissioner shall grant a certificate of authority upon payment of the application fee prescribed in 33-31-212 if the commissioner is satisfied that each of the following conditions is met:

(a) The persons responsible for the conduct of the applicant's affairs are competent and trustworthy.

(b) The health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments. This requirement does not apply to the physical or mental health care services provided by a health maintenance organization to a person receiving medicaid services under the Montana medicaid program as established in Title 53, chapter 6.

(c) The health maintenance organization is financially responsible and can reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner may consider:

- (i) the financial soundness of the arrangements for health care services and the schedule of charges used in connection with the services;
 - (ii) the adequacy of working capital;
 - (iii) any agreement with an insurer, a health service corporation, a government, or any other organization for ensuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the health maintenance organization;
 - (iv) any agreement with providers for the provision of health care services;
 - (v) any deposit of cash or securities submitted in accordance with 33-31-216; and
 - (vi) any additional information that the commissioner may reasonably require.
- (d) The enrollees must be afforded an opportunity to participate in matters of policy and operation pursuant to 33-31-222.

(e) Nothing in the proposed method of operation, as shown by the information submitted pursuant to 33-31-201 or by independent investigation, violates any provision of this chapter or rules adopted by the commissioner.

(2) The commissioner may deny a certificate of authority only if the requirements of 33-31-404 are complied with.

(3) The commissioner shall examine each health maintenance organization applying for an initial certificate of authority to do business in this state. In lieu of making an examination under this part of any health maintenance organization domiciled in another state, the commissioner may accept an examination report on the organization prepared by the insurance department of the organization's state of domicile.

History: En. Sec. 4, Ch. 457, L. 1987; amd. Sec. 4, Ch. 437, L. 1991; amd. Sec. 2, Ch. 590, L. 1995; amd. Sec. 57, Ch. 472, L. 1999; amd. Sec. 3, Ch. 577, L. 1999; amd. Sec. 8, Ch. 325, L. 2003.

Administrative Rules:

ARM 6.6.2508 Services.

ARM 6.6.2509 Other requirements.

33-31-203. Powers of insurers and health service corporations. (1) An insurer authorized to transact insurance in this state or a health service corporation authorized to do business in this state may, either directly or through a subsidiary or affiliate, organize and operate a health maintenance organization under the provisions of this chapter. Notwithstanding any other law which may be inconsistent with this section, two or more insurers, health service corporations, or subsidiaries or affiliates thereof may jointly organize and operate a health maintenance organization. The business of insurance is considered to include the provision of health care services by a health maintenance organization owned or operated by an insurer or a subsidiary thereof.

(2) Notwithstanding any insurance or health service corporation laws, an insurer or a health service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through a health maintenance organization and to provide coverage if the health maintenance organization fails to meet its obligations.

(3) The enrollees of a health maintenance organization constitute a permissible group under this title. The insurer or health service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers under the contracts described in subsection (2).

(4) Nothing in this section exempts a health maintenance organization that provides health care services from complying with the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

History: En. Sec. 16, Ch. 457, L. 1987.

33-31-204. Acquisition, control, or merger of a health maintenance organization. (1) Except as provided in 33-2-1106 and subsection (2), no person may tender for, request, or invite tenders of, or enter into an agreement to exchange securities for or acquire in the open market or otherwise, any voting security of a health maintenance organization or enter into any other agreement if, after the consummation thereof, that person would, directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of the health maintenance organization.

(2) No person may enter into an agreement to merge or consolidate with or otherwise to acquire control of a health maintenance organization, unless, at the time any offer, request, or invitation is made or any agreement is

entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the acquiring person has filed with the commissioner and has sent to the health maintenance organization information required by 33-2-1104(2) and the commissioner has approved the offer, request, invitation, agreement, or acquisition pursuant to 33-2-1105.

History: En. Sec. 28, Ch. 457, L. 1987.

33-31-205 through 33-31-210 reserved.

33-31-211. Annual statements -- revocation for failure to file -- penalty for false swearing. (1) Unless it is operated by an insurer or a health service corporation as a plan, each authorized health maintenance organization shall annually on or before March 1 file with the commissioner a full and true statement of its financial condition, transactions, and affairs as of the preceding December 31. The statement must be in the general form and content required by the commissioner. The statement must be completed in accordance with the national association of insurance commissioners' annual statement instructions and the Accounting Practices and Procedures Manual of the national association of insurance commissioners. The statement must be verified by the oath of at least two principal officers of the health maintenance organization. The commissioner may waive any verification under oath. In addition, a health maintenance organization shall, unless it is operated by an insurer or a health service corporation as a plan, annually file on or before June 1 an audited financial statement. A health maintenance organization's audited financial statement must comply with rules adopted by the commissioner concerning audited financial statements.

(2) At the time of filing the annual statement required by March 1, the health maintenance organization shall pay the commissioner the fee for filing the statement as prescribed in 33-31-212. The commissioner may refuse to accept the fee for continuance of the insurer's certificate of authority, as provided in 33-31-212, may impose a penalty of \$100, or may suspend or revoke the certificate of authority of a health maintenance organization that fails to file an annual statement when due. Each day that the insurer fails to file its annual statement constitutes a separate violation. The total penalty may not exceed \$1,000.

(3) The commissioner may, after notice and hearing, impose a fine not to exceed \$5,000 for each violation upon a director, officer, partner, member, insurance producer, or employee of a health maintenance organization who knowingly subscribes to or concurs in making or publishing an annual statement required by law that contains a material statement that is false.

(4) The commissioner may require reports considered reasonably necessary and appropriate to enable the commissioner to carry out the duties required of the commissioner under this chapter, including but not limited to a statement of operations, transactions, and affairs of a health maintenance organization operated by an insurer or a health service corporation as a plan.

History: En. Sec. 9, Ch. 457, L. 1987; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 5, Ch. 413, L. 1997; amd. Sec. 41, Ch. 531, L. 1997; amd. Sec. 58, Ch. 472, L. 1999; amd. Sec. 67, Ch. 227, L. 2001.

33-31-212. Fees. (1) Each health maintenance organization shall pay to the commissioner the following fees:

- (a) for filing an application for a certificate of authority or amendment to a certificate of authority, \$300;
- (b) for filing an amendment to the organization documents that requires approval, \$25;
- (c) for filing each annual statement, \$25;
- (d) for annual continuation of certificate of authority, \$300.

(2) All fees, miscellaneous charges, fines, penalties, and those amounts received pursuant to 33-31-211(3) and 33-31-405 collected by the commissioner pursuant to this chapter and the rules adopted under this chapter must be deposited in the state special revenue fund to the credit of the state auditor's office.

History: En. Sec. 22, Ch. 457, L. 1987; amd. Sec. 8, Ch. 351, L. 1989; amd. Sec. 6, Ch. 628, L. 1989; amd. Sec. 5, Ch. 437, L. 1991; amd. Sec. 48, Ch. 380, L. 2003.

33-31-213. and 33-31-214 reserved.

33-31-215. Investment regulations. Except for a health maintenance organization operated as a plan by a health service corporation, a domestic health maintenance organization may invest its funds only as prescribed in chapter 12.

History: En. Sec. 12, Ch. 457, L. 1987; amd. Sec. 49, Ch. 304, L. 1999.

33-31-216. Protection against insolvency. (1) Except as provided in subsections (4) through (7), each authorized health maintenance organization shall deposit with the commissioner cash, securities, or any combination of cash or securities acceptable to the commissioner in the amount set forth in this section.

(2) The amount of the deposit for a health maintenance organization during the first year of its operation is \$200,000.

(3) At the beginning of each succeeding year, unless not applicable, the health maintenance organization

shall deposit with the commissioner cash, securities, or any combination of cash or securities acceptable to the commissioner, in an amount equal to 4% of its estimated annual uncovered expenditures for that year.

(4) Unless not applicable, a health maintenance organization that is in operation on October 1, 1987, shall make a deposit equal to the greater of:

- (a) 1% of the preceding 12 months' uncovered expenditures; or
- (b) 4% of its estimated annual uncovered expenditures for each year.

(5) The commissioner may waive any of the deposit requirements set forth in subsections (1) through (4) whenever the commissioner is satisfied that:

(a) the health maintenance organization has sufficient net worth and an adequate history of generating net income to ensure its financial viability for the next year;

(b) the health maintenance organization's performance and obligations are guaranteed by an organization with sufficient net worth and an adequate history of generating net income; or

(c) the health maintenance organization's assets or its contracts with insurers, health service corporations, governments, or other organizations are reasonably sufficient to ensure the performance of its obligations.

(6) When a health maintenance organization achieves a net worth not including land, buildings, and equipment of at least \$1 million or achieves a net worth including organization-related land, buildings, and equipment of at least \$5 million, the annual deposit requirement under subsection (3) does not apply. The annual deposit requirement under subsection (3) does not apply to a health maintenance organization if the total amount of the accumulated deposit is greater than the capital requirement for the formation or admittance of a disability insurer in this state. If the health maintenance organization has a guaranteeing organization that has been in operation for at least 5 years and has a net worth not including land, buildings, and equipment of at least \$1 million or that has been in operation for at least 10 years and has a net worth including organization-related land, buildings, and equipment of at least \$5 million, the annual deposit requirement under subsection (3) does not apply. If the guaranteeing organization is sponsoring more than one health maintenance organization, however, the net worth requirement is increased by a multiple equal to the number of those health maintenance organizations. This requirement to maintain a deposit in excess of the deposit required of a disability insurer does not apply during any time that the guaranteeing organization maintains for each health maintenance organization it sponsors a net worth at least equal to the capital and surplus requirements for a disability insurer.

(7) All income from deposits belongs to the depositing health maintenance organization and must be paid to it as it becomes available. A health maintenance organization that has made a securities deposit may withdraw the deposit or any part of it after making a substitute deposit of cash, securities, or any combination of cash or securities of equal amount and value. A health maintenance organization may not substitute securities without prior approval by the commissioner.

(8) In any year in which an annual deposit is not required of a health maintenance organization, at the health maintenance organization's request, the commissioner shall reduce the previously accumulated deposit by \$100,000 for each \$250,000 of net worth in excess of the amount that allows the health maintenance organization to be exempt from the annual deposit requirement. If the amount of net worth no longer supports a reduction of its required deposit, the health maintenance organization shall immediately redeposit \$100,000 for each \$250,000 of reduction in net worth. However, the health maintenance organization's total deposit may not be required to exceed the maximum required under this section.

(9) (a) Subject to subsection (9)(b) and unless it is operated by an insurer or a health service corporation as a plan, each health maintenance organization must have a minimum capital of at least \$200,000 in addition to any deposit requirements under this section. The capital account must be in excess of any accrued liabilities and be in the form of cash, securities, or any combination of cash or securities acceptable to the commissioner.

(b) A health maintenance organization licensed under this chapter after October 1, 1999, must have a minimum capital of at least \$750,000. The amount required to be deposited with the commissioner under subsection (2) must be included in the calculation of the capital needed to meet the \$750,000 minimum.

(10) Each health maintenance organization shall demonstrate that if it becomes insolvent:

(a) enrollees hospitalized on the date of insolvency will be covered until discharged; and

(b) enrollees will be entitled to similar alternate insurance coverage that does not contain any medical underwriting or preexisting limitation requirements.

History: En. Sec. 13, Ch. 457, L. 1987; amd. Sec. 6, Ch. 413, L. 1997; amd. Sec. 59, Ch. 472, L. 1999.

33-31-217 through 33-31-220 reserved.

33-31-221. Powers of health maintenance organizations. (1) The powers of a health maintenance organization include but are not limited to the following:

(a) the purchase, lease, construction, renovation, operation, or maintenance of a hospital, a medical facility, or both, its ancillary equipment, and such property as may reasonably be required for its principal office or for such purposes as may be necessary in the transaction of the business of the organization;

(b) the making of loans to a medical group under contract with it in furtherance of its program or the making of loans to a corporation under its control for the purpose of acquiring or constructing a medical facility or hospital or in furtherance of a program providing health care services to enrollees;

(c) the furnishing of health care services through a provider who is under contract with or employed by the health maintenance organization;

(d) the contracting with a person for the performance on its behalf of certain functions, such as marketing, enrollment, and administration;

(e) the contracting with an insurer authorized to transact insurance in this state, or with a health service corporation authorized to do business in this state, for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization; and

(f) the offering of other health care services in addition to basic health care services.

(2) A health maintenance organization shall file notice, with adequate supporting information, with the commissioner before exercising a power granted in subsection (1)(a), (1)(b), or (1)(d). The commissioner may, after notice and hearing, within 60 days disapprove the exercise of a power under subsection (1)(a), (1)(b), or (1)(d) only if, in his opinion, it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. The commissioner may make reasonable rules exempting from the filing requirement of this subsection those activities having a de minimis effect. The commissioner may exempt certain contracts from the filing requirement whenever exercise of the authority granted in this section would have little or no effect on the health maintenance organization's financial condition and ability to meet obligations.

(3) Nothing in this section exempts the activities of a health maintenance organization from any applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

History: En. Sec. 5, Ch. 457, L. 1987.

33-31-222. Governing body. (1) The governing body of a health maintenance organization may include providers or other individuals, or both.

(2) The governing body shall establish a mechanism to give the enrollees an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions, or through the use of other mechanisms.

History: En. Sec. 6, Ch. 457, L. 1987.

33-31-223. Fiduciary responsibilities. (1) Any director, officer, employee, or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of the health maintenance organization is responsible for the funds in the manner of a fiduciary to the health maintenance organization.

(2) A health maintenance organization shall maintain in force a fidelity bond on employees and officers in an amount not less than \$100,000 or such other sum as may be prescribed by the commissioner. Each bond must be written with at least a 1-year discovery period and, if written with less than a 3-year discovery period, must contain a provision that a cancellation or termination of the bond, whether by or at the request of the insured or by the underwriter, may not take effect prior to the expiration of 90 days after written notice of the cancellation or termination has been filed with the commissioner unless the commissioner approves an earlier cancellation or termination date.

History: En. Sec. 7, Ch. 457, L. 1987.

Part 3 Operations

33-31-301. (Temporary) Evidence of coverage -- schedule of charges for health care services. (1) Each enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance policy issued by an insurer or a contract issued by a health service corporation, whether by option or otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

(2) A health maintenance organization may not issue or deliver an enrollment form, an evidence of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this state before a copy of the enrollment form, the evidence of coverage, or the amendment to the approved enrollment form or evidence of coverage is filed with and approved by the commissioner in accordance with [33-1-501](#).

(3) An evidence of coverage issued or delivered to a person residing in this state may not contain a provision or

statement that is untrue, misleading, or deceptive as defined in [33-31-312](#)(1). The evidence of coverage must contain:

- (a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate, of:
 - (i) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;
 - (ii) any limitations on the services, kinds of services, or benefits to be provided, including any deductible or copayment feature;
 - (iii) the location at which and the manner in which information is available as to how services may be obtained;
 - (iv) the total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts; and
 - (v) a clear and understandable description of the health maintenance organization's method for resolving enrollee complaints;
- (b) definitions of geographical service area, emergency care, urgent care, out-of-area services, dependent, and primary provider if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment that is given to each enrollee along with the evidence of coverage.
- (c) clear disclosure of each provision that limits benefits or access to service in the exclusions, limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and exceptions that must be disclosed include but are not limited to:
 - (i) emergency and urgent care;
 - (ii) restrictions on the selection of primary or referral providers;
 - (iii) restrictions on changing providers during the contract period;
 - (iv) out-of-pocket costs, including copayments and deductibles;
 - (v) charges for missed appointments or other administrative sanctions;
 - (vi) restrictions on access to care if copayments or other charges are not paid; and
 - (vii) any restrictions on coverage for dependents who do not reside in the service area.
- (d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and nervous and mental disorders;
- (e) except as provided in [33-22-262](#), a provision requiring immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of an enrollee or the enrollee's dependents;
- (f) a provision providing coverage as required in [33-22-133](#);
- (g) except as provided in [33-22-262](#), a provision requiring medical treatment and referral services to appropriate ancillary services for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits and coverage provided in Title 33, chapter 22, part 7; however:
 - (i) after the primary care physician refers an enrollee for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction;
 - (ii) if an enrollee chooses a provider other than the health maintenance organization provider for treatment and referral services, the enrollee's designated provider shall limit treatment and services to the scope of the referral in order to receive payment from the health maintenance organization;
 - (iii) the amount paid by the health maintenance organization to the enrollee's designated provider may not exceed the amount paid by the health maintenance organization to one of its providers for equivalent treatment or services;
 - (iv) the provisions of this subsection (3)(g) do not apply to services for mental illness provided under the Montana medicaid program as established in Title 53, chapter 6;
- (h) a provision as follows:

"Conformity With State Statutes: Any provision of this evidence of coverage that on its effective date is in conflict with the statutes of the state in which the insured resides on that date is amended to conform to the minimum requirements of those statutes."

 - (i) a provision that the health maintenance organization shall issue, without evidence of insurability, to the enrollee, dependents, or family members continuing coverage on the enrollee, dependents, or family members:
 - (i) if the evidence of coverage or any portion of it on an enrollee, dependents, or family members covered under the evidence of coverage ceases because of termination of employment or termination of membership in the class or classes eligible for coverage under the policy or because the employer discontinues the business or the coverage;
 - (ii) if the enrollee had been enrolled in the health maintenance organization for a period of 3 months preceding the termination of group coverage; and
 - (iii) if the enrollee applied for continuing coverage within 31 days after the termination of group coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by the group contract from

which the enrollee converts.

(j) a provision that clearly describes the amount of money an enrollee shall pay to the health maintenance organization to be covered for basic health care services.

(4) A health maintenance organization may amend an enrollment form or an evidence of coverage in a separate document if the separate document is filed with and approved by the commissioner in accordance with [33-1-501](#) and issued to the enrollee.

(5) (a) Except as provided in [33-22-262](#), a health maintenance organization shall provide the same coverage for newborn infants, required by subsection (3)(e), as it provides for enrollees, except that for newborn infants, there may be no waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.

(b) Except as provided in [33-22-262](#), a health maintenance organization may not issue or amend an evidence of coverage in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an enrollee or dependents from and after the moment of birth.

(c) If a health maintenance organization requires payment of a specific fee to provide coverage of a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain a provision that requires notification to the health maintenance organization, within 31 days after the date of birth, of the birth of an infant and payment of the required fee.

(6) The provisions of [33-1-501](#) govern the filing and approval of health maintenance organization forms.

(7) The commissioner may require a health maintenance organization to submit any relevant information considered necessary in determining whether to approve or disapprove a filing made pursuant to this section. (*Terminates June 30, 2009--sec. 14, Ch. 325, L. 2003.*)

33-31-301. (Effective July 1, 2009). Evidence of coverage -- schedule of charges for health care services.

(1) Each enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance policy issued by an insurer or a contract issued by a health service corporation, whether by option or otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

(2) A health maintenance organization may not issue or deliver an enrollment form, an evidence of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this state before a copy of the enrollment form, the evidence of coverage, or the amendment to the approved enrollment form or evidence of coverage is filed with and approved by the commissioner in accordance with [33-1-501](#).

(3) An evidence of coverage issued or delivered to a person resident in this state may not contain a provision or statement that is untrue, misleading, or deceptive as defined in [33-31-312](#)(1). The evidence of coverage must contain:

(a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate, of:

(i) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(ii) any limitations on the services, kinds of services, or benefits to be provided, including any deductible or copayment feature;

(iii) the location at which and the manner in which information is available as to how services may be obtained;

(iv) the total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts; and

(v) a clear and understandable description of the health maintenance organization's method for resolving enrollee complaints;

(b) definitions of geographical service area, emergency care, urgent care, out-of-area services, dependent, and primary provider if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment that is given to each enrollee along with the evidence of coverage.

(c) clear disclosure of each provision that limits benefits or access to service in the exclusions, limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and exceptions that must be disclosed include but are not limited to:

(i) emergency and urgent care;

(ii) restrictions on the selection of primary or referral providers;

(iii) restrictions on changing providers during the contract period;

(iv) out-of-pocket costs, including copayments and deductibles;

(v) charges for missed appointments or other administrative sanctions;

(vi) restrictions on access to care if copayments or other charges are not paid; and

(vii) any restrictions on coverage for dependents who do not reside in the service area.

(d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and nervous and mental disorders;

(e) a provision requiring immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of an enrollee or the enrollee's dependents;

(f) a provision providing coverage as required in [33-22-133](#);

(g) a provision requiring medical treatment and referral services to appropriate ancillary services for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits and coverage provided in Title 33, chapter 22, part 7; however:

(i) after the primary care physician refers an enrollee for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction;

(ii) if an enrollee chooses a provider other than the health maintenance organization provider for treatment and referral services, the enrollee's designated provider shall limit treatment and services to the scope of the referral in order to receive payment from the health maintenance organization;

(iii) the amount paid by the health maintenance organization to the enrollee's designated provider may not exceed the amount paid by the health maintenance organization to one of its providers for equivalent treatment or services;

(iv) the provisions of this subsection (3)(g) do not apply to services for mental illness provided under the Montana medicaid program as established in Title 53, chapter 6;

(h) a provision as follows:

"Conformity With State Statutes: Any provision of this evidence of coverage that on its effective date is in conflict with the statutes of the state in which the insured resides on that date is amended to conform to the minimum requirements of those statutes."

(i) a provision that the health maintenance organization shall issue, without evidence of insurability, to the enrollee, dependents, or family members continuing coverage on the enrollee, dependents, or family members:

(i) if the evidence of coverage or any portion of it on an enrollee, dependents, or family members covered under the evidence of coverage ceases because of termination of employment or termination of membership in the class or classes eligible for coverage under the policy or because the employer discontinues the business or the coverage;

(ii) if the enrollee had been enrolled in the health maintenance organization for a period of 3 months preceding the termination of group coverage; and

(iii) if the enrollee applied for continuing coverage within 31 days after the termination of group coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by the group contract from which the enrollee converts.

(j) a provision that clearly describes the amount of money an enrollee shall pay to the health maintenance organization to be covered for basic health care services.

(4) A health maintenance organization may amend an enrollment form or an evidence of coverage in a separate document if the separate document is filed with and approved by the commissioner in accordance with [33-1-501](#) and issued to the enrollee.

(5) (a) A health maintenance organization shall provide the same coverage for newborn infants, required by subsection (3)(e), as it provides for enrollees, except that for newborn infants, there may be no waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.

(b) A health maintenance organization may not issue or amend an evidence of coverage in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an enrollee or dependents from and after the moment of birth.

(c) If a health maintenance organization requires payment of a specific fee to provide coverage of a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain a provision that requires notification to the health maintenance organization, within 31 days after the date of birth, of the birth of an infant and payment of the required fee.

(6) The provisions of [33-1-501](#) govern the filing and approval of health maintenance organization forms.

(7) The commissioner may require a health maintenance organization to submit any relevant information considered necessary in determining whether to approve or disapprove a filing made pursuant to this section.

History: En. Sec. 8, Ch. 457, L. 1987; amd. Sec. 3, Ch. 590, L. 1995; amd. Sec. 2, Ch. 183, L. 1997; amd. Sec. 60, Ch. 472, L. 1999; amd. Sec. 9, Ch. 325, L. 2003; amd. Sec. 2, Ch. 409, L. 2005.

33-31-302. Information to enrollees. Each authorized health maintenance organization shall provide to its enrollees 30 days' advance notice in writing of any material change in the operation of the health maintenance organization that will affect them directly.

History: En. Sec. 10, Ch. 457, L. 1987.

33-31-303. Complaint system. (1) (a) Each authorized health maintenance organization shall establish and maintain a complaint system to provide reasonable procedures to resolve written complaints initiated by enrollees. A health maintenance organization may not use a complaint system:

(i) before the commissioner approves it; and

(ii) unless the health maintenance organization describes it in each evidence of coverage issued or delivered to an enrollee in this state.

(b) Each time the health maintenance organization denies a claim or initiates disenrollment, cancellation, or nonrenewal, it shall notify the affected enrollee of the right to file a complaint and the procedure for filing a complaint.

(c) Each health maintenance organization shall acknowledge a complaint within 10 days of receiving it.

(d) Each health maintenance organization shall retain records of all complaints for 3 years and shall develop a summary for each year that must include:

(i) a description of the procedures of the complaint system;

(ii) the total number of complaints handled through the complaint system, a compilation of causes underlying the complaints filed, the date on which each complaint was filed, the date on which each complaint was resolved, the disposition of each complaint filed, the time it took to process each complaint, and a summary of each administrative change made because of a complaint; and

(iii) the number, amount, and disposition of malpractice claims made by enrollees of the health maintenance organization that were settled during the year by the health maintenance organization.

(e) The health maintenance organization shall annually on or before March 1 file with the commissioner the summary described in subsection (1)(d) for the preceding year.

(2) The commissioner shall hold in confidence the information provided by the health maintenance organization pursuant to subsection (1)(d)(iii).

(3) The commissioner may examine a complaint system.

History: En. Sec. 11, Ch. 457, L. 1987.

Administrative Rules:

ARM 6.6.2509 Other requirements.

33-31-304. Dual choice. An employer in this state that offers its employees the option to enroll in a health maintenance organization and an employee benefit fund in this state that offers its members the option to enroll in a health maintenance organization may not be required to pay more for health benefits provided by the health maintenance organization than it would otherwise be required to provide by any prevailing collective bargaining agreement or other contract for the provision of health benefits to its employees, if the employer or benefits fund pays to the health maintenance organization chosen by each employee or member an amount equal to the lesser of:

(1) the amount paid on behalf of its other employees or members of health benefits; or

(2) the health maintenance organization's charge for coverage approved by the commissioner pursuant to 33-31-301.

History: En. Sec. 29, Ch. 457, L. 1987.

33-31-305. Dentist participation as provider. A contract for dental care services through a health maintenance organization that is offered, delivered, or renewed under this chapter must allow a dentist to request participation as a provider on the same terms and conditions as those by which other dentists participate. This opportunity for participation must be offered for each contract or plan. Each contract or plan must provide at least one annual period during which a dentist may exercise this right.

History: En. Sec. 2, Ch. 265, L. 1989.

33-31-306. Point-of-service option. (1) (a) A health maintenance organization that has at least 10,000 enrollees shall offer a point-of-service option benefit plan to each purchaser of a health care services agreement. The purchaser may accept or reject the addition of a point-of-service option to the health care services agreement.

(b) For the purposes of subsection (1)(a), an enrollee does not include an individual receiving medicaid services under the Montana medicaid program provided for in Title 53, chapter 6, or an individual participating in an approved medicare risk contract administered by a licensed health maintenance organization.

(2) Any difference in premium charged for the point-of-service option benefit plan compared to the premium for a standard health care services agreement may not exceed the expected cost to the insurer of

benefits and expenses based on sound actuarial principles.

(3) This section may not be construed to permit a health maintenance organization to offer stand-alone indemnity insurance coverage.

History: En. Sec. 2, Ch. 165, L. 1997.

33-31-307. Affiliation periods. (1) A health maintenance organization that offers health insurance coverage in connection with a group health plan and that does not impose a preexisting condition exclusion allowed by 33-22-246 or 33-22-514 with respect to any particular coverage option may impose an affiliation period for that coverage option if:

(a) the affiliation period is applied uniformly without regard to any health status-related factors; and

(b) the affiliation period does not exceed 2 months, or 3 months in the case of a late enrollee, as defined in 33-22-140.

(2) A health maintenance organization is not required to provide health care services or benefits during the affiliation period, and a premium may not be charged to the participant or beneficiary for any coverage during the affiliation period. An affiliation period begins on the enrollment date and runs concurrently with any waiting period under the plan.

(3) A health maintenance organization may use a method other than an affiliation period to address adverse selection if the method is approved by the commissioner.

(4) The definitions in 33-22-140 apply to this section.

History: En. Sec. 43, Ch. 416, L. 1997.

33-31-308 through 33-31-310 reserved.

33-31-311. Insurance producer license required -- application, issuance, renewal, fees -- penalty. (1) An individual, partnership, or corporation may not act as or represent to the public that the individual, partnership, or corporation is an insurance producer of a health maintenance organization unless the individual, partnership, or corporation is:

(a) licensed as a disability insurance producer by the commissioner pursuant to chapter 17, parts 1, 2, and 4 of this title or licensed as an insurance producer as provided in 33-30-311; and

(b) appointed or authorized by the health maintenance organization to solicit health care service agreements on its behalf.

(2) Application, appointment, and qualification for a health maintenance organization insurance producer license, fees applicable to and the issuance of a health maintenance organization insurance producer license, and renewal of a health maintenance organization insurance producer license must be in accordance with the provisions of chapter 17 that apply to a disability insurance producer.

(3) An individual, partnership, or corporation that holds a disability insurance producer license on October 1, 1987, need not requalify by an examination to be licensed as a health maintenance organization insurance producer.

(4) The commissioner may, in accordance with 33-1-317, 33-17-411, and chapter 17, part 10, suspend, revoke, refuse to issue or renew a health maintenance organization insurance producer license or impose a fine upon the licensee.

History: En. Sec. 15, Ch. 457, L. 1987; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 153, Ch. 42, L. 1997; amd. Sec. 68, Ch. 227, L. 2001.

33-31-312. Prohibited practices. (1) A health maintenance organization, or representative thereof, may not cause or knowingly permit the use of advertising that is untrue or misleading, solicitation that is untrue or misleading, or any form of evidence of coverage that is deceptive. For purposes of this chapter:

(a) a statement or item of information is considered to be misleading, whether or not it may be literally untrue, if, in the total context in which the statement is made or the item of information is communicated, a reasonable person not possessing special knowledge regarding health care coverage may reasonably understand the statement or item of information as indicating a benefit or advantage or the absence of an exclusion, limitation, or disadvantage of possible significance to an enrollee or person considering enrollment in a health maintenance organization if the benefit or advantage or absence of limitation, exclusion, or disadvantage does not in fact exist; and

(b) an evidence of coverage is considered to be deceptive if, when taken as a whole and with consideration given to typography, format, and language, it can cause a reasonable person not possessing special knowledge regarding health maintenance organizations to expect benefits, services, charges, or other advantages that the evidence of coverage does not provide or which the health maintenance organization issuing the evidence of coverage does not regularly make available to enrollees covered under the evidence of coverage.

(2) Title 33, chapter 18, applies to health maintenance organizations and evidences of coverage issued by a health maintenance organization, except to the extent that the commissioner determines that the nature of health

maintenance organizations and evidences of coverage render the chapter clearly inappropriate.

(3) A health maintenance organization shall clearly disclose in the evidence of coverage the circumstances under which it may disenroll, cancel, or refuse to renew an enrollee. A health maintenance organization may disenroll, cancel, or refuse to renew an enrollee only if the enrollee:

- (a) has failed to pay required premiums by the end of the grace period;
- (b) has committed acts of physical or verbal abuse that pose a threat to providers or other enrollees of the health maintenance organization;
- (c) has allowed a nonenrollee to use the health maintenance organization's certification card to obtain services or has knowingly provided fraudulent information in applying for coverage;
- (d) has moved outside of the geographical service area of the health maintenance organization;
- (e) has violated rules of the health maintenance organization stated in the evidence of coverage;
- (f) has violated rules adopted by the commissioner for enrollment in a health maintenance organization; or
- (g) is unable to establish or maintain a satisfactory physician-patient relationship with the physician responsible for the enrollee's care. Disenrollment of an enrollee for this reason must be permitted only if the health maintenance organization can demonstrate that it provided the enrollee with the opportunity to select an alternate primary care physician, made a reasonable effort to assist the enrollee in establishing a satisfactory physician-patient relationship, and informed the enrollee that he may file a grievance on this matter.

(4) A health maintenance organization may not disenroll an enrollee under subsection (3) for reasons related to the physical or mental condition of the enrollee or for any of the following reasons:

- (a) failure of the enrollee to follow a prescribed course of treatment; or
- (b) administrative actions, such as failure to keep an appointment.

(5) (a) A health maintenance organization that disenrolls a group certificate holder for any reason not listed in subsection (3) or provided in rules adopted by the commissioner shall make arrangements to provide similar alternate insurance coverage to enrollees. The insurance coverage must be continued until the disenrolled group certificate holder finds its own coverage or a period of 12 months elapses, whichever comes first. The premium on the individual coverage must be at the then-customary rate applicable to the individual coverage offered by the insurer, health service corporation, or health maintenance organization that provides the alternate insurance coverage.

(b) If a health maintenance organization disenrolls an enrollee covered on an individual basis for any reason not listed in subsection (3) or provided in rules adopted by the commissioner, coverage must be continued until the anniversary date of the policy or for 1 year, whichever is earlier. A health maintenance organization that disenrolls an individual enrollee for failure to pay a required premium or for fraudulent statements on the enrollment form need not provide alternate insurance coverage to that enrollee.

(6) A health maintenance organization may not refer to itself as an insurer unless licensed as an insurer or use a name deceptively similar to the name or description of an insurer authorized to transact insurance in this state.

(7) A person may not refer to itself as a health maintenance organization or HMO unless it holds a valid certificate of authority issued by the commissioner.

History: En. Sec. 14, Ch. 457, L. 1987.

Administrative Rules:

ARM 6.6.2506 Requirements for contracts and evidences of coverage.

ARM 6.6.2507 Prohibited practices.

33-31-313. Premium increase restriction -- exception. (1) A health maintenance organization may not increase a premium for an individual's or an individual's group health care services agreement more frequently than once during a 12-month period unless failure to increase the premium more frequently than once during the 12-month period would:

- (a) place the health maintenance organization in violation of the laws of this state; or
- (b) cause the financial impairment of the health maintenance organization to the extent that further transaction of insurance by the health maintenance organization would injure or be hazardous to its enrollees or to the public.

(2) Subsection (1) does not apply to a premium increase necessitated by a state or federal law, by a court decision, by a state rule, or by a federal regulation.

History: En. Sec. 7, Ch. 413, L. 1997.

33-31-314 through 33-31-320 reserved.

33-31-321. Disclosure standards -- health maintenance organizations. (1) In order to provide for full and fair disclosure in the sale of disability insurance, an enrollment form or evidence of coverage may not be delivered or issued for delivery in this state by a health maintenance organization unless an outline of coverage is delivered to the applicant at the time the application is made. The outline of coverage must be filed with the commissioner as required by 33-1-501.

(2) The outline of coverage must include:

(a) a general description of the principal benefits and coverages provided by the policy;

(b) a general description of the insureds financial responsibility under the policy, including, if applicable, the amount of the deductible, the amount or percentage of copayment, and the maximum annual out-of-pocket expenses to be paid by the insured;

(c) a statement of the maximum lifetime benefit available under the policy;

(d) a statement of the estimated periodic premium to be paid by the insured;

(e) a general description of the factors or case characteristics that the insurer may consider in establishing or changing the premiums and, if applicable, in determining the insurability of the applicant; and

(f) a general description of the trend of premium increases or decreases for comparable policies issued by the insurer during the preceding 5 years, if the trend data is available.

(3) The outline of coverage may include any other information that the insurer considers relevant to the applicants selection of an appropriate health benefit plan.

(4) An insurer or producer shall provide to an individual, upon request, an outline of coverage for any health benefit product marketed to the general public. The outline of coverage provided under this subsection may exclude the statement of the estimated periodic premium to be paid by the insured.

History: En. Sec. 7, Ch. 527, L. 1995.

33-31-322. Uniform health benefit plan -- health maintenance organization. Each health maintenance organization delivering or issuing for delivery in this state an enrollment form or evidence of coverage shall make available a uniform health benefit plan providing benefit value, as defined in 33-22-1803, comparable to the uniform health benefit plan required in 33-22-245(2).

History: En. Sec. 10, Ch. 527, L. 1995; amd. Sec. 31, Ch. 416, L. 1997.

Part 4

Supervision, Rehabilitation, and Liquidation

33-31-401. Examination. (1) The commissioner may examine the affairs of a health maintenance organization as often as is reasonably necessary to protect the interests of the people of this state. The commissioner shall make an examination at least once every 3 years. The commissioner shall examine a health maintenance organization operated by an insurer or health service corporation as a plan at least once every 5 years. The provisions of 33-1-408 and 33-1-409 apply to examinations under this section.

(2) Each authorized health maintenance organization and provider shall submit its relevant books and records for the examinations and in every way facilitate the examinations. For the purpose of examination, the commissioner may administer oaths to and examine the officers and insurance producers of the health maintenance organization and the principals of the providers concerning their business.

(3) (a) Upon presentation of a detailed account of the charges and expenses of examinations by the commissioner, the health maintenance organization being examined shall pay to the examiner as necessarily incurred on account of the examination the actual travel expenses, a reasonable living-expense allowance, and a per diem, all at reasonable rates customary therefor and as established or adopted by the commissioner. The commissioner may present an account periodically during the course of the examination or at the termination of the examination as the commissioner considers proper. A person may not pay and an examiner may not accept any additional emolument on account of any examination.

(b) If a health maintenance organization fails to pay the charges and expenses as referred to in subsection (3)(a), the commissioner shall pay them out of the funds of the commissioner in the same manner as other disbursements of funds. The amount paid is a lien upon all of the person's assets and property in this state and may be recovered by suit by the attorney general on behalf of the state and restored to the appropriate fund.

(4) In lieu of an examination, the commissioner may accept the report of an examination made by the commissioner of another state.

History: En. Sec. 17, Ch. 457, L. 1987; amd. Sec. 7, Ch. 628, L. 1989; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 6, Ch. 437, L. 1991; amd. Sec. 61, Ch. 472, L. 1999; amd. Sec. 69, Ch. 227, L. 2001.

33-31-402. Suspension or revocation of certificate of authority. (1) The commissioner may in his discretion suspend or revoke any certificate of authority issued to a health maintenance organization under this chapter if he finds that any of the following conditions exist:

(a) The health maintenance organization is operating in contravention of its basic organizational document or in a manner contrary to that described in any other information submitted under 33-31-201 and provided that such operation adversely affects the health maintenance organization's ability to provide benefits and operate under the application approved by the commissioner, unless amendments to such submissions have been filed with and approved by the commissioner.

(b) The health maintenance organization issues evidences of coverage or uses a schedule of charges for health care services that do not comply with the requirements of 33-31-301.

(c) The health maintenance organization does not provide or arrange for basic health care services.

(d) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.

(e) The health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation under 33-31-222.

(f) The health maintenance organization has failed to implement the complaint system required by 33-31-303 to resolve valid complaints in a reasonable manner.

(g) The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner.

(h) The continued operation of the health maintenance organization would be hazardous to its enrollees.

(i) The health maintenance organization has otherwise failed to substantially comply with this chapter.

(2) The commissioner may in his discretion suspend or revoke a certificate of authority only if he complies with the requirements of 33-31-404.

(3) When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization may not, during the period of such suspension, enroll any additional enrollees except newborn infants or other newly acquired dependents of existing enrollees and may not engage in any advertising or solicitation.

(4) If the commissioner revokes the certificate of authority of a health maintenance organization, the health maintenance organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and may not transact further business except as may be essential to the orderly conclusion of its affairs. It may not engage in further advertising or solicitation following the effective date of the order of revocation. The commissioner may by written order permit further operation of the health maintenance organization if he finds further operation to be in the best interest of enrollees to the extent that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

History: En. Sec. 18, Ch. 457, L. 1987; amd. Sec. 7, Ch. 437, L. 1991.

33-31-403. Supervision, rehabilitation, or liquidation of a health maintenance organization. (1) The supervision, rehabilitation, or liquidation of a health maintenance organization is considered to be the supervision, rehabilitation, or liquidation of an insurer and must be conducted under the supervision of the commissioner pursuant to chapter 2, part 13. The commissioner may apply for an order directing him to supervise, rehabilitate, or liquidate a health maintenance organization upon any one or more grounds set out in 33-2-1321, 33-2-1331, or 33-2-1341 or when in his opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this state. Enrollees shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

(2) A claim by a health care provider for an uncovered expenditure has the same priority as a claim by an enrollee if the provider of services agrees not to assert the claim against any enrollee of the health maintenance organization.

History: En. Sec. 19, Ch. 457, L. 1987.

33-31-404. Administrative procedures. (1) When the commissioner has cause to believe that grounds for the denial of an application for a certificate of authority exist or that grounds for the suspension or revocation of a certificate of authority exist, he shall give written notice to the health maintenance organization specifically stating the grounds for denial, suspension, or revocation and fixing a time of at least 30 days after the notice for a hearing on the matter.

(2) After the hearing, or upon the failure of the health maintenance organization to appear at the hearing, the commissioner shall make written findings and act as he considers advisable. The commissioner shall mail the written findings to the health maintenance organization. The action of the commissioner is subject to review by the district court having jurisdiction. The court may, in disposing of the issue before it, modify, affirm, or reverse the order of the commissioner in whole or in part.

(3) Where notice and hearing are required with regard to actions taken by the commissioner under this chapter, the requirements of 33-1-314 through 33-1-316 and Title 33, chapter 1, part 7, apply, except that the formal rules of pleading and evidence must be observed. To the extent that 33-1-314 through 33-1-316 and Title 33, chapter 1, part 7, do not address the notice and hearing requirements of this chapter, the provisions of Title 2, chapter 4, parts 6 and 7, apply.

History: En. Sec. 21, Ch. 457, L. 1987; amd. Sec. 8, Ch. 437, L. 1991.

33-31-405. Penalties and enforcement. (1) The commissioner may, in addition to suspension or revocation of a certificate of authority under 33-31-402, after notice and hearing, impose an administrative penalty in an amount not less than \$500 or more than \$10,000 if he gives reasonable notice in writing of the intent to levy the penalty and the health maintenance organization has a reasonable time within which to remedy the defect in its operations that gave rise to the penalty citation.

(2) If the commissioner has cause to believe that a violation of this chapter has occurred or is threatened, the commissioner may:

(a) give notice to the health maintenance organization and to the representatives or other persons who appear to be involved in the suspected violation;

(b) arrange a conference with the alleged violators or their authorized representatives to attempt to ascertain the facts relating to the suspected violation; and

(c) if it appears that a violation has occurred or is threatened, arrive at an adequate and effective means of correcting or preventing the violation.

(3) (a) The commissioner may issue an order directing a health maintenance organization or its representative to cease and desist from engaging in an act or practice in violation of this chapter.

(b) Within 15 days after service of the cease and desist order, the respondent may request a hearing to determine whether acts or practices in violation of this chapter have occurred. The hearing must be conducted pursuant to Title 2, chapter 4, part 6, and judicial review must be available as provided by Title 2, chapter 4, part 7.

(4) If a health maintenance organization violates a provision of this chapter and the commissioner elects not to issue a cease and desist order or if the respondent does not comply with a cease and desist order issued pursuant to subsection (3), the commissioner may institute a proceeding to obtain injunctive or other appropriate relief in the district court of Lewis and Clark County.

History: En. Sec. 23, Ch. 457, L. 1987; amd. Sec. 9, Ch. 437, L. 1991.

Administrative Rules:

ARM 6.6.2510 Penalties.