

DEPARTMENT OF  
PUBLIC HEALTH AND HUMAN SERVICES  
HEALTH POLICY & SERVICES DIVISION



MARC RACICOT  
GOVERNOR

LAURIE EKANGER  
DIRECTOR

STATE OF MONTANA

COGSWELL BLDG., 1400 BROADWAY  
PO BOX 202951  
HELENA, MONTANA 59620-2951

August 8, 1998

Diona Kristian, Title XXI Project Officer  
Division of Integrated Health Systems  
Health Care Financing Administration  
Mail Stop C3-18-26  
7500 Security Boulevard  
Baltimore, Maryland, 21244-1850

Dear Ms. Kristian:

Attached is Montana's response to the questions raised by the Health Care Financing Administration which we received on July 29, 1998. These questions and our response further clarify the Title XXI state plan which Montana originally submitted on April 10, 1998.

We continue to await HCFA's response as to when and how the number of Native American children who are eligible for the CHIP program will be reflected in Montana's allotment? This information is very important to us as we are close to finalizing our budget for the next two years. Our legislature meets every other year.

I would again like to thank HCFA for your continued assistance. I have submitted an electronic copy of this response to Rick Fenton, Kathleen Farrell, Dee Raisl, and you. This hard copy contains the attachment referenced in our response to question four. If you do not receive the electronic version, or if you have further questions about our response, please feel free to contact me directly at (406) 444-4144 or through the Internet at mdalton@mt.gov.

Sincerely,

Mary E. Dalton, CHIP Coordinator

Enclosure

cc: Richard Fenton - Central Office  
Kathleen Farrell - Central Office  
Dee Raisl - Region VIII  
Spencer Ericson - Region VIII  
Nancy Ellery  
7.1

med/chipqua4

PHONE (406)444-4540 FAX: (406) 444-1861

Response to HCFA Questions and Comments  
Montana's Title XXI State Plan  
August 18, 1998

Section 4.1.9

1. Section 4.1.9, the eligibility of inmates of public institutions. Montana's policy as indicated in your response for a child who becomes an inmate of a public institution is not consistent with Title XXI. In addition to what has been approved in other States (i.e., termination of eligibility when a child becomes an inmate), we believe that a State could expedite re-enrollment to CHIP in order to receive FFP for services rendered if the child is an inpatient at a medical institution as allowable in Medicaid. Please revise your policy to meet CHIP requirements.

When a child becomes an inmate of a public institution, CHIP coverage will terminate

Section 4.3

2. Section 4.3, the enrollment process. Please provide further details on the process of forwarding the CHIP application to the County Public Assistance Office, including the expedited time frame for forwarding the information and whether the date of the CHIP application will constitute the initial date of the application for Medicaid. Please clarify the follow-up procedure that the State will use to ensure that potentially Medicaid eligible children enroll in Medicaid (note that a simple referral procedure to Medicaid would not meet the requirements of Title XXI.) Also, how will children who are identified as potentially Medicaid eligible but later determined not to be Medicaid eligible be enrolled in CHIP?

The following guidance is in follow-up to our conversation regarding the eligibility broker. After careful review of both Medicaid and CHIP laws and policies, we have determined that under a State Child Health Insurance Plan (**non-Medicaid** option), an eligibility broker may under certain circumstances assist families during the Medicaid application process. A private contractor (such as an eligibility broker), who is contracted with the State to perform Title XXI enrollment functions, may assist an applicant in completing the Medicaid application if the child has been found through

**the CHIP screening process to be potentially eligible for Medicaid, as long as the enrollment broker is being paid with only Title XXI funds, State employees continue to perform the final Medicaid eligibility determination and the family continues to have the option of seeking application assistance from the State employees.**

**FAMILIES WHO GIVE PERMISSION TO FORWARD INFORMATION TO MEDICAID**

- A) The CHIP program will screen all applicants for Medicaid eligibility. If the family income suggests probable eligibility for Medicaid, the state (phase I) or its eligibility broker (phase II) will notify the family in writing that the child cannot be insured by the Children's Health Insurance Plan. (See C below.)
- B) The CHIP application form will contain a statement that demographic information from the CHIP application will automatically be sent to the county public assistance office to begin the Medicaid application process for children who appear to be Medicaid eligible. (Families may check a box saying that this information may not be forwarded.)\*
- C) The demographic information from the CHIP application will be entered on the first page of our standard Medicaid application by the state! (phase I) or its enrollment broker (phase II) and sent to the appropriate county public assistance office. This Medicaid application form is a common form used by anyone applying for Medicaid. It is not unique to CHIP. The demographic information we are forwarding is also the same information which would be supplied by any other Montanan wishing to start the application process for Medicaid. We would anticipate that it will take one or two days for the mail to deliver this application to the appropriate county office.
- D) Upon receipt of this Medicaid application in the county office, the time clock for processing Medicaid eligibility will begin. The county office will contact the family and set up an in-person interview which is part of Montana's Medicaid eligibility process. The same Medicaid eligibility process and time frames will be used for these "CHIP referred" families as for all other eligibility determinations. Medicaid eligibility is routinely determined within 30 days of receipt of the application in the county office.\*\*
- E) Simultaneously with the Medicaid application being forwarded to the county, a CHIP denial letter will be sent to the family. This letter will tell the family: a) that they appear to be Medicaid eligible and that we have forwarded the demographic information to the appropriate county public assistance office to begin the Medicaid application process, b) they will receive a phone call or letter from their county public assistance office to set up an interview to determine Medicaid eligibility, c) they should take the full Medicaid application (which we have included with this letter) and the supporting documentation specified on the application to their interview, d) the importance of obtaining health care coverage for children and how Medicaid can assist them, and e) that

if they have further questions, they may call the state (phase I) or its eligibility broker (phase II) who will assist them.

\*Demographic information includes name, address, phone number, date and place of birth, sex, social security number, marital status, and citizenship.

\*\*Montana examined the feasibility of making the date of CHIP application the date for Medicaid application as well. We have rejected this option because we believe that this would compress the time frames that families must respond in and would result in more denials of Medicaid eligibility for the "technical" reason that families failed to provide information required by Medicaid in a timely manner. If that happened, we fear that many families would become frustrated with the process and drop out.

#### FAMILIES WHO REFUSE PERMISSION TO FORWARD INFORMATION TO MEDICAID

- A) Families may check a box on the CHIP application form saying that CHIP demographic information may not be forwarded to the county public assistance office to begin the Medicaid application process. (They will have to pro-actively take this step. Otherwise, the CHIP application form will contain a statement that demographic information from the CHIP application will automatically be sent to the county public assistance office to begin the Medicaid application process for children who appear to be Medicaid eligible.)
- B) The CHIP program will screen applicants for Medicaid eligibility. If the family income suggests probable eligibility for Medicaid, the state (phase I) or its eligibility broker (phase II) will notify the family in writing that the child cannot be insured by the Children's Health Insurance Plan. This denial letter will stress the importance of health care coverage and services for children and will urge the family to complete and forward the attached Medicaid application to the county public assistance office. The family will be informed that they can contact the state (phase I) or its eligibility broker (phase II) if they have further questions.
- C) The state (phase I) or its eligibility broker (phase II) will contact the family two weeks after the denial letter is issued to inquire whether the family has applied for Medicaid. As part of this contact, the eligibility broker will again stress the importance of applying for Medicaid so that the children have health care coverage.

#### FAMILIES WHO ARE DETERMINED INELIGIBLE FOR MEDICAID

Families who have been referred by the CHIP program and who are subsequently determined ineligible for Medicaid by the county public assistance office will be sent a letter denying Medicaid eligibility. The family will send this denial notice from Medicaid and their annual enrollment fee to the CHIP eligibility broker and ask that CHIP eligibility be determined. The eligibility broker will have the CHIP application in their files so this

will not need to be resubmitted. Enrollment of these children in the CHIP program will be subject to available funding.

**Section 8.2**

- 3. Section 8.2, the enrollment fee. The Department has reviewed Montana’s proposal to extend the table in 42 CFR 447.52(b) so that families with higher incomes would have a higher maximum monthly charge. The annual enrollment fees proposed in your response exceed the maximum monthly charge that is permissible under section 2103(e)(3). According to 42 CFR 447.52(c), a family may not be charged an enrollment fee that exceeds the monthly amounts specified in 42 CFR 447.52(b). Please revise your plan to comply with section 2103(e)(3) and the applicable regulations.**

Montana does not agree with the HCFA interpretation of section 2103(e)(3) or your refusal to extend the table cited as an example in 42 CFR 447.52(b). We would point out that this table was established in 1978 and has never been updated. The federal poverty level for a family of three in 1998 is \$1137.50/month and for a family of five is \$1604.17/month, yet the table stops at \$1000/month. Failure to extend this table results in families with less income being charged a proportionately greater share than families with more income.

We understand that we are clearly at an impasse with HCFA on this issue. Therefore, with great reluctance we amend our cost sharing proposal to the following:

Annual Enrollment Fee

- A) No annual enrollment fee will be assessed for families below 100% of the federal poverty level.
- B) A \$12 annual enrollment fee will be charged for a family of one who is at or above 100% of the federal poverty level. This would apply only in the case of an emancipated minor, since all families with a parent present will have at least two members.
- C) A \$15 annual enrollment fee will be charged for families of two or more who are at or above 100% of the federal poverty level.

Co-payment

- A) No co-payment will be assessed for families below 100% of the federal poverty level.
- B) For families at or above 100% of the federal poverty level, the following co-payments will apply:
  - Inpatient hospital services (includes \$25/admission

hospitalization for physical, mental and substance abuse reasons)	
-Emergency room visit	\$ 5/visit
-Outpatient hospital visit (includes outpatient treatment for physical, mental, and substance abuse reasons - excludes outpatient visit for x-ray or laboratory services only)	\$ 5/visit
-Physician, mid-level practitioner, optometrist audiologist, mental health professional, or substance abuse counselor services (excludes pathologist, radiologist, or anesthesiologist services)	\$ 3/visit
-Outpatient prescription drugs	\$ 3/prescription for generic drug
	\$ 5/prescription for brand-name drug

- C) No co-payment will apply to well-baby or well-child care, including age-appropriate immunizations.
- D) Co-payment will be capped at \$200/family/year. This is 2.5% of the family income for a family of one and 1% of the family income for a family of five at 100% of the federal poverty level. Co-payment will be tracked by the insurance company and communicated to the family with their statement of benefits paid.

**4. Section 9.10, the source of funding. Please detail the relationship between "Washington National Insurance Company," "Pioneer Life Insurance Company," and "Washington Life." Please describe the specific type(s) of insurance services provided by this/these company(ies); the types of violations allegedly committed by this/these company(ies); and the penalty process, including a reference to the applicable provision in State insurance law this/these company(ies) may have violated.**

There is no "Washington Life" insurance company. Pioneer Life Insurance Company (Pioneer Life) is licensed under certificate of authority number 3899, effective November 20, 1974, to act as an insurer and transact life and disability insurance in Montana. Washington National Insurance Company (Washington National) is licensed under certificate of authority number 3564, effective December 10, 1923, to act as an insurer and transact life and disability insurance in Montana. A company named

Conseco, Inc. acquired Pioneer Life in June 1997 and Washington National in December 1997.

The State Auditor and Commissioner of Insurance of the State of Montana (commissioner), pursuant to his authority entered a CEASE AND DESIST ORDER, Case No. 96-18 against Washington National on July 17, 1996. He claimed Washington National violated Section 33-18-232 of the Montana Code Annotated (MCA), by failing to pay a claim in 1996 by Nadine Anderson within 30 days of its receipt without good reason.

The commissioner entered a CEASE AND DESIST ORDER, Case No. 97-33 against respondents Washington National and Pioneer Life on December 18, 1997. He alleged that the respondents committed numerous violations of Montana law by improperly delaying or denying claims, incorrectly calculating premium refunds, illegally excluding or reducing mandated coverages or benefits by means of policy endorsements or riders, and failing to provide information requested by the commissioner. He also alleged that the respondents mailed letters to certain Montana health care providers demanding reimbursement for alleged overpayments on the basis of "special audits" extending as far back as January 1, 1993, but such audits provided no information regarding recalculation of patient co-payments or deductibles.

Conseco, Inc. and the commissioner reached an agreement on February 6, 1998, under which Conseco, who now owns both Washington National and Pioneer Life, admitted to violating Section 33-18-232 by failing to pay the claim of Nadine Anderson. The respondents neither admitted nor denied any other violations of Montana law alleged by the commissioner, but under the ownership of Conseco, agreed to resolve past errors and contribute \$210,000 into a trust account designated by the commissioner. The \$210,000 can be used either to qualify the State of Montana for matching federal funds for the Title XXI program or to fund no-obligation grants to Montana public health clinics which provide medical services for uninsured and underinsured low-income Montana patients.

This \$210,000 has been made available to the CHIP program through an intergovernmental transfer of funds. This was accomplished with an MOU between the Department of Public Health and Human Services and the Insurance Commissioner's office. Conseco, Inc., Washington National, and Pioneer Life are not a party in the MOU and will not benefit from this transfer.

A copy of the agreement between Conseco, Inc., and the commissioner is attached to the hard copy of this letter sent to the Central Office.

**Section 5.1**

**STATE INITIATED CHANGE**

Montana wishes to make the following amendment to section 5.1, Outreach and Coordination on page **19** of the original state plan. In the paragraph describing outreach and coordination methods during phase I, children currently on a waiting list for the Caring Program for Children, not children currently enrolled in the program, will be sent applications for the CHIP program. In addition, children on our "Children with Special Health Care Needs" program will not be targeted through a specific outreach campaign until phase II.

med/chipqua4

**RECEIVED**

**JUL 09 1998**

HEALTH POLICY & SERVICES

**BEFORE THE STATE AUDITOR  
AND COMMISSIONER OF INSURANCE  
HELENA, MONTANA**

**IN THE MATTER OF:**  
**WASHINGTON NATIONAL INSURANCE COMPANY**  
**and PIONEER LIFE INSURANCE COMPANY,**  
**Respondents.**

**CASE NO. 87-33**  
**CONSENT ORDER**

**TO: Washington National Insurance Company and**  
**Pioneer Life Insurance Company**  
**c/o James L. Young, Vice President and Associate General Counsel**  
**Conseco Companies**  
**11815 N. Pennsylvania Street, A3B**  
**P.O. Box 1911**  
**Camel, Indiana 46032-4911**

**c/o Ark Monroe, III**  
**Mitchell, Williams, Selig, Gates & Woodyard, P.L.L.C.**  
**320 West Capitol Avenue, Suite 1000**  
**Little Rock, Arkansas 72201-3525**

**The State Auditor and Commissioner of Insurance of the State of Montana**  
**(commissioner), pursuant to the authority of the Montana Insurance Code, Section**  
**13-1-101, et seq., Montana Code Annotated (1997) [hereinafter cited as MCA], hereby**  
**alleges the following:**

**I. FINDINGS OF FACT**

- 1. On July 17, 1996, the commissioner entered a CEASE AND DESIST**  
**ORDER, Care No, 96-18, against Respondent Washington National Insurance**  
**Company (Washington National) based upon denial of coverage to Nadine Anderson**  
**and served his order upon Respondent by certified mail, return receipt requested.**
- 2. On December 8, 1997, the commissioner entered a CEASE AND DESIST**

1 ORDER AND ORDER TO PROVIDE INFORMATION, Case No. 97-33, against  
2 Respondents and served it upon Respondents by certified mail, return receipt  
3 requested.

4 3 Conesco, Inc., acquired Respondent Pioneer Life and Pioneer Financial  
6 Services, Inc. (also known as Pioneer Insurance Group and hereafter collectively  
6 referred to as Pioneer) in June 1997 and acquired Respondent Washington National in  
7 December 1997.

8 4. On December 18, 1997, James L. Young, Vice President and Associate  
9 General Counsel of the Conesco Companies, notified the commissioner that both  
10 Respondents are now wholly owned subsidiaries of Conesco, Inc., and that on behalf of  
11 Respondents, he and Ark Monroe, Esq., waived the requirement of an administrative  
12 hearing within 20 days of the commissioner's order of December 8, 1997, and reserved  
13 Respondents' right to a hearing on the allegations contained in that order.

14 5. On December 24, 1997, the commissioner agreed to extend the deadline  
15 for compliance with his Order to Provide Information until January 30, 1998.

16 6. On January 22, 1998, the commissioner agreed to further extend the  
17 deadline for compliance with his Order to Provide Information until February 28, 1998.

18 7. In his CEASE AND DESIST ORDER AND ORDER TO PROVIDE  
19 INFORMATION, Case No. 97-33, the commissioner alleged in substance the following:

20 'A. Washington National Insurance Company (Washington National) is  
21 licensed under certificate of authority number 3564, effective December 10, 1923, to act  
22 as an insurer and transact life and disability insurance in Montana.

23 B. Pioneer Life Insurance Company (Pioneer Life) is licensed under  
24 certificate of authority number 3899, effective November 20, 1874, to act as an insurer  
25 and transact life and disability insurance in Montana.

1 C. Pioneer, on behalf of Washington National and in connection with certain  
2 health insurance policies which Washington National first issued and which were  
3 subsequently reinsured by Pioneer, mailed letters to certain Montana health care  
4 providers demanding reimbursement for alleged overpayments on the basis of "special  
5 audits" extending as far back as January 1, 1993, but such audits provided no  
6 information regarding recalculation of patient co-payments or deductibles.

7 8. In addition to those demand letters and Montana health care providers  
8 specified in the commissioner's December 8, 1997, CEASE AND DESIST ORDER AND  
9 ORDER TO PROVIDE INFORMATION, Case No. 97-33, the commissioner alleged that  
10 Respondents mailed numerous similar letters demanding reimbursements to numerous  
11 additional Montana health care providers based upon various audit periods.

12 9. After issuing his July 17, 1996, CEASE AND DESIST ORDER, Case No.  
13 96-18, the commissioner alleged that Respondent Washington National committed  
14 numerous additional violations of Montana law by improperly delaying or denying  
15 claims, incorrectly calculating premium refunds, illegally excluding or reducing  
16 mandated coverages or benefits by means of policy endorsements or riders, and failing  
17 to provide information requested by the commissioner.

## 18 II. RESPONDENTS' STIPULATIONS AND CONSENT

19 In consideration of these allegations and by signing this Consent Order,  
20 Respondents waive their right to a formal hearing and hereby stipulate and consent to  
21 the following:

22 1. That Conseco, Inc., acquired Respondent Pioneer in June 1997 and  
23 acquired Respondent Washington National in December 1997.

24 2. That Respondent Washington National violated Section 33-18-232(1),  
26 MCA, by failing to pay a claim in 1996 by Nadine Anderson within 30 days of its receipt

1 without good reason.

2 3. That Respondents neither admit nor deny any other violations of Montana  
3 law alleged by the commissioner but, under *the* new ownership of Conseco, desire to  
4 efficiently and finally resolve all outstanding disagreements with the commissioner in  
5 the best interests of their Montana insureds and the improvement of relations with the  
6 people of Montana,

7 4. That Respondents will resolve past errors involving payment of claims or  
8 refund of premiums by making prompt and appropriate adjustments after being notified  
9 of such errors.

10 5. That Respondents, under *the* new ownership of Conseco, will contribute  
11 the sum of \$210,000 on or before March 1, 1998, into a trust account designated by the  
12 commissioner, such sum to be used on or before December 31, 1998, solely and  
13 completely for one of the two following purposes:

14 A. To qualify *the* State of Montana for matching federal funds in establishing  
15 and operating a State Children's Health Insurance Program (SCHIP) pursuant to Title  
16 XXI of the Social Security Act and the Balanced Budget Act of 1997 (PL105-33), Title  
17 IV, Subtitle J; or

18 B. To fund no-obligation grants to Montana public health clinics which  
19 provide medical services for uninsured and underinsured low-income Montana patients.

20 6. That subject to Paragraphs 8 and 9, Respondents, in addition to any and  
21 all penalties available to the commissioner upon notice and hearing as prescribed by  
22 Montana law, will pay a "liquidated fine" of \$1,000 for each violation of Section 33-111-  
23 233, MCA, which occurs within two years from the date of this CONSENT ORDER and  
24 which violation is attributable to:

25

1 condition through a group policy endorsement or rider;

2 B. Exclusion of mandated coverage or benefits for Caesarean-section  
3 delivery through any health policy endorsement or rider;

4 C. Wrongful denial of a claim for state-mandated benefits such as maternity,  
5 mammography, and wellness benefits, whether or not excluded through a policy  
6 endorsement or rider;

7 D. Denial of a good-health discount on the basis of an insured's claim for  
8 mandated wellness benefits; or

9 E. Payment of any portion of a claim for benefits more than 30 days after  
10 receipt of proof of loss without good reason within the meaning of Section 33-18-232(1),  
11 MCA.

12 7. That subject to Paragraph 8 Respondents will pay 18 percent interest per  
13 year on any claim for benefits which, within two years of the date of this CONSENT  
14 ORDER, remains unpaid for more than 30 working days after receipt of such claim  
15 without good reason as determined by the commissioner within the meaning of Section  
16 33-18-232(2), MCA.

17 8. That within the first six months after the date of this CONSENT ORDER  
18 Respondents can avoid the "liquidated fines" required in Paragraph 6 and the interest  
19 payments required in Paragraph 7 by resolving any such wrongful denials or delays of  
20 claims within 5 working days, absent extenuating circumstances, after the  
21 commissioner notifies Respondents of such wrongful denial or delay.

22 9. That within two years of the date of this CONSENT ORDER, Respondents  
23 can avoid the "liquidated fines" required in Paragraph 6 by demonstrating within the  
24 meaning of Section 33-18-233(3), MCA, that they have consistently paid 90 percent of  
25 the total amount outstanding in claims within 20 working days and all of the amount

1 within 30 working days of receipt of claims.

2 10. That on or before October 1, 1998, Respondent Washington National will  
3 correctly recalculate and refund to its Montana insureds all premiums wrongfully  
4 collected since January 1, 1994, as a result of multiple premium increases within a 12-  
5 month period.

6 11. That Respondents, pursuant to *the* commissioner's ORDER TO PROVIDE  
7 INFORMATION, Case No. 97-33, will respond on or before February 28, 1998, and  
8 thereafter cooperate with the commissioner to determine on or before May 1, 1998, the  
9 extent and cause of any improper demands for refunds from Montana physicians and  
10 the appropriate adjustments, if any, which are necessary to correct such improper  
11 demands for refunds.

12 12. That neither Respondents nor any of their affiliated companies will  
13 demand refunds from Montana physicians based upon medical services rendered more  
14 than one year prior to the date of the first demand for such refund.

15 13. That Respondents and all their affiliated companies will abandon all  
16 efforts to collect refunds from Montana physicians for medical services rendered more  
17 than one year prior to the date of the first demand for such refund.

18 14. That Respondents and all their affiliated companies will refund to Montana  
19 physicians all amounts collected erroneously or in contravention of Paragraphs 11, 12,  
20 or 13 above as a result of demand letters and special audits, provided however that  
21 such physicians or the commissioner shall have notified Respondents or their affiliated  
22 Companies of the error or contravention of paragraphs 11, 12, or 13 above, alleged in  
23 any given case with reasonable particularity.

24 15. That Respondents and all their affiliated companies will respond promptly  
25 and in good faith to such further requests for information or response as the

1 commissioner within his authority shall make.

2 16. That Respondents will dedicate a single member of their compliance or  
3 claims-handling staff as liaison to the commissioner's office and will take specific  
4 corrective measures in good faith to improve access, including phone access, to their  
5 claims-handling offices for Montana consumers and the commissioner's office.

6 III. COMMISSIONER'S STIPULATIONS AND CONSENT

7 Pursuant to the stipulations and consent by Respondents, the commissioner  
8 under authority of the Montana Insurance Code and Section 2-4-603, MCA, hereby  
9 agrees to the following:

10 1. That, subject to Paragraph 3 below, he considers this CONSENT ORDER  
11 to constitute the final disposition of all outstanding disagreements with Respondents in  
12 the best interests of their Montana insureds and the improvement of relations between  
13 Respondents and the people of Montana.

14 2. That he will not use any stipulations or admissions by Respondents  
15 contained in this CONSENT ORDER against them unless he institutes an action for  
16 violation of the terms of this CONSENT ORDER.

17 3. That if the commissioner determines that Respondents violated the terms  
18 or conditions of this CONSENT ORDER, the commissioner may institute civil or  
19 administrative action against them, use any stipulations or admissions contained herein  
20 against them, and levy any allowable fine or impose any allowable remedy in addition to  
21 any action taken or payment made under this CONSENT ORDER by Respondents.

22 4. That if the commissioner determines that any of Respondents' affiliated  
a3 companies violated the terms or conditions of Paragraphs 12, 13, or 14 above, the  
24 commissioner may institute civil or administrative action against them, use any  
25 stipulations or admissions contained herein against them, and levy any allowable fine or

1 impose any allowable remedy in addition to any action taken or payment made under  
2 this CONSENT ORDER by Respondents.

3 5 That the commissioner, in the best interest of Montana consumers and  
4 recognizing the substantial progress that Conaeco has already made in correcting the  
5 serious problems which it acquired with Respondents, will cooperate in good faith with  
6 Conesco and Respondents to promptly and appropriately resolve past errors involving  
7 payment of claims or refund of premiums.

8 6. That the commissioner, in exercising his discretion pursuant to this  
9 CONSENT ORDER to designate any recipient or use for the \$210,000 contribution by  
10 Respondents, will impose no obligations upon such recipient and no conditions upon  
11 such use except those expressly contemplated by the parties to this CONSENT  
12 ORDER.

13 7. That the commissioner, within the first six months after the date of this  
14 CONSENT ORDER, will not require from Respondents the "liquidated fines" or interest  
15 payments referred to herein if Respondents resolve any wrongful denials or delays of  
16 claims within 5 working days, absent extenuating circumstances, after the  
17 commissioner notifies Respondents of such wrongful denial or delay.

18 8. That the commissioner will not require from Respondents the "liquidated  
19 fines" referred to herein if, within two years of the date of this CONSENT ORDER,  
20 Respondents demonstrate within the meaning of Section 33-18-233(3), MCA, that they  
21 have consistently paid 90 percent of the total amount outstanding in claims within 20  
22 working days and all of the amount within 30 working days of receipt of claims.

23 9. That the commissioner will cooperate with Respondents in good faith to  
24 determine on or before May 1, 1998, the extent and cause of any improper demands for  
25 refunds from Montana physicians and the appropriate adjustments, if any, which are

necessary to correct such Improper demands for refunds.

10. That in *the* interest of obtaining full disclosure and accurate analysis from Respondents regarding the extent and cause of any improper demands for refund: from Montana physicians and the appropriate adjustments, if any, which are necessary to correct such improper demands for refunds, the commissioner will not seek additional fines or sanctions based on such improper demands for refunds or any response to his ORDER TO PROVIDE INFORMATION, Case No. 97-33.

DATED this 6<sup>th</sup> day of February, 1998.

Authorized Representative for Respondents  
*Executive Vice President*

Mark O'Keefe, State Auditor  
and Commissioner of Insurance