

MONTANA ADMINISTRATIVE REGISTER

ISSUE NO. 14

The Montana Administrative Register (MAR), a twice-monthly publication, has three sections. The notice section contains state agencies' proposed new, amended or repealed rules; the rationale for the change; date and address of public hearing; and where written comments may be submitted. The rule section indicates that the proposed rule action is adopted and lists any changes made since the proposed stage. The interpretation section contains the attorney general's opinions and state declaratory rulings. Special notices and tables are found at the back of each register.

Inquiries regarding the rulemaking process, including material found in the Montana Administrative Register and the Administrative Rules of Montana, may be made by calling the Administrative Rules Bureau at (406) 444-2055.

Page Number

TABLE OF CONTENTS

NOTICE SECTION

ADMINISTRATION, Department of, Title 2

2-2-287 (Teachers' Retirement Board) Notice of Public Hearing on Proposed Adoption, Amendment and Repeal - Teachers' Retirement System. 1565-1574

STATE AUDITOR, Title 6

6-116 Notice of Public Hearing on Proposed Amendment, Repeal and Adoption - Life Insurance and Annuities Replacement. 1575-1599

6-117 Notice of Proposed Amendment - Continuing Education Fees. No Public Hearing Contemplated. 1600-1602

ENVIRONMENTAL QUALITY, Department of, Title 17

(Board of Environmental Review)

17-102 (Water Quality) Notice of Public Hearing on Proposed Amendment - Trigger Values. 1603-1607

17-103 (Water Quality) Notice of Public Hearing on Proposed Amendment - Certification Options - General Prohibitions to Surface Water Quality Standards and Procedures. 1608-1611

17-104 (Air Quality) Notice of Public Hearing on Proposed Amendment - Air Quality Permit Application - Operation Fees. 1612-1616

ENVIRONMENTAL QUALITY, Continued

17-105 (Water Quality) Notice of Supplemental
Comment Period - Montana Surface Water Quality
Standards - Nondegradation Rules - Groundwater
Pollution Control System Rules. 1617-1618

MILITARY AFFAIRS, Department of, Title 34

34-4 Notice of Proposed Adoption - Administration
of the Education Benefit Program for the Montana
National Guard. No Public Hearing Contemplated. 1619-1623

PUBLIC HEALTH AND HUMAN SERVICES, Department of, Title 37

37-126 Notice of Proposed Repeal - Medicaid Health
Plan Enrollment. No Public Hearing Contemplated. 1624-1626

37-127 Notice of Public Hearing on Proposed
Adoption - Network Adequacy in Managed Care. 1627-1642

37-128 Notice of Public Hearing on Proposed
Adoption - Use of Automated External
Defibrillators. 1643-1650

REVENUE, Department of, Title 42

42-2-640 Notice of Proposed Adoption - Ethics of
Department of Revenue Employees. No Public Hearing
Contemplated. 1651-1656

RULE SECTION

COMMERCE, Department of, Title 8

AMD (Board of Real Estate Appraisers) Fees. 1657

ENVIRONMENTAL QUALITY, Department of, Title 17

(Board of Environmental Review)

AMD (Air Quality) Maximum Achievable Control
Technology (MACT) Approval for Hazardous Air
Pollutants. 1658-1659

AMD (Air Quality) Open Burning. 1660

AMD (Water Quality) Permit Requirements of
Lagoons. 1661

REVENUE, Department of, Title 42

EMERG Universal System Benefits Programs.
NEW 1662-1671

INTERPRETATION SECTION

Opinions of the Attorney General.

5	Cities and Towns - Comprehensive Master Plans, Planning and Zoning Districts - Counties - County Government - Freeholders - Petitions to Create Planning and Zoning Districts - Jurisdiction - County Planning Boards and Planning and Zoning Commissions - Land Use - Jurisdiction of County Planning Boards and Planning and Zoning Commissions - Planning and Zoning District Boundaries.	1672-1679
---	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------

Before the Department of Commerce, Board of Respiratory Care Practitioners.

Notice of Petition for Declaratory Ruling.

	In the Matter of the Petition for Declaratory Ruling on the Interpretation and Further Delineation of 37-28-102(3)(a) and (b), MCA, and a Less Broad Guideline than that Found in ARM 8.59.402(2).	1680-1684
--	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------

SPECIAL NOTICE AND TABLE SECTION

	Function of Administrative Rule Review Committee.	1685-1686
	How to Use ARM and MAR.	1687
	Accumulative Table.	1688-1698
	Boards and Councils Appointees.	1699-1708
	Vacancies on Boards and Councils.	1709-1716

BEFORE THE TEACHERS' RETIREMENT BOARD
OF THE STATE OF MONTANA

In the matter of the adoption of)
 new rule I, the amendment of rules)
 2.44.307, 2.44.401, 2.44.414,)
 2.44.506, 2.44.511, 2.44.515,) NOTICE OF PUBLIC
 2.44.517, and 2.44.518 and the) HEARING ON PROPOSED

 repeal of rules 2.44.404, 2.44.410,) ADOPTION, AMENDMENT
 2.44.415, 2.44.502, 2.44.503,) AND REPEAL
 2.44.510, 2.44.516, and 2.44.519)
 pertaining to the Teachers')
 Retirement System.)

TO: All Concerned Persons

1. On August 16, 1999, at 8:00 a.m. a public hearing will be held in the Boardroom of the Teachers' Retirement System at 1500 Sixth Avenue, Helena, Montana, to consider the proposed adoption of new rule I, the amendment of ARM 2.44.307, 2.44.401, 2.44.414, 2.44.506, 2.44.511, 2.44.515, 2.44.517, and 2.44.518 and the repeal of ARM 2.44.404, 2.44.410, 2.44.415, 2.44.502, 2.44.503, 2.44.510, 2.44.516, and 2.44.519.

2. The Teachers' Retirement Board will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing or need an alternative accessible format of this notice. If you require an accommodation, contact the Teachers' Retirement Board no later than 5:00 p.m. on August 9, 1999, to advise us of the nature of the accommodation that you need. Please contact Penney Clark, 1500 Sixth Avenue, Helena MT, 59620, (406) 444-3134.

3. The proposed new rule provides as follows:

RULE I SERVICE PURCHASE RESOLUTIONS (1) The effective date of any resolution adopted for the purpose of allowing employees to purchase service with contributions on a picked-up, pre-tax basis, must be at least 2 months following the month in which the resolution is adopted. For example: if the resolution is adopted by the governing board on July 8, 1999, the earliest effective date would be September 1, 1999 for additional contributions withheld from compensation earned after September 1, 1999, and reported on the employer's teachers' retirement system (TRS) report for September, 1999.

(2) On the first monthly report coinciding with the effective date of the resolution, all additional contributions must stop and cannot be reinstated until the employee and employer have signed the irrevocable election form required by 19-20-415, MCA.

(3) The service purchase-irrevocable election form will be available only through the office of the teachers' retirement system and must be requested at least 30 days prior to the effective date of the resolution to ensure the member will be able to continue payroll deductions uninterrupted.

(4) Employers who fail to withhold additional contributions in compliance with the applicable state and federal laws and rules adopted by the board will be notified that the additional contributions cannot be credited to the member's account. The employer will be required to take a credit on their next monthly report for any amounts reported in error, and to correct their tax withholding records.

AUTH: 19-20-201, MCA

IMP: 19-20-415, MCA

Section 9 of HB 118, 1999 Session Laws, Chapter Number 111, requires employers to adopt a resolution before members can have contributions deducted for the purpose of purchasing additional service on a tax-deferred basis. This law also requires employees to sign an irrevocable election form following adoption of the resolution before the tax-deferred deductions can begin. These rules and regulations must be followed to the letter if the TRS is to maintain its tax-favored status as a qualified pension plan. This rule is necessary to establish timelines which employer and employees must follow to ensure that members have time to make an informed decision regarding purchasing additional service with tax-deferred dollars. In addition these timelines will help ensure that employees do not miss out on the opportunity to purchase service via payroll deduction because they cannot request, receive and complete the required paper work in time for the next monthly payroll following adoption of the resolution.

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

2.44.307 MEMBERSHIP OF TEACHER'S AIDES AND PART-TIME EMPLOYEES (1) Teacher's aides employed after September 1, 1989, are required to participate in the teachers' retirement system provided their predominate duties are those of a teacher's aide and not a substitute teacher or any other

position for which membership is mandatory under 19-20-302, MCA and that they are:

(a) employed in an instructional services capacity for 50% or more of the academic day at least 3.5 hours per day and;

(b) employed for the equivalent of 30 full time days at least 210 hours during the school year.

(2) remains the same.

(3) A part-time teacher's aide, as defined in (1), who receives compensation for duties that are not of an instructional services capacity shall have those salaries reported to the teachers' retirement system provided:

(a) the non-instructional duties are a diminutive part of the duties performed by the part-time teacher's aide; and

(b) the individual, by virtue of the non-instructional duties, would not otherwise be eligible for membership under the public employees' retirement system.

(3) and (4) remain the same, but are renumbered (4) and (5).

AUTH: 19-20-201, MCA

IMP: 19-20-302, MCA

Administrative Rule 2.44.401 defines a full day as 7 hours; the proposed amendments are necessary to clarify that 50% of the academic day is 3.5 hours. Section 19-20-302, MCA, requires that an individual be employed for at least 30 days in the fiscal year to be eligible for membership, therefore, a part-time teacher's aide must also be employed for at least 210 hours (7 hours X 30) to be eligible for membership. At times teacher's aides perform other duties that are not of an instructional nature and would not qualify for membership under 19-20-302, MCA, however, it is unnecessarily burdensome for employers to not report these earnings to TRS. The proposed amendments would allow the school district to report non-instructional duties of a teacher's aide if they were only a small part of the duties of the teacher's aide, and the individual would not otherwise be eligible for membership in PERS.

2.44.401 CALCULATING SERVICE CREDITS (1) The basic period of time for calculating service credit shall be the school term July 1 through June 30. Service credit in the Montana teachers' retirement system shall be based upon the following unless otherwise provided by rule or statute:

(a) nine (9) months or 180 days of full-time employment shall equal 1.0 year service credit for any employment

eligible to be qualified under the teachers' retirement system.

(b) remains the same.

(c) remains the same.

(2) remains the same.

(3) For employees of the university system and community colleges part-time service credit shall be awarded ~~by dividing the contracted credit hours taught and compensated for by the full time credit hours per quarter or semester prorated based upon the portion of the full-time contract completed and/or the daily rate of pay if available.~~

AUTH: 19-20-201, MCA

IMP: 19-20-401 through 19-20-411, MCA

As part-time university and community college faculty become less involved in teaching and more involved in grant activity it has become impossible to base service credit on credit hours taught. Using the member's full-time equivalent or daily rate of pay to calculate service credit results in a more accurate calculation of the actual service credit earned by the member.

2.44.414 INSTALLMENT PURCHASE (1) ~~Additional service may be purchased in a lump sum payment, or the member may sign a contract with the board to purchase service through installment payments not to exceed 60 months. If a member signs a revocable payroll deduction authorization and subsequently reduces the monthly payment amount or terminates monthly payments before the terms of the contract are fulfilled, the member's account will be credited with the prorated portion of the service purchased to date.~~

(2) remains the same.

AUTH: 19-20-201, MCA

IMP: 19-20-401 through 19-20-411, and 19-20-415, MCA

Section 9 of HB 118, 1999 Session Laws, Chapter Number 111, created both revocable and irrevocable payroll deduction options and incorporated the preponderance of this rule into law. This amendment is necessary to provide for crediting any service credit purchased in the event the member reduces or terminates the monthly payments he/she has agreed to contribute under a revocable authorization.

2.44.506 BENEFIT PAYMENTS (1) remains the same.

(2) remains the same.

(3) At the time application for retirement benefits is made, each applicant must submit a copy of their final year's contract, ~~and~~ any previous contract(s) as may be requested and a copy of their letter of resignation if one was submitted to their employer. If a member does not have a written contract, a statement from their employer verifying their daily or hourly rate of pay, their full time equivalent and the number of days they were employed in the fiscal year will be ~~excepted~~ accepted.

(4) remains the same.

AUTH: 19-20-201, MCA

IMP: 19-20- 703, 19-20-716, MCA

Section 18 of HB 118, 1999 Session Laws, Chapter Number 111, gives members the option to sign an irrevocable election to contribute on termination pay with tax-deferred dollars. In compliance with IRS regulations, the irrevocable election must be signed at least 90 days prior to termination. A copy of the member's letter of resignation is necessary to corroborate and verify that the irrevocable election form was signed at least 90 days prior to termination.

2.44.511 REINSTATEMENT OF BENEFITS (1) Upon completion of employment, a previously retired member who is reinstated with the same benefit amount that the retired member was receiving at the time of retirement, shall also have his/her retirement effective date reinstated to the original retirement effective date for the purpose of determining eligibility for the guaranteed annual benefit adjustment (GABA). ~~was subsequently reemployed for a period of less than 1 year and was removed from retirement, may have his retirement reinstated beginning with the month following the termination of his employment. The reinstated retirement benefit will be that which he would have been entitled to receive had he not returned to employment.~~

(2) ~~Upon completion of a minimum of 1 year's service as an active member and upon ceasing teaching, a previously retired member may have his retirement reinstated. His retirement benefit will be based on the then current retirement provisions. If upon termination of employment the~~ previously retired member's retirement benefits are recalculated, his/her retirement effective date, for the purpose of determining eligibility for GABA, will be the most recent date of retirement.

~~(3) When a reactivated member retires for the second time the additional benefit provided by the termination pay~~

~~used in the calculation of the original benefit shall be added at the time of the second retirement, after benefits have been recalculated without giving consideration to the previous termination pay.~~

AUTH: 19-20-201, MCA

IMP: 19-20-302, 19-20-804, MCA

The majority of this rule was incorporated into section 18 of HB 118, 1999 Session Laws, Chapter Number 111, and is no longer necessary. HB 72, 1999 Session Laws, Chapter Number 360, provides for a guaranteed annual benefit increase of 1.5% paid each January to all recipients whose most recent retirement effective date is at least 36 months prior to January 1 of the year in which the adjustment is to be made. These amendments are necessary to establish the most recent retirement effective date in the event the retiree returns to teaching and benefits are terminated.

2.44.515 CORRECTION OF ERRORS ON CONTRIBUTIONS AND OVERPAYMENTS (1) remains the same.

(2) remains the same.

(3) remains the same.

(4) Interest shall accrue on contributions not reported or amounts overpaid at the same rate as that credited to member accounts to members at the actuarial assumed rate unless arrangements are made as provided under (5) to repay the amount owed immediately once the employer, member or retired member is notified of the error.

(5) Interest will be waived if the amount owed is repaid in no more than 12 equal monthly installments following the date of notification of the error.

AUTH: 19-20-201, MCA

IMP: 19-20-208, MCA

Occasionally a retiree will receive benefits that they are not entitled to because they returned to full-time employment, or because benefits were to be reduced upon the death of the member or beneficiary and the TRS is not notified. Also, employers occasionally fail to report an employee who is eligible for membership or fail to report all of the salary the member earned. When an error occurs, any overpayment or amounts not reported must be paid to the TRS. The policy embodied in this amendment is intended to encourage members and employers to promptly pay any amounts owed within one year by waiving the interest that could be charged. If the

overpayment is not returned within one year, interest at the rate of 8% will be charged from the date the error is discovered.

2.44.517 FORMULA FOR DETERMINING CONTRIBUTIONS DUE ON TERMINATION PAY (1) Except as provided in ~~subsection~~ (2), the formula for determining contributions due under ~~option (i) 19-4-101(5)(a)~~ Option 1, 19-20-716, MCA shall be a percentage of the termination pay, based upon the member's age at the time of retirement, times the total years of creditable service. ~~The total contributions due to adequately compensate the system for the additional benefit for termination pay under option (i), shall be divided between the member and the employer in the same ratio as employee and employer contributions required under 19-4-602 and 19-4-605, MCA are to the total.~~

(2) remains the same.

AUTH: 19-20-201, MCA

IMP: 19-20-101, 19-20-716, MCA

Amendments are necessary to correct statute site and to delete language that would change the contribution rate paid by employees and employers on termination pay. The formula has not resulted in any changes in the contribution rates since 1989 but has the potential to cause the employer rate to increase thereby creating an unfunded mandate to school districts.

2.44.518 LIMIT ON EARNED COMPENSATION (1) The earned compensation for each year used in calculating a member's average final compensation may not exceed either the member's actual earned compensation or earnings adjusted by this rule for the preceding year, by more than 10% except for increases that:

(a) result from collective bargaining agreements;

(b) have been granted by the employer to all other similarly situated employees. The employer must certify the similarly situated group of employees, the increase received by each employee and the methodology for determining the increases;

(c) result from compensation received for summer employment, provided summer compensation does not exceed the lessor of:

(i) not to exceed one-ninth of the academic year contract for each full month or prorated for each portion of a month employed during the summer; or

(ii) 110% of the summer compensation the member was eligible to earn each month during the preceding summer;

(d) have resulted from change of employer; or

(e) have resulted from re-employment for a period of not less than one year following a break in service.

(2) The member must provide adequate documentation to permit the board to make an informed decision concerning exceptions to the 10% limitation. Adequate documentation includes but is not limited to the following:

(a) employment contracts;

(b) official minutes of board meetings.

(3) The assignment of additional duties of a one time or temporary nature shall not be exempt from the 10% limitation.

(4) The 10% cap shall be calculated as per the following example and applied consistently to all members:

	YEAR	0	1	2	3	TOTAL EXCESS
AY COMP:		45,000	50,000	54,000	60,000	
SUMMER COMP (1/9 Per mo.)			1,000	1,000	0	
EXTRA COMP		0	0	1,500	1,500	
TOTAL COMPENSATION		45,000	51,000	56,500	61,500	
THE CAP	NA		49,500	55,550	62,150	
DIFFERENCE (BUT NOT < 0.00)			1,500	950	0	
LESS EXEMPT EARNINGS			1,000	1,000	0	
EXCESS (BUT NOT < 0.00)			500	0	0	500
AVERAGE FINAL COMPENSATION			50,500	56,500	61,500	

(The following chart is all new text.)

	FY 1996	FY 1997	FY 1998	FY 1999
BASE CONTRACT	\$64,750.00	\$70,230.00	\$90,000.00	\$90,000.00
10% CAP	NA	NA	77,253.00	84,978.00
EXCESS BASE EARNINGS	NA	NA	12,747.00	5,022.00
SUMMER COMPENSATION (3 months)	21,583.00	23,700.00	30,000.00	20,000.00
SUMMER 10% CAP	NA	23,410.00	25,751.00	NA
EXCESS SUMMER EARNINGS	NA	290.00	4,249.00	NA
TOTAL EXCESS		\$22,308.00		

AVERAGE FINAL COMPENSATION	\$93,640.00	\$103,004.00	\$104,978.00
----------------------------	-------------	--------------	--------------

Average final compensation is equal to total compensation less excess earnings.

AUTH: 19-20-201, MCA

IMP: 19-20-715, MCA

Amendments are necessary to clarify the application of the 10% limitations on compensation to summer employment as well as academic year earnings. The statement of intent attached to the enabling legislation stated that the legislature intended to limit the effect on the retirement system of isolated salary increases received by selected individuals through promotions or one-time salary enhancements during their last years of employment. As the 10% cap has been applied to regular earnings, more and more dollars have been reported as summer compensation for selected individuals. While the legislature intended that the Board adopt rules to allow for exemptions for summer employment, it is inconsistent with the legislature's intent to exempt a member's total summer compensation from the cap when summer compensation per month is greater than 1/9 of the member's academic year contract or increases more than 10% per year over what the member could have earned each month in the preceding summer.

5. ARM 2.44.404 which can be found on page 2-3254 of the Administrative Rules of Montana, is proposed to be repealed.

AUTH: 19-4-201, MCA

IMP: 19-4-401, MCA

ARM 2.44.410 which can be found on page 2-3256 of the Administrative Rules of Montana, is proposed to be repealed.

AUTH: 19-4-201, MCA
IMP: 19-4-412, MCA

ARM 2.44.415 which can be found on page 2-3258 of the Administrative Rules of Montana, is proposed to be repealed.

AUTH: 19-20-201, MCA
IMP: Title 19, chapter 20, part 4 MCA

ARM 2.44.502 which can be found on page 2-3261 of the Administrative Rules of Montana, is proposed to be repealed.

AUTH: 19-4-201 and 19-20-201, MCA
IMP: 19-4-801 through 19-4-804 and 19-20-801 through 19-20-804, MCA

ARM 2.44.503 which can be found on page 2-3261 of the Administrative Rules of Montana, is proposed to be repealed.

AUTH: 19-4-201, MCA
IMP: 19-4-801 and 19-4-802, MCA

ARM 2.44.510 which can be found on page 2-3265 of the Administrative Rules of Montana, is proposed to be repealed.

AUTH: 19-4-201 and 19-20-201, MCA
IMP: 19-4-804 and 19-20-804, MCA

ARM 2.44.516 which can be found on page 2-3267 of the Administrative Rules of Montana, is proposed to be repealed.

AUTH: 19-4-201, MCA
IMP: 19-4-101(5) and 19-4-208, MCA

The above administrative rules are proposed to be repealed because the body of the rules have been substantially codified in chapter 111 of the session laws of 1999, or because the laws implemented by these rules have been repealed.

ARM 2.44.519 which can be found on page 2-3270 of the Administrative Rules of Montana, is proposed to be repealed because the laws implemented by this rule have been repealed under House Bill 72, adopted by the 1999 legislature and signed by the Governor.

AUTH: 19-4-201, MCA

IMP: 19-4-711, 19-4-712, and 19-4-713, MCA

6. Concerned persons may present their data, views, or arguments, either orally or in writing, at the hearing. Written data views or arguments may also be submitted to David L. Senn, Teachers' Retirement System, PO Box 200139, Helena, MT 59620-0139, and must be received no later than August 20, 1999.

7. Penney Clark, Teachers' Retirement System, PO Box 200139, Helena, MT 59601-0139, has been designated to preside over and conduct the hearing.

8. The Teachers' Retirement Board maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the list shall make a written request which includes the name and mailing address of the person to receive notice and specifies that the person wishes to receive notices regarding the Teachers' Retirement System. Such written requests may be mailed or delivered to Penney Clark, Teachers' Retirement System, 1500 Sixth Avenue, PO Box 200139, Helena, MT 59620-0139, faxed to the office at (406) 444-2641, or may be made by completing a request form at any rules hearing held by the Teachers' Retirement Board.

9. The bill sponsor notice requirements of 2-4-302, MCA apply and have been fulfilled.

/s/ David L. Senn

David L. Senn, Executive Director
Teachers' Retirement Board

/s/ Dal Smilie

Dal Smilie, Rule Reviewer

Certified to the Secretary of State July 12, 1999

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

In the matter of the proposed) NOTICE OF PUBLIC HEARING
amendment of rules 6.6.302) ON PROPOSED AMENDMENT,
through 6.6.309, the proposed) REPEAL, AND ADOPTION OF
repeal of rule 6.6.310, and) RULES
the proposed adoption of new)
rule I pertaining to life)
insurance and annuities)
replacement.)

TO: All Interested Persons

1. On September 13, 1999, at 10:00 a.m., a public hearing will be held in room 136 of the Mitchell Building, 126 North Sanders, Helena, Montana, to consider the proposed amendment of rules 6.6.302 through 6.6.309, the proposed repeal of rule 6.6.310, and the proposed adoption of new rule I pertaining to life insurance and annuities replacement.

2. The proposed amendments provide as follows (new text is underlined; text to be deleted is interlined):

6.6.302 PURPOSE- (1) The purpose of this subchapter is:
(1) ~~(a)~~ (a) To regulate the activities of insurers and ~~agents~~ producers with respect to the replacement of existing life insurance and annuities;-
(2) ~~(b)~~ (b) To protect the interests of life insurance and annuity purchasers ~~policyowners~~ by establishing minimum standards of conduct to be observed in ~~the replacement or proposed replacement of existing life insurance by~~ financed purchase transactions. It will:
~~(a)~~ (a) ~~(i)~~ (i) ~~Assuring~~ Assure that ~~the policyowner received purchasers receive~~ information with which a decision can be made in his or her own best interests;
~~(b)~~ (b) ~~(ii)~~ (ii) ~~Reducing~~ Reduce the opportunity for misrepresentation and incomplete disclosures; and
~~(c)~~ (c) ~~(iii)~~ (iii) ~~Establishing~~ Establish penalties for failure to comply with the requirements of this subchapter.

AUTH: Sec. 33-1-313, MCA
IMP: Sec. 33-18-204, MCA

6.6.303 DEFINITIONS. (1) ~~"Cash dividend" means the current illustrated dividend which can be applied toward payment of the gross premium.~~
(2) ~~"Conservation" means any attempt by the existing insurer or its agent to continue existing life insurance in force when it has received proper notice as required by~~

~~6.6.306(3)(d) of this sub chapter from a replacing insurer that the existing life insurance is or will be replaced.~~

~~(3) (1) "Direct-response sales solicitation" means any sale of life insurance where the insurer does not utilize an agent in the sale or delivery of the policy a solicitation through mailings, telephone, the internet or other mass communication media.~~

~~(4) (2) "Existing insurer" means the insurance company whose policy is or will be changed or terminated affected in such a manner as described within the definition of "replacement".~~

~~(5) (3) "Existing life insurance policy or contract" means any an individual life insurance policy (policy) or annuity contract (contract) in force, including life insurance a policy under a binding or conditional receipt or a life insurance policy or a contract that is within an unconditional refund period, but excluding life insurance obtained through the exercise of a dividend option.~~

~~(4) "Financed purchase" means the purchase of a new policy involving the actual or intended use of funds obtained by the withdrawal or surrender of, or by borrowing from values of an existing policy to pay all or part of any premium due on the new policy. If a withdrawal, surrender, or borrowing involving the policy values of an existing policy are used to pay premiums on a new policy owned by the same policyholder within 13 months before or after the effective date of the new policy and is known or should be known to the proposing producer, or to the replacing insurer, or if the withdrawal, surrender, or borrowing is shown on any illustration of the existing and new policies made available to the prospective policy owner by the insurer or its producers, it will be deemed prima facie evidence of a financed purchase.~~

~~(5) "Illustration" means a presentation or depiction that includes non-guaranteed or variable elements of a policy of life insurance over a period of years as described in 33-20-604, MCA.~~

~~(6) "Generic Name" means a short title which is descriptive of the premium and benefit patterns of a policy or a rider. "Policy summary," for the purposes of this subchapter:~~

~~(a) For policies or contracts other than universal life policies, means a written statement regarding a policy or contract which shall contain to the extent applicable, but need not be limited to, the following information:~~

- ~~(i) current death benefit;~~
- ~~(ii) annual contract premium;~~
- ~~(iii) current cash surrender value;~~
- ~~(iv) current dividend;~~
- ~~(v) application of current dividend; and~~
- ~~(vi) amount of outstanding loan.~~

(b) For universal life policies, means a written statement that shall contain at least the following information:

(i) the beginning and end date of the current report period;

(ii) the policy value at the end of the previous report period and at the end of the current report period;

(iii) the total amounts that have been credited or debited to the policy value during the current report period, identifying each by type (e.g., interest, mortality, expense and riders);

(iv) the current death benefit at the end of the current report period on each life covered by the policy;

(v) the net cash surrender value of the policy as of the end of the current report period; and

(vi) the amount of outstanding loans, if any, as of the end of the current report period.

(7) "Producer" shall be defined to include agents and producers.

(8) "Registered contract" means a variable annuity contract or variable life insurance policy subject to the prospectus delivery requirements of the Securities Act of 1933.

~~(7)~~ (9) "Replacement" means any a transaction in which a new life insurance policy, contract or registered contract is to be purchased, and it is known or should be known to the proposing agent producer, or to the proposing insurer, if there is no agent producer, that by reason of such transaction, an existing life insurance policy or contract has been, or is to be:

(a) Lapsed, forfeited, surrendered, or partially surrendered, assigned to the replacing insurer or otherwise terminated;

(b) Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;

(c) Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;

(d) Reissued with any reduction in cash values; or

~~(e) Pledged as collateral or subjected to borrowing, whether in single loan or under a schedule or borrowing over a period of time, in amounts exceeding 25% of the loan value set forth in the policy. Used in a financed purchase.~~

(10) "Replacing insurer" means the insurance company that issues or proposes to issue a new policy or contract that replaces an existing policy or contract or is a financed purchase.

~~(8) "Replacing insurer" means the insurance company that issues a new policy which is a replacement of existing life~~

insurance.

~~(9) (11) "Sales proposal material" means individualized sales aids of all kinds which are designed to justify the replacement or conservation of existing life insurance and used by an insurer, agent, or broker for presentation to policyowners. Sales aids of a generally descriptive nature, which are maintained in the insurer's advertising compliance file, shall not be considered a sales proposal within the meaning of this definition a sales illustration and any other written, printed or electronically presented information created, or completed or provided by the company or producer and used in the presentation to the policy or contract owner related to the policy or contract purchased.~~

AUTH: Sec. 33-1-313, MCA

IMP: Sec. 33-18-204, MCA

6.6.304 EXEMPTIONS (1) Unless otherwise specifically included, this subchapter shall not apply to transactions involving:

~~(1) (a) Annuities Credit life insurance;~~

~~(2) (b) Individual credit life insurance Group life insurance or group annuities where there is no direct solicitation of individuals by an insurance producer. Direct solicitation shall not include any group meeting held by an insurance producer solely for the purpose of education or enrolling individuals in a group policy. Group life insurance or group annuity certificates marketed through direct response solicitation shall be subject to the provisions of ARM 6.6.307;~~

~~(3) (c) Group life insurance, group credit life insurance, and life insurance policies issued in connection with a pension, profit sharing or other benefit plan qualifying for tax deductibility of premiums, provided, however, that as to any plan described in this rule, full and complete disclosure of all material facts shall be given to the administrator of any plan to be replaced An application to the existing insurer that issued the existing policy or contract when a contractual change or a conversion privilege is being exercised;~~

~~(4) (d) Variable life insurance under which the death benefits and cash values vary in accordance with unit values of investments held in a separate account; or Proposed life insurance that is to replace life insurance under a binding or conditional receipt issued by the same company;~~

~~(5) (e) Where the application is made to the existing insurer that issued the existing life insurance and a contractual change or conversion privilege is being exercised; or Policies or contracts used to fund:~~

~~(i) an employee pension or welfare benefit plan that is~~

covered by the Employee Retirement and Income Security Act (ERISA);

(ii) a plan described by section 401(a), 401(k) or 403(b) of the Internal Revenue Code, where the plan, for purposes of ERISA, is established or maintained by an employer;

(iii) a governmental or church plan defined in section 414, a governmental or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under section 457 of the Internal Revenue Code; or

(iv) a nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor.

(f) Notwithstanding (e), this subchapter shall apply to policies or contracts used to fund any plan or arrangement that is funded solely by contributions an employee elects to make, whether on a pre-tax or after-tax basis, and where the insurance company has been notified that plan participants may choose from among 2 or more annuity providers or policy providers and there is a direct solicitation of an individual employee by an insurance producer for the purchase of a contract or policy. As used in this rule, direct solicitation shall not include any group meeting held by an insurance producer solely for the purpose of educating individuals about the plan or arrangement or enrolling individuals in the plan or arrangement;

~~(g) When the existing life insurance is a non-convertible term life insurance policy which will expire in five years or less and cannot be renewed. Where new coverage is provided under a life insurance policy or contract and the cost is borne wholly by the insured's employer or by an association for which the insured is a member; or~~

(h) Existing life insurance that is a non-convertible term life insurance policy that will expire in 5 years or less and cannot be renewed.

AUTH: Sec. 33-1-313, MCA

IMP: Sec. 33-18-204, MCA

~~6.6.305 DUTIES OF AGENTS PRODUCERS-~~ (1) ~~Each agent shall submit to the replacing insurer with or as part of each application for life insurance: A producer who initiates an application shall submit to the insurer, with or as part of the application, a statement signed by both the applicant and the producer as to whether the applicant has existing policies or contracts. If the answer is "no," the producer's duties with respect to replacement are complete.~~

~~(a) A statement signed by the applicant as to whether or not such insurance will replace existing life insurance; and~~

~~(b) A signed statement as to whether or not the agent~~

~~knows replacement is or may be involved in the transaction.~~

~~(2) Where a replacement is involved, the agent shall: If the applicant answered "yes" to the question regarding existing coverage referred to in (1), the producer shall present and read to the applicant, not later than at the time of taking the application, a notice regarding replacements in the form as described in Appendix A or other substantially similar form approved by the commissioner. The notice shall be completed and signed by both the applicant and the producer attesting that the notice has been read aloud by the producer or that the applicant did not wish the notice to be read aloud (in which case the producer need not have read the notice aloud) and left with the applicant.~~

~~(a) Obtain with or as part of each application a list of all existing life insurance to be replaced. Such existing life insurance shall be identified by name of insurer and the policy number. In the event that a policy number has not been assigned by the existing insurer, alternative identification information, such as an application or receipt number, must be listed.~~

~~(b) Present to the applicant, not later than at the time of taking the application, a "Notice Regarding Replacement of Life Insurance" in the form substantially as described in 6.6.310(1) or (2) Sample form A or B, whichever is applicable. The notice must be signed by the agent and receipt of it acknowledged by the applicant. A copy of the notice must be left with the applicant.~~

~~(c) Submit to the replacing insurer with the application, a copy of the "Notice Regarding replacement of Life Insurance", signed by the agent and receipt of it acknowledged by the applicant and a separate statement including the information described in (2)(a) unless such information is included in the application.~~

~~(3) The notice shall list all life insurance policies or annuities proposed to be replaced, properly identified by name of insurer, the insured or annuitant, and policy or contract number if available; and shall include a statement as to whether each policy or contract will be replaced or whether a policy will be used as a source of financing for the new policy or contract. If a policy or contract number has not been issued by the existing insurer, alternative identification, such as an application or receipt number, shall be listed.~~

~~(4) In connection with a replacement transaction the producer shall leave with the applicant at the time an application for a new policy or contract is completed the original or a copy of all sales material. With respect to electronically presented sales material, it shall be provided to the policyholder in printed form no later than at the time of policy or contract delivery.~~

(5) Except as provided in [RULE I], in connection with a replacement transaction the producer shall submit to the insurer to which an application for a policy or contract is presented, a copy of each document required by this rule, a statement identifying any preprinted or electronically presented company approved sales materials used, and copies of any individualized sales materials, including any illustrations used in the transaction.

AUTH: Sec. 33-1-313, MCA
IMP: Sec. 33-18-204, MCA

6.6.306 DUTIES OF REPLACING INSURERS THAT USE PRODUCERS-

(1) ~~Each~~ Where a replacement is involved in the transaction, the replacing insurer shall:

~~(1) (a) Inform its field representatives of the requirements of this sub chapter. Verify that the required forms are received and are in compliance with this subchapter;~~

(b) Notify any other existing insurer that may be affected by the proposed replacement within 5 business days of receipt of a completed application indicating replacement or when the replacement is identified if not indicated on the application, and mail a copy of the available illustration or policy summary for the proposed policy or available disclosure document for the proposed contract within 5 business days of a request from an existing insurer;

(c) Retain copies of the notification regarding replacement required in ARM 6.6.305(2), indexed by producer, in its home or regional office for at least 5 years or until the next regular examination by the insurance department of a company's state of domicile, whichever is later; and

(d) Provide to the policy or contract owner notice of the right to return the policy or contract within 30 days of the delivery of the contract and receive an unconditional full refund of all premiums or considerations paid on it, including any policy fees or charges or, in the case of a variable or market value adjustment policy or contract, a payment of the cash surrender value provided under the policy or contract plus the fees and other charges deducted from the gross premiums or considerations or imposed under such policy or contract.

(2) ~~Require with or as part of each completed application for life insurance:~~ In transactions where the replacing insurer and the existing insurer are the same or subsidiaries or affiliates under common ownership or control, allow credit for the period of time that has elapsed under the replaced policy's or contract's incontestability and suicide period up to the face amount of the existing policy or contract. With regard to financed purchases the credit may be limited to the amount the face amount of the existing policy

is reduced by the use of existing policy values to fund the new policy or contract.

~~(a) A statement signed by the applicant as to whether or not such insurance will replace existing life insurance; and~~

~~(b) A statement signed by the agent as to whether or not he or she knows replacement is or may be involved in the transaction.~~

(3) Where a replacement is involved If an insurer prohibits the use of sales material other than that approved by the company, as an alternative to the requirements of ARM 6.6.305(5) the insurer may:

(a) Require with or as part of each application for life insurance a list of all of the applicant's existing life insurance to be replaced. Such existing life insurance shall be identified by name of insurer and the policy number. In the event that a policy number has not been assigned by the existing insurer, alternative identification information, such as an application or receipt number, must be listed. Require with each application a statement signed by the producer that:

(i) Represents that the producer used only company-approved sales material;

(ii) Lists, by identifying number or other descriptive language, the sales material that was used; and

(iii) States that copies of all sales material were left with the applicant in accordance with ARM 6.6.305(4); and

(b) Require from the agent with the application for life insurance a copy of the "Notice Regarding Replacement of Life Insurance" signed by the agent and receipt of it acknowledged by the applicant, and a copy of all sales proposals used for presentation to the applicant. Within 10 days of the issuance of the policy or contract:

(i) Notify the applicant by sending a letter or by verbal communication with the applicant by a person whose duties are separate from the marketing area of the insurer, that the producer has represented that copies of all sales material have been left with the applicant in accordance with ARM 6.6.305(4);

(ii) Provide the applicant with a toll free number to contact company personnel involved in the compliance function if such is not the case; and

(iii) Stress the importance of retaining copies of the sales material for future reference;

(c) Unless otherwise modified by the provisions of (3)(d) or (3)(e) furnish to the applicant a Policy Summary in accordance with the provisions of the Life Insurance Solicitation Regulation (Sub Chapter 2). Keep a copy of the letter or other verification in the policy file at the home or regional office for at least 5 years after the termination or expiration of the policy or contract; and

~~(d) Delay, if it is not also the existing insurer, the~~

~~issue of its policy for twenty days after it sends the existing insurer a written communication that includes the name of the insured, the identification information with respect to the existing life insurance to be replaced that is obtained pursuant to (3)(a), and a copy of the policy summary, unless it provides in its "Notice Regarding Replacement of Life Insurance" and in either its policy or in a separate written notice that is delivered with the policy that the applicant has a right to an unconditional refund of all premiums paid, which right may be exercised within a period of twenty days commencing from the date of delivery of the policy, and it sends the written communication required by this rule to the existing insurer within 3 working days of the date its policy is issued, in which event the replacing insurer may issue its policy immediately.~~

~~(e) (d) Provide, if it is also the existing insurer, the policyowner a Ppolicy Ssummary for the new policy prepared in accordance with (3)(e), prior to accepting the applicant's initial premium or premium deposit. , unless the replacing insurer provides in its "Notice Regarding Replacement of Life Insurance" and in either its policy or in separate written notice that is delivered with the policy that the applicant has a right to an unconditional refund of all premiums paid, which right may be exercised within a period of 20 days commencing from the date of delivery of the policy, in which event, the replacing insurer must furnish the Policy Summary at or prior to delivery of the policy.~~

~~(f) Maintain copies of the written communication required by (3)(d), the "Notice Regarding Replacement of Life Insurance", the policy summary, and all sales proposals used, and a replacement register, cross indexed, by replacing agent and existing insurer to be replaced, for at least three years or until the conclusion of the next succeeding regular examination by the insurance department of its state of domicile, whichever is later.~~

AUTH: Sec. 33-1-313, MCA
IMP: Sec. 33-18-204, MCA

6.6.307 DUTIES OF INSURERS WITH RESPECT TO DIRECT-RESPONSE SALES. ~~Each insurer shall:~~ (1) ~~Inform its responsible personnel of the requirements of this sub chapter~~
In the case of an application that is initiated as a result of a direct response solicitation, the insurer shall require, with or as part of each completed application for a policy or contract, a statement asking whether the applicant, by applying for the proposed policy or contract, intends to replace, discontinue or change an existing policy or contract.
If the applicant indicates a replacement or change is not intended or if the applicant fails to respond to the

statement, the insurer shall send the applicant, with the policy or contract, a notice regarding replacement in Appendix B, or other substantially similar form approved by the commissioner.

(2) Require with or as part of each completed application for life insurance a statement signed by the applicant as to whether or not such insurance will replace existing life insurance. If the insurer has proposed the replacement or if the applicant indicates a replacement is intended and the insurer continues with the replacement, the insurer shall:

(a) Provide to applicants or prospective applicants with the policy or contract a notice, as described in Appendix C, or other substantially similar form approved by the commissioner. In these instances the insurer may delete the references to the producer, including the producer's signature, without having to obtain approval of the form from the commissioner. The insurer's obligation to obtain the applicant's signature shall be satisfied if it can demonstrate that it has made a diligent effort to secure a signed copy of the notice referred to in this rule. The requirement to make a diligent effort shall be deemed satisfied if the insurer includes in the mailing a self-addressed postage prepaid envelope with instructions for the return of the signed notice referred to in this rule; and

(b) Comply with the requirements of ARM 6.6.306(1)(b), if the applicant furnishes the names of the existing insurers, and the requirements of ARM 6.6.306(1)(c), (1)(d) and (2).

(3) Where no replacement is proposed by an insurer in the solicitation of a direct response sale and a replacement is involved:

(a) At the time the policy is mailed to the applicant, include a "Notice Regarding Replacement of Life Insurance" in a form substantially as described in 6.6.310(3) Sample form C.

(4) Where a replacement is proposed by an insurer in the solicitation of a direct response sale a replacement is involved:

(a) Request from the applicant with or as part of the application a list of all existing life insurance to be replaced. Such existing life insurance shall be identified by the name of insurer.

(b) If the applicant furnishes the name of the existing insurers, then the replacing direct response insurer shall mail the applicant a "Notice Regarding Replacement of Life Insurance" in a form substantially as described in 6.6.310(3) Sample form C within three working days after receipt of the application and shall comply with all of the provisions of 6.6.306(3)(c)(d)(e) and (f), except that it need not maintain a replacement register required by 6.6.306(3)(f).

(c) If the applicant does not furnish the names of the

~~existing insurers, then the replacing direct response insurer shall at the time the policy is mailed to the applicant, include a "Notice Regarding Replacement of Life Insurance" in a form substantially as described in 6.6.310(3) Sample form C.~~

AUTH: Sec. 33-1-313, MCA
IMP: Sec. 33-18-204, MCA

~~6.6.308 DUTIES OF THE EXISTING INSURER. Each existing insurer which undertakes a conservation effort shall:~~

~~(1) Furnish the policyowner with a policy summary for the existing life insurance within twenty days from the date it receives the written communication required by 6.6.306(3)(d) from the replacing insurer. Such policy summary shall be completed in accordance with the provisions of the Life Insurance Solicitation Regulation, (Sub Chapter 2) except that information relating to premiums, cash values, death benefits and dividends, if any shall be computed from the current policy year of the existing life insurance. The policy summary shall include the amount of any outstanding policy indebtedness, the sum of any other dividend, accumulations or additions, and may include any other information that is not in violation of any regulation or statute. Life insurance cost index and equivalent level annual dividend figures need not be included in the policy summary. If index figures are included in the policy summary, the policyowner must be notified at the time the policy summary is delivered that such figures should only be used for comparing the relative costs of similar policies.~~

~~(2) Furnish the replacing insurer with a copy of the policy summary for the existing life insurance within three working days of the date that the policy summary is sent by the existing insurer to either its agent or directly to the policyowner.~~

~~(3) Maintain a file containing the following:~~

~~(a) Written communication required by 6.6.306(3)(d) received from replacing insurers; and~~

~~(b) Copies of policy summaries prepared pursuant to (1) and all sales proposals used.~~

~~This material shall be indexed by replacing insurer and held for three years or until the conclusion of the next regular examination conducted by the insurance department of its domicile whichever is later. (1) Where a replacement is involved in the transaction, the existing insurer shall:~~

~~(a) Upon notice that its existing policy or contract may be replaced or a policy may be part of a financed purchase, retain copies of the notification in its home or regional office, indexed by replacing insurer, notifying it of the replacement for at least 5 years or until the conclusion of the next regular examination conducted by the insurance~~

department of its state of domicile, whichever is later;

(b) Send a letter to the policy or contract owner of the right to receive information regarding the existing policy or contract values including, if available, an in force illustration or policy summary if an in force illustration cannot be produced within 5 business days of receipt of a notice that an existing policy or contract is being replaced. The information shall be provided within 5 business days of receipt of the request from the policy or contract owner;

(c) Upon receipt of a request to borrow, surrender or withdraw any policy or contract values, send to the applicant a notice, advising the policy or contract owner of the effect release of policy or contract values will have on the non-guaranteed elements, face amount or surrender value of the policy or contract from which the values are released. The notice shall be sent separate from the check if the check is sent to anyone other than the policy or contract owner. In the case of consecutive automatic premium loans or systematic withdrawals from a contract, the insurer is only required to send the notice at the time of the first loan or withdrawal.

AUTH: Sec. 33-1-313, MCA

IMP: Sec. 33-18-204, MCA

6.6.309 VIOLATIONS AND PENALTIES- (1) ~~Any insurer, agent, representative, officer or employee of such insurer failing to comply with the requirements of this sub chapter shall be subject to such penalties as may be appropriate under the Insurance Laws of Montana. The following practices shall be considered violations of this subchapter:~~

(a) Any deceptive or misleading information set forth in sales material;

(b) Failing to ask the applicant in completing the application the pertinent questions regarding the possibility of financing or replacement;

(c) The intentional incorrect recording of an answer;

(d) Advising an applicant to respond negatively to any question regarding replacement in order to prevent notice to the existing insurer; or

(e) Advising a policy or contract owner to write directly to the company in such a way as to attempt to obscure the identity of the replacing producer or company.

~~(2) This sub chapter does not prohibit the use of additional material other than that which is required that is not in violation of this sub chapter or any other Montana statute or regulation.~~

~~(3) (2) Policyowners~~ Policy and contract owners have the right to replace existing life insurance policies or annuity contracts after indicating in or as part of the applications for new coverage that replacement life insurance that such is

not their intention; however, patterns of such action by ~~policyowners~~ policy or contract owners of the same producer who purchase the replacing policies from the same agent shall be deemed prima-facie evidence of the ~~agent's~~ producer's knowledge that replacement was intended in connection with the ~~sale of those policies, and such patterns or identified transactions,~~ and these patterns of action shall be deemed prima-facie evidence of the ~~agent's~~ producer's intent to violate this subchapter.

(3) Where it is determined that the requirements of this subchapter have not been met, the replacing insurer shall provide to the policy owner an in force illustration if available or policy summary for the replacement policy or available disclosure document for the replacement contract and the notice regarding replacements in Appendix A.

(4) Violations of this subchapter may subject the violators to penalties that may include the revocation or suspension of a producer's or company's license, monetary fines and the forfeiture of any commissions or compensation paid to a producer as a result of the transaction in connection with which the violations occurred. In addition, where the commissioner has determined that the violations were material to the sale, the insurer may be required to make restitution, restore policy or contract values and pay interest.

AUTH: Sec. 33-1-313, MCA
IMP: Sec. 33-18-204, MCA

3. ARM 6.6.310 SAMPLE FORMS, the rule proposed for repeal, is found at page 6-112 of the ARM.

AUTH: Sec. 33-1-313, MCA
IMP: Sec. 33-18-204, MCA

4. The new rule proposed for adoption provides as follows:

RULE I DUTIES OF ALL INSURERS THAT USE PRODUCERS

(1) Each insurer shall:

(a) Maintain a system of supervision and control to insure compliance with the requirements of this subchapter that shall include at least the following:

(i) Inform its producers of the requirements of this subchapter and incorporate the requirements of the subchapter into all relevant producer training manuals prepared by the insurer;

(ii) Provide to each producer a written statement of the company's position with respect to the acceptability of replacements providing guidance to its producer as to the appropriateness of these transactions;

(iii) A system to review the appropriateness of each replacement transaction that the producer does not indicate is in accord with (a)(ii);

(iv) Procedures to confirm that the requirements of this subchapter have been met; and

(v) Procedures to detect transactions that are replacements of existing policies or contracts by the existing insurer, but that have not been identified as such by the applicant or producer.

(b) Have the capacity to produce, upon request, and make available to the insurance department, records of each producer's:

(i) Replacements, including financed purchases, as a percentage of the producer's total annual sales for life insurance and annuity contracts not exempted from this subchapter;

(ii) Number of lapses of policies and contracts by the producer as a percentage of the producer's total annual sales of life insurance and annuity contracts not exempted from this subchapter;

(iii) Number of transactions that are unidentified replacements of existing policies or contracts by the existing insurer detected by the company's monitoring system as required by (a)(v) of this rule; and

(iv) Replacements, indexed by replacing producer and existing insurer.

(c) Require with or as a part of each application for life insurance or an annuity a signed statement by both the applicant and the producer as to whether the applicant has existing policies or contracts;

(d) Require with each application for life insurance or an annuity that indicates an existing policy or contract a completed notice regarding replacements as contained in Appendix A;

(e) When the applicant has existing policies or contracts, retain completed and signed copies of the notice regarding replacements in its home or regional office for at least 5 years after the termination or expiration of the proposed policy or contract;

(f) When the applicant has existing policies or contracts, obtain and retain copies of any sales material as required by ARM 6.6.305(5), the basic illustration and any supplemental illustrations used in the sale and the producer's and applicant's signed statements with respect to financing and replacement in its home or regional office for at least 5 years after the termination or expiration of the proposed policy or contract;

(g) Ascertain that the sales material and illustrations used in the replacement meet the requirements of this subchapter and are complete and accurate for the proposed

policy or contract; and

(h) If an application does not meet the requirements of this subchapter, notify the producer and applicant and fulfill the outstanding requirements.

5. The following Appendices A through D are all new text. These will be appendices to ARM Title 6, Chapter 6, Subchapter 3.

APPENDIX A

IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES
This document must be completed and signed
by the applicant and the producer, if there is one,
and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy or contract and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract?
 YES NO

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new

policy or contract?
___ YES ___ NO

If you answered "Yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured, and the contract number if available) and whether each policy will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. [If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer.] Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____.

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant's Signature and Printed Name Date

Producer's Signature and Printed Name Date

I do not want this notice read aloud to me. _____
(Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS: Are they affordable?
 Could they change?
 You're older--are premiums higher for the
 proposed new policy?
 How long will you have to pay premiums on the
 new policy? On the old policy?

POLICY VALUES: New policies usually take longer to build cash
 values and to pay dividends.
 Acquisition costs for the old policy may have
 been paid, you will incur costs for the new
 one.
 What surrender charges do the policies have?
 What expense and sales charges will you pay on
 the new policy?
 Does the new policy provide more insurance
 coverage?

INSURABILITY: If your health has changed since you bought
 your old policy, the new one could cost you
 more, or you could be turned down.
 You may need a medical exam for a new policy.
 [Claims on most new policies for up to the
 first two years can be denied based on
 inaccurate statements.
 Suicide limitations may begin anew on the new
 coverage.]

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

 How are premiums for both policies being paid?
 How will the premiums on your existing policy
 be affected?
 Will a loan be deducted from death benefits?
 What values from the old policy are being used
 to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?

What are the interest rate guarantees for the new contract?

Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?

Is this a tax free exchange? (See your tax advisor.)

Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

Will the existing insurer be willing to modify the old policy?

How does the quality and financial stability of the new company compare with your existing company?

APPENDIX B

NOTICE REGARDING REPLACEMENT
REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one? If you are, your decision could be a good one--or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed policy or contract's benefits.

Make sure you understand the facts. You should ask the company or agent that sold you your existing policy or contract to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

APPENDIX C

IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy or contract and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract?
 YES NO

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract?
 YES NO

Please list each existing policy or contract you are contemplating replacing (include the name of the insurer,

the insured, and the contract number if available) and whether each policy will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. [If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer.] Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant's Signature and Printed Name

Date

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS: Are they affordable?
 Could they change?
 You're older--are premiums higher for the
 proposed new policy?
 How long will you have to pay premiums on the
 new policy? On the old policy?

POLICY VALUES: New policies usually take longer to build cash
 values and to pay dividends.
 Acquisition costs for the old policy may have
 been paid, you will incur costs for the new
 one.
 What surrender charges do the policies have?
 What expense and sales charges will you pay on
 the new policy?
 Does the new policy provide more insurance
 coverage?

INSURABILITY: If your health has changed since you bought
 your old policy, the new one could cost you
 more, or you could be turned down.
 You may need a medical exam for a new policy.
 [Claims on most new policies for up to the
 first two years can be denied based on
 inaccurate statements.
 Suicide limitations may begin anew on the new
 coverage.]

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

 How are premiums for both policies being paid?
 How will the premiums on your existing policy
 be affected?
 Will a loan be deducted from death benefits?
 What values from the old policy are being used
 to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?

What are the interest rate guarantees for the new contract?

Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?

Is this a tax free exchange? (See your tax advisor.)

Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

Will the existing insurer be willing to modify the old policy?

How does the quality and financial stability of the new company compare with your existing company?

6. REASON: At the direction of the legislature and upon request of the insurance industry and consumer groups, this agency periodically reviews its rules to determine whether the rules are necessary and to make changes to better reflect what is happening in the market place. There have been some drafting changes to make the proposed rules consistent with changes made in the statutes and other rules such as referring to producers instead of agent. The substantive changes that were made close a loop hole that allowed replacement of annuities to be made without complying with the same requirements that were placed on replacement life insurance. Since the impact can in many instances be the same for replacement of annuities as life insurance, the present rules needed to be changed to reflect these present day changes in the market place in order to avoid consumer abuse.

7. Interested persons may present their data, views, or arguments, either orally or in writing, at the hearing. Written data, views, or arguments may also be submitted to Peter Funk, Attorney, State Auditor's Office, P.O. Box 4009, Helena, MT 59604-4009 and must be received no later than September 17, 1999.

8. The State Auditor's Office will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing. If you require an accommodation, contact the office no later than 5:00 p.m., September 7, 1999, to advise us as to the nature of the accommodation needed. Please contact Sandi Binstock, State Auditor's Office, P.O. Box 4009, Helena, MT 59604-4009; telephone (406) 444-1744; Montana Relay 1-800-332-6148; TDD (406) 444-3246; facsimile (406) 444-3497. Persons with disabilities who need an alternative accessible format of this document in order to participate in this rule-making process should contact Sandi Binstock.

9. Peter Funk, attorney, has been designated to preside over and conduct the hearing.

10. The State Auditor's Office maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the list shall make a written request which includes the name and mailing address of the person to receive notices and specifies whether the person wishes to receive notices regarding insurance rules, securities rules, or both. Such written request may be mailed or delivered to the State Auditor's Office, P.O. Box 4009, Helena, MT 59604, faxed to 406-444-3497, or may be made by completing a request

form at any rules hearing held by the State Auditor's Office.

11. The bill sponsor notice requirements of 2-4-392, MCA, do not apply.

MARK O'KEEFE, State Auditor
and Commissioner of Insurance

By: /s/ Frank Coté
Frank Coté
Deputy Insurance Commissioner

By: /s/ Gary Spaeth
Gary L. Spaeth
Rule Reviewer

Certified to the Secretary of State on July 12, 1999.

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

In the matter of the) NOTICE OF PROPOSED
amendment of rule) AMENDMENT
6.6.4102 pertaining to) NO PUBLIC HEARING
continuing education) CONTEMPLATED
fees.

TO: All Interested Persons

1. On August 30, 1999, the state auditor and commissioner of insurance proposes to amend Rule 6.6.4102 pertaining to continuing education fees.

2. The proposed amendments are as follows (new material is underlined; material to be deleted is interlined):

6.6.4102 CONTINUING EDUCATION FEES

~~(1) Licensees:~~

~~(a) Filing annual certification of course completion \$ 10.00~~

~~(b) Late renewal fee \$ 20.00~~

~~(c) The late renewal fee is separate and distinct from the annual certification of course completion fee. Licensees required to pay the late renewal fee in a given year must also pay the annual certification of course completion fee for that year.~~

~~(2) Sponsoring organizations:~~

~~(a) Submission of a course or program for review and initial biennial certification \$75.00~~

~~(b) Submission of a course or program by an individual Montana insurance producer or consultant for review and one-time approval \$25.00~~

~~(c) A maximum submission fee of \$1,500.00 may be charged a sponsoring organization during a biennium for initial review of courses.~~

~~(3) (1) Accredited educational institutions are exempt from fee requirements for courses provided for academic credit.~~

~~(4) All fees are non-refundable.~~

AUTH: Sec. 33-1-313, 33-2-708 and 33-17-1206, MCA
IMP: Sec. 33-2-708, 33-17-1204, 33-17-1205 and 33-17-1207, MCA

3. This amendment will become effective on January 1, 2000.

4. Rule 6.6.4102 is proposed for amendment due to the

passage of Senate Bill 132 during the 1999 Montana Legislative Session. Senate Bill 132 repealed most insurance fees including continuing education fees and replaced them with a single fee on insurance companies.

5. Interested parties may submit their data, views or arguments concerning the proposed amendment in writing to Sandi Binstock, Montana Insurance Department, P.O. Box 4009, Helena, Montana 59604, and must be received no later than August 26, 1999.

6. If a person who is directly affected by the proposed amendment wishes to express their data, views and arguments orally or in writing at a public hearing, they must make a written request for a hearing and submit this request along with any written comments they have to Sandi Binstock, Montana Insurance Department, P.O. Box 4009, Helena, Montana 59604. A written request for hearing must be received no later than August 26, 1999.

7. If the agency receives requests for a public hearing on the proposed amendment from either 10% or 25, whichever is less, of the persons who are directly affected by the proposed action; from the administrative rule review committee of the legislature; from a governmental subdivision or agency; or from an association having not less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of those persons directly affected has been determined to be 50 persons based on the 500 persons who have indicated interest in the rules of this agency and who the agency has determined could be directly affected by these rules.

8. The State Auditor's Office maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the list shall make a written request which includes the name and mailing address of the person to receive notices and specifies whether the person wishes to receive notices regarding insurance rules, securities rules, or both. Such written requests may be mailed or delivered to the State Auditor's Office, P.O. Box 4009, Helena, MT 59604, faxed to the office at 406-444-3497, or may be made by completing a request form at any rules hearing held by the State Auditor's Office.

MARK O'KEEFE, State Auditor
and Commissioner of Insurance

By: /s/ Frank Coté
Frank Coté
Deputy Insurance Commissioner

By: /s/ Gary Spaeth
Gary L. Spaeth
Rule Reviewer

Certified to the Secretary of State on July 12, 1999.

BEFORE THE BOARD OF ENVIRONMENTAL REVIEW
OF THE STATE OF MONTANA

In the matter of the amendment) NOTICE OF PUBLIC HEARING ON
of ARM 17.30.602, 17.30.622) PROPOSED AMENDMENT
through 17.30.629, 17.30.702,)
and 17.30.1001 pertaining to)
trigger values) (WATER QUALITY)

TO: All Concerned Persons

1. On August 23, 1999, at 9 a.m. in Room 111 of the Metcalf Building, 1520 East Sixth Avenue, Helena, Montana, the Board of Environmental Review will hold a public hearing to consider the proposed amendment of the above-captioned rules.

2. The Board will make reasonable accommodations for persons with disabilities who wish to participate in this hearing or need an alternative accessible format of this notice. If you require an accommodation, contact the Board no later than 5 p.m., August 13, 1999, to advise us of the nature of the accommodation you need. Please contact the Board at P.O. Box 200901, Helena, Montana, 59620-0901; phone (406) 444-2544; fax (406) 444-4386.

3. The rules proposed to be amended provide as follows. Text of present rule with matter to be stricken interlined and new matter underlined.

17.30.602 DEFINITIONS In this subchapter the following terms have the meanings indicated below and are supplemental to the definitions given in 75-5-103, MCA:

(1) through (29) Remain the same.

(30) The board hereby adopts and incorporates by reference department Circular WQB-7, entitled "Montana Numeric Water Quality Standards" (~~November 1998~~ June 1999 edition), which establishes limits for toxic, carcinogenic, bioconcentrating, nutrient, and harmful parameters in water. Copies of Circular WQB-7 may be obtained from the Department of Environmental Quality, PO Box 200901, Helena, MT 59620-0901.

(31) remains the same.

AUTH: 75-5-201, 75-5-301, MCA

IMP: 75-5-301, MCA

17.30.622 A-1 CLASSIFICATION STANDARDS (1) through (3) remain the same.

(4) The board hereby adopts and incorporates by reference the following:

(a) department Circular WQB-7, entitled "Montana Numeric Water Quality Standards" (~~November 1998~~ June 1999 edition), which establishes limits for toxic, carcinogenic, bioconcentrating, nutrient, and harmful parameters in water; and

(b) and (c) remain the same.

AUTH: 75-5-201, 75-5-301, MCA

IMP: 75-5-301, MCA

17.30.623 B-1 CLASSIFICATION STANDARDS (1) and (2) remain the same.

(3) The board hereby adopts and incorporates by reference the following:

(a) department Circular WQB-7, entitled "Montana Numeric Water Quality Standards" (~~November 1998~~ June 1999 edition), which establishes standards for toxic, carcinogenic, bioconcentrating, nutrient, and harmful parameters in water; and

(b) and (c) remain the same.

AUTH: 75-5-201, 75-5-301, MCA

IMP: 75-5-301, MCA

17.30.624 B-2 CLASSIFICATION STANDARDS (1) and (2) remain the same.

(3) The board hereby adopts and incorporates by reference the following:

(a) department Circular WQB-7, entitled "Montana Numeric Water Quality Standards" (~~November 1998~~ June 1999 edition), which establishes standards for toxic, carcinogenic, bioconcentrating, nutrient, and harmful parameters in water; and

(b) and (c) remain the same.

AUTH: 75-5-201, 75-5-301, MCA

IMP: 75-5-301, MCA

17.30.625 B-3 CLASSIFICATION STANDARDS (1) and (2) remain the same.

(3) The board hereby adopts and incorporates by reference the following:

(a) department Circular WQB-7, entitled "Montana Numeric Water Quality Standards" (~~November 1998~~ June 1999 edition), which establishes standards for toxic, carcinogenic,

bioconcentrating, nutrient, and harmful parameters in water;
and

(b) and (c) remain the same.

AUTH: 75-5-201, 75-5-301, MCA

IMP: 75-5-301, MCA

17.30.626 C-1 CLASSIFICATION STANDARDS (1) and (2)
remain the same.

(3) The board hereby adopts and incorporates by
reference the following:

(a) department Circular WQB-7, entitled "Montana Numeric
Water Quality Standards" (~~November 1998~~ June 1999 edition),
which establishes standards for toxic, carcinogenic,
bioconcentrating, nutrient, and harmful parameters in water;
and

(b) and (c) remain the same.

AUTH: 75-5-201, 75-5-301, MCA

IMP: 75-5-301, MCA

17.30.627 C-2 CLASSIFICATION STANDARDS (1) and (2)
remain the same.

(3) The board hereby adopts and incorporates by
reference the following:

(a) department Circular WQB-7, entitled "Montana Numeric
Water Quality Standards" (~~November 1998~~ June 1999 edition),
which establishes standards for toxic, carcinogenic,
bioconcentrating, nutrient, and harmful parameters in water;
and

(b) and (c) remain the same.

AUTH: 75-5-201, 75-5-301, MCA

IMP: 75-5-301, MCA

17.30.628 I CLASSIFICATION STANDARDS (1) and (2)
remain the same.

(3) The board hereby adopts and incorporates by
reference the following:

(a) department Circular WQB-7, entitled "Montana Numeric
Water Quality Standards" (~~November 1998~~ June 1999 edition),
which establishes standards for toxic, carcinogenic,
bioconcentrating, nutrient, and harmful parameters in water;
and

(b) and (c) remain the same.

AUTH: 75-5-201, 75-5-301, MCA

IMP: 75-5-301, MCA

17.30.629 C-3 CLASSIFICATION STANDARDS (1) and (2) remain the same.

(3) The board hereby adopts and incorporates by reference the following:

(a) department Circular WQB-7, entitled "Montana Numeric Water Quality Standards" (~~November 1998~~ June 1999 edition), which establishes standards for toxic, carcinogenic, bioconcentrating, nutrient, and harmful parameters in water; and

(b) and (c) remain the same.

AUTH: 75-5-201, 75-5-301, MCA

IMP: 75-5-301, MCA

17.30.702 DEFINITIONS Unless the context clearly states otherwise, the following definitions, in addition to those in 75-5-103, MCA, apply throughout this subchapter (Note: 75-5-103, MCA, includes definitions for "degradation", "existing uses", "high quality waters", and "parameter."):

(1) through (23) remain the same.

(24)(a) The board hereby adopts and incorporates by reference:

(i) department Circular WQB-7, entitled "Montana Numeric Water Quality Standards" (~~November 1998~~ June 1999 edition), which establishes limits for toxic, carcinogenic, bioconcentrating, nutrient, and harmful parameters in water; and

(ii) through (24)(b) remain the same.

AUTH: 75-5-301, 75-5-303, MCA

IMP: 75-5-303, MCA

17.30.1001 DEFINITIONS For the purpose of this subchapter, the following definitions, in addition to those in 75-5-103, MCA, will apply:

(1) through (14) remain the same.

(15) "WQB-7" means department Circular WQB-7, entitled "Montana Numeric Water Quality Standards" (~~November 1998~~ June 1999 edition), which establishes limits for toxic, carcinogenic, bioconcentrating, nutrient, and harmful parameters in water.

AUTH: 75-5-201, 75-5-401, MCA

IMP: 75-5-301, 75-5-401, MCA

4. The Board is proposing the amendment of ARM 17.30.602, 17.30.622 through 17.30.629, 17.30.702, and 17.30.1001 to incorporate by reference revisions to Montana's numeric water quality standards listed in department Circular WQB-7 (November 1998 edition). The Board is proposing to repeal the trigger values for seven parameters in WQB-7 that were disapproved by the U.S. Environmental Protection Agency (EPA) on December 24, 1998. EPA disapproved the use of the seven trigger values because EPA determined that those values were inappropriate for determining "significant" changes in water quality for purposes of complying with federal antidegradation requirements. The trigger values disapproved by EPA are for total residual chlorine, hexavalent chromium, cyanide, 4,6-dinitro-o-cresol, endosulfan I, methoxychlor and parathion. These values were determined to be inappropriate because they either exceed the applicable water quality standard or are set at levels that are one-quarter or one-half of the standard. If the Board does not correct or repeal the disapproved values within 90 days after disapproval, § 303(c) of the Clean Water Act requires EPA to promulgate replacement values for the State. Although the Board could refuse to make these changes, the Board has rejected this alternative because EPA action would eventually preempt the WQB-7 trigger values for the parameters anyway and because refusal would not be consistent with the state policy to maintain primacy in the area of water quality regulation.

Under Montana's nondegradation rules, "trigger values" are used to determine whether a proposed activity is "nonsignificant" based upon the criteria in ARM 17.30.715. The trigger values are either based upon the method detection level (MDL) or, when unavailable, the estimated detection level (EDL). In order to replace the disapproved trigger values with values acceptable to EPA, a comprehensive and time-consuming review of the analytical methods and detection limits would be required. Rather than delay correcting the disapproved values until an appropriate replacement value has been determined, the Board is proposing the repeal of the seven disapproved trigger values from WQB-7.

Removing the trigger values from WQB-7 will not have a significant impact upon the process of determining significance under ARM 17.30.715. For these parameters, determining nonsignificance can be conducted by comparing the concentration of the specific parameter at the edge of the mixing zone to 15% of the lowest applicable standard.

5. Concerned persons may submit their data, views or arguments concerning the proposed action either in writing or

orally at the hearing. Written data, views or arguments may also be submitted to the Board of Environmental Review, P.O. Box 200901, Helena, Montana, 59620-0901, no later than August 27, 1999. To be guaranteed consideration, the comments must be postmarked on or before that date.

6. James B. Wheelis, attorney for the Board, has been designated to preside over and conduct the hearing.

BOARD OF ENVIRONMENTAL REVIEW

by: /s/ Joe Gerbase

JOE GERBASE, Chairperson

Reviewed by:

/s/ John F. North
John F. North, Rule Reviewer

Certified to the Secretary of State July 12, 1999.

BEFORE THE BOARD OF ENVIRONMENTAL REVIEW
OF THE STATE OF MONTANA

In the matter of the amendment)	NOTICE OF PUBLIC HEARING ON
of ARM 17.30.105 and 17.30.637)	PROPOSED AMENDMENT
pertaining to certification)	
options and general)	
prohibitions to surface water)	
quality standards and)	(WATER QUALITY)
procedures)	

TO: All Concerned Persons

1. On August 24, 1999, at 9 a.m., or as soon thereafter as may be practicable, in Room 111 of the Metcalf Building, 1520 East Sixth Avenue, Helena, Montana, the Board of Environmental Review will hold a public hearing to consider the proposed amendment of the above-captioned rules.

2. The Board will make reasonable accommodations for persons with disabilities who wish to participate in this hearing or need an alternative accessible format of this notice. If you require an accommodation, contact the Board no later than 5 p.m., August 13, 1999, to advise us of the nature of the accommodation you need. Please contact the Board at P.O. Box 200901, Helena, Montana, 59620-0901; phone (406) 444-2544; fax (406) 444-4386.

3. The rules proposed to be amended provide as follows. Text of present rule with matter to be stricken interlined and new matter underlined.

17.30.105 DEPARTMENT CERTIFICATION OPTIONS (1) Upon
~~completing its review of an application, the department shall~~
Except as provided in (2), the department shall take one of the
following actions upon completing its review of an application
for certification submitted under this subchapter:

(a) remains the same.

(b) issue certification for any activity which the department finds will not result in a discharge that will violate any effluent limitation or water quality standard stated in or developed pursuant to ARM Title 17, chapter 30; or

(c) issue conditional certification for any activity that with the conditions imposed will not result in a discharge that will violate any effluent limitation or water quality standard stated in or developed pursuant to ARM Title 17, chapter 30; ~~or.~~

~~(d)~~ (2) The department may waive certification if the department finds that the activity will:

~~(i)~~ (a) cause minimal or no impacts to the quality of state waters; or

~~(ii)~~ (b) require an application for a Montana ~~point~~
pollutant discharge elimination system permit under ARM Title

17, chapter 30, subchapter 13, a Montana ground water pollution control system permit under ARM Title 17, chapter 30, subchapter 10, ~~or a short-term exemption from water quality standards under 75-5-308, MCA, or a short-term narrative water quality standard under 75-5-318, MCA~~ ARM 17.30.637(3)(a).

AUTH: 75-5-401, 75-5-318, MCA

IMP: 75-5-402, 75-5-403, 75-5-318, MCA

17.30.637 GENERAL PROHIBITIONS (1) through (2) remain the same.

~~(3) No wastes are to be discharged and no activities conducted which, either alone or in combination with other wastes or activities, will cause violations of surface water quality standards; provided, a short term exemption from a surface water quality standard may be authorized by the department under the following conditions:~~

~~(a) If the department of fish, wildlife and parks reviews a short term construction or hydraulic project under 87-5-501, et seq., MCA, or 75-7-101, et seq., MCA, an increase in turbidity caused by the project will be exempt from the applicable turbidity standard unless the department is advised by the department of fish, wildlife and parks that the project may result in a significant increase in turbidity. If the department is advised that the project may cause a significant increase in turbidity, the project will be exempt from the applicable turbidity standard only if it is carried out in accordance with conditions prescribed by the department in an ARM 17.30.637(3) authorization.~~

~~(i) An ARM 17.30.637(3) application form must be submitted to the department by the applicant and an ARM 17.30.637(3) authorization issued by the department prior to the day on which the applicant commences the short term construction or hydraulic project.~~

~~(b) If the department approves the location, timing, and methods of game fish population restoration authorized by the department of fish, wildlife and parks, restoration activities causing violations of surface water quality standards may be exempt from the standards.~~

~~(c) If a short term activity other than those described in (a) and (b) above causes unavoidable short term violations of the turbidity, total dissolved solids, or temperature standards, the activity is exempt from the standard if it is carried out in accordance with conditions prescribed by the department in an ARM 17.30.637(3) authorization form.~~

~~(i) An ARM 17.30.637(3) application form must be submitted to the department by the applicant and an ARM 17.30.637(3) authorization issued by the department prior to the day on which the applicant commences the short term activity.~~

(4) through (10) remain the same, but are renumbered (3)

through (9).

~~(11) On all public water supply watersheds, detailed plans and specifications for the construction and operation of logging roads will be submitted to the department for its approval as required by Title 75, chapter 6, MCA.~~

AUTH: 75-5-201, 75-5-301, 75-5-318, 75-6-112, MCA

IMP: 75-5-301, 75-5-318, 75-6-112, MCA

4. The Board is proposing the amendment of ARM 17.30.105 and 17.30.637 in response the enactment of Senate Bill 499 and Senate Bill 72 by the 1999 Montana Legislature. The Board is also proposing amendments to ARM 17.30.105 in order to provide the Department the discretion to require 401 certification for federally permitted discharges in instances where the department also requires a state-issued discharge permit, an authorization to exceed water quality standards, or an authorization to use short-term narrative standards.

In December 1998, the U.S. Environmental Protection Agency (EPA) disapproved certain portions of Montana's Water Quality Act during its review of Montana's revised water quality standards. One of the statutes disapproved by EPA is § 75-5-308, MCA, which formerly allowed short-term exemptions from water quality standards for pesticide application, emergency remediation activities, treatment of water supplies, and construction activities. EPA disapproved the portion of the statute that allowed short-term exemptions from water quality standards for stream construction projects and treatment of water supplies. As a result of EPA's disapproval, Chapter 588, Laws of 1999 (Senate Bill 499), amended § 75-5-308, MCA, to eliminate the Department's authority to authorize short-term exemptions from water quality standards for stream-related construction activities and treatment of water supplies. ARM 17.30.637(3), which implements § 75-5-308, MCA, is being deleted, because it is no longer consistent with the Department's lack of authority to authorize exemptions for stream construction projects.

Chapter 588, Laws of 1999, also amended Montana's Water Quality Act by enacting a new provision that allows the Department to authorize short-term narrative standards for stream-related construction activities. Due to the legislative changes made to § 75-5-308, MCA, and the enactment of statutory authority for the Department to authorize short-term narrative standards for stream construction activities, ARM 17.30.105(1)(d)(ii) is being amended to reflect these changes. As proposed, the Department may waive 401 certification if the Department requires: (1) a state-issued discharge permit; (2) a short-term exemption from water quality standards for pesticide application or remediation activities under § 75-5-308, MCA; or (3) a short-term narrative standard for stream-related

construction activities under § 75-5-318, MCA. The reference to exemptions authorized under ARM 17.30.637(3)(a) is being deleted as the authority to allow exemptions from standards for construction activities has been eliminated by the amendments to § 75-5-308, MCA. These changes are necessary in order to be consistent with the legislative amendments to the Water Quality Act contained in Senate Bill 499.

The Board is also proposing to amend ARM 17.30.105 to provide the Department the option of waiving 401 certification, rather than requiring a waiver when it requires a state authorization or permit. ARM 17.30.105 describes the options that the Department may take after completing its review of applications requesting 401 certification pursuant to the federal Clean Water Act (CWA). Section 401 of the CWA requires a person who is applying for a federal license or permit that may result in a discharge to surface water to obtain certification from the State that the discharge will comply with the State's water quality standards and effluent limitations. As currently written, the Department is required to waive its ability to impose conditions in the federal permit during the certification process, if the Department requires the applicant to obtain a state-issued discharge permit or requires the applicant to obtain a short-term exemption from water quality standards under ARM 17.30.637(3)(a).

The proposed amendment would eliminate the requirement to waive 401 certification of a federal permit if the Department also requires a state-issued discharge permit or authorization. This amendment is proposed to allow the Department to impose certification conditions that will be placed in the federal permit. Although the Department has authority to place these conditions in its permit or authorization, placement in the federal permit will provide an additional inspection and enforcement mechanism to further ensure compliance.

ARM 17.30.105 is also being amended to correct an error in the reference to Montana's discharge permits.

Section 7 of Chapter 195, Laws of 1999 (Senate Bill 72), amended § 75-6-112(3), MCA, in Montana's Public Water Supply Act by removing the prohibition against logging road construction in public water supply watersheds unless detailed plans and specifications were submitted to the Department. The Board is proposing to delete ARM 17.30.637(11), because there is no longer a requirement for plans and specifications in the law.

5. Concerned persons may submit their data, views or arguments concerning the proposed action either in writing or orally at the hearing. Written data, views or arguments may also be submitted to the Board of Environmental Review, P.O. Box 200901, Helena, Montana, 59620-0901, no later than August 28, 1999. To be guaranteed consideration, the comments must be postmarked on or before that date.

6. James B. Wheelis, attorney for the Board, has been designated to preside over and conduct the hearing.

Reviewed by: BOARD OF ENVIRONMENTAL REVIEW

/s/ John F. North
John F. North
Rule Reviewer

by: /s/ Joe Gerbase
JOE GERBASE, Chairperson

Certified to the Secretary of State July 12, 1999.

BEFORE THE BOARD OF ENVIRONMENTAL REVIEW
OF THE STATE OF MONTANA

In the matter of the amendment)	NOTICE OF PUBLIC HEARING ON
of ARM 17.8.504 and 17.8.505,)	PROPOSED AMENDMENT
pertaining to air quality)	
permit application and)	(AIR QUALITY)
operation fees)	

TO: All Concerned Persons

1. On August 13, 1999, at 1:30 p.m. in Room 35 of the Metcalf Building, 1520 East Sixth Avenue, Helena, Montana, the Board of Environmental Review will hold a public hearing to consider the proposed amendment of the above-captioned rules.

2. The Board will make reasonable accommodations for persons with disabilities who wish to participate in this hearing or need an alternative accessible format of this notice. If you require an accommodation, contact the Board no later than 5 p.m., August 2, 1999, to advise us of the nature of the accommodation you need. Please contact the Board at P.O. Box 200901, Helena, Montana, 59620-0901; phone (406) 444-2544; fax (406) 444-4386.

3. The rules proposed to be amended provide as follows. Text of present rule with matter to be stricken interlined and new matter underlined.

17.8.504 AIR QUALITY PERMIT APPLICATION FEES

(1) remains the same.

(2) A permit application is incomplete until the proper application fee is paid to the department. If a fee submitted with an air quality permit application is insufficient, the department shall notify the applicant in writing of the appropriate fee that must be submitted for the application to be processed under ARM 17.8.720(2). If the fee assessment is appealed to the board pursuant to ARM 17.8.511, and if the fee deficiency is not corrected by the applicant, the permit application is incomplete until issuance of the board's decision or until completion of any judicial review of the board's decision. Upon final disposition of an appeal, any portion of the fee due to the department or the applicant must be paid immediately.

(3) An air quality permit application fee is separate and distinct from any air quality operation fee required to be submitted to the department pursuant to ARM 17.8.505. ~~However, the department may not assess more than 1 fee simultaneously.~~

~~(4) The air quality permit application fee is based on the estimated amount of air pollutants to be emitted annually from the source of air contaminants. The estimated amount of air pollutants to be emitted annually is determined according to the emissions inventory included in the permit application. A permit application fee may not be assessed for emissions covered by either an existing air quality permit or an air quality permit application which is pending at the time of the application and for which the appropriate fee has been paid. However, the department may assess the minimum fee for those permit applications that do not result in an increase in emissions.~~

~~(5) (4) The air quality permit application fee is: an administrative fee of \$454.42, plus \$14.15 per ton of PM 10, sulfur dioxide, lead, oxides of nitrogen and volatile organic compounds emitted.~~

~~(a) \$500.00 for applicants subject to only ARM Title 17, chapter 8, subchapter 7, at the time of application; or~~

~~(b) \$1,500.00 for applicants subject to ARM Title 17, chapter 8, subchapters 8, 9 or 10, at the time of application.~~

AUTH: 75-2-111, 75-2-220, MCA

IMP: 75-2-211, 75-2-220, MCA

17.8.505 AIR QUALITY OPERATION FEES (1) remains the same.

(2) Fees shall be assessed under this rule for all sources of air contaminants described above in (1) that are operating as of January 1 of the calendar year in which fees are billed.

(2) and (3) remain the same, but are renumbered (3) and (4).

~~(4) (5) The air quality operation fee is based on the actual, or estimated actual, amount of air pollutants emitted during the previous calendar year and is an administrative fee of \$367.88 \$400.00, plus \$14.15 \$20.86 per ton of PM-10, sulfur dioxide, lead, oxides of nitrogen and volatile organic compounds emitted, except that the total fee may not be greater than \$200,000 per permit.~~

(6) A separate air quality operation fee is assessed for each source of air contaminants under (1), except that a source of air contaminants may not be required to pay more than one administrative fee if the facility is subject to more than one air quality permit issued by the department. The fee charged may not exceed \$250,000.00.

~~(5) (7) An air quality operation fee is separate and distinct from any air quality permit application fee required~~

to be submitted to the department pursuant to ARM 17.8.504. ~~However, the department may not assess more than 1 fee simultaneously.~~

(6) and (7) remain the same, but are renumbered (8) and (9).

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

4. Pursuant to § 75-2-220, MCA, the Department of Environmental Quality may assess air quality permit application fees and air quality operation fees. In the aggregate, these fees must be sufficient to cover the Department's costs of developing and administering the permitting requirements of Title 75, Chapter 2, MCA, the Clean Air Act of Montana. The structure and amount of the fees is to be determined by the Board of Environmental Review, and ARM 17.8.510 requires the Board to annually review these air quality fees.

Air quality permit application fees are charged to all facilities that apply for an air quality permit pursuant to ARM Title 17, chapter 8, subchapters 7, 8, 9 or 10. Air quality operation fees are required for all facilities that hold an air quality permit, or that will be required to obtain an air quality permit pursuant to § 7661a of the federal Clean Air Act, the Title V operating permit program.

Presently, the permit application fee in ARM 17.8.504 includes a flat administrative charge of \$454.42 plus \$14.15 per ton of regulated pollutants emitted by the facility, based on the estimated annual emissions from the regulated facility. The Board is proposing to eliminate the per ton charge and assess \$500 for permit applicants subject to minor new source review and \$1,500 for permit applicants subject to major new source review.

Under ARM 17.8.505, the present air quality permit operation fees also include both a flat administrative charge and a uniform charge per ton of regulated pollutants emitted. The Board is proposing to increase the administrative charge from \$367.88 to \$400 and is proposing to increase the per ton charge from \$14.15 to \$20.86.

The amount of money the Department needs to generate through fees depends on the legislative appropriation and the amount of carryover available from the previous fiscal year. The emission component of the operation fee may also need adjustment to compensate for changes in the total amount of pollutants emitted in the state. The Department has calculated the amount of fee fund carryover from fiscal year

1999, and has calculated the total actual emissions from all regulated facilities. The proposed amendments to the air quality application and operation fees will generate sufficient fees to satisfy the legislative appropriation and adequately fund the Department's air quality program when the projected carryover funds and anticipated revenues are included.

The Board is proposing to delete the per ton charge from the air quality permit application fee and revise the flat administrative charge to account for deletion of the per ton charge. The Department has had difficulty determining the correct per ton charge for new sources of air contaminants because the charge has been based on estimates of expected emissions. Most applications have been deemed incomplete initially due to expected emissions being unknown at that time. Deleting the per ton charge would eliminate this difficulty.

For each fee, the flat administrative charge reflects the presumptive minimum department resources devoted to regulation of a facility by Department staff. The proposed permit application fees of \$500 and \$1,500 represent the Department's cost for the minimum time devoted to a preconstruction permit application review for the type of source covered by the respective fee. The administrative charge of \$400 proposed as part of the operation fee represents the Department's cost for the minimum time devoted to compliance monitoring activities associated with a regulated facility. The uniform charge per ton of regulated pollutant emitted, which the Board is proposing to retain as part of the air quality operating fee, is premised on the fact that many permitting and compliance activities are general in nature and are not specific to a particular pollutant or regulated facility.

Beyond a certain point additional emissions do not translate to additional source-specific Department staff workload. Accordingly, the air quality operation fee is capped at an amount that allows for sufficient funds to be collected, while ensuring that no single facility will pay a disproportionate amount. The Board is proposing to increase the cap from \$200,000 to \$250,000, commensurate with the general increase in air quality permit fees, to meet the legislature's appropriation.

The Board is proposing to delete language from ARM 17.8.504(3) and (4), and ARM 17.8.505(7). The existing language in ARM 17.8.504(3) and 17.8.505(5), prohibiting assessment of more than one air quality fee simultaneously, would no longer be applicable under the proposed amendments and the Board is proposing to delete that language. Air

quality permit application fees no longer would be based on emissions, so that ARM 17.8.504(4), regarding calculation of emissions for purposes of the application fee, also would no longer be applicable.

The Board is proposing to add a new ARM 17.8.505(2) to specify that the operating status of a facility at the beginning of the calendar year is the basis for determining whether an operation fee is due for that calendar year. Operating fees are not billed and collected until the end of the calendar year and it has been the Department's practice to require fees for the year from all regulated facilities that are operating on January 1. Specifying a particular date is necessary to provide facilities subject to the fees and the Department with notice of the facilities that will be required to pay the fees. Because fees are not assessed and paid until the end of the year for which they are assessed, specifying January 1 is necessary to ensure that the Department receives fees to fund the regulatory activities that have been conducted prior to fee collection at the end of the year. This amendment would not affect the amount of the operation fee, which may still be prorated to cover partial-year operation, pursuant to ARM 17.8.505(8), or which may change when fees are annually adjusted. This amendment would also create greater consistency between the date the obligation to pay operation fees is fixed and the use of prior calendar year emissions to determine the fee amount pursuant to ARM 17.8.505(5).

The Board is proposing several additional amendments to clarify the air quality permit fee rules. The Board is proposing to include a reference to ARM 17.8.720(2) in ARM 17.8.504 to tie the two corresponding provisions together. ARM 17.8.720(2) concerns the process involved in making an air quality permit completeness determination, and 17.8.504 provides that submission of an insufficient permit application fee may be grounds for finding an application to be incomplete. The amendment is necessary to provide readers with notice that both sections should be read together.

The Board is proposing to add a new ARM 17.8.505(6) to clarify that the operation fee is assessed for each facility obligated to pay the fee under ARM 17.8.505(1), but that a per ton charge is not assessed more than once if a facility is subject to more than one air quality permit issued by the Department. The new section would also provide that the operating fee cap applies to each facility, rather than each permit. ARM 17.8.505(4) presently provides a fee cap per permit. At least one facility in the state is subject to more than one air quality permit. These amendments are necessary

to avoid overcharging a facility for operation fees when the facility is subject to more than one air quality permit.

Pursuant to House Bill 194, enacted by the 1999 Montana Legislature and codified as an amendment to § 2-4-302, MCA, "[if] an agency proposes to adopt, increase, or decrease a monetary amount that a person shall pay or will receive, such as a fee, cost or benefit, the notice [of proposed rulemaking] must include an estimate, if known, of: (a) the cumulative amount for all persons of the proposed increase, decrease, or new amount; and (b) the number of persons affected."

For the proposed air quality permit application fees, it is estimated that 44 permit applicants would pay a total of \$24,000 in fees for calendar year 1999. This represents the same number of permit applicants and a net decrease of \$770 from 1998.

For the proposed air quality operation fees, it is estimated that 374 sources of air contaminants would pay a total of \$2,128,475 in fees for calendar year 1999. This represents 19 fewer sources, and an increase of \$567,119 from 1998.

5. Concerned persons may submit their data, views or arguments concerning the proposed action either in writing or orally at the hearing. Written data, views or arguments may also be submitted to the Board of Environmental Review, P.O. Box 200901, Helena, Montana, 59620-0901, no later than August 20, 1999. To be guaranteed consideration, the comments must be postmarked on or before that date.

6. James B. Wheelis, attorney for the Board, has been designated to preside over and conduct the hearing.

Reviewed by: BOARD OF ENVIRONMENTAL REVIEW

/s/ John F. North by: /s/ Joe Gerbase
John F. North, Rule Reviewer JOE GERBASE, Chairperson

Certified to the Secretary of State July 12, 1999.

BEFORE THE BOARD OF ENVIRONMENTAL REVIEW
OF THE STATE OF MONTANA

In the matter of the amendment)	
of rules 17.30.602, 17.30.622)	NOTICE OF
through 17.30.629, 17.30.702,)	SUPPLEMENTAL
and 17.30.1001 pertaining to)	COMMENT PERIOD
the Montana surface water)	
quality standards, the)	
nondegradation rules, and the)	
groundwater pollution control)	(Water Quality)
system rules)	

TO: All Concerned Persons

1. On March 25, 1999, the Board of Environmental Review published notice of the proposed amendment to ARM 17.30.602, 17.30.622 through 17.30.629, 17.30.702, and 17.30.1001 pertaining to dioxin standards at page 477 of the 1999 Montana Administrative Register, Issue No. 6. The proposed amendments deal with dioxin standards. The Board held a hearing on April 15, 1999. The comment period, as extended, closed on April 30, 1999.

Upon review of the written and oral comments received, the Board has identified 10 issues on which it has requested the Department to provide additional information. The Board is also inviting public comment on these and any other pertinent issues.

2. The issues on which the Board invites comment are:

(a) Would the use of the toxicity equivalency factor (TEF) method be appropriate given that some dioxin/furan congeners that do not have TEF values apparently impact important genetic process?

(b) Section 75-5-203, MCA, provides that the Board may not adopt a rule that is more stringent than comparable federal regulations or guidelines unless the Board makes certain findings. Are there federal regulations or guidelines that are comparable to the proposed dioxin standards? If so, are the proposed standards more stringent than the federal regulations or guidelines?

(c) Does 2,3,7,8-TCDD break down into other harmful dioxin/furans?

(d) In some instances many of the dioxin/furan congeners in a sample are reported as "not detected". What value should be used for calculating a TEF in these cases?

(e) Is the TEF method in conjunction with the dioxin standard and the common practice of using one half of the "detection limit" for analyses that are reported as less than values sensitive enough to determine compliance with permit limits and water quality standards in even the cleanest waters of the state?

(f) The department has referenced an EPA document published in March 1989 for the calculation of the dioxin TEF. That document is now 10 years old. Is it appropriate to use a 10 year-old document as the basis for the dioxin water quality standard?

(g) The TEF method for calculating the health risk associated with dioxins and furans considers 17 congeners. Are any of the many other dioxin/furan compounds harmful to human health?

(h) The TEF method proposed by the Board relies on animal and laboratory studies of cellular and hormone response to dioxin and furan compounds rather than on direct relationships of these compounds to human health risk. Is this approach appropriate?

(i) Commentors have stated that the rule amendments were proposed because of ground water contamination from the Missoula White Pine and Sash facility. Is the potential for dioxin contamination at other locations great enough to justify adoption of the proposed dioxin standards?

(j) The rule amendments incorporate a 1989 EPA document entitled "Interim Procedures for Estimating Risks Associated with Exposures to Mixtures of Chlorinated Dibenzo-p-Dioxins and -Dibenzofurans (CDDs and CDFs) and 1989 Update". Is it appropriate to base a rule on an interim procedure document?

3. Interested persons may submit their data, views or arguments concerning the proposed action either in writing or orally at the hearing. Written data, views or arguments may also be submitted to the Board of Environmental Review, P.O. Box 200901, Helena, Montana 59620-0901, no later than August 12, 1999. To be guaranteed consideration, the comments must be postmarked on or before that date.

BOARD OF ENVIRONMENTAL REVIEW

by: /s/ Joe Gerbase
JOE GERBASE, Chairperson

Reviewed by:

/s/ John F. North
John F. North, Rule Reviewer

Certified to the Secretary of State July 12, 1999.

BEFORE THE DEPARTMENT OF MILITARY AFFAIRS
OF THE STATE OF MONTANA

In the matter of the) NOTICE OF PROPOSED ADOPTION
proposed adoption of new) OF NEW RULES I THROUGH VI
rules for the administration) PERTAINING TO THE
of the Education Benefit) ADMINISTRATION OF THE PROGRAM
Program for the Montana) FOR THE MONTANA NATIONAL
National Guard) GUARD

NO PUBLIC HEARING CONTEMPLATED

TO: All Concerned Persons

1. On August 21, 1999, the department of military affairs proposes to adopt new rules I through VI pertaining to the administration of the Montana national guard education benefit program (EBP).

2. The rules, as proposed to be adopted, provide as follows.

RULE I ELIGIBILITY OF MEMBERS (1) Any active member of the Montana army national guard or air national guard who meets the established criteria may be eligible to participate in the education benefit program (EBP), if attending state funded institutions of higher learning.

(2) The EBP is a tuition waiver scholarship. The tuition waiver would pay for the cost of tuition for credit bearing courses only. Tuition is defined as the total semester hour cost of instruction to a student as published in the catalog of the institution, specifically excluding mandatory fees, book charges, and room and board.

(3) The EBP incentive applies to members who are accepted, enrolled and matriculated at state funded institutions on a full-time or part-time basis in an undergraduate degree-granting program. Members must meet the institution's eligibility requirements for admission in a degree-granting program before this incentive can be used. Members must be pursuing their first undergraduate degree.

(4) Minimum enrollment for a part-time student is at least 3, but less than 12, credit hours per semester. Minimum enrollment for a full-time student is at least 12 or more semester credit hours.

(5) An applicant must be a resident student of the state of Montana as defined by 20-25-501(1)(d), MCA in order to apply for the EBP.

(6) Members may receive the EBP award for no more than 8 semesters of full-time study, or the equivalent of 4 academic years, or, for no more than 16 semesters of part-time study in an approved undergraduate degree-granting program. Periods of

federal active duty and activation by the governor of the state of Montana will be excluded from the above computation of the maximum period of eligibility. The adjutant general may, for exceptional circumstances, grant an extension of the eligibility period upon a written application from the member.

(7) The adjutant general may prioritize participation in this program in accordance with supplemental criteria deemed necessary to maintain readiness of the state military militia.

AUTH: 10-1-121, MCA

IMP: 10-1-121, MCA

RULE II ELIGIBILITY CRITERIA (1) A member may apply for the EBP if he is an active member of the Montana army national guard or the Montana air national guard. Members of the active military, inactive national guard (ING), individual ready reserve (IRR) or active guard and reserve (AGR) are not eligible.

(2) An applicant must be a graduate of an initial active duty for training (IADT) or a commissioning source.

(3) Applicants must be in a pay grade of enlisted - E1-E7, warrant officer - WO1-WO2, or officer - O1-O2.

(4) Applicants must have attended all scheduled unit training assemblies and scheduled annual training periods or have authorized absences. January 1 through June 30 establishes eligibility for the fall semester; July 1 through December 31 establishes eligibility for the winter semester as well as pre-approved summer courses. Members who cannot attend unit training assemblies due to sickness, injury, or some other unforeseen circumstance beyond the individual's control will be given the opportunity to perform equivalent training in accordance with regulations in order to maintain eligibility for the EBP. Prior service enlistees or appointees may gain eligibility if they have joined the Montana army national guard or air national guard prior to the start of a semester and meet all other eligibility requirements. The enlistment or appointment date as entered on the individual's contract or commissioning document will be used to determine eligibility. The first day of class at the college/university establishes the start of the semester.

(5) Applicants must have an expiration of term of service (ETS)/expiration of service (EOS) or service obligation date beyond the semester for which the EBP is being requested. Individuals who extend or reenlist for the EBP must do so for six years and provide appropriate documentation of extensions with their application for the tuition benefit.

(6) Applicants must not be flagged for favorable personnel actions.

(7) Applicants must have been accepted and matriculated for admission or enrolled at a Montana institution of higher

learning, either part-time or full-time, in a first award undergraduate degree-granting program.

(8) Applicants may not apply for the EBP prior to college/university acceptance.

(9) Applicants must be in good academic standing according to definition of the institution. Additionally, the enrolled service member must maintain a cumulative grade point average of 2.0 or better.

(10) If employer reimbursement for tuition is being received, the EBP award shall be reduced by the amount of such education reimbursement.

AUTH: 10-1-121, MCA

IMP: 10-1-121, MCA

RULE III SUSPENSION OF EDUCATIONAL BENEFITS

(1) During a semester, an applicant's/member's eligibility for the EBP will be suspended for that semester anytime the applicant/member fails to meet the eligibility requirements that have been established. If EBP is suspended, the applicant/member may be liable for the payment of the value of tuition that was waived during that semester.

AUTH: 10-1-121, MCA

IMP: 10-1-121, MCA

RULE IV ELIGIBILITY REVIEW AND CONTINUATION PROGRAM

(1) Participation in the EBP will be determined on a semester-by-semester basis in accordance with the applicable eligibility criteria set forth in these rules. Applicants may apply for participation in the EBP by submitting a Montana national guard scholarship program application, which is available from the Montana national guard education office.

(2) Commitment to any individual member of continued EBP assistance beyond that authorized for a particular semester is contingent upon an annual funding availability and the applicant/member meeting eligibility criteria contained within these rules then in effect under the statute.

AUTH: 10-1-121, MCA

IMP: 10-1-121, MCA

RULE V OBLIGATION TO REPAY EDUCATIONAL BENEFITS (1) Any member failing to complete an active term of enlistment may be held liable for repayment of the value of EBP benefits received during that term of enlistment.

AUTH: 10-1-121, MCA

IMP: 10-1-121, MCA

RULE VI AVAILABILITY OF THE TUITION FEE WAIVER (1) The availability of the EBP is contingent upon approval by the Montana board of regents.

AUTH: 10-1-121, MCA

IMP: 10-1-121 and 20-25-421, MCA

3. These proposed new rules I through VI are reasonably necessary for the following reasons. There have been changes in the Montana Code Annotated reflecting the intent of the legislature to provide additional financial support for the secondary education of Montana national guard soldiers. Education of Montana soldiers is essential to maintain the quality performance of the Montana national guard. In addition, these monies contribute to the recruitment and retention of high caliber soldiers to serve in the Montana national guard. The proposed rules encompass the changing law in state contribution to secondary education as it pertains to the department of military affairs.

4. In accordance with 2-4-302(2)(d), MCA, Representative Robert Pavlovich from Butte, and Senator Don Hargrove from Belgrade, who sponsored the bill, have been provided with copies of these proposed rules.

5. Interested parties may submit data, views or arguments in writing to: MAJ James P. Moran, Full-Time Staff Judge Advocate, Department of Military Affairs, PO Box 4789, Helena, MT 59604-4789. Any comments must be received no later than August 19, 1999.

6. If a person who is directly affected by the proposed adoption wishes to express data, views and arguments orally or in writing at a public hearing, the person must make written request for a hearing and submit this request along with any written comments to: MAJ James P. Moran, Full-Time Staff Judge Advocate, Department of Military Affairs, PO Box 4789, Helena, MT 59604-4789. A written request for hearing must be received no later than August 19, 1999.

7. If the agency receives requests for a public hearing on the proposed adoption from either 10% or 25, whichever is less, of the persons who are directly affected by the proposed adoption; from the administrative rule review committee of the legislature; from a governmental subdivision or agency; or from an association having not less than 25 members who will be directly affected, a hearing will be held at a later date. Notice of the hearing will be published in the Montana Administrative Register. Ten percent of the persons directly affected has been determined to be at least 40 persons based

upon the average number of 400 Montana army and air national guard members who are matriculated in institutions of higher learning during a semester.

8. Alternative accessible formats of this document will be provided upon request. Persons who need an alternative format of this rule notice, or who require some other reasonable accommodation in order to participate in this process, should contact MAJ James P. Moran, Full-Time Staff Judge Advocate, Department of Military Affairs, PO Box 4789, Helena, MT 59604-4789; telephone: (406) 841-3325.

9. Any person/party may be placed on the Department of Military Affairs' list of interested persons/parties by contacting MAJ James P. Moran, Full-Time Staff Judge Advocate, Department of Military Affairs, in writing, at the address listed above or may be made by completing a request form at any rules hearing held by the department.

DEPARTMENT OF MILITARY AFFAIRS

BY: /s/ James P. Moran
James P. Moran
Rule Reviewer

/s/ John E. Prendergast
John E. Prendergast
Major General, MTNG
Director, Military Affairs

Certified to the Secretary of State this 8th day of July,
1999.

BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES OF THE
STATE OF MONTANA

In the matter of the repeal)	NOTICE OF PROPOSED
of ARM 46.12.3215 pertaining)	REPEAL
to medicaid health plan)	
enrollment)	NO PUBLIC HEARING
)	CONTEMPLATED

TO: All Concerned Persons

1. On August 21, 1999, the Department of Public Health and Human Services proposes to repeal the above-stated rule.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who need an alternative accessible format of this notice. If you request an accommodation, contact the department no later than 5:00 p.m. on August 9, 1999, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970.

2. The rule 46.12.3215 as proposed to be repealed is on pages 46-3326 and 3327 of the Administrative Rules of Montana.

AUTH: Sec. 53-2-201, 53-6-111 and 53-6-113, MCA
IMP: Sec. 53-6-101, 53-6-103 and 53-6-131, MCA

3. ARM 46.12.3215 requires medicaid recipients to enroll in health insurance plans if the Department determines it is cost-effective to do so and if the Department pays the premiums on behalf of the recipient. 1991 federal law mandated that states have a premium payment program. The law required states to pay the full deductible and co-insurance up to health insurance approved amounts for any policy where the state medicaid agency was paying the premiums. Forty-nine states, including Montana, did not comply with this federal requirement because few health insurance policies would ever be determined cost effective. Health Care Financing Administration (HCFA) and Government Accounting Office reports discussed this situation and the impracticality of enforcing the provision. HCFA never enforced the provision. In 1997, federal law was changed to make premium payment a state option. If the state kept the option it still had to meet the deductible/co-insurance requirement. Montana kept the option but was still not in compliance. In 1998, a joint state/federal audit performed by the Legislative Audit Division brought this compliance deficit to the attention of the Department. HCFA, when contacted by the Legislative Audit Division, indicated they would enforce the requirement prospectively. The Department determined the best course of action would be to no longer use section 1906 of the

Social Security Act to authorize the premium payment program but to operate the program under section 1905 which does not require payment of deductibles/co-insurance. Section 1905, however, does not include a provision making it a condition of eligibility for recipients to enroll in cost-effective insurance. Elimination of the rule is necessary to avoid a conflict between ARM 46.12.3215 and section 1905. This will not prevent any recipient from receiving the benefit of having their health insurance premium paid by the Department.

Two other options were considered. (1) The Department could have discontinued the benefit and eliminated the premium payment program. This would have been detrimental to both recipients and the medicaid program, since both would lose the value of the health plans. Medicaid would have assumed all the costs for current premium payment beneficiaries and the beneficiaries would have lost the chance to keep insurance that would have provided them uninterrupted coverage once they no longer received medicaid. Many of these recipients would have been uninsurable after leaving Medicaid. (2) The other option would have been to comply with the section 1906 requirement. This would have resulted in few cases ever being determined cost-effective. The increased direct medical costs combined with higher allowed amounts from private carriers would have caused many cases to calculate as not cost-effective. There would also have been an additional risk to the Department because many policies would have required a 50% co-insurance on mental health services, particularly for juvenile inpatient treatment. Each policy covering that service could have had the potential to obligate Montana medicaid to pay tens of thousands of dollars towards a 50% co-insurance on \$30,000 per month treatment plans. The Department rejected both options.

4. Interested persons may submit their data, views or arguments concerning the proposed action in writing to Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210, no later than August 19, 1999. The Department also maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. For placement on the mailing list, please write the person at the address above.

5. If a person who is directly affected by the proposed action wishes to express data, views and arguments orally or in writing at a public hearing, that person must make a written request for a public hearing and submit such request, along with any written comments to Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210, no later than August 19, 1999.

6. If the Department of Public Health and Human Services receives requests for a public hearing on the proposed action from either 10% or 25, whichever is less, of those who are

directly affected by the proposed action, from the Administrative Rule Review Committee of the legislature, from a governmental agency or subdivision, or from an association having no less than 25 members who are directly affected, a hearing will be held at a later date and a notice of the hearing will be published in the Montana Administrative Register. Ten percent of those directly affected has been determined to be 50 based on the 500 cases affected by rules covering medicaid health plan enrollment.

/s/ Dawn Sliva
Rule Reviewer

/s/ Laurie Ekanger
Director, Public Health and
Human Services

Certified to the Secretary of State July 12, 1999.

BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES OF THE
STATE OF MONTANA

In the matter of the adoption) NOTICE OF PUBLIC HEARING
of Rules I through XXI) ON PROPOSED ADOPTION
pertaining to network)
adequacy in managed care)

TO: All Concerned Persons

1. On August 11, 1999, at 1:30 p.m., a public hearing will be held in the auditorium of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana to consider the proposed adoption of the above-stated rules.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing or need an alternative accessible format of this notice. If you request an accommodation, contact the department no later than 5:00 p.m. on August 3, 1999, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970.

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

RULE I DEFINITIONS The following definitions, in addition to those contained in 33-36-103, MCA, apply to this chapter:

(1) "Access plan" means a document filed by a health carrier with the department that complies with the standards set forth in [Rules II through IV] and 33-36-201, MCA.

(2) "Advanced practice registered nurse" means a nurse midwife, a nurse anesthetist, a nurse practitioner, or a clinical nurse specialist.

(3) "Geographic service area" means the sum of the geographic areas of Montana in which a health carrier has a network that has been deemed adequate by the department and for which the health carrier has received approval from the insurance commissioner as an "area of operation" in which to market and issue health insurance coverage.

(4) "Mid-level provider" means a physician assistant or an advanced practice registered nurse.

(5) "Primary care provider (PCP)" means a physician, mid-level provider, federally qualified health center or rural health clinic as defined in ARM 46.12.1708, migrant health center or other community-based provider that is designated by a health carrier to supervise, coordinate, or provide initial or continuing care to an enrollee, and if required by the health carrier, initiate a referral for specialty care services

rendered to the enrollee.

(6) "Specialty provider" or "specialist" means a physician or other provider whose area of specialization is an area other than general medicine, family medicine, general internal medicine or general pediatrics. A provider whose area of specialization is obstetrics and/or gynecology may be either a PCP or a specialist within the meaning of this rule.

(7) "Urgent care" means those health care services that are not emergency services but that are necessary to treat a condition or illness that could reasonably be expected to present a serious risk of harm if not treated within 24 hours.

AUTH: Sec. 33-36-105, MCA

IMP: Sec. 33-36-103 and 33-36-105, MCA

RULE II ACCESS PLAN FILING AND REVIEW GUIDELINES

(1) When a health carrier submits a proposed access plan to the department for review and approval, the department will either approve, disapprove, or request additional information on the proposed plan within 60 calendar days. The department has a total of 60 days to review and issue a decision concerning any proposed access plan, not including any 30 day response period that may be granted a health carrier proposing the plan. The department may grant up to two 30 day response periods during the review of each access plan.

(2) During the departmental review of its proposed access plan, a health carrier must respond to a departmental request for information within 30 calendar days after the date of the request. If the response remains incomplete, the department may grant the health carrier a second 30 day period within which to submit a complete response. If, after two departmental requests for information, the health carrier fails to provide information that the department deems sufficient to satisfy its requests, the access plan will be disapproved and the health carrier will be required to submit a new proposed access plan prior to enrolling initial or additional enrollees.

(3) The total number of days allowed for the review of a given proposed access plan may not exceed 120 calendar days, including both time spent by the department in review of the proposed plan and any time granted to a health carrier to respond to departmental requests for additional information.

AUTH: Sec. 33-36-105, MCA

IMP: Sec. 33-36-105 and 33-36-201, MCA

RULE III ACCESS PLAN UPDATES (1) Health carriers shall be responsible for monitoring the status of their networks and must submit an updated access plan to the department within 30 calendar days of a material change in the status of their network. For the purposes of this rule, a material change is a change in the composition of a health carrier's provider network or a change in the size or demographic characteristics of the population enrolled with the health carrier that renders the health carrier's network non-compliant with one or more of the

network adequacy standards set forth at [Rules VII, IX, and XII]. If the revised access plan is not submitted within 30 calendar days after the material change in network status occurs, the health carrier must cease enrolling new recipients in the affected geographic service area until the revised access plan is approved by the department. Review of the revised access plan is subject to the procedures and consequences outlined in [Rule II].

(2) In addition to the requirement in (1) above, the health carrier must submit an updated access plan to the department by at least 2 years after the date the carrier's access plan was last approved by the department.

AUTH: Sec. 33-36-105, MCA

IMP: Sec. 33-36-105 and 33-36-201, MCA

RULE IV ACCESS PLAN SPECIFICATIONS (1) In addition to meeting the requirements of 33-36-201(6), MCA, an access plan for each health carrier offered in Montana must describe or contain the following:

(a) a list of participating providers which describes the type of provider, their specialty or credentials, and also their names, addresses, zip codes, and phone numbers. The list must indicate which providers are accepting new patients;

(b) the health carrier's policy for making referrals within and outside of the network including, at a minimum, the health carrier's method for complying with each of the standards set forth in [Rules XIII, XIV, and XV];

(c) the health carrier's process for monitoring on a periodic basis the need for and satisfaction with health care services of the enrolled population and ensuring on an ongoing basis, the sufficiency of the network to meet those needs and, at a minimum, the health carrier's methods for complying with each of the standards set forth in [Rule XVII];

(d) the health carrier's policy to address the needs of enrollees with limited English proficiency and/or illiteracy, those with diverse cultural and ethnic backgrounds, and those with physical and mental disabilities, in order to insure that these characteristics do not pose barriers to gaining access to services. The policy shall, at a minimum, describe the health carrier's methods for complying with each of the standards set forth in [Rule XVI]; and

(e) a copy of the information filed with the commissioner of insurance outlining important information about the health carrier's services and features which must be provided by the health carrier to either potential enrollees or covered enrollees. This information must be presented in language that is comprehensible to the average layperson. The information to be provided includes, but is not limited to:

(i) a listing of participating providers, as described in (1)(a) above;

(ii) a summary description of the health carrier's standards for provider credentials and methodology for reviewing providers' credentials on an ongoing basis required by [Rule

VIII];

(iii) the procedures in place for selecting and changing providers;

(iv) a copy of the information filed with the commissioner of insurance detailing the health carrier's benefits, including a comprehensive list of covered and non-covered services;

(v) the health carrier's policy regarding enrollee responsibility for co-insurance, copayments, and deductibles;

(vi) a detailed description of the health carrier's procedures along with authorization for specialty care that comply with [Rule XIII], a schedule of the fees, including co-insurance, copayments and deductibles, for which an enrollee will be responsible;

(vii) policies pertaining to approval of and access to emergency services that meet the requirements of [Rule VI];

(viii) telephone numbers and procedures for contacting an authorized representative of the health carrier who can facilitate review of post-evaluation or post-stabilization services required immediately after receipt of emergency services;

(ix) a description of the health carrier's grievance procedures, including specific instructions and guidelines for filing and appealing grievances;

(x) a policy regarding use of and payment for in-network services; and

(xi) a policy regarding use of and payment for out-of-network services.

(f) the health carrier's method of providing and paying for emergency screening and services 24 hours a day, 7 days a week, in accordance with [Rule VI];

(g) a process for enabling enrollees to change primary care professionals that meets the standards of [Rule XV];

(h) a process for transfer of enrollees to other providers must include a provision for transitional care as described in [Rule XIV];

(i) the process used to address and correct instances where a health carrier has an insufficient number or type of participating providers accessible to enrollees to provide a covered benefit. This process must comply with the requirements of [Rules IX and X]; and

(j) the health carrier's method of complying with geographic accessibility requirements as outlined in [Rule IX and X].

AUTH: Sec. 33-36-105, MCA

IMP: Sec. 33-36-105 and 33-36-201, MCA

RULE V ACCESS CRITERIA (1) The department will utilize the criteria set forth in this chapter and Title 33, chapter 36, MCA to determine whether the network maintained by a health carrier offering a managed care plan in Montana is sufficient in numbers and type of providers.

AUTH: Sec. 33-36-105, MCA
IMP: Sec. 33-36-105 and 33-36-201, MCA

RULE VI MANDATORY COVERAGE (1) The following must be reimbursed without regard to either prior authorization or the contractual relationship between the health carrier and the provider:

- (a) emergency services as defined in 33-36-103, MCA;
- (b) covered services that do not meet the criteria for emergency services, but which were medically necessary and immediately required because of an unforeseen illness, injury or condition and the enrollee could not reasonably access services through the health carrier because he or she was outside the health carrier's service area; and
- (c) renal dialysis, if covered, that is provided while the enrollee is outside the health carrier's service area for no more than 30 calendar days.

AUTH: Sec. 33-36-105, MCA
IMP: Sec. 33-36-105, 33-36-201 and 33-36-205, MCA

RULE VII PROVIDER-ENROLLEE RATIO REQUIREMENTS (1) In order to be deemed adequate, a health carrier's network must include one mid-level PCP per 1,500 projected enrollees or one physician PCP per 2,500 projected enrollees.

AUTH: Sec. 33-36-105, MCA
IMP: Sec. 33-36-105, and 33-36-201, MCA

RULE VIII VERIFICATION OF PROVIDER CREDENTIALS (1) Each health carrier shall establish and describe in its access plan the criteria utilized to review the credentials of the providers in its network. A health carrier must require a provider's credentials to be reviewed prior to the health carrier employing or entering into contractual relationship with a provider and a provider's credentials are to be reverified at least every 3 years thereafter.

AUTH: Sec. 33-36-105, MCA
IMP: Sec. 33-36-105 and 33-36-201, MCA

RULE IX GEOGRAPHIC ACCESS CRITERIA (1) In order to be deemed adequate, a provider network must fulfill all access criteria of the rules in this chapter within the following geographic restrictions:

- (a) to the extent that services are covered by the health carrier, the health carrier must have an adequate network of primary care providers, a hospital, and/or medical assistance facility, and a pharmacy that is located within a 45 mile radius of each enrollee's residence or place of work, unless:
 - (i) the usual and customary travel pattern of the general population within the service area to reach health care providers is further, and if the fact that the usual and customary travel pattern exists is documented by the health

carrier; or

(ii) the provider is available but does not meet the health carrier's reasonable credentialing requirements;

(b) if no qualified provider exists within a 45 mile radius of an enrollee's residence or place of work, the health carrier must document how covered services will be provided at no additional charge to enrollees through referrals to qualified providers both inside and outside the 45 mile radius; and

(c) enrollees may, at their discretion, select participating primary care providers located farther than 45 miles from their homes and/or places of business.

AUTH: Sec. 33-36-105, MCA

IMP: Sec. 33-36-105 and 33-36-201, MCA

RULE X EXCEPTIONS TO GEOGRAPHIC ACCESS CRITERIA (1) The department may grant exceptions to the geographic accessibility standard in [Rule IX] if good cause to do so exists.

(2) Good cause includes but is not limited to the circumstance where the health carrier has documented a good faith effort to negotiate a contract with local providers but has failed to reach an agreement within 60 days after the offer of a written contract from the health carrier. A good faith effort includes offering terms and conditions at least as favorable as those offered to other entities providing the same or similar services.

AUTH: Sec. 33-36-105, MCA

IMP: Sec. 33-36-105 and 33-36-201, MCA

RULE XI SERVICE AREAS (1) A network's service area may encompass more than one geographic service area provided the network in all such areas meets the network adequacy criteria.

AUTH: Sec. 33-36-105, MCA

IMP: Sec. 33-36-105 and 33-36-201, MCA

RULE XII MAXIMUM WAIT TIMES FOR APPOINTMENTS (1) An adequate network must meet the following criteria for all enrollees:

(a) emergency services must be available and accessible at all times;

(b) urgent care appointments must be available within 24 hours;

(c) appointments for non-urgent care with symptoms must be available within 5 calendar days;

(d) appointments for immunizations must be available within 21 calendar days; and

(e) appointments for routine or preventive care must be available within 45 calendar days.

AUTH: Sec. 33-36-105, MCA

IMP: Sec. 33-36-105 and 33-36-201, MCA

RULE XIII REFERRAL AND SPECIALTY CARE REQUIREMENTS

(1) Procedures for referrals to consulting specialists must be clearly outlined in the access plan, in literature provided to all enrollees, and in literature provided to all participating providers.

(2) Women and adolescent females who do not designate a gynecological health care provider as their PCP must be allowed direct access (without prior authorization or referral from a PCP) to a participating provider whose area of specialization is gynecology for routine gynecological care no less frequently than one time per year.

(3) Pregnant females must be allowed direct access, without prior authorization or referral from a PCP, to a participating provider whose area of specialization is obstetrics.

(4) An enrollee must be allowed to designate a participating pediatrician, family physician, or, if the health carrier allows a mid-level provider to be a PCP, a mid-level provider specializing in primary care of children as the PCP for the enrollee's children and/or adolescents who are covered by the health carrier.

(5) The access plan must include a process to address and correct instances where a health carrier has an insufficient number or type of participating providers accessible to enrollees to provide a covered benefit. In these instances, the health carrier must ensure that covered services are provided at no greater cost to the enrollee than if the services were obtained from a participating provider.

(6) The access plan must include policies and procedures by which an enrollee with a condition that requires ongoing care from a specialist may obtain a standing referral to a participating specialty provider. For purposes of this rule, standing referral means a referral for ongoing care to be provided by a participating specialty care provider that authorizes a series of visits with the specialist for either a specific time period or a limited number of visits, and which is provided according to a treatment plan developed by the enrollee's PCP, the specialty provider, and the enrollee.

AUTH: Sec. 33-36-105, MCA

IMP: Sec. 33-36-105 and 33-36-201, MCA

RULE XIV CONTINUITY OF CARE AND TRANSITIONAL CARE (1) A health carrier must allow the following new enrollees to continue to receive services from their previous providers for the time periods noted below, so long as those providers agree to abide by the payment rates, credentialing, referral process, quality-of-care standards and protocols, and reporting standards that apply to comparable participating providers:

(a) a new enrollee with a life-threatening, disabling or degenerative condition may obtain care from their previous provider for a period of 60 days, beginning the date of the enrollee's enrollment with the health carrier;

(b) a new enrollee who has received a diagnosis of

terminal illness with life expectancy of less than 6 months, may continue to obtain care from their previous provider until death if it occurs prior to the end of the 6 month period, or, if it does not, for a period of 6 months from the date of the enrollee's enrollment with the health carrier, unless the period is extended after the enrollee's medical needs and the appropriateness of requiring a transition to a participating provider are reassessed. Such a reassessment must be conducted at or before the end of the 6 month period by the health carrier for such a terminally ill enrollee; and

(c) a new enrollee in the second or third trimester of pregnancy may obtain care from their previous provider through the completion of postpartum care.

(2) A health carrier must allow enrollees in the categories described in (1)(a) through (1)(c) above to continue to receive services from their existing providers when their provider's contract is terminated without cause, so long as those providers agree to abide by the payment rates, quality-of-care standards and protocols, and reporting standards which apply to comparable participating providers.

(3) A health carrier may not hold an enrollee covered by this rule responsible for any additional payments, copayments, co-insurance or deductibles beyond what would be required if the services were provided by a participating provider.

AUTH: Sec. 33-36-105, MCA

IMP: Sec. 33-36-105 and 33-36-201, MCA

RULE XV SELECTING AND CHANGING PROVIDERS (1) Enrollees must be allowed to change primary care providers at least once per benefit year.

(2) The health carrier will monitor the frequency of enrollees' requests to change primary care providers and shall have in place a policy to address situations in which a provider has patient turnover rates that are significantly higher than the average rate within the health carrier's network.

AUTH: Sec. 33-36-105, MCA

IMP: Sec. 33-36-105 and 33-36-201, MCA

RULE XVI REMOVAL OF BARRIERS TO ACCESS (1) The health carrier must have a policy in place to address the needs of enrollees with limited English proficiency and/or illiteracy, those with diverse cultural and ethnic backgrounds, and those with physical and mental disabilities, in order to insure that these characteristics do not pose barriers to gaining access to services. This policy shall, at a minimum, describe the health carrier's methods for providing the following:

(a) interpreter services to allow effective communication regarding treatment, medical history and health education;

(b) appropriate and sufficient personnel, physical resources and equipment to meet the basic health care needs of these enrollees; and

(c) education to providers and other employees about the

needs of these covered persons.

AUTH: Sec. 33-36-105, MCA

IMP: Sec. 33-36-105 and 33-36-201, MCA

RULE XVII MONITORING THE NETWORK (1) The health carrier must establish methods for periodically assessing the sufficiency of the network to meet the health care needs of covered persons as well as assessing their satisfaction with services. The following must be included in this assessment:

- (a) changes in volume of specialty services needed;
- (b) changes in number of primary care providers needed;
- (c) other changes in health care utilization that might indicate changes in the health status of covered persons;
- (d) enrollee satisfaction with billing and record keeping;
- (e) provider satisfaction with billing and record keeping;
- (f) enrollee satisfaction with educational materials available to them;
- (g) enrollee satisfaction with 24-hour access to medical advice and services;
- (h) enrollee satisfaction with the referral process; and
- (i) provider satisfaction with the referral process.

AUTH: Sec. 33-36-105, MCA

IMP: Sec. 33-36-105 and 33-36-201, MCA

RULE XVIII LETTERS OF INTENT (1) In order to demonstrate that its network is adequate, a health carrier may utilize letters of intent from individual providers with whom it does not yet have a contract, so long as the providers do not constitute more than 15% of the total network. If letters of intent from providers are utilized, within 6 months after the access plan is submitted to the department the health carrier must submit to the department verification that it has an adequate network.

AUTH: Sec. 33-36-105, MCA

IMP: Sec. 33-36-105 and 33-36-201, MCA

RULE XIX RESPONSIBILITY FOR CONTRACTED SERVICES (1) A health carrier offering a managed care plan that uses a contractual arrangement to provide services to covered persons remains responsible for meeting the requirements of this chapter, including documentation requirements.

AUTH: Sec. 33-36-105, MCA

IMP: Sec. 33-36-105, MCA

RULE XX CORRECTIVE ACTION (1) The department may recommend corrective action to the health carrier in the event the health carrier fails to comply with the network adequacy requirements set forth in these rules.

(2) If a health carrier fails to implement adequate corrective action, the department will provide the commissioner

of insurance with documentation of the network's inadequacy.

AUTH: Sec. 33-36-105, MCA
IMP: Sec. 33-36-105, MCA

RULE XXI APPEAL FROM DEPARTMENT DECISION (1) If a health carrier or health care provider is aggrieved by any decision made by the department pursuant to Title 33, chapter 36, part 2, MCA, and these rules, the aggrieved party may request a hearing before the department by submitting the request in writing to the department's Quality Assurance Division, Office of Fair Hearings, 616 Helena Avenue, Steamboat Block, P.O. Box 202953 Helena, MT 59620-2953.

(2) The hearing will be conducted in accordance with the Montana Administrative Procedure Act, Title 2, chapter 4, part 6, MCA and ARM 1.3.211 through 1.3.225 and ARM 1.3.230 through 1.3.233. For purposes of such hearings, the department hereby adopts and incorporates by reference ARM 1.3.211 through 1.3.225 and ARM 1.3.230 through 1.3.233, which contain the attorney general's model rules for contested cases. Copies of these rules may be obtained from the department's Office of Legal Affairs, P.O. Box 202951, Helena, MT 59620-2951.

(3) The provisions of ARM 46.2.201, 46.2.202, 46.2.205 through 46.2.212, 46.2.214 and 46.12.590A do not apply to such hearings.

AUTH: Sec. 2-4-201 and 33-36-105, MCA
IMP: Sec. 2-4-201 and 33-36-105, MCA

3. The Department is proposing these rules to carry out the mandate of Chapter 413 (Senate Bill 365), passed by the 1997 Legislature, which added Title 33, Chapter 36, to the Montana Code Annotated and required the Department to develop rules setting standards to ensure the provider networks of managed care plans adequately provide their enrollees with access to health care. Department staff did an exhaustive search of available literature on the subject of network adequacy as a basis for these rules. Staff also met with insurance carriers, consumers, consumer advocates, and other interested parties five times during the past 21 months to discuss and refine these proposed rules.

The definitions contained in Rule I are necessary to explain the meaning of the terms used in the accompanying rules that are not already defined in the relevant statutes.

Rule II sets forth the time frames found necessary for both the Department to review proposed access plans and for the health carrier to respond to requests for additional information. The options of not setting any time lines, setting shorter time lines, or setting longer time lines were all rejected as unreasonable. Not setting any time frames or setting longer time frames would result in a prolonged period of review that could hurt health carriers, since without Department approval of

an access plan, a health carrier would be unable to do business in Montana. Shorter time frames would jeopardize the ability of the Department to review a plan adequately and safeguard the rights of members of health plans to be assured of an adequate provider network.

Rule III, by requiring that health carriers must update an approved access plan within 30 days of a material change in either the provider network or the population served, ensures that plans remain adequate over time. The Department rejected alternatives to the 30-day requirement because shorter time frames would be too restrictive for health carriers and longer time frames would not adequately protect the rights of health care consumers. The proposed penalty of not being able to add new enrollees if the time limit is exceeded is needed to ensure that health carriers have an incentive to comply with the reporting requirement and to protect health care enrollees from an inadequate network of providers. Ensurance of plan adequacy also necessitates that access plans be updated at least every 2 years. Alternatives to the 2-year period were considered and rejected because shorter time frames would be unduly burdensome on health carriers. Longer time frames would not allow health care consumers to be informed about the availability of health care coverage and coverage policies under the insurance they are purchasing.

Rule IV is necessary to set out the components of the access plan. Both more stringent and less stringent standards were considered but rejected. The areas are consistent with what other states have adopted and are designed to protect the rights of health care consumers without being too burdensome to health carriers.

Rule V is necessary to clarify that both the statutes in Title 33, chapter 36, MCA, and these rules will be used to determine the adequacy of a health carrier's access plan. Since the rule reflects legal reality, no alternatives were considered.

Rule VI is necessary to indicate reasonable circumstances under which services must be covered by a health carrier. Subsection (1)(a), was clearly necessary since 33-36-201, MCA, specifies that emergency services must be covered 24 hours per day, 7 days per week. Because of the statutory requirement, no alternatives were considered. Subsections (1)(b) and (c) of Rule VI outline that services must be paid for medically necessary unforeseen care and for renal dialysis as well, and are necessary to ensure access by consumers who might be traveling outside a network service area and experience the need for health care when they could not reasonably use a network provider. The alternative of not paying for such care was rejected as too restrictive for health care consumers, precluding them from ever being able to travel outside the health carrier's geographic service area with the assurance that needed health care would be paid for. On the other hand, the Department rejected the alternative of making

the health carrier pay for any and all health care services as unreasonable because a consumer would have no incentive to utilize a network provider, potentially resulting in the inflation of the cost of health care coverage that all members of a plan must bear.

The minimum ratio of PCPs per enrollees set out in Rule VII is necessary to ensure adequate access to providers by consumers without being too burdensome on the health carrier. More and less stringent criteria were considered but rejected as being less reasonable by the interested parties consulted concerning these rules.

Rule VIII, requiring health carriers to initially verify the credentials of providers before contracting with them and to recredential them every 3 years after that, is necessary to ensure consumer protection from unqualified providers. Alternatives were not adopted because the rule as it stands is consistent with industry standards, more stringent requirements would be unduly burdensome without offering additional consumer protections, and less stringent criteria would not adequately protect health care consumers.

Rule IX's requirement that a health carrier must have an adequate network of providers within a 45-mile radius of the covered person's home or place of work is necessary to ensure covered persons physical access to providers. A shorter distance was considered and rejected as unrealistic, given Montana's sparse population and vast geographic area. The Department rejected a longer distance as unduly burdensome to health care consumers needing care. A longer distance might also threaten a sometimes fragile health care network in Montana's rural areas by allowing health care providers to refuse to contract with local providers. Subsections (1)(a)(i) and (ii) of this rule allow exceptions to the 45-mile radius requirement, in necessary reflection of the facts that there may be no properly qualified providers within that radius and that there are Montanans who might wish to purchase a managed care product but who are living and/or working in communities that do not have a health care provider within 45 miles. The Department rejected as unreasonable the alternative of not allowing such exceptions.

Rule X establishes a process to allow exceptions to the 45-mile radius requirement of Rule IX for "good cause", provisions that are needed to recognize the fact that health carriers may not be able to meet that requirement through no fault of their own. The alternative of not allowing this exception was considered and rejected because a single health care provider who did not want to contract with the health carrier could then effectively prevent the carrier from selling a product in that particular service area. This would effectively decrease competition among health carriers, possibly resulting in higher prices for health care consumers and less choice of health care plans.

Rule XI is needed to allow a health carrier to establish a network encompassing more than a single geographic service area. The alternative of requiring an access plan to be filed for each geographic area was rejected because it would be burdensome to health carriers while providing no benefit to health care consumers.

Rule XII, in order to ensure adequate consumer access, establishes maximum wait times for appointments. Differences in relative urgency necessitated the variance in deadlines for different types of appointments. More and less stringent time frames were evaluated and rejected because the rule, as proposed, protects the health care consumer without being too burdensome to the health carriers.

Rule XIII is necessary to outline the rights of consumers to access providers of their own choice. The reference to a woman's rights to use a gynecologist once a year and an obstetrician if she is pregnant without prior authorization or referral is in reflection of the fact that current state law requires such access. For the same reason, no other alternatives were considered. Subsection (4), specifying that a member may choose a provider specializing in primary care of children as a PCP for their children, was necessary to ensure the most appropriate PCP for children. The alternative of not allowing a specialist in pediatric care to be chosen was considered and rejected because children have unique health care needs that these specialists are trained to deliver. Language specifying that this choice may include mid-level providers if the plan recognizes them as a PCP is proposed to offer greater choice to health care consumers. The rule does not mandate that plans recognize mid-level providers as PCPs as this would be outside the scope of the enabling legislation.

Rule XIII(5) is needed to ensure that a health carrier has a process in place to address instances when a plan has an inadequate number or type of participating providers, in order to protect and ensure consumer access. The requirement that this care be provided to the member at no greater cost than if the member received the service from a participating provider was necessary because health care consumers have paid for health coverage and need a guarantee that they can receive needed health care at no additional cost if the health carrier has an inadequate network of providers. For that reason, no alternative was considered or accepted. Finally, for protection of consumers with conditions requiring ongoing care from a specialist, the requirement was needed that health carriers must establish a treatment plan that authorizes care for a period of time or a number of visits. The Department evaluated and rejected more and less stringent standards. The rule, as proposed, protects the health care consumer with special health care needs without being too burdensome to a health carrier.

Rule XIV(1) is necessary to protect consumers by outlining the

transition period to a new provider under which a new member may continue to see their previous provider for certain conditions.

Also needed to protect consumers is Rule XIV(2), which gives existing members of a health plan the same rights if their provider is terminated from the plan without cause. The alternative of not allowing a transition period was considered and rejected. All of the conditions specified in the proposed rule require coordinated medical care to ensure the health of the consumer. The alternatives of allowing a longer transition period or requiring that a health carrier pay for care indefinitely were rejected as unduly burdensome on the health carrier and because they are a departure from the managed care concept that is the basis of care. Specifically, the alternative of allowing this transition period only in the third trimester of pregnancy was considered and rejected because many complications manifest themselves in the second trimester. Allowing for the transition period in the second trimester protects the health of the mother and unborn child. Rule XIV(3), also needed to protect consumers, specifies that this care must be provided at no additional cost to the consumer. The alternative of not requiring a health carrier to have such a provision in place was considered and rejected because health care consumers have paid for health coverage and need a guarantee that they can receive needed health care at no additional cost in these special circumstances.

Rule XV is necessary to require a process allowing plan members to change their primary care provider once per year, in order to facilitate consumer choice of provider. The options of allowing members to change PCPs more and less frequently were evaluated and rejected. This rule, as proposed, protects the health care consumer without being burdensome to a health carrier. The requirement of subsection (2) that the health carrier monitor the frequency of requests to change PCPs was needed as an added safeguard to ensure that the quality of health care provided by the PCP is monitored by the health carrier.

Rule XVI is needed to ensure that barriers to receiving health care for populations such as people with physical and mental disabilities, diverse cultural backgrounds, and limited English proficiency or illiteracy are addressed. More and less stringent standards were considered and rejected because the rule, as proposed, protects the health care consumer with special needs without being unduly burdensome to health carriers.

Rule XVII is needed to assure network adequacy by requiring the establishment of methods for periodically assessing the sufficiency of the network and provider and consumer satisfaction with the network. These are all key components of an adequate provider network. The measures listed are the minimum determined by the Department as necessary to protect the rights of the health care consumer without being unduly

burdensome on the health carrier. Specific requirements such as specifying that an independent satisfaction survey be done and a standardized evaluation tool be used were rejected as unduly burdensome and expensive given the penetration of managed care in the state at this time.

Rule XVIII is needed to assist a health carrier to prove that it has an adequate network even though contracts may not yet have been signed with all necessary providers. Allowing letters of intent to account for no more than 15% of the total network and requiring plans to submit verification of an adequate network within 6 months are needed as a safeguard to ensure the network is adequate. The alternative of letting a plan demonstrate an adequate network with letters of intent from more than 15% of the provider panel was rejected because it does not adequately protect the health care consumer and guarantee access to health care services. The alternative of letting a plan demonstrate an adequate network with letters of intent from less than 15% of the provider panel was rejected because it is unduly burdensome to the health carrier and health care consumers are adequately protected under the proposed rule.

Rule XIX is necessary to protect network adequacy by clarifying that the health carrier remains responsible for meeting the requirements of these rules whether or not services are provided through a subcontract with another entity. No other choice was considered because this protects health care consumers should a health carrier decide to subcontract with another entity.

Rule XX is needed to allow a remedy for a network deficiency short of cancellation. The alternative would be for the Department to recommend cancellation of licensure or sanctions to the Commissioner of Insurance for even minor infractions. The Department rejected this alternative since it was unduly harsh and would not serve the public well.

Rule XXI is needed to provide an appeal from a decision of the Department that aggrieves a health carrier or provider. The appeal process complies with state statutes and other alternatives were not considered.

4. The Department intends to adopt these rule changes effective October 1, 1999.

5. Interested persons may submit their data, views or arguments either orally or in writing at the hearing. Written data, views or arguments may also be submitted to Kathy Munson, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 202951, Helena, MT 59620-2951, no later than August 19, 1999. The Department also maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. For placement on the mailing list, please write the person at the address above.

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

/s/ Dawn Sliva
Rule Reviewer

/s/ Laurie Ekanger
Director, Public Health and
Human Services

Certified to the Secretary of State July 12, 1999.

BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES OF THE
STATE OF MONTANA

In the matter of the adoption) NOTICE OF PUBLIC HEARING
of Rules I through VII) ON PROPOSED ADOPTION
pertaining to the use of)
automated external)
defibrillators)

TO: All Concerned Persons

1. On August 11, 1999, at 3:00 p.m., a public hearing will be held in the auditorium of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana to consider the proposed adoption of the above-stated rules.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing or need an alternative accessible format of this notice. If you request an accommodation, contact the department no later than 5:00 p.m. on August 2, 1999, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970.

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

RULE I DEFINITIONS In addition to the definitions contained in 50-6-501, MCA, the following definitions apply to this chapter (Note: 50-6-501, MCA, includes definitions for "automated external defibrillator (AED)" and "entity".):

(1) "Automated external defibrillator (AED)" means a medical device that:

(a) has received approval for marketing from the U.S. food and drug administration;

(b) is capable of recognizing the presence or absence of ventricular fibrillation or rapid ventricular tachycardia and of determining, without intervention by an operator, whether defibrillation should be performed;

(c) upon determining that defibrillation should be performed, automatically charges and indicates that it is ready to deliver an electrical impulse to an individual's heart; and

(d) may be used by an operator of the device to deliver an electrical impulse to an individual's heart.

(2) "AED training program" means a course of instruction approved by the department which provides the initial education in the use of the AED and which has requirements for continued assurance of the competency of individuals in using an AED.

(3) "CPR" means cardiopulmonary resuscitation.

(4) "Entity" means a public agency, department, office, board, or commission or other governmental organization or a private corporation, partnership, group or business or other private organization.

AUTH: Sec. 50-6-503, MCA

IMP: Sec. 50-6-501, MCA

RULE II WRITTEN PLAN (1) An entity wishing to use or allow the use of an AED shall develop, update as changes are made, and adhere to a written plan that:

(a) for a stationary location specifies the physical address where the AED will be located;

(b) for a mobile location specifies the geographic area in which the AED will be used and specifies how the AED will be transported to the scene of a cardiac arrest;

(c) includes the names of the individuals currently authorized to use the AED;

(d) describes how the AED use will be coordinated with each licensed emergency medical service providing coverage in the area where the AED is located, including how emergency medical services will be activated every time that an AED is attached to a patient;

(e) specifies the name, telephone number(s) and address of the Montana licensed physician who will be providing medical supervision to the AED program and how the physician, or the physician's designee, will supervise the AED program;

(f) specifies the name, telephone number(s) and address of the physician's designee, if any, who will assist the physician in supervising the AED program;

(g) specifies the maintenance procedures for the AED, including how it will be maintained, tested and operated according to the manufacturer's guidelines;

(h) requires that written records of all maintenance and testing performed on the AED be kept;

(i) describes the records that will be maintained by the program; and

(j) describes how the required reports of AED use will be made to the physician supervising the AED program, or their designee, and to the department.

AUTH: Sec. 50-6-503, MCA

IMP: Sec. 50-6-501 and 50-6-503, MCA

RULE III WRITTEN NOTICE (1) Prior to allowing any use of an AED, an entity must provide the following, in addition to a copy of the plan required by [Rule II], to each licensed emergency medical service and public safety answering point or emergency dispatch center in the area where the AED is located:

(a) a written notice, on a form provided by the department, that includes the following information:

(i) the name of the entity that is establishing the AED program;

- (ii) the business address and telephone number, including physical location, of the entity;
- (iii) the name, telephone number and address of the individual who is responsible for the onsite management of the AED program;
- (iv) the starting date of the AED program; and
- (v) where the AED is physically located.

AUTH: Sec. 50-6-503, MCA
IMP: Sec. 50-6-502 and 50-6-503, MCA

RULE IV REPORTS (1) Every time an AED is attached to a patient, its use must be reported to the supervising physician or the physician's designee and the report must include the information required by the supervising physician.

(2) Every time an AED is attached to a patient, the supervising physician or their designee shall provide to the department, on a form provided by the department, the following information:

- (a) the name of the entity responsible for the AED;
- (b) the name, address and telephone number of the supervising physician;
- (c) the date of the call;
- (d) the age of the patient;
- (e) the gender of the patient;
- (f) location of the cardiac arrest;
- (g) estimated time of the cardiac arrest;
- (h) whether or not CPR was initiated prior to the application of the AED;
- (i) whether or not the cardiac arrest was witnessed;
- (j) the time the first shock was delivered to the patient;
- (k) the total number of shocks delivered;
- (l) whether or not there was a pulse after the shocks and whether or not the pulse was sustained; and
- (m) whether or not the patient was transported, and if so, the name of the transporting agency and the location to which the patient was transported.

AUTH: Sec. 50-6-503, MCA
IMP: Sec. 50-6-502 and 50-6-503, MCA

RULE V TRAINING (1) In order to be authorized by an AED program plan to use an AED, an individual must:

- (a) have current training in adult cardiopulmonary resuscitation that meets the standards of the American heart association and must renew this training at intervals not to exceed 2 years;
- (b) complete one of the approved AED training programs listed in (2) below and renew the training at intervals not to exceed 2 years.

(2) AED training programs developed by the following organizations are approved by the department:

- (a) American heart association;
- (b) American national red cross;

- (c) national safety council;
- (d) medic first aid; and
- (e) American safety.

AUTH: Sec. 50-6-503, MCA
IMP: Sec. 50-6-502 and 50-6-503, MCA

RULE VI MEDICAL PROTOCOL (1) A medical protocol for defibrillation use must be consistent with the energy requirements for defibrillation set out on pages 2211 through 2212 of "Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care, Recommendations of the 1992 National Conference" published in the Journal of the American Medical Association on October 28, 1992, Volume 268, Number 16.

(2) The department hereby adopts and incorporates by reference the energy requirements for defibrillation referred to in (1) above, which set standards for proper defibrillation. A copy of the document referred to in (1) above may be obtained from the Department of Public Health and Human Services, Emergency Medical Services and Injury Prevention Program, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

AUTH: Sec. 50-6-503, MCA
IMP: Sec. 50-6-502, MCA

RULE VII PERFORMANCE REQUIREMENTS OF DEFIBRILLATORS

- (1) An AED used by an AED program must be capable of:
- (a) delivering a shock of a waveform that is either:
 - (i) damped sinusoidal; or
 - (ii) biphasic truncated exponential.
 - (b) delivering the shocks required by the AED program's authorized medical protocol; and
 - (c) operating satisfactorily in the environment in which it is intended to function.

AUTH: Sec. 50-6-503, MCA
IMP: Sec. 50-6-503, MCA

3. The rules specify the minimum requirements for entities who want to establish programs allowing the use of automated external defibrillation on persons who have sustained a cardiac arrest, and are necessitated by the passage of House Bill 126 by the 1999 Legislature, specifically, the rulemaking mandate of 50-6-503, MCA.

Rule I is necessary to prescribe definitions for key words used in the rules. While statutory definitions would ordinarily not be reiterated in the rules, the statutory definitions for "AED" and "entity" are included in this case to make the definitions accessible to users of the rules, because the rules will in fact be in effect substantially in advance of the date the revised 1999 Montana Code Annotated containing the HB 126 enacted language will be published and available.

Rule II, specifying the content of the written plan which must be maintained by the entity which operates an AED program and which must be provided to the local emergency medical services and the 9-1-1 center, is required by 50-6-501, MCA, and its required contents are also specified in that statute. The required contents, aside from being mandated by statute, are necessary to ensure each AED is operated pursuant to directives that protect the health of those persons upon whom the AED may be used. Therefore, the Department found it necessary that the written plan specify the physical address where the AED is to be maintained, the names of the persons authorized to operate the AED, how the AED program will coordinate with local emergency medical services, the name of the physician who will be overseeing the AED program, the maintenance procedures for the AED and how the required reports will be made to the supervising physician and to the Department. Those provisions also ensure that an entity with an AED program provides emergency medical services with the information necessary to coordinate with the emergency medical services and with the dispatch entity. The Department considered requiring the plan to specify where, at each physical location, the AED would be kept. However, this information is not necessary for the responding emergency medical service nor for the public safety answering point and would therefore be unnecessarily onerous for the entities with the AEDs. For entities which offer mobile AED services, the Department considered whether to require, in the written plan, precise detail about the location of each AED. However, this requirement was not considered practical, was too difficult for the local entity, and was consequently rejected.

Rule III specifies what each entity operating an AED program must include in written notice to each local emergency medical service and public safety answering point mandated by 50-6-502, MCA. Information which must be included in the notice includes the name of the entity and its business address and telephone number, the name of the responsible individual, when the AED program will begin and where the AED's will be located. This written notice is necessary to assure there is effective integration among the entities offering the AED program, the licensed emergency medical services, and the dispatch center. It is well established that an AED program is effective only if there is good coordination with the EMS system. If the EMS system is not activated each time an AED is used, there is a decrease in the patient's probability of survival. The Department has required in the listing of what must be included in the notice only those items found through experience to assist in such coordination. The Department considered not including the starting date of the AED program in the written notice. However, to assure effective coordination with the EMS system and the dispatch center, this was considered necessary information.

Rule IV contains the reporting requirements that HB 126 mandated, and requires that the entity report to the supervising

physician, or the physician's designee, every time an AED is attached to a patient and it specifies the information which must be reported to the Department that the Department finds valuable in assessing the success of AED programs and their general public health impact. The information to be submitted to the overseeing physician was found reasonably to be left to the professional judgment of the supervising physician.

These reporting requirements are necessary to the quality control of the AED program. The authority is provided to the supervising physician to require information necessary to properly provide medical oversight while recognizing there may be variations from program to program. The information required for submission to the Department is necessary to evaluate the overall effectiveness of the AED program and to determine if changes are necessary in the program to assure public health and safety and/or to improve the efficacy of the AED programs.

Also concerning Rule IV, the Department considered a reduced number of data elements to be submitted to the Department for each use of the AED. The Department consulted with one of the nation's leading experts in AED programs, Doctor Roger White of the Mayo Clinic in Rochester, Minnesota, in determining which data elements are necessary to assure appropriate program evaluation. The proposed rule reflects the results of those discussions and is considered the minimum data set necessary for program evaluation.

Rule V specifies the training requirements found by the Department to be necessary before an individual may be allowed to use an AED in an approved program. The rule requires completion of one of the major national AED training programs listed and requires that each individual must renew their training in one of these programs every 2 years. The rule also requires that each individual must complete training in cardiopulmonary resuscitation every 2 years according to the standards of the American Heart Association, national standards found to be persuasive.

Rule V is also necessary to assure that each person operating an AED is properly trained in both cardiopulmonary resuscitation and in the use of the AED. If persons are not properly trained in both areas, it may reduce the effectiveness of the AED program and could, potentially, be harmful to patients. The Department is required, by statute, to adopt requirements regarding cardiopulmonary resuscitation and to list the approved AED training programs, which it has done after an exhaustive search of the most reliable programs currently in existence.

The Department considered not specifying that CPR and AED training should be renewed every 2 years. However, the Department determined that it is essential to public health and safety to require that each individual complete this training every 2 years. And, considering these training programs are not

lengthy, it was determined that this requirement would not be a burden on the entity nor on the individual.

Rule VI, setting up a medical protocol for AED use as required by 50-6-502, MCA, requires the medical protocol for AED use by entities to be consistent with the "Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care, Recommendations of the 1992 National Conference" as published in the Journal of the American Medical Association on October 28, 1992. This is necessary to assure that each AED program uses medically appropriate protocols and that the protocols are not harmful to the patient. The guidelines in question are those adopted nationally and endorsed by the American Heart Association and are therefore considered the most reliable available. The Department considered placing the entire protocol in the rules and considered adopting other medical protocols. However, the referenced protocol is available in the peer-reviewed literature, is scientifically based and is generally considered as the medical appropriate standard for AED use.

Rule VII, as required by 50-6-503, MCA, establishes the performance requirements that AEDs must meet. The two waveforms listed in the rule (damped sinusoidal or biphasic truncated exponential) are the waveforms currently supported by peer-reviewed literature as being effective for use in AEDs. The Department considered not including any specific waveforms; however, in the interest of patient safety, this requirement is included. As additional waveforms are considered acceptable, via peer-reviewed literature, this rule will need to be updated. The Department considered adding a number of very specific additional performance requirements for AEDs. However, considering the variety of locations in which the AEDs will be used, and considering that the AEDs must be approved by the Food and Drug Administration, the Department considered that "operating satisfactorily in the environment in which it is intended to function" is the most realistic requirement.

4. Interested persons may submit their data, views or arguments either orally or in writing at the hearing. Written data, views or arguments may also be submitted to Kathy Munson, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 202951, Helena, MT 59620-2951, no later than August 19, 1999. The Department also maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. For placement on the mailing list, please write the person at the address above.

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

6. The bill sponsor notice requirements of 2-4-203, MCA, apply and have been fulfilled.

/s/ Dawn Sliva
Rule Reviewer

/s/ Laurie Ekanger
Director, Public Health and
Human Services

Certified to the Secretary of State July 12, 1999.