MINUTES

MONTANA HOUSE OF REPRESENTATIVES
54th LEGISLATURE - REGULAR SESSION

SELECT COMMITTEE ON HEALTH CARE

Call to Order: By **CHAIRMAN SCOTT ORR**, on February 16, 1995, at 3:34 P.M.

ROLL CALL

Members Present:

Rep. Scott J. Orr, Chairman (R)
Rep. Carley Tuss, Vice Chairman (D)
Rep. Beverly Barnhart (D)
Rep. John Johnson (D)
Rep. Royal C. Johnson (R)
Rep. Betty Lou Kasten (R)
Rep. Thomas E. Nelson (R)
Rep. Bruce T. Simon (R)
Rep. Richard D. Simpkins (R)
Rep. Liz Smith (R)
Rep. Carolyn M. Squires (D)

Members Excused: None

Members Absent: None

Staff Present: David Niss, Legislative Council
Susan Fox, Legislative Council
Vivian Reeves, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:

Hearing:	None
Executive Action:	HB 155 Tabled
	HB 511 Do Pass as amended
	HB 533 Do Pass as amended
	HB 405 Do Pass as amended
	HB 446 Do Pass as amended
	HB 466 Do Pass as amended

{Tape: 1; Side: 1.}

EXECUTIVE ACTION ON HB 155

Motion/Vote: **REP. LIZ SMITH MOVED TO TABLE HB 155.** Voice vote was taken. **The motion carried unanimously, 11 to 0.**

EXECUTIVE ACTION ON HB 511

Motion: **REP. ROYAL JOHNSON MOVED HB 511 DO PASS.**

Discussion: **REP. R. JOHNSON** explained amendment #1. **EXHIBIT 1**

Susan Fox, Legislative Council, added the amendment refers to the administration of the state health plan.

Motion: **REP. R. JOHNSON MOVED TO ADOPT AMENDMENT #1.**

Vote: Question was called. Voice vote was taken. **The motion carried unanimously.**

Motion: **REP. ROYAL JOHNSON MOVED TO ADOPT AMENDMENT #2. EXHIBIT 2**

Discussion: **REP. R. JOHNSON** asked **Ms. Fox** to explain the amendment #2 and she did.

Mike Craig, Planning and Research Director, Montana Health Care Authority, suggested it be codified to the Department of Justice. **REP. R. JOHNSON** indicated that step would be taken in the next amendment.

Vote: Question was called. Voice vote was taken. **The motion carried unanimously.**

Motion: **REP. R. JOHNSON MOVED TO ADOPT AMENDMENT #3. EXHIBIT 3**

Discussion:

REP. R. JOHNSON explained the amendment and stated that a fiscal note would be required.

REP. BETTY LOU KASTEN asked how much funding is envisioned.

REP. R. JOHNSON said the amendment states it shall be designed and developed with guidance from the advisory council.

REP. KASTEN redirected her question to **Peter Blouke.**

Mr. Blouke, Director, Social and Rehabilitation Services (SRS) Department, stated that a Medstat data base would be developed to study a number of aspects of the health care system. He stated that this Medstat system and the Blue Cross/Blue Shield (BCBS) Medstat system deals with different data platforms. To develop a comprehensive health care data base the collection of issues relating to outcome measures and quality of care should be included. He indicated that there would be some fiscal impact to move from what is currently being done, to what could be done.

REP. RICHARD SIMPKINS inquired if this permits contracting out if the information is available from a private source.

REP. R. JOHNSON answered that it permits any of those things.

REP. SIMPKINS stated that the information available on the state computers and the BCBS computers deal primarily with Medicare and Medicaid. He asked **Mr. Blouke** if SRS had other data on Medicaid.

Mr. Blouke replied that SRS had only Medicaid. He stated that BCBS has regular insurance in addition to Medicare. He indicated that BCBS has expressed interest in working with the SRS, but the issues of confidentiality would have to be dealt with. He estimated that combining the information from SRS and BCBS would encompass about 80% of the health care expenditures, and stated that there is already a lot of information available.

REP. R. JOHNSON explained new Section 11.

REP. BEVERLY BARNHART said that **REP. JOHN COBB'S** bill could be inserted regarding quarterly reports to the health care council.

Ms. Fox said that **REP. COBB'S** bill deals with this same section of law but is substantially different.

Vote: Question was called. Voice vote was taken. **The motion carried unanimously.**

Motion: **REP. R. JOHNSON MOVED TO ADOPT AMENDMENT #4. EXHIBIT 4**

Discussion: **REP. JOHN JOHNSON** inquired if the five members representing the health care planning regions would be reimbursed for their expenses. **REP. R. JOHNSON** said yes.

REP. J. JOHNSON referred to new Section 4 and inquired if that would include the reimbursement for the five members representing the health care planning regions. **Ms. Fox** referred to page 2, line 28 of HB 511, and suggested to strike "The" and insert "A".

Motion: **REP. J. JOHNSON MOVED TO AMEND HB 511, PAGE 2, LINE 28 TO STRIKE "THE" AND INSERT "A".**

Discussion: **REP. BARNHART** suggested holding HB 511 until similar bills come up to hear them together. She inquired if **REP. R. JOHNSON** were familiar with the other bills. **REP. R. JOHNSON** asked what the bill numbers were. **REP. BARNHART** said it was **SEN. EVE FRANKLIN'S** bill. **REP. R. JOHNSON** stated that he was not familiar with her bill.

REP. BARNHART said it was her understanding that the Select Committee on Health Care would hear similar bills together, and she suggested holding HB 511.

REP. R. JOHNSON stated that he was familiar with **SEN. LARRY BAER'S** bill. **REP. R. JOHNSON** said that he would not want his bill put into HB 511 because it goes off in a different direction. He said that it could perhaps be coordinated with HB

511. However, as he was unfamiliar with **SEN. FRANKLIN'S** bill, he would leave it up to the **CHAIRMAN SCOTT ORR** whether or not to hold HB 511.

REP. KASTEN reminded the Committee that there is a motion on the table.

CHAIRMAN ORR asked if there was discussion on the amendment to strike "The" and insert "A" on page 2, line 28, HB 511.

Vote: Question was called. Voice vote was taken. **The motion carried unanimously.**

Motion: **REP. R. JOHNSON MOVED THE BILL AS AMENDED.**

Discussion: **CHAIRMAN ORR** said that **REP. BARNHART'S** question would be in order. **REP. BARNHART** asked if she needed to repeat it. **CHAIRMAN ORR** said no, but **REP. BRUCE SIMON** would like to respond to that question.

REP. SIMON stated that it may not be wise to hold on to the bills in this Committee and wait for the Senate to do something. He suggested that the bills should be transmitted and then this Committee could discuss these issues with a like Committee from the Senate to try to come to a consensus on the bills.

REP. CARLEY TUSS inquired if **REP. SIMON** was suggesting a large conference committee toward the end of the session?

REP. SIMON stated that he would hope that the conference would take place much earlier in the process with "like" members of the Senate to have a serious discussion of the bills.

REP. CAROLYN SQUIRES inquired if there has been any discussion with the House or Senate leadership which would indicate that the Senate would even want to form a committee of this nature?

CHAIRMAN ORR said he has not had any discussion regarding a committee of this nature.

REP. SQUIRES inquired if **CHAIRMAN ORR** had yet spoken to leadership about holding bills in regards to transmittal, even if they do not have a fiscal impact.

{Tape: 1; Side: 2.}

CHAIRMAN ORR apologized that he had not yet spoken to leadership and stated that he would do so. **REP. SQUIRES** explained her concerns. **CHAIRMAN ORR** agreed with **REP. SQUIRES** and said he would speak to leadership. **REP. SMITH** asked if **SEN. FRANKLIN'S** bill had been heard yet. **REP. SQUIRES** stated that it was not, however, a press conference was held.

REP. SIMPKINS stated that there is a supremacy conflict and that a joint committee would be the only way to iron these out. He suggested that the bills be passed to the Senate and after the transmittal date, review the bills from the Senate and make recommendations.

REP. SIMON encouraged **CHAIRMAN ORR** to communicate to the President of the Senate that this Committee is interested in a discussion with representatives from the Senate to form a Joint Committee to discuss the health care bills.

REP. KASTEN stated that she had already spoken to everyone on her subcommittee list to see if any of the bills could be meshed. **EXHIBIT 5**

REP. SIMON spoke in regard to the bills in his subcommittee. **EXHIBIT 5**

REP. BARNHART said that she was not suggesting to hold everything up. Her suggestion was in regard to the two other bills which are similar.

REP. R. JOHNSON inquired if the Committee were still discussing the motion.

CHAIRMAN ORR said they were still on the Do Pass motion.

REP. SIMPKINS stated that HB 511 had an appropriation and the other two bills did not. He suggested passing this bill from this Committee to the Appropriations Committee, and then looking at the other two bills when they are passed from the Senate.

Vote: Question was called. Voice vote was taken. **The motion carried unanimously, 11 to 0.**

EXECUTIVE ACTION ON HB 533

Motion: **REP. R. JOHNSON MOVED TO ADOPT AMENDMENT #1.**

Discussion: **Tanya Ask, Blue Cross/Blue Shield,** explained the amendment. **EXHIBIT 6**

CHAIRMAN ORR requested that **REP. R. JOHNSON** inquired about the new effective date of January 1, 1996. **Ms. Ask** explained this was done to allow contracts to be modified on renewal. She said the sponsor, **REP. PEGGY ARNOTT** was in agreement with the amendment.

REP. SIMPKINS inquired about the wording: "block of business in the individual disability insurance policy certificate." **Ms. Ask** explained that not often in the individual market are a lot of individual options added on. However, dental/vision, and other options like that would be treated as one block of business because the basic contract remains the same.

REP. SIMPKINS inquired if a policy had a choice of deductibles, co-insurance and stop-loss would that all remain in the same block of business as long as the basic benefits remained the same.

Ms. Ask responded that in the individual marketplace there is usually not much variation of deductible on co-insurance, however, it would all remain within the block of business.

REP. J. JOHNSON inquired if portability of insurance and guaranteed issue are different or if they are one and the same. **Ms. Ask** stated that portability and guaranteed issue are two different terms. She explained the terms.

REP. J. JOHNSON asked if they could have portability without guaranteed issue in the same bill. **Ms. Ask** stated that HB 533 deals only with portability of the preexisting waiting period. However, theoretically, guaranteed issue could be included in the same bill.

REP. R. JOHNSON inquired if there was anyone opposed to these amendments.

REP. KASTEN inquired about the difference between "health care insurer as defined in 33-22-125," in amendment #4. **EXHIBIT 6** **Ms. Ask** explained the differences.

REP. KASTEN asked if it brings the scope down. **Ms. Ask** said yes.

REP. SMITH asked referred to page 2, new Section 2 of HB 533 and asked if it would be more clear to change the title of the section to "Portability of preexisting waiting period" rather than "Portability of insurance required." **Ms. Ask** said that it may be better to say "Portability of insurance waiting period required."

REP. BARNHART inquired if the question pertained to the amendment. **REP. SMITH** apologized and said it didn't.

Ms. Ask clarified that they might want to say "portability of waiver of any time period applicable."

Vote: Question was called. Voice vote was taken. **The motion carried unanimously.**

CHAIRMAN ORR said they would discuss the bill.

REP. SIMON commented on Section 2 and said that the "headlines" are guidelines and perhaps the staff could suggest some language that would be more instructive. He stated that the headlines do not affect statute.

REP. SIMPKINS inquired about the waiver of preexisting conditions.

Tom Hopgood, Health Insurance Association of America, suggested clarifying the title of Section 2, and call it "Waiver of preexisting condition exclusion."

Motion: **REP. SIMPKINS MOVED TO AMEND THE TITLE OF SECTION 2, HB 533 TO READ "WAIVER OF PREEXISTING CONDITION EXCLUSION".**

REP. BARNHART inquired about the 30 days. **CHAIRMAN ORR** inquired if the question had to do with the amendment. **REP. BARNHART** answered no.

REP. SIMON questioned if an amendment were really in order to change the title since the title change is not statute. He suggested that the staff could make the change without a formal amendment.

REP. SIMPKINS stated that it is a matter of record if it is done by amendment.

Vote: Question was called. Voice vote was taken. **The motion carried unanimously.**

REP. BARNHART inquired about the 30 days.

REP. SIMPKINS said to change it to "60 days", or change it to "applies for the insurance within 30 days of expiration of the previous insurance." **REP. NELSON** stated that it is fine the way it is.

REP. SIMPKINS asked if the insurance terminates on the date that a person quits a job. **Mr. Hopgood** said that the industry has no problem with changing it to 60 days.

REP. NELSON asked **REP. SIMPKINS** if the premium is paid until the end of the month and asked if he was talking about group insurance. **REP. SIMPKINS** said yes.

REP. NELSON stated that generally if the premium is due on the first of the month and premiums are paid a month at a time, then if an employee terminated on the second of the month, coverage would last until the end of the month.

Motion: **REP. SIMPKINS MOVED TO AMEND HB 533, LINE 7, PAGE 2 TO 60 DAYS.**

Discussion: **REP. R. JOHNSON** inquired what **Mr. Cote** had to say about the termination of contracts due to unemployment.

Frank Cote said that under certain contracts if someone were to leave employment, the contracts are written in such a way that the coverage would cease at that point of termination. There may be a refund due to the employer or to the employee. A concern he had about using the effective date was that the employee doesn't have any control over that. If it were the date of application,

the employee would know when the date of application was; which may or may not cause another problem for the industry. He indicated the problem that by the time the underwriting is complete, it may be beyond 30 or 60 days.

REP. R. JOHNSON asked what the purpose is for changing 30 days to 60 days, other than to make it 30 days longer? **Frank Cote** said that is what it would do; make it 30 days longer. **REP. R. JOHNSON** stated that it does not answer the problem. **Mr. Cote** agreed that it may not.

REP. R. JOHNSON asked if it would make any difference if it were changed to 120 days. **Mr. Cote** replied that probably would not be well received.

REP. NELSON explained that if the period is too long, it has an upward impact on everyone's insurance rates. He indicated the shorter the time period, the less impact it will have on the cost of insurance. The reason is the longer the period the greater the risk something will happen. He agreed with **Mr. Cote** that it would not hurt to go to 60 days.

REP. SIMON asked for **Ron Kunik's** comments on the issue.

Mr. Kunik, Montana Medical Benefit Plan, stated that it would be fair to the consumer to allow them 30 days to submit their application.

{Tape: 2; Side: 1.}

REP. SIMPKINS referred to line 7, page 2, HB 533, and suggested rewording it to "was continuous to a date and the individual applies for replacement insurance within 30 days after the termination of the previous insurance."

REP. KASTEN suggested to keep the 30 days and go to the date of application.

CHAIRMAN ORR asked how that would read. **REP KASTEN** said "continuous to the date not more than 30 days prior to the date of application of the new coverage."

REP. SIMPKINS said the focus is on the gap between the termination and applying for new insurance. He said it is not within 30 days of applying; it is within 30 days after the termination of the previous insurance.

At this time REP. SIMPKINS withdrew his motion to amend line 7, page 2, HB 533 to 60 days.

REP. SQUIRES asked if the application time works for the benefit of the consumer. **Mr. Cote** answered yes.

REP. SQUIRES asked if a person would be covered if they applied on the fifteenth day of the 30 days. **REP. KASTEN** corrected "the 29th day." **Mr. Cote** answered yes.

REP. NELSON asked if the premium was due today--February 16--would the application have to be made before the sixteenth of March, or whatever 30 days later happened to be. He indicated that many people would interpret this to mean that they can go up to the sixteenth of April, because they would think that they have insurance during the 30-day grace period. He stated that they would only have insurance during the 30-day grace period if the February premium was paid.

REP. SQUIRES supported **REP. NELSON'S** comments.

REP. KASTEN asked **Mr. Cote** if the date of employment termination was also the date of policy termination. **Mr. Cote** said that it could be in some contracts.

REP. KASTEN stated that to carry any portion of the insurance it would be necessary to be on COBRA or pay the policy for this 30 day period.

REP. NELSON referred to line 7, page 2, HB 533 and suggested changing "30 days" to "60 days" and changing "effective date" to "application date."

CHAIRMAN ORR stated the phrase on line 7, page 2 would read "60 days prior to the application date." **REP. SQUIRES** asked **Mr. Hopgood** to clarify.

Mr. Hopgood indicated that if they use the date of application, then it should be 30 days so as not to unduly increase the price of coverage. He suggested rewording it to "previous coverage was continuous to a date not more than 30 days prior to the date of application for new coverage."

REP. SMITH said that there has to be termination.

Mr. Hopgood said there would be coverage regardless of how the coverage terminates.

REP. SIMPKINS said that people would get confused about the grace period. People will think that they have 30 days from the end of their grace period.

Mr. Hopgood stated "you are trying to find a one-size-fits-all." He indicated that he has almost 300 different contacts. He suggested wording the phrase to benefit the most people.

Motion/Vote: REP. TUSS MOVED TO ACCEPT THE TOM HOPGOOD LANGUAGE, PAGE 2, LINE 7, TO READ "PREVIOUS COVERAGE WAS CONTINUOUS TO THE DATE NOT MORE THAN 30 DAYS PRIOR TO THE DATE OF APPLICATION FOR

NEW COVERAGE." Question was called. Voice vote was taken. **The motion carried unanimously.**

Motion/Vote: REP. SIMON MOVED HB 533 DO PASS AS AMENDED. Voice vote was taken. **The motion carried 11 to 0.**

EXECUTIVE ACTION ON HB 405

Motion: REP. NELSON MOVED THAT HB 405 DO PASS.

Motion: REP. NELSON MOVED AMENDMENT #1. EXHIBIT 7

Discussion: Larry Akey, Montana Association of Life Underwriters, explained amendment #1 and stated the amendment allows large employers to participate in purchasing pools.

REP. SIMPKINS asked if there are other amendments to HB 405 as well. **CHAIRMAN ORR** stated he wasn't aware of any.

REP. R. JOHNSON inquired if there were anyone in the room who disagreed with these amendments. **REP. R. JOHNSON** requested that **Ed Grogan** make a statement.

Mr. Grogan, Montana Medical Benefit Plan, Montana Medical Benefit Trust, and the Montana business and Health Alliance, indicated that he did not have a copy of the amendment, so he did not know if he disagreed or not. (He was given a copy of the amendment). He indicated that at one time there was discussion about changing the number from 1000 to a smaller figure because of Montana's lack of population density.

REP. TUSS indicated that **Mr. Grogan** was referring to line 26, page 2, of HB 405. She said he is talking about changing it to a smaller number, but it should be changed it to a larger number for more inclusion.

REP. R. JOHNSON inquired if **Mr. Grogan's** amendment referred to 1000 on page 2, line 25. He indicated that all the amendment did was put in the numerals instead of spelling it out. He asked if that was **Mr. Grogan's** question.

Mr. Grogan said no. He said there was discussion about changing the number to smaller than 1000 so that there would not be such a big pool. He suggested that instead of 1000, perhaps it should be 500.

REP. R. JOHNSON inquired if there were anyone else who disagreed with any part.

Mr. Kunik stated that he had previously addressed an issue regarding agents soliciting business for the alliance.

CHAIRMAN ORR stated that amendment #12 is in regard to that.

REP. SIMPKINS read the insert of amendment number 13 and inquired if that takes care of it.

Mr. Kunik asked if his concern was if the alliance is submitting this to 40 different groups, how does an agent get licensed for 40 different groups. **Mr. Kunik** said that as a producer he was not able to solicit business for different companies unless he is appointed with them.

REP. SIMPKINS asked if a company wanted an agent to bid, they would license him and submit the bid to him. He explained that "you're not soliciting; really you are asking for a bid."

REP. NELSON said that is true.

Mr. Kunik stated that regarding insurance, he is not allowed to solicit any health program. **REP. KASTEN** asked if the word "marketing" would cause a problem in item 13 of the Nelson amendment. **REP. NELSON** explained his use of the word "marketing." **REP. KASTEN** inquired if there was a difference between soliciting and marketing? **REP. NELSON** stated that there is a subtle difference in the law.

REP. KASTEN asked if the wording was okay? **REP. NELSON** said yes and referred to **Mr. Kunik's** concern about having to be appointed with a company before giving him a bid. He said that is the process a solicitor goes through to be contracted with that company in order to solicit products on the marketplace.

REP. KASTEN referred to item 6 of the Nelson amendment. She said that there may be 1000 employees within the employer group, but may only get 75% of the total pool. She inquired if that would be in compliance, or if it would be necessary to change item 6 in order to bring **REP. NELSON'S** concept into reality. Could the policy still be issued?

REP. SMITH said that from 1000 eligible employees, it would be an almost impossible marketing task for one agent to solicit 1000 lives under a group.

REP. NELSON confirmed that it would have to be a bigger organization.

REP. SMITH stated that a person marketing disability insurance policies, certificates or contracts for a voluntary purchasing pool must be licensed as an insurance producer and emphasized that's not the provider.

REP. NELSON said that the producer is the agent.

REP. SMITH stated that the 1000 eligible employees is almost an impossible marketing concept.

REP. NELSON said that when reviewing this issue with the Montana Health Care Authority (MHCA) that he also had the same objection. However, **REP. NELSON** was the only one who felt that it should be lower than 500. He requested that a member of the HCA speak on this issue.

REP. NELSON referred to page 2, line 25 and restated the question.

{Tape: 2; Side: 2.}

Mr. Craig, said the idea in the HCA's work is the concept that the more bodies in the pool, the greater the negotiating power, and therefore the greater the ability to bring down costs.

REP. NELSON inquired if it would be just as good if the 1000 were changed to 500 or 250.

Mr. Craig indicated that the HCA was not sure what number would establish viability. It is important to maintain the concept of the purchasing pool as a consumer's idea; not the insurer's. He indicated that if it is changed to 250 or 500 it is more likely to reach the goal, but the ability to sustain itself and remain financially viable may be a problem.

REP. NELSON agreed and said this is because the healthy people may be able to drop out and buy insurance for less.

Mr. Craig agreed.

REP. SIMPKINS questioned page 2, line 29 and asked if this refers to 1000 employees and not 1000 lives. He indicated that 1000 employees could be 3000 lives. He said that this makes it much worse as far as pools are concerned. He inquired when this slips from valid to invalid.

REP. NELSON spoke about marketing time and the law of averages.

REP. SIMPKINS asked if this is an approach that perhaps a bank would want to get into, or somebody that has a consumer base, that would replace association group-type things, because this is a guaranteed issue, rather than an association group that is underwritten. He asked if the idea is to use this basis as a pool to get guaranteed issue if the company wants it?

REP. NELSON said yes, if it all fits under small group reform and there is guaranteed issue. If small group reform is repealed, then there would probably be relaxed underwriting standards.

REP. SIMPKINS stated that if they have 1000, there has to be allowance for slippage. It may take five months to get it issued.

REP. NELSON disagreed because it is for small group insurance, and each group is one application. If it took 20 employers to get to 1000, then that would be 20 applications. For this to work, an agent would organize several groups and put them together.

REP. KASTEN asked how eligibility is defined. She stated that she had no problem with the 1000. She asked if there are 1000 eligible employees in the group, is that the 1000 that is referred to here, or is it after so many people refuse to join with their employer?

Ms. Clifford, State Auditor's Office, responded that HB 405 would be codified within the set of laws that deal with small group insurance. The definition of eligible employee is anyone who works 30 hours or more a week. She indicated that whether or not they want to be insured through the plan, they would still be part of the "head count."

Motion: REP. SIMON MOVED TO AMEND THE NELSON AMENDMENT, PAGE 3, LINE 6, AND STRIKE "UNDER ALL PLANS OFFERED THROUGH THE GROUP."

REP. R. JOHNSON stated that **REP. SIMON'S** amendment could be voted on separately instead of voting to amend the Nelson amendment.

REP. SIMON stated that this was inadvertently left off of the Nelson amendment. **REP. SIMON withdrew his motion.**

CHAIRMAN ORR asked if there were any further discussion to the Nelson amendment as printed.

Vote: Question was called. Voice vote was taken. **The motion carried unanimously.**

Motion: REP. SIMON MOVED TO FURTHER AMEND THE NELSON AMENDMENT, PAGE 3, LINE 6, STRIKE "UNDER ALL PLANS OFFERED THROUGH THE GROUP."

Discussion: REP. BARNHART asked for an explanation.

Mr. Akey said that because subsection 4 of the bill has been removed, the phrase that is being amended would not make sense as it is now written.

VOTE: Question was called. Voice vote was taken. **The motion carried unanimously.**

CHAIRMAN ORR asked for discussion on the body of the bill.

Discussion: REP. SIMPKINS questioned if this bill is really a viable bill.

REP. NELSON stated that this bill has been passed in about 17 other states, but he was not sure what their experience had been.

He indicated that this bill was drafted against another bill which was written to allow the free-market system to work.

REP. SIMON stated that this bill is proceeding partially on the recommendation of the MHCA.

REP. SMITH stated a concern on page 2, line 25, "Qualification for voluntary purchasing pool for small employers." She suggested changing the 1000 to a lower number.

REP. NELSON commented on lowering the number and letting the marketplace take its course.

REP. SIMPKINS asked what the standard is in the industry today to get an association group established.

Mr. Turkiewicz, representing the Montana Automobile Dealers Association (MADA) and Insurance Trust, indicated that they have 1495 eligible employees in their group. He thought that the Banker's Association had about 1200 eligible employees.

Ms. Bennett, Montana Logging Association, stated that about 13 years ago the Montana Logging Association established a health insurance program with about 300 lives. Today there are over 1000 insured, approximately 2500. They do about $2 million in premiums annually, and pay just under that in claims. Less than 5% utilize 85% of the program.

REP. NELSON stated that **Mr. Kunik** is an agent and does underwriting. If an agent has 25 cases on the books with 20 lives apiece, that would be 500. He asked if there would be any pricing benefit to that group, as compared to separate groups of 20 lives going their own way, assuming that they are all of average health and in the same type of business.

Mr. Kunik said Montana Medical looked at 500 and he thought that insurers would look at it at 500 and more.

REP. NELSON asked if that was 500 lives or employees. **Mr. Kunik** said employees. **REP. NELSON** said that's employees, so spouses would be added on to that?

REP. SIMPKINS said that this is putting together a group which somebody will bid for, but if they don't want to take 500 lives then they don't have to bid. This gives an offer to the company and the company would decide whether or not to back them.

Motion: REP. SMITH MOVED TO AMEND HB 405, PAGE 2, LINE 25, TO STRIKE 1000 AND INSERT 500.

REP. TUSS said that she was apprehensive about cutting this figure too far. She stated that the insurance representatives indicate that 1000 is a better figure in terms of spreading the cost, rate of return, and stability. **REP. TUSS** suggested if the

figure is to be cut, a more moderate number such as 750 or 800 would be better.

Motion: REP. SMITH MOVED A SUBSTITUTE AMENDMENT TO STRIKE 1000 AND INSERT 750.

REP. SIMON indicated he would oppose this motion on grounds that he would rather err on the side of having the purchasing pools large enough to be viable. He said that the number could be lowered in two years if people are having difficulty putting together the pools.

REP. SIMPKINS stated concern about putting together 1000. Perhaps, once 1000 employees are reached, the figure may drop down but would be required to bring the figure up to a 1000 employees within a year.

{Tape: 3; Side: 1.}

Vote: Question was called. Roll call vote was taken. **The motion failed 8 to 3 with REPS. ROYAL JOHNSON, TOM NELSON AND REP. LIZ SMITH voting yes.**

Vote: Question was called. Voice vote was taken. **Motion carried unanimously.**

EXECUTIVE ACTION ON HB 446

The chair was passed to **VICE CHAIRMAN TUSS** so that **REP. ORR** may present his bill for executive action.

Motion: REP. ORR MOVED THAT HB 446 DO PASS.

Motion: REP. ORR MOVED TO ADOPT THE TECHNICAL AMENDMENT. REP. ORR requested **Mr. Akey** to explain the amendment.

Discussion:

Mr. Akey explained the amendment. **EXHIBIT 8** He explained that the Commissioner's concern was that there not be two different sets of preexisting condition exclusions in statute. He stated that the Commissioner had some concern about the clause "a condition that would have caused an ordinarily prudent person to seek medical advice," and questioned what an ordinarily prudent person might be. He explained amendment 3, new Section 2 on riders and stated the necessity to exclude disability income policies from the exclusion so that a person with a chronic condition cannot buy a disability income policy, works for five years and then tries to collect under the disability income policy. He clarified that if the chronic condition existed when the disability income policy was purchased, they ought not to be able to just live with it for another five years and then collect on their insurance policy for the rest of their life. He stated

that amendment 5, new section 5 makes HB 446 effective in its entirety upon its passage and approval.

REP. SQUIRES asked what constitutes a prudent person.

Mr. Akey stated that "ordinarily prudent" language was in the statutes until four years ago and "ordinarily prudent" is in the statutes of a number of other states. He said that there are a lot of phrases in code that may not have a precise definition, but when people read it they know what it means. He said that "ordinarily prudent" is one of those. He asked what is a reasonable person and indicated that "reasonable person" is used throughout the statute all the time.

Mr. Hopgood stated that words like "ordinarily prudent," "conspicuously," "reasonable person," "knew or should have known" run all throughout the code book.

REP. SQUIRES referred to the technical amendment, page 1, amendment 3, subsection (b) and asked if it could be re-worded. She asked if "reasonable" would be better language?

Mr. Hopgood asked what the difference was between reasonable and ordinarily prudent.

REP. SQUIRES inquired if "non-negligent person" would be better language?

Mr. Hopgood said that one of the legal elements for negligence is the duty of care that a reasonable person has.

REP. SQUIRES stated her concern that a person may be excluded in the process.

REP. NELSON said that he understood **REP. SQUIRES'** concern and stated that they're not dealing with social welfare, they're dealing with insurance. He stated a necessity to be very careful when making changes. He stated that the language "ordinarily prudent" or "reasonably prudent" is fine. He commented that if this "gate-keeper" language is taken out, the whole concept of insurance would collapse because it opens the door for people who wait until they are sick with a catastrophic condition before buying insurance. The purpose of insurance is the pooling of people to share in risks. He referred to **Ms. Bennett's** comment that "5% of the people use 85% of the benefits, and it's those 5% that will get in and destroy it for the rest of us." He stated that he would resist changing it.

REP. SIMON stated that in most cases the evidence with regard to "ordinarily prudent" will be very clear. However, there will be some cases where there is an argument as to whether a person was acting as an ordinarily prudent person. He stated that in some cases it would be decided by the courts.

REP. KASTEN asked if case law backs up the phrase "ordinary prudent" person.

Mr. Niss stated that the courts only construe what is written; they are not the legislators. He stated that there is some case law to construe "ordinarily prudent." He commented that it is a common phrase and in the context of HB 446 is that it means a non-negligent person with respect to his or her own health care.

REP. BARNHART stated some concern about amendment 3, subsection (b). She said that pregnancy should not be on the effective date of coverage because it seems punitive.

REP. NELSON stated that if that is not in there, then a person could buy an insurance policy on the way to the hospital to deliver a baby.

REP. BARNHART said that is not what she wants, but that when a person buys an insurance policy they have to disclose medical conditions. She said that if a pregnant woman is on the way to the hospital everybody is going to know that she is pregnant.

Ms. Clifford stated that if you have an "ordinarily prudent" person clause then it is more likely that situations will go to court. She indicated that if a person has knowledge of a condition, and lies on the insurance policy, then that would be a breach of contract. She stated that with this phraseology, "you are helping the person who doesn't have knowledge of their condition."

REP. SIMON indicated that early pregnancy is not outwardly evident. However an woman could obtain health insurance knowing that she is in fact pregnant; which could potentially result in a some very high costs if there are any complications.

VICE CHAIR TUSS referred to amendment 3, subsection (b) in regard to "ordinarily prudent" and asked **Mr. Hopgood** if this language was used to prevent fraud.

Mr. Hopgood said essentially that would be correct.

VICE CHAIR TUSS stated that usually the delineations would be clear regarding "ordinarily prudent" and that only a small number of cases would have questions raised by subsection (b). She asked **Mr. Hopgood** if that were correct. **Mr. Hopgood** said yes.

VICE CHAIRMAN TUSS asked if **Mr. Hopgood** would be in favor of striking subsection (b) in favor of "a condition for which the individual was advised to pursue medical care during the preceding two years," and if that would answer some of the fraud concerns?

{Tape: 3; Side: 2.}

Mr. Hopgood stated concern for that statement, as an individual could have almost crippling headaches for six months, for example, and not seek medical attention, then apply for health insurance and be asked "have you seen a doctor within two years for any condition?" The answer would be no. "The language that you've just suggested would not bring that person within the statute." He stated that it is necessary to have "ordinarily prudent" or "reasonably prudent" language in there in order to prevent "gaming of the system."

VICE CHAIRMAN TUSS said that she understood and that his example is very clear and that it would not fall under subsection (b). She provided an example where an individual goes through their normal daily activities and then one day the individual feels a little tired. The individual doesn't hardly notice this, but thinks that maybe an extra nap during the day will help. And then the individual thinks this is really different from the way their body felt or their life's activities were 2½ years ago. And that individual goes to the doctor and finds out that they have some chronic condition such as leukemia or cancer. But, over time the individual's mind and body adapted to those changes because they were so subtle. You might think that an "ordinarily prudent" or "reasonably prudent" person with a major diagnosis like cancer might have sought medical evaluation, except that the symptoms were so subtle that the individual adapted to them. **VICE CHAIRMAN TUSS** asked **Mr. Hopgood** how that situation would fit into subsection (b).

Mr. Hopgood stated that in that situation she described a factual pattern which would not cause a "reasonably prudent" person to seek medical advice.

VICE CHAIRMAN TUSS inquired of **Mr. Hopgood** if in his mind there are examples of things that would not fall into this subsection. **Mr. Hopgood** said that is correct.

VICE CHAIRMAN TUSS referred to the discussion about a woman knowing she's seven months pregnant but if she's two weeks pregnant she may not know. She asked what possible difference does it make when at the end she has an infant, and that gestational age is documented in the medical records. "Does it matter when you know or can predict or assess what the gestational age of that lifebirth may be?"

Mr. Hopgood stated that evidence would certainly demonstrate whether or not the pregnancy existed on the effective date of coverage. He stated that is why that date in there.

VICE CHAIR TUSS said, "I'm just curious. What would happen if you took it out and relied on hospital records? Why would that automatically give an exclusion when gestational age would almost automatically tell you where you were, and whether there was fraud or misrepresentation?"

Mr. Hopgood stated he was not sure that he understood her question.

VICE CHAIR TUSS said she was curious as to why it is necessary to leave that exception in, when if there was fraud or deliberate deception it could be determined by the gestational age recorded in hospital records.

Mr. Hopgood asked why it shouldn't be in there. **VICE CHAIRMAN TUSS** indicated that she was asking him.

REP. SIMON said that the purpose of amendment 3, subsection (c) being specific about pregnancy is because a pregnancy usually lasts nine months. He indicated that amendment 3, subsection (b) refers to the last three years. He indicated that pregnancy needs to be noted because it is only a nine-month event. "It just says if you are pregnant prior to getting coverage, you are not covered for pregnancy. The gestation period would be very strong evidence as to whether or not you were pregnant prior to or after the coverage was obtained. He indicated that this was very clear language which allows the use of the gestational period to determine whether or not an individual was pregnant prior to obtaining coverage.

REP. SIMPKINS stated that if it were deleted, and an individual was pregnant at the time that coverage was obtained. He inquired where else does it say in the policy that it is void?

REP. BARNHART stated that when an application for insurance is made, the applicant is supposed to disclose and existing conditions and a woman is asked if she is pregnant.

REP. BARNHART asked **Ms. Clifford** if a person takes out a policy, don't they ask if an individual has a preexisting condition.

Ms. Clifford said yes.

REP. BARNHART asked what happens if a woman knows that she is pregnant but lies on the application?

Ms. Clifford said that it would be a breach of contract. It would be a close case if it were within a few weeks, and the policyholder would probably argue that they did not know of the pregnancy. However, if it were within a reasonable time period that an individual should know of the pregnancy, there could be a breach of contract.

REP. NELSON discussed the preexisting condition exclusion and said a preexisting condition is something that was not listed on the application that the person knew about.

Mr. Kunik stated that if a person applies for coverage and answer no on the pregnancy question. Then prenatal claims are submitted. If the doctor says that the time of conception was

either three days before the coverage or three days after the coverage, there is room for question on the actual date of conception.

Mr. Kunik commented that a "reasonably prudent" person refers to "something that actually happens that you can see, or feel, or what have you, that would cause to get medical attention."

REP. SMITH commented on the gestation period.

REP. KASTEN asked, "How often is a health plan issued and there is no waiting period?"

REP. NELSON stated that it depends on the company. He said probably not very often, and gave an example.

REP. KASTEN asked if companies issue a policy without any waiting period, can that policy be used the day the policy was purchased. **REP. NELSON** said yes.

REP. SIMPKINS said that the insurance company has the right to only look back five years in the medical records to see if they have sought medical attention for a health condition.

REP. KASTEN discussed pregnancy and preexisting condition.

REP. SIMPKINS said that pregnancy does not apply to the 12 month preexisting. He stated that if an individual has had a heart attack in the past, and then has a heart attack within 12 months of application, the insurance company has a right to look at the individual's medical records.

REP. R. JOHNSON inquired what the Committee was voting on.

VICE CHAIR TUSS said the Committee is voting on Amendment 1, numbered 1 through 7, submitted by **REP. ORR.** There have been no substitutes in the language.

Vote: Voice vote was taken. **Motion carried 8 to 3 with REPS. SQUIRES, BARNHART, TUSS voting no.**

Motion/Vote: **REP. ORR MOVED HB 446 DO PASS AS AMENDED.** Question was called. **Motion carried 9 to 2 with REP. SQUIRES AND REP. BARNHART voting no.**

EXECUTIVE ACTION ON HB 466

The chair was returned to **CHAIRMAN ORR.**

Motion: **REP. SIMON MOVED TO AMEND HB 466, PAGE 1, LINE 27, AND STRIKE "INCLUDING" AND INSERT "EXCLUDING".**

Discussion: **REP. SIMON** explained the amendment. He said his reason for offering the amendment is that there are a number of problems with including the state group benefits plan, the Montana university system plan, and any self-funded disability insurance plan provided by a political subdivision of the state. He said that the self-funded disability plans and political subdivisions do not have premiums as they are self-funded. It would be difficult to figure an assessment because everybody else would be based on premium and it would also create potential problems in budgeting for these types of plans because they are taxpayer supported.

REP. NELSON said he had no objection to the amendment.

REP. R. JOHNSON inquired if there were any other reasons for amending the word to "excluding".

REP. SIMON said that the assessable risk pool is already quite large; it includes every carrier that sells disability insurance in Montana whether they sell small group or not.

{Tape: 4; Side: A}

REP. R. JOHNSON asked what the percentage of the total would be.

REP. SIMON said that he did not know the number of workers. He said that when that number is compared to the total number of insured in Montana it is a small percentage of the total.

REP. SMITH objected to the amendment and stated that if these were included it would lower the cost of health insurance. **REP. TUSS** requested **Mr. Akey** speak on this amendment.

REP. TUSS asked **Mr. Akey** to explain what this amendment would do. **Mr. Akey** said the impact of HB 466 would be to marginally increase the pool that assessments could be placed against, if the reinsurance pool goes to assessment. Currently the entire commercial insurance market is assessed, but the self-insured plans of the state, university system, and the political subdivisions of the state (primarily cities, counties and school districts) would not be assessed. He indicated that **REP. SIMON'S** amendment would exclude those public entities, as they are currently left out of the reinsurance pool.

REP. SIMON inquired if **Mr. Akey** could give the Committee an idea of what he meant by "marginally?"

Mr. Akey indicated roughly 20% expansion of the reinsurance pool.

REP. SQUIRES asked **Mr. Akey** if those public entities have ever been included in a pool of this type? **Mr. Akey** answered no.

REP. SQUIRES asked if this could be considered by excluding them in a kind of double taxation for the individuals considered being purchased toward that number?

Mr. Akey said that the purpose behind the reinsurance mechanism was to fund the cost of guaranteed issue; fund the socially desirable goal of bringing people into the insurance market. "The logic behind the language in **REP. NELSON'S** bill is why should that funding of the social good be limited only to those that have commercial insurance and why should we not have public employees also help fund that social goal?" He said, "To the extent that you view it as double taxation for those public employees, I think you also need to view it as double taxation on commercially insured."

Joyce Brown, State Employee Benefit Plan, disagreed with **Mr. Akey** in that the commercial insurers have been excluding high-risk individuals and that this program is designed to help support them now that they will be taking high-risk individuals. She indicated that the public entities have already been taking all the high-risk individuals in their segment of the market offering guaranteed issue and portability. She indicated that the double taxation is that the public entities would be both covering the high-risk individuals in their own segment of the market plus the high-risk individuals in the commercial insurers segment of the market.

Vote: Question was called. Voice vote was taken. **The motion carried 7 to 4.**

Motion: **REP. J. JOHNSON MOVED AMENDMENT 1.**

REP. J. JOHNSON explained the amendment. **EXHIBIT 9** The amendment would include services of a speech pathologist and audiologist covered under a case management plan of care as directed by a referring physician; and medically necessary nutrition services covered under a case management plan of care as directed by a referring physician, including assessment and counselling for the conditions enumerated on the amendment.

Mona Jamison, Attorney, stated that these additions are cost effective and would provide preventative care. She said these services will not actuarially increase the cost; an individual would cost 25 cents, and a family of four would cost 50 cents. She stated, "this is one of those little increases that I think you will see long term benefits in terms of other aspects of the plan."

REP. SIMON asked **Ms. Jamison** what services a speech pathologist or audiologist would provide under a case management plan? He indicated that he was unsure about including them in a basic plan. He asked if this would include a hearing aid?

Ms. Jamison said it would not include hearing aids. She said that these services would be such things as head injury, learning how to eat, how to chew, how to talk, and the basic fundamental living skills. She reiterated that these services would be included only under the direction of the referring physician. She indicated that people wanting to learn how to improve their speaking patterns, their diction, or to lose their accents would not be covered.

REP. SQUIRES stated that she supported amendment 1 to provide these nutrition and speech services. She indicated that she had worked in a hospital and in a rehabilitation center. She said that many patients in that department would need these services. She stated that a speech pathologist teaches and monitors a head injury or stroke patient's eating, swallowing, and speech after the patient becomes more cognizant. She said that some head injury and cancer patients are fed via a tube in their stomach.

REP. SIMON said that he could agree with **REP. SQUIRES**, however, he could probably make that case for all kinds of services. He questioned where a person would stop adding on services. He indicated that the objective is to make small employer health insurance available and affordable. He indicated that every service which is added will increase the cost of the insurance, and that he intends to vote no on the amendment.

REP. SIMPKINS suggested making HB 531 the basic standard benefits plan for Montana and designating HB 466 for small group insurance by striking all of sections 5 and 6. He suggested a postponement to decide whether or not to make two different bills.

REP. J. JOHNSON stated that he agreed.

At this time REP. J. JOHNSON withdrew his motion for amendment 1.

REP. NELSON presented an amendment that dealt with Multiple Employer Welfare Associations (MEWA). **EXHIBIT 10** He said that without this amendment there would be a conflict with the federal statute.

Motion: **REP. NELSON MOVED AMENDMENT #2.**

Tim Filz, Attorney, representing a number of MEWA's, Billings, Montana, stated that the Employees Retirement Income Security Act (ERISA) is a federal statute which is a general state and preempts state regulation of welfare benefit plans. Welfare benefit plans include MEWA's as a general statement. There are certain types of MEWA's which are not included and not defined as welfare benefit plans, and not covered by ERISA. He explained that a MEWA is a group of employers which self-fund general health benefits. ERISA preempts state regulation with a couple of exceptions, as follows: 1) they allow for insurance companies to be regulated even though there is an indirect impact on welfare benefit plans, and 2) ERISA does allow states to regulate

MEWA's as long as they do not do so in a fashion inconsistent with the remaining provisions of ERISA. The anti-demur clause in ERISA states that a state in its regulatory framework cannot deem a welfare benefit plan to be an insurance company. "We believe that the Small Employer Health Availability Act in defining a welfare benefit plan to be a carrier violated the anti-demur provision of ERISA by labeling a MEWA to be an insurance carrier."

REP. R. JOHNSON asked what this amendment does to HB 466?

REP. NELSON stated that it excludes MEWA's. To avoid breaking the law they have to change the law.

Vote: Question was called. Voice vote was taken. **The motion carried 10 to 1.**

Discussion: **REP. NELSON** presented amendment #3 and requested that **Mr. Niss** review the amendment.

Mr. Niss said that the change is on page 4, subdivision (c) requires the annual review rather than a periodic review of methodology in the reinsurance pool; and subdivision (d). **EXHIBIT 11**

{Tape: 4; Side: 2.}

REP. NELSON requested that **Greg Van Horssen** explain the amendment.

Mr. Van Horssen, State Farm Insurance, said that this amendment states that if a carrier stays in the state to market individual policies only, it can be assured that because it doesn't participate in the group program its assessments will remain 5% or less of its individual plan cost.

REP. SQUIRES inquired that a carrier may opt out if they choose, but if they opt out they don't pay any more than 5%.

Mr. Van Horssen said that is correct.

Vote: Question was called. Voice vote was taken. **The motion carried unanimously.**

Discussion: **REP. SIMPKINS** presented and explained an amendment which dealt with individual policies and small group policies, and called it the uniform plan. The concept of the amendment is to separate HB 466 and HB 531. Then, HB 466 would deal with how it would be applied in the small group; HB 531 would deal with individual policies. The only change in small group policies would be the extra benefits received. **REP. SIMPKINS** suggested amending HB 531 to be the benefits package; not group insurance (HB 531, beginning on page 17). Under an individual policy, the function of this plan is shopping comparison which places a

benchmark for price comparison only. The benefits offered by the individual policy at the benchmark price would be a standardized 250% deductible, and a standardized co-insurance and a stop loss. **REP. SIMPKINS** said that this same plan can be offered in the small group policy and is underwritten. The small group would have minimum allowed (which is like the benchmark), variable co-payments, variable deductibles, and guaranteed issue. He stated that this would work very well in conjunction with medical savings accounts.

REP. TUSS stated that she was confused and asked if **REP. SIMPKINS** were trying to split off a section of HB 466 and push it into HB 531?

REP. SIMPKINS said that if this is done HB 466 will have no description of the benefits. HB 466 will only have the application of the small group programs.

REP. TUSS said that this would "wipe out" a three-tier approach in favor of a single plan.

REP. SIMPKINS stated that this would "wipe out" a three-tier approach for a two-tier approach. The two-tier approach would be individual and small group.

REP. ORR asked, "what was the three-tier?"

REP. TUSS replied that the three-tier was the basic, standard, and an underwritten high performance plan.

REP. SIMPKINS stated that choice is offered in small group by an underwritten plan. He explained that the three-tier is underwriting anything.

REP. TUSS said anything that two people agree to.

REP. SIMPKINS said that the small group must be offered a guaranteed issue of this uniform plan. These plans may be underwritten, if desired.

REP. TUSS said that she was worried about guaranteed issue to absolutely everybody. She stated, "The way I'm hearing you, is that some folks are not going to be guaranteed issuance."

REP. SIMPKINS stated that he understood that the way the individual plan stands now it is not a guaranteed issue; only under small group. He stated that his conceptual amendment would "beef up" the current coverage of the small group.

REP. TUSS requested that **Mr. Akey** explain the conceptual amendment.

Mr. Akey stated that guaranteed issue was never offered on the individual market. Under the language of the current statute,

guaranteed issue is limited to small employers which is 3 to 25, and two plans that are guaranteed issue. Each company must offer at least two plans; a standard plan and a basic plan.

Mr. Akey stated his understanding of this conceptual amendment the standard plan and basic plan would be replaced by a single plan to be called a uniform plan.

REP. TUSS asked **Mr. Akey** what would happen when a standard plan and a basic plan are put into the uniform plan? "What happens to what we are trying to achieve which is affordable and accessible health care to more people through insurance?"

Mr. Akey stated that people who can't get underwritten plans would be forced into this plan which is the minimum allowed.

REP. TUSS asked if this was some subtle form of "cherry-picking?"

Mr. Akey said that it puts the people who are sick into one specific kind of plan which is the minimum benefits level allowed, and that people who are well may buy whatever policies are available on the marketplace.

REP. SIMON stated that the attempt is to structure a single benefit package, whether in small group or the individual market, that would be identical. The benefit package on the individual side would be for price comparison only because it is not guaranteed issue. There would be a policy that every company must offer with identical benefits so that consumers may compare prices of that particular company and policy.

REP. SIMON stated that on the group side, the same benefit package called the uniform plan, would be the guaranteed issue policy that would be available to everybody. If desired, this plan may be underwritten. He said that there is uniformity across both sides. The benefit package is identical in both the individual and the small group. It is exactly the same policy, only on the group side it is guaranteed issue policy which is an attempt to keep that policy price within the reach of small employers to be able to provide that coverage.

REP. R. JOHNSON commented about the plan for the sick people and the plan for everybody else. He asked **Mr. Akey**, "Who underwrites all of the people who are sick?

Mr. Akey stated he understood that every insurance carrier doing business in Montana would be required to offer the uniform plan on a guaranteed issue basis. He gave an example of an employer who wanted a certain quality of health insurance, but one of the employees had a heart condition and that quality of coverage was denied because of the sick individual. The agent would offer the uniform plan because it is a guaranteed issue plan.

REP. R. JOHNSON asked if under that particular scenario, that employer would probably just accept the basic plan and never add any of the underwriting options onto it because of one employee?

Mr. Akey answered if they stay with guaranteed issue, whole group coverage. He stated that other benefits could not be added because one sick employee and the insurance company would not want to take that risk on the underwritten plan.

REP. SIMPKINS asked **Mr. Akey** what would happen with the multiple.

Mr. Akey stated that the way he understands the concept is that if an employer with a sick employee wanted coverage above the guaranteed issue, the insurance company could deny that coverage as long as that sick employee is with that employer. **Mr. Akey** said that he does not know what the minimum level is. He stated judging from it affordability and the fact that it is the minimum level allowed, he felt that it would be a fairly low benefit policy that all of the sick people would be driven into. "All of our businesses that have sick people will be forced into this bottom plan."

Mr. Akey stated that the existing situation provides a standard plan, a basic plan, and that everything between is guaranteed issue. He gave the example that company Y could offer a basic plan at the absolute minimum which is allowed. Company Z could offer a basic plan somewhere in the middle. He stated that the standard plan was really the uniform plan to the extent that they had a uniform plan out there. Under the existing laws everything below the standard plan is guaranteed issue; everything above it could be underwritten.

Mr. Akey indicated that the conceptual amendment would eliminate the standard plan and drop the floor where guaranteed issue would be offered. Everything above it could be underwritten.

REP. SIMPKINS stated that he envisioned offering guaranteed issue more in the middle where it would be a halfway decent plan. He stated that the bare minimum would not be satisfactory for group coverage.

Mr. Akey stated that it depends on how the minimum level of benefits is defined. If the minimum level of benefits is defined such that it is a decent plan. He stated that in this plan you cannot write below it, and anything that is above it is only available to well people.

REP. SQUIRES requested that **Chuck Butler, Blue Cross/Blue Shield,** give his synopsis of what he has heard here.

CHAIRMAN ORR agreed and stated that after **Mr. Butler** speaks the Chair will rule. This bill will be transferred out and that this hearing will be held at a later date with HB 531.

Mr. Butler stated that **Mr. Akey** explained it well and that he agreed with **Mr. Akey.**

REP. SQUIRES stated that she finds it remarkable that the Commissioner has worked two years on the small guaranteed plan, and that the Health Care Authority has worked hard, gathered information, and provided them with the information and now they have a council instead of a Health Care Authority. She said, "What I have seen done to people in this particular venture really upsets me and so, therefore, I would ask you **Mr. Chairman** to please take the vote, get it over with and adjourn the meeting."

REP. SIMPKINS commented that there is no motion.

REP. SIMON commented that what **Mr. Akey** said may be true. **REP. SIMON** stated that he hoped the uniform would be a decent plan. He indicated that this is a way to obtain coverage for more people.

{Tape: 5; Side: 1.}

CHAIRMAN ORR stated that **REP. SIMPKINS** conceptual amendment is to strike sections 5 and 6 from HB 466 and transfer them to HB 531.

REP. SIMPKINS stated that is correct. He suggested starting with HB 531 to show what benefits could be proposed.

CHAIRMAN ORR said, "The amendment is to just strike sections 5 and 6 from HB 466." He indicated that they are already in HB 531. **REP. SIMON** suggested transferring HB 531 into HB 466. **REP. SIMPKINS** stated that HB 531 has a better lay-out of the plan. **REP. SIMON** said it would be the same to take the benefits from HB 531 and amend them into HB 466. **REP. NELSON** stated that he had agreed that the benefits from HB 531 would be transferred to HB 466 to replace sections 5 and 6.

Motion: REP. NELSON MOVED THAT HB 466, THAT SECTIONS 5 AND 6 BE DELETED AND CONCEPTUAL AMENDMENT TO MOVE THE BENEFIT PLAN OUT OF HB 531 INTO HB 466.

Discussion: REP. J. JOHNSON inquired if gray bills would be provided afterwards to see how this fits together.

CHAIRMAN ORR said the staff indicated that if this amendment passed, it would show up in the second reading on the floor, which would be as fast as obtaining a gray bill.

Mr. Niss explained the amendment would be making a reference to the basic plan as contained in HB 531, on pages 3 to 6. He said, "we aren't talking about moving a whole mass of language from HB 531 and into HB 466. We're just talking about rather than referring to the standard and basic plan in 33-22-18 referring only to the basic plan as created in HB 531."

Ms. Fox inquired if **REP. NELSON** wanted the language from HB 531 in HB 466.

REP. NELSON indicated either that, or make reference to HB 531; which ever is the best.

REP. R. JOHNSON asked which he was going to do.

REP. NELSON requested that the attorney draft the conceptual amendment in the best fashion.

Mr. Niss said that **REP. NELSON'S** benefit package, the health care plan which would take the place of standard and basic plan, would "rise or fall on the passage of HB 531, whereas if you incorporated this health care benefit plan that is contained in HB 531 into HB 466," then HB 466 could proceed independently."

REP. NELSON chose to do the latter so that it will proceed independently.

REP. R. JOHNSON indicated that this would move massive language from one bill to the other. **Mr. Niss** stated that it is not massive language. He indicated that it would be four pages.

Motion: **REP. NELSON SAID "I SO MOVED THAT."**

Mr. Niss restated the amendment is that it would delete from HB 466 any reference standard and basic plan, and insert in the place of those references a different basic plan and move the basic plan as contained in HB 531 into HB 466, and that basic plan takes the place of current standard and basic plans current law and in HB 466.

At this time REP. R. JOHNSON retracted his request for action on this particular situation because he found the explanation confusing.

Mr. Niss stated to understand the changes it is necessary to have pages 3 to 6 of HB 531. **REP. SMITH** asked who drafted the basic plan contained in HB 531. **CHAIRMAN ORR** said that it was from his bill, and that it is Project '94 Heal Montana language.

REP. SMITH asked when these benefits would be addressed?

CHAIRMAN ORR said after transmittal.

REP. SMITH commented on the basic plan on page 6, HB 531 and indicated that she would have to reject the amendment because she will not approve the mandates.

REP. R. JOHNSON requested that **Mr. Butler** speak.

REP. R. JOHNSON stated that **Ms. Ask** testified on HB 531 with regard to the basic health benefit plan in section 3, pages 3 to

6. He stated that there are some technical issues regarding mental retardation.

REP. SIMON stated that he felt that mental retardation should be taken out because it is inappropriate.

At this time REP. NELSON withdrew his motion and made a substitute motion.

Motion: **REP. NELSON MOVED AN AMENDMENT TO LEAVE HB 531 ALONE AND MAKE REFERENCE IN HB 466 TO THE BENEFITS THAT ARE IN HB 531.**

Discussion: **REP. SIMON** explained that by adopting the language in HB 531 by reference into HB 466 "we can act on HB 466 tonight," and then still have time to look at HB 531 to make the technical amendments that **Mr. Butler** referred to, and discuss the benefit package. He indicated that it would be by reference only. HB 531 would remain in this Committee to be worked over. He stated that whatever changes the Committee decided to make in HB 531 would automatically happen in HB 466 because it is by reference.

REP. R. JOHNSON stated that he had no problem with this amendment by reference. He asked what would happen if HB 531 never leaves this Committee.

Mr. Niss stated that would be the purpose of the coordination instructions. **REP. R. JOHNSON** asked if coordination instructions would be put in. **Mr. Niss** said yes.

Ms. Fox stated that if HB 531 were to fail then HB 466 would be left status quo with what it is today.

REP. SIMPKINS suggested discussing the benefits. **CHAIRMAN ORR** asked if everyone was clear on the motion.

Ms. Fox clarified that HB 466 as it is would not include any benefit plan with passage of this motion. "What you would be left with is the benefit plans that are included right now in the small employer group coverage."

REP. SIMPKINS asked, "There is no individual?"

Ms. Fox stated that the motion would strike sections 5 and 6 from HB 466; there would be no benefits left in this bill.

REP. SIMON said that by the adoption of the language from HB 531 by reference into HB 466, "we would then strike the sections of law that pertain to the standard and basic plan." If HB 531 were to fail, and the language had been struck from HB 466 the effect is to return HB 466 to it to current statute which would basically returns it with a basic and standard plan.

Vote: Question was called. Voice vote was taken. **The motion carried unanimously.**

Motion/Vote: **REP. NELSON MOVED HB 466 DO PASS AS AMENDED.** Question was called. Roll call vote was taken. **Motion carried 6 to 5 with REP. SQUIRES, REP. BARNHART, REP. J. JOHNSON, REP. SMITH, AND REP. TUSS voting no.**

ADJOURNMENT

Adjournment: 8:15 P.M.

SCOTT ORR, Chairman

for VIVIAN REEVES, Secretary

SO/vr

Note: These minutes were written by Vivian Reeves and edited by Patti Borneman, Word Processing Supervisor.

HOUSE OF REPRESENTATIVES

Select Committee on Health Care

ROLL CALL DATE Feb. 16, 1995

NAME	PRESENT	ABSENT	EXCUSED
Rep. Scott Orr, Chairman	✓		
Rep. Carley Tuss, Vice Chairman	✓		
Rep. Beverly Barnhart	✓		
Rep. John Johnson	✓		
Rep. Royal Johnson	✓		
Rep. Betty Lou Kasten	✓		
Rep. Tom Nelson	✓		
Rep. Bruce Simon	✓		
Rep. Dick Simpkins	✓		
Rep. Liz Smith	✓		
Rep. Carolyn Squires	✓		

HOUSE STANDING COMMITTEE REPORT

February 17, 1995

Mr. Speaker: We, the committee on **Select Committee on Health Care** report that **House Bill 511** (first reading copy -- white) **do pass as amended.**

Signed: _____
Scott Orr, Chair

And, that such amendments read:

1. Title, line 9.
Following: "AUTHORITY;"
Insert: "TRANSFERRING THE RESPONSIBILITY FOR THE HEALTH CARE DATA BASE TO THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES; TRANSFERRING THE RESPONSIBILITY FOR CERTIFICATES OF PUBLIC ADVANTAGE TO THE DEPARTMENT OF JUSTICE;"
Strike: "AND 50-1-201"
Insert: "50-4-502, 50-4-601, 50-4-603, 50-4-604, 50-4-609, 50-4-610, 50-4-611, AND 50-4-612,"

2. Title, line 10.
Following: line 9
Insert: "50-1-201,"
Following: "50-4-303,"
Insert: "50-4-304,"

3. Title, lines 11 and 12.
Strike: "50-4-502,"
Insert: "AND"
Following: "50-4-503,"
Strike: the remainder of line 11 through "50-4-612," on line 12

4. Page 2, line 12.
Strike: "regional board"
Following: "members"
Insert: "who represent health care planning regions and"

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Committee Vote:
Yes 11, No 0.

411554SC.Hbk

5. Page 2, line 28.
Strike: "The"
Strike: "A"

6. Page 7, lines 15 through 25.
Strike: section 9 in its entirety
Renumber: subsequent sections

7. Page 8, line 5.
Insert: "**Section 9.** Section 50-4-502, MCA, is amended to read:

"**50-4-502. Health care data base -- information submitted ~~-- enforcement~~.** (1) The ~~authority~~ department, with advice from the health care advisory council, shall design and develop ~~and maintain~~ a ~~unified~~ health care data base ~~that enables the authority, on a statewide basis, to:~~

~~(a) determine the distribution and capacity of health care resources, including health care facilities, providers, and health care services;~~

~~(b) identify health care needs and direct statewide and regional health care policy to ensure high quality and cost effective health care;~~

~~(c) conduct evaluations of health care procedures and health care protocols;~~

~~(d) compare costs of commonly performed health care procedures between providers and health care facilities within a region and make the data readily available to the public; and~~

~~(e) compare costs of various health care procedures in one location of providers and health care facilities with the costs of the same procedures in other locations of providers and health care facilities~~ that includes data on health care resources and the cost and quality of health care services. The purpose of the data base is to assist in developing and monitoring the progress of incremental health care reform measures that increase access to health care services, promote cost containment, and maintain quality of care.

(2) The ~~authority~~ department shall ~~by rule require~~ work in conjunction with health care providers, health insurers, health care facilities, private entities, and entities of state and local governments to ~~file with the authority the reports, data, schedules, statistics, and other information determined by the authority to be~~ determine the information necessary to fulfill the purposes of the data base provided in subsection (1). ~~Material to be filed with the authority may include health insurance claims and enrollment information used by health insurers.~~

~~(3) The authority may issue subpoenas for the production of information required under this section and may issue subpoenas for and administer oaths to any person. Noncompliance with a~~

~~subpoena issued by the authority is, upon application by the authority, punishable by a district court as contempt pursuant to Title 3, chapter 1, part 5.~~

~~(4) The data base must:~~

~~(a) use unique patient and provider identifiers and a uniform coding system identifying health care services; and~~

~~(b) reflect all health care utilization, costs, and resources in the state and the health care utilization and costs of services provided to Montana residents in another state.~~

~~(5) Information in the data base required by law to be kept confidential must be maintained in a manner that does not disclose the identity of the person to whom the information applies. Information in the data base not required by law to be kept confidential must be made available by the authority upon request of any person.~~

~~(6)~~(3) The ~~authority~~ department shall adopt by rule a confidentiality code to ensure that information in the data base is maintained and used according to state law governing confidential health care information.

(4) The department shall make recommendations to the legislature by October 1, 1996, on the actions needed to establish the data base, including an estimate of the fiscal impact on state and local government, health care providers, health insurers, health care facilities, and private entities.
"

NEW SECTION. **Section 10. Definitions.** As used in this part, the following definitions apply:

(1) "Data base" means the health care data base created pursuant to 50-4-502.

(2) "Department" means the department of social and rehabilitation services provided for in Title 2, chapter 15, part 22.

(3) "Health care" includes both physical health care and mental health care.

(4) "Health care advisory council" means the council provided for in [sections 1 through 6].

(5) "Health care facility" means all facilities and institutions, whether public or private, proprietary or nonprofit, that offer diagnosis, treatment, and inpatient or ambulatory care to two or more unrelated persons. The term includes all facilities and institutions included in 50-5-101(19). The term does not apply to a facility operated by religious groups relying solely on spiritual means, through prayer, for healing.

(6) "Health care provider" or "provider" means a person who is licensed, certified, or otherwise authorized by the laws of this state to provide health care in the ordinary course of

business or practice of a profession.

(7) "Health insurer" means any health insurance company, health service corporation, health maintenance organization, insurer providing disability insurance as described in 33-1-207, and, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities."

Section 11. Section 50-4-601, MCA, is amended to read:

"**50-4-601. Finding and purpose.** The legislature finds that the goals of controlling health care costs and improving the quality of and access to health care will be significantly enhanced in some cases by cooperative agreements among health care facilities. The purpose of this part is to provide the state, through the ~~authority~~ department, with direct supervision and control over the implementation of cooperative agreements among health care facilities for which certificates of public advantage are granted. It is the intent of the legislature that supervision and control over the implementation of these agreements substitute state regulation of facilities for competition between facilities and that this regulation have the effect of granting the parties to the agreements state action immunity for actions that might otherwise be considered to be in violation of state or federal, or both, antitrust laws."

Section 12. Section 50-4-603, MCA, is amended to read:

"**50-4-603. Certificate of public advantage -- standards for certification -- time for action by ~~authority~~ department.** (1) Parties to a cooperative agreement may apply to the ~~authority~~ department for a certificate of public advantage. The application for a certificate must include a copy of the proposed or executed agreement, a description of the scope of the cooperation contemplated by the agreement, and the amount, nature, source, and recipient of any consideration passing to any person under the terms of the agreement.

(2) The ~~authority~~ department shall hold a public hearing on the application for a certificate before acting upon the application. The ~~authority~~ department may not issue a certificate unless the ~~authority~~ department finds that the agreement is likely to result in lower health care costs or in greater access to or quality of health care than would occur without the agreement. If the ~~authority~~ department denies an application for a certificate for an executed agreement, the agreement is void upon the decision of the ~~authority~~ department not to issue the certificate. Parties to a void agreement may not implement or carry out the agreement.

(3) The ~~authority~~ department shall deny the application for a certificate or issue a certificate within 90 days of receipt of

a completed application."

Section 13. Section 50-4-604, MCA, is amended to read:

"**50-4-604. Reconsideration by ~~authority~~ department.** (1) If the ~~authority~~ department denies an application and refuses to issue a certificate, a party to the agreement may request that the ~~authority~~ department reconsider its decision. The ~~authority~~ department shall reconsider its decision if the party applying for reconsideration submits the request to the ~~authority~~ department in writing within 30 calendar days of the ~~authority's~~ department's decision to deny the initial application.

(2) The ~~authority~~ department shall hold a public hearing on the application for reconsideration. The hearing must be held within 30 days of receipt of the request for reconsideration unless the party applying for reconsideration agrees to a hearing at a later time. The hearing must be held pursuant to 2-4-604.

(3) The ~~authority~~ department shall make a decision to deny the application or to issue the certificate within 30 days of the conclusion of the hearing required by subsection (2). The decision of the ~~authority~~ department must be part of written findings of fact and conclusions of law supporting the decision. The findings, conclusions, and decision must be served upon the applicant for reconsideration."

Section 14. Section 50-4-609, MCA, is amended to read:

"**50-4-609. Revocation of certificate by ~~authority~~ department.** (1) The ~~authority~~ department shall revoke a certificate previously granted by it if the ~~authority~~ department determines that the cooperative agreement is not resulting in lower health care costs or greater access to or quality of health care than would occur in absence of the agreement.

(2) A certificate may not be revoked by the ~~authority~~ department without giving notice and an opportunity for a hearing before the ~~authority~~ department as follows:

(a) Written notice of the proposed revocation must be given to the parties to the agreement for which the certificate was issued at least 120 days before the effective date of the proposed revocation.

(b) A hearing must be provided prior to revocation if a party to the agreement submits a written request for a hearing to the ~~authority~~ department within 30 calendar days after notice is mailed to the party under subsection (2)(a).

(c) Within 30 calendar days of receipt of the request for a hearing, the ~~authority~~ department shall hold a public hearing to determine whether or not to revoke the certificate. The hearing must be held in accordance with 2-4-604.

(3) The ~~authority~~ department shall make its final decision and serve the parties with written findings of fact and

conclusions of law in support of its decision within 30 days after the conclusion of the hearing or, if no hearing is requested, within 30 days of the date of expiration of the time to request a hearing.

(4) If a certificate of public advantage is revoked by the ~~authority~~ department, the agreement for which the certificate was issued is terminated."

Section 15. Section 50-4-610, MCA, is amended to read:

"**50-4-610. Appeal.** A party to a cooperative agreement may appeal, in the manner provided in Title 2, chapter 4, part 7, a final decision by the ~~authority~~ department to deny an application for a certificate or a decision by the ~~authority~~ department to revoke a certificate. A revocation of a certificate pursuant to 50-4-609 does not become final until the time for appeal has expired. If a decision to revoke a certificate is appealed, the decision is stayed pending resolution of the appeal by the courts."

Section 16. Section 50-4-611, MCA, is amended to read:

"**50-4-611. Record of agreements to be kept.** The ~~authority~~ department shall keep a copy of cooperative agreements for which a certificate is in effect pursuant to this part. A party to a cooperative agreement who terminates the agreement shall notify the ~~authority~~ department in writing of the termination within 30 days after the termination."

Section 17. Section 50-4-612, MCA, is amended to read:

"**50-4-612. Rulemaking.** The ~~authority~~ department shall adopt rules to implement this part. The rules shall include rules:

(1) specifying the form and content of applications for a certificate;

(2) specifying necessary details for reconsideration of denial of certificates, revocations of certificates, hearings required or authorized by this part, and appeals; and

(3) to effect the active supervision by the ~~authority~~ department of agreements between health care facilities. These rules may include reporting requirements for parties to an agreement for which a certificate is in effect."

NEW SECTION. **Section 18. Definitions.** For the purposes of this part, the following definitions apply:

(1) "Certificate of public advantage" or "certificate" means a written certificate issued by the department as evidence of the department's intention that the implementation of a cooperative agreement, when actively supervised by the department, receive state action immunity from prosecution as a violation of state or federal antitrust laws.

(2) "Cooperative agreement" or "agreement" means a written agreement between two or more health care facilities for the sharing, allocation, or referral of patients; personnel; instructional programs; emergency medical services; support services and facilities; medical, diagnostic, or laboratory facilities or procedures; or other services customarily offered by health care facilities.

(3) "Department" means the department of justice provided for in Title 2, chapter 15, part 20.

(4) "Health care facility" means all facilities and institutions, whether public or private, proprietary or nonprofit, that offer diagnosis, treatment, and inpatient or ambulatory care to two or more unrelated persons. The term includes all facilities and institutions included in 50-5-101(19). The term does not apply to a facility operated by religious groups relying solely on spiritual means, through prayer, for healing."

8. Page 8, line 6.
Following: "Sections"
Insert: "50-1-201,"

9. Page 8, line 7.
Following: "50-4-303,"
Insert: "50-4-304,"

10. Page 8, lines 8 and 9.
Strike: "50-4-502,"
Insert: "and"
Following: "50-4-503,"
Strike: the remainder of line 8 through "50-4-612," on line 9

11. Page 8, line 10.
Insert: "

NEW SECTION. **Section 20. Name change -- directions to code commissioner.** Wherever the name of or a reference to the Montana health care authority appears in legislation enacted by the 1995 legislature to be codified in Title 50, chapter 4, part 6, the code commissioner is directed to change the reference to the department of justice."
Renumber: subsequent sections

12. Page 8, line 11.
Strike: "instruction."
Insert: "instructions. (1)"

13. Page 8, line 14.
Insert: "(2) [Section 10] is intended to be codified as an

integral part of Title 50, chapter 4, part 5, and the provisions of Title 50, chapter 4, part 5, apply to [section 10].

(3) [Section 18] is intended to be codified as an integral part of Title 50, chapter 4, part 6, and the provisions of Title 50, chapter 4, part 6, apply to [section 18]."

14. Page 8, line 20.
Strike: "11, 12, and 14"
Insert: "20 through 22, and 24"

15. Page 8, line 22.
Strike: "10"
Insert: "19"

-END-

HOUSE STANDING COMMITTEE REPORT

February 17, 1995

Mr. Speaker: We, the committee on **Select Committee on Health Care** report that **House Bill 533** (first reading copy -- white) **do pass as amended.**

Signed: _____
Scott Orr, Chair

And, that such amendments read:

1. Title, line 7.
Strike: "AND"

2. Title, line 8.
Following: "MCA"
Insert: "; AND PROVIDING A DELAYED EFFECTIVE DATE AND AN APPLICABILITY DATE"

3. Page 1.
Following: line 13
Insert: "(1) "Block of business" means an individual disability insurance policy certificate or contract product type written and sold by a health care insurer to a defined set of individuals. All individuals covered by the type of policy or contract are considered to be within the block of business."

Renumber: subsequent subsections

4. Page 1, line 14.
Strike: "health care insurer as defined in 33-22-125"
Insert: "disability insurer, a health service corporation, or a health maintenance organization"

5. Page 1, line 27.
Strike: "standard health benefit plan referred to in 33-22-1811

Committee Vote:
Yes 11, No 0.

411429SC.Hbk

and 33-22-1812"
Insert: "plan being applied for"

6. Page 1, line 30.
Following: "benefit society"
Insert: ", that provides benefits similar to or exceeding the plan being applied for"

7. Page 2, line 3.
Strike: "**Portability of insurance required.**"
Insert: "**Waiver of preexisting condition exclusion.**"

8. Page 2, line 7.
Strike: "effective"
Following: "date of"
Insert: "application for"

9. Page 2, lines 14 and 15.
Strike: "by premium" on line 14 through "state" on line 15
Insert: "across the block of business"

10. Page 3.
Following: line 18
Insert: "NEW SECTION. **Section 6. Applicability.** [This act] applies to a policy, certificate, or contract of disability insurance and a health service membership contract entered into or renewed on or after [the effective date of this act].

NEW SECTION. **Section 7. Effective date.** [This act] is effective January 1, 1996."

-END-

HOUSE STANDING COMMITTEE REPORT

February 17, 1995

Mr. Speaker: We, the committee on **Select Committee on Health Care** report that **House Bill 405** (first reading copy -- white) **do pass as amended.**

Signed: _____
Scott Orr, Chair

And, that such amendments read:

1. Title, line 5.
Strike: "SMALL EMPLOYER"

2. Page 1, line 30.
Strike: "that obtains"
Insert: "that has been organized and is maintained in good faith for purposes other than that of obtaining"
Following: "insurance"
Strike: ","
Insert: "or of"

3. Page 2, line 17.
Strike: "of small employers"
Insert: "or to the member employers of a voluntary purchasing pool"

4. Page 2, line 22.
Strike: "for small employers"

5. Page 2, line 23.
Strike: "small employers"
Insert: "disability insurance purchasers"

6. Page 2, line 25.
Strike: "one thousand"
Insert: "1,000"

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Committee Vote:
Yes 11, No 0.

411553SC.Hbk

7. Page 2, line 26.
Following: "membership."
Insert: "The voluntary purchasing pool shall accept for membership any small employers and may accept for membership any employers with more that 25 eligible employees that otherwise meet the requirements for membership."

8. Page 2, line 27.
Page 3, line 7.
Page 3, line 19.
Strike: "small"

9. Page 3, lines 1 through 5.
Strike: subsection (4) in its entirety
Renumber: subsequent subsections

10. Page 3, line 6.
Strike: "under all plans offered through the group"

11. Page 3, line 11.
Page 3, line 12.
Page 3, line 14.
Page 3, line 18.
Following: "policies"
Insert: ", certificates,"

12. Page 3, line 13.
Following: "member"
Strike: "small"
Following: "subject to"
Strike: the remainder of line 13
Insert: "the provisions of this part."

13. Page 3, lines 20 and 21.
Strike: subsection (8) in its entirety
Insert: "(7) A person marketing disability insurance policies, certificates, or contracts for a voluntary purchasing pool must be licensed as an insurance producer."

14. Page 3, line 24.
Strike: "5" in both places
Insert: "18" in both places

-END-

HOUSE STANDING COMMITTEE REPORT

February 17, 1995

Mr. Speaker: We, the committee on **Select Committee on Health Care** report that **House Bill 446** (first reading copy -- white) **do pass as amended.**

Signed: _____
Scott Orr, Chair

And, that such amendments read:

1. Title, line 5.
Strike: "INDIVIDUAL"

2. Title, line 6.
Strike: "33-22-101"
Insert: "33-22-110"
Following: "; AND"
Strike: through "MCA"
Insert: "PROVIDING AN IMMEDIATE EFFECTIVE DATE AND A RETROACTIVE APPLICABILITY DATE"

3. Page 1, line 10 through page 2, line 17.
Strike: sections 1 through 3 in their entirety
Insert: "**Section 1.** Section 33-22-110, MCA, is amended to read:
"**33-22-110. Preexisting conditions.** (1) ~~A~~ Except as provided in subsection (2), a policy or certificate of disability insurance may not exclude coverage for a condition for which medical advice or treatment was recommended by or received from a provider of health care services unless the condition occurred within 5 years preceding the effective date of coverage of an insured person. The condition may only be excluded for a maximum of 12 months.
(2) A health benefit plan may exclude coverage or limit benefits for a preexisting condition for a maximum of 12 months. A health benefit plan may not define a preexisting condition more restrictively than:

Committee Vote:
Yes 9, No 2.

411426SC.Hbk

(a) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the 3 years preceding the effective date of coverage of the insured person;

(b) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the 3 years preceding the effective date of coverage of the insured person; or

(c) a pregnancy existing on the effective date of coverage of the insured person.

(3) For purposes of subsection (2), a "health benefit plan" means a hospital-incurred or medical expense-incurred policy or certificate, a subscriber contract, or a contract of insurance provided by a health service corporation or a health maintenance subscriber contract.

(4) An insurer may use an application form designed to elicit the complete health history of an applicant and, on the basis of the answers on that application, perform underwriting in accordance with the insurer's established underwriting standards."

NEW SECTION. **Section 2. Riders.** Except for a policy issued under chapter 22, part 18, a policy of disability insurance may exclude coverage for specific conditions through the use of elimination riders. Except for a policy of disability income insurance, a condition excluded by an elimination rider may be excluded for a period not to exceed 5 years from the effective date of coverage of the insured person."
Renumber: subsequent sections

4. Page 3, line 26.
Strike: "[section 2]"
Insert: "33-22-110(2)"

5. Page 5, line 6.
Strike: section 5 in its entirety
Insert: "
NEW SECTION. **Section 4. Retroactive applicability.** [Section 2] applies retroactively, within the meaning of 1-2-109, to policies, certificates, or contracts of disability insurance issued prior to [the effective date of this act], except for policies, certificates, or contracts issued under Title 33, chapter 22, part 18.

NEW SECTION. **Section 5. Effective date.** [This act] is effective on passage and approval."
Renumber: subsequent section

6. Page 5, line 8.

Strike: "Sections 1 and"
Insert: "Section"
Strike: "are"
Insert: "is"

7. Page 5, line 9.
Following: "chapter 22," in both places
Insert: "part 1,"

-END-

HOUSE STANDING COMMITTEE REPORT

February 18, 1995

Mr. Speaker: We, the committee on **Select Committee on Health Care** report that **House Bill 466** (first reading copy -- white) **do pass as amended.**

Signed: _____
Scott Orr, Chair

And, that such amendments read:

1. Title, line 10.
Following: "EMPLOYEES;"
Insert: "CONTINGENTLY"

2. Title, line 11.
Following: "PLANS;"
Insert: "REQUIRING AN ANNUAL ACTUARIAL REVIEW OF THE SMALL EMPLOYER CARRIER REINSURANCE PROGRAM; LIMITING THE ASSESSMENT ON ASSESSABLE CARRIERS WHO ARE NOT SMALL EMPLOYER CARRIERS;"

3. Title, line 12.
Following: "33-22-1811,"
Insert: "33-22-1819,"

4. Title, line 13.
Following: "AND"
Insert: "CONTINGENTLY"

5. Page 1, line 27.
Strike: "including"
Insert: "excluding"

6. Page 2, lines 4 through 6.
Following: line 3
Insert: "[" on line 4

Committee Vote:
Yes 6, No 5.

Strike: subsection (5) in its entirety
Insert: "][(5) "Basic health benefit plan" means a lower cost health benefit plan developed pursuant to 33-22-1812.]"

7. Page 2, lines 10 and 11.
Following: "corporation," on line 10
Insert: "and"
Strike: ", and," on line 10 through "arrangement" on line 11

8. Page 2, line 26.
Following: line 25
Insert: "["
Following: "~~33-22-1812.~~"
Insert: "] [(10) "Committee" means the health benefit plan committee created pursuant to 33-22-1812.]"

9. Page 4, line 29.
Page 5, line 2
Following: "under the"
Insert: "[uniform] ["
Following: "basic"
Insert: "]"

10. Page 5, lines 26 and 27.
Following: "~~(27)~~" on line 26
Insert: "["
Strike: "Standard" on line 26
Insert: "Uniform"
Strike: "[section 6]." on line 27
Insert: "the uniform health benefit plan (section 3) as provided in House Bill No. 31.] ["Standard health benefit plan" means a health benefit plan developed pursuant to 33-22-1812.]"

11. Page 9, line 25.
Following: "to small employers"
Insert: "[the uniform benefit plan (section 3) as provided in House Bill No. 531.] ["

12. Page 9, line 27.
Following: "plan."
Insert: "]"

13. Page 9, lines 28 and 29.
Following: the first "a"
Insert: "[uniform health benefit plan (section 3) as provided in House Bill No. 531] ["
Following: the first "plan" on line 29
Insert: "]"

Following: "for" on line 29
Insert: "[the] ["
Following: "either" on line 29
Insert: "]"

14. Page 10, line 3.
Following: "employers"
Insert: "[a uniform health benefit plan (section 3) as provided in House Bill No. 531] ["

15. Page 10, line 4.
Following: the second "plan"
Insert: "]"

16. Page 10, line 8.
Following: "a"
Insert: "[uniform] ["
Following: "standard"
Insert: "]"

17. Page 10, line 21.
Following: "the"
Insert: "[uniform health benefit plan (section 3) as provided in House Bill No. 531] ["

18. Page 10, line 22.
Following: "plans"
Insert: "]"

19. Page 10, line 24.
Following: "carrier of a"
Insert: "[uniform health benefit plan (section 3) as provided in House Bill No. 531] ["

20. Page 10, line 25.
Following: "benefit plan"
Insert: "]"

21. Page 11, line 21.
Following: "modify"
Insert: "[the uniform health benefit plan (section 3) as provided in House Bill No. 531] ["
Following: "plan"
Insert: "]"

22. Page 12, line 20 through page 14, line 25.
Strike: sections 5 and 6 in their entirety
Renumber: subsequent sections

23. Page 14.
Following: line 25
Insert: "**Section 5.** Section 33-22-1819, MCA, is amended to read:

"**33-22-1819. Program plan of operation -- treatment of losses -- exemption from taxation.** (1) Within 180 days after the appointment of the initial board, the board shall submit to the commissioner a plan of operation and may at any time submit amendments to the plan necessary or suitable to ensure the fair, reasonable, and equitable administration of the program. The commissioner may, after notice and hearing, approve the plan of operation if the commissioner determines it to be suitable to ensure the fair, reasonable, and equitable administration of the program and if the plan of operation provides for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation is effective upon written approval by the commissioner.

(2) If the board fails to submit a suitable plan of operation within 180 days after its appointment, the commissioner shall, after notice and hearing, promulgate and adopt a temporary plan of operation. The commissioner shall amend or rescind any temporary plan adopted under this subsection at the time a plan of operation is submitted by the board and approved by the commissioner.

(3) The plan of operation must:

(a) establish procedures for the handling and accounting of program assets and money and for an annual fiscal reporting to the commissioner;

(b) establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;

(c) establish procedures for reinsuring risks in accordance with the provisions of this section;

(d) establish procedures for collecting assessments from assessable carriers to fund claims incurred by the program;

(e) establish procedures for allocating a portion of premiums collected from reinsuring carriers to fund administrative expenses incurred or to be incurred by the program; and

(f) provide for any additional matters necessary for the implementation and administration of the program.

(4) The program has the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals. In addition, the program may:

(a) enter into contracts as are necessary or proper to carry out the provisions and purposes of this part, including the authority, with the approval of the commissioner, to enter into

contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(b) sue or be sued, including taking any legal actions necessary or proper to recover any premiums and penalties for, on behalf of, or against the program or any reinsuring carriers;

(c) take any legal action necessary to avoid the payment of improper claims against the program;

(d) define the health benefit plans for which reinsurance will be provided and to issue reinsurance policies in accordance with the requirements of this part;

(e) establish conditions and procedures for reinsuring risks under the program;

(f) establish actuarial functions as appropriate for the operation of the program;

(g) appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in operation of the program, policy and other contract design, and any other function within the authority of the program;

(h) to the extent permitted by federal law and in accordance with subsection (8)(c), make annual fiscal yearend assessments against assessable carriers and make interim assessments to fund claims incurred by the program; and

(i) borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default are legal investments for carriers and may be carried as admitted assets.

(5) A reinsuring carrier may reinsure with the program as provided for in this subsection (5):

(a) With respect to a basic health benefit plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a basic or standard health benefit plan.

(b) A small employer carrier may reinsure an entire employer group within 60 days of the commencement of the group's coverage under a health benefit plan.

(c) A reinsuring carrier may reinsure an eligible employee or dependent within a period of 60 days following the commencement of coverage with the small employer. A newly eligible employee or dependent of the reinsured small employer may be reinsured within 60 days of the commencement of coverage.

(d) (i) The program may not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the carrier has incurred an initial level of claims for the employee or dependent of $5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier is responsible for 20% of the next $100,000 of benefit payments

during a calendar year and the program shall reinsure the remainder. A reinsuring carrier's liability under this subsection (d)(i) may not exceed a maximum limit of $25,000 in any calendar year with respect to any reinsured individual.

(ii) The board annually shall adjust the initial level of claims and maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment may not be less than the annual change in the medical component of the consumer price index for all urban consumers of the United States department of labor, bureau of labor statistics, unless the board proposes and the commissioner approves a lower adjustment factor.

(e) A small employer carrier may terminate reinsurance with the program for one or more of the reinsured employees or dependents of a small employer on any anniversary of the health benefit plan.

(f) A small employer group health benefit plan in effect before January 1, 1994, may not be reinsured by the program until January 1, 1997, and then only if the board determines that sufficient funding sources are available.

(g) A reinsuring carrier shall apply all managed care and claims-handling techniques, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

(6) (a) As part of the plan of operation, the board shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology must include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology must provide for the development of base reinsurance premium rates that must be multiplied by the factors set forth in subsection (6)(b) to determine the premium rates for the program. The base reinsurance premium rates must be established by the board, subject to the approval of the commissioner, and must be set at levels that reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard health benefit plan, adjusted to reflect retention levels required under this part.

(b) Premiums for the program are as follows:

(i) An entire small employer group may be reinsured for a rate that is one and one-half times the base reinsurance premium rate for the group established pursuant to this subsection (6).

(ii) An eligible employee or dependent may be reinsured for a rate that is five times the base reinsurance premium rate for the individual established pursuant to this subsection (6).

(c) The board ~~periodically~~ shall annually review the methodology established under subsection (6)(a), including the system of classification and any rating factors, to ensure that it is actuarially sound and that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology that are subject to the approval of the commissioner.

(d) The board may consider adjustments to the premium rates charged by the program to reflect the use of effective cost containment and managed care arrangements.

(7) If a health benefit plan for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued must meet the requirements relating to premium rates set forth in 33-22-1809.

(8) (a) Prior to March 1 of each year, the board shall determine and report to the commissioner the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(b) To the extent permitted by federal law, each assessable carrier shall share in any net loss of the program for the year in an amount equal to the ratio of the total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery by each assessable carrier divided by the total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery by all assessable carriers in the state.

(c) The board shall make an annual determination in accordance with this section of each assessable carrier's liability for its share of the net loss of the program and, except as otherwise provided by this section, make an annual fiscal yearend assessment against each assessable carrier to the extent of that liability. If approved by the commissioner, the board may also make interim assessments against assessable carriers to fund claims incurred by the program. Any interim assessment must be credited against the amount of any fiscal yearend assessment due or to be due from an assessable carrier. Payment of a fiscal yearend or interim assessment is due within 30 days of receipt by the assessable carrier of written notice of the assessment. An assessable carrier that ceases doing business within the state is liable for assessments until the end of the calendar year in which the assessable carrier ceased doing business. The board may determine not to assess an assessable carrier if the assessable carrier's liability determined in accordance with this section does not exceed $10.

(d) An assessable carrier who is not a small employer carrier is not subject to an assessment of more than 5% of its

underwriting profit on a line of insurance offered by the carrier.

(9) The participation in the program as reinsuring carriers; the establishment of rates, forms, or procedures; or any other joint collective action required by this part may not be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers, either jointly or separately.

(10) The board, as part of the plan of operation, shall develop standards setting forth the minimum levels of compensation to be paid to producers for the sale of basic and standard health benefit plans. In establishing the standards, the board shall take into consideration the need to ensure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide ongoing service to small employers, the levels of compensation currently used in the industry, and the overall costs of coverage to small employers selecting these plans.

(11) The program is exempt from taxation.

(12) On or before March 1 of each year, the commissioner shall evaluate the operation of the program and report to the governor and the legislature in writing the results of the evaluation. The report must include an estimate of future costs of the program, assessments necessary to pay those costs, the appropriateness of premiums charged by the program, the level of insurance retention under the program, the cost of coverage of small employers, and any recommendations for change to the plan of operation."

Renumber: subsequent sections

24. Page 14, lines 28 and 29.
Following: "board" on line 28
Insert: "["
Following: "~~committee,~~"
Insert: "] [, in consultation with members of the committee,]"

25. Page 15, lines 11 and 12.
Following: "part" on line 11
Insert: "["
Following: "~~part~~." on line 12
Insert: "] [but do apply to a standard health benefit plan delivered or issued for delivery to small employers in this state pursuant to this part.]"

26. Page 15, line 14.
Strike: "**Repealer.**"
Insert: "Contingent repealer."
Following: "repealed"

Insert: "contingent upon the passage and approval of House Bill No. 531"

27. Page 15, line 15.
Insert: "
NEW SECTION. **Section 9. Coordination instruction.** If House Bill No. 531 is passed and approved, then the material in the first set of brackets referring to the uniform health benefit plan (section 3) as provided in House Bill No. 531 or to the health benefit plan committee is to be codified. If House Bill No. 531 fails, then the material in the second set of brackets referring to basic and standard health benefit plans and deleting references to the health benefits plan committee must be codified."

28. Page 15, lines 16 through 18.
Strike: section 10 in its entirety
Renumber: subsequent section

-END-

HOUSE OF REPRESENTATIVES

ROLL CALL VOTE

Select Committee on Health Care

DATE Feb. 16, 1995 BILL NO. 405 NUMBER 1

MOTION: Rep. Smith moved to amend HB 405, page 2, line 25 to strike 1000 and insert 750. The phrase would read "750 eligible employees."

NAME	AYE	NO
Rep. Scott Orr, Chairman		✓
Rep. Carley Tuss, Vice Chairman		✓
Rep. Beverly Barnhart		✓
Rep. John Johnson		✓
Rep. Royal Johnson	✓	
Rep. Betty Lou Kasten		✓
Rep. Tom Nelson	✓	
Rep. Bruce Simon		✓
Rep. Dick Simpkins		✓
Rep. Liz Smith	✓	
Rep. Carolyn Squires		✓
	3	8

last
2nd last

EXHIBIT 1
DATE Feb. 16, 1995
HB 511

Amendments to House Bill No. 511
First Reading Copy

For the Select Committee on Health Care

Prepared by Susan Byorth Fox
February 11, 1995

1. Title, line 9.
Strike: the first "SECTIONS"
Insert: "SECTION"
Strike: "AND 50-1-201"

2. Title, line 10.
Following: line 9
Insert: "50-1-201,"
Following: "50-4-303,"
Insert: "50-4-304,"

3. Page 2, line 12.
Strike: "regional board"
Following: "members"
Insert: "who represent health care planning regions"

4. Page 8, line 6.
Following: "Sections"
Insert: "50-1-201,"
{*Internal References to 50-1-201:*
50-4-202r}

5. Page 8, line 7.
Following: "50-4-303,"
Insert: "50-4-304,"

EXHIBIT 2
DATE Feb. 16, 1995
HB 511

Amendments to House Bill No. 511
First Reading Copy

Requested by Rep. Royal Johnson
For the Select Committee on Health Care

Prepared by Susan Byorth Fox
February 13, 1995

1. Title, line 9.
Following: "AUTHORITY;"
Insert: "TRANSFERRING THE RESPONSIBILITY FOR CERTIFICATES OF PUBLIC ADVANTAGE TO THE DEPARTMENT OF JUSTICE;"

Strike: "AND"
Insert: ", 50-4-601, 50-4-603, 50-4-604, 50-4-609, 50-4-610, 50-4-611, AND 50-4-612,"

2. Title, lines 11 and 12.
Following: "50-4-502,"
Insert: "AND"
Strike: "50-4-601," on line 11 through "50-4-612," on line 12

3. Page 8, line 5.
Insert: "**Section 10.** Section 50-4-601, MCA, is amended to read:
"**50-4-601. Finding and purpose.** The legislature finds that the goals of controlling health care costs and improving the quality of and access to health care will be significantly enhanced in some cases by cooperative agreements among health care facilities. The purpose of this part is to provide the state, through the ~~authority~~ department, with direct supervision and control over the implementation of cooperative agreements among health care facilities for which certificates of public advantage are granted. It is the intent of the legislature that supervision and control over the implementation of these agreements substitute state regulation of facilities for competition between facilities and that this regulation have the effect of granting the parties to the agreements state action immunity for actions that might otherwise be considered to be in violation of state or federal, or both, antitrust laws."

Section 11. Section 50-4-603, MCA, is amended to read:
"**50-4-603. Certificate of public advantage -- standards for certification -- time for action by ~~authority~~ department.** (1) Parties to a cooperative agreement may apply to the ~~authority~~ department for a certificate of public advantage. The application for a certificate must include a copy of the proposed or executed agreement, a description of the scope of the cooperation contemplated by the agreement, and the amount, nature, source, and recipient of any consideration passing to any person under the terms of the agreement.

(2) The ~~authority~~ department shall hold a public hearing on the application for a certificate before acting upon the application. The ~~authority~~ department may not issue a certificate

unless the ~~authority~~ department finds that the agreement is likely to result in lower health care costs or in greater access to or quality of health care than would occur without the agreement. If the ~~authority~~ department denies an application for a certificate for an executed agreement, the agreement is void upon the decision of the ~~authority~~ department not to issue the certificate. Parties to a void agreement may not implement or carry out the agreement.

(3) The ~~authority~~ department shall deny the application for a certificate or issue a certificate within 90 days of receipt of a complete application."

Section 12. Section 50-4-604, MCA, is amended to read:

"**50-4-604. Reconsideration by ~~authority~~ department.** (1) If the ~~authority~~ department denies an application and refuses to issue a certificate, a party to the agreement may request that the ~~authority~~ department reconsider its decision. The ~~authority~~ department shall reconsider its decision if the party applying for reconsideration submits the request to the ~~authority~~ department in writing within 30 calendar days of the ~~authority's~~ department's decision to deny the initial application.

(2) The ~~authority~~ department shall hold a public hearing on the application for reconsideration. The hearing must be held within 30 days of receipt of the request for reconsideration unless the party applying for reconsideration agrees to a hearing at a later time. The hearing must be held pursuant to 2-4-604.

(3) The ~~authority~~ department shall make a decision to deny the application or to issue the certificate within 30 days of the conclusion of the hearing required by subsection (2). The decision of the ~~authority~~ department must be part of written findings of fact and conclusions of law supporting the decision. The findings, conclusions, and decision must be served upon the applicant for reconsideration."

Section 13. Section 50-4-609, MCA, is amended to read:

"**50-4-609. Revocation of certificate by ~~authority~~ department.** (1) The ~~authority~~ department shall revoke a certificate previously granted by it if the ~~authority~~ department determines that the cooperative agreement is not resulting in lower health care costs or greater access to or quality of health care than would occur in absence of the agreement.

(2) A certificate may not be revoked by the ~~authority~~ department without giving notice and an opportunity for a hearing before the ~~authority~~ department as follows:

(a) Written notice of the proposed revocation must be given to the parties to the agreement for which the certificate was issued at least 120 days before the effective date of the proposed revocation.

(b) A hearing must be provided prior to revocation if a party to the agreement submits a written request for a hearing to the ~~authority~~ department within 30 calendar days after notice is mailed to the party under subsection (2)(a).

(c) Within 30 calendar days of receipt of the request for a hearing, the ~~authority~~ department shall hold a public hearing to determine whether or not to revoke the certificate. The hearing

must be held in accordance with 2-4-604.

(3) The ~~authority~~ department shall make its final decision and serve the parties with written findings of fact and conclusions of law in support of its decision within 30 days after the conclusion of the hearing or, if no hearing is requested, within 30 days of the date of expiration of the time to request a hearing.

(4) If a certificate of public advantage is revoked by the ~~authority~~ department, the agreement for which the certificate was issued is terminated."

Section 14. Section 50-4-610, MCA, is amended to read:

"**50-4-610. Appeal.** A party to a cooperative agreement may appeal, in the manner provided in Title 2, chapter 4, part 7, a final decision by the ~~authority~~ department to deny an application for a certificate or a decision by the ~~authority~~ department to revoke a certificate. A revocation of a certificate pursuant to 50-4-609 does not become final until the time for appeal has expired. If a decision to revoke a certificate is appealed, the decision is stayed pending resolution of the appeal by the courts."

Section 15. Section 50-4-611, MCA, is amended to read:

"**50-4-611. Record of agreements to be kept.** The ~~authority~~ department shall keep a copy of cooperative agreements for which a certificate is in effect pursuant to this part. A party to a cooperative agreement who terminates the agreement shall notify the ~~authority~~ department in writing of the termination within 30 days after the termination."

Section 16. Section 50-4-612, MCA, is amended to read:

"**50-4-612. Rulemaking.** The ~~authority~~ department shall adopt rules to implement this part. The rules shall include rules:

(1) specifying the form and content of applications for a certificate;

(2) specifying necessary details for reconsideration of denial of certificates, revocations of certificates, hearings required or authorized by this part, and appeals; and

(3) to effect the active supervision by the ~~authority~~ department of agreements between health care facilities. These rules may include reporting requirements for parties to an agreement for which a certificate is in effect."

NEW SECTION. **Section 17. Definitions.** For the purposes of this part, the following definitions apply:

(1) "Certificate of public advantage" or "certificate" means a written certificate issued by the department as evidence of the department's intention that the implementation of a cooperative agreement, when actively supervised by the department, receive state action immunity from prosecution as a violation of state or federal antitrust laws.

(2) "Cooperative agreement" or "agreement" means a written agreement between two or more health care facilities for the sharing, allocation, or referral of patients; personnel; instructional programs; emergency medical services; support

services and facilities; medical, diagnostic, or laboratory facilities or procedures; or other services customarily offered by health care facilities.

(3) "Department" means the department of justice provided for in Title 2, chapter 15, part 20.

(4) "Health care facility" means all facilities and institutions, whether public or private, proprietary or nonprofit, that offer diagnosis, treatment, and inpatient or ambulatory care to two or more unrelated persons. The term includes all facilities and institutions included in 50-5-101(19). The term does not apply to a facility operated by religious groups relying solely on spiritual means, through prayer, for healing."

4. Page 8, lines 8 and 9.
Following: "50-4-502,"
Insert: "and"
Strike: "50-4-601" on line 8 through "50-4-612," on line 9

5. Page 8, line 10.
Insert: "

NEW SECTION. **Section 19. Name change -- directions to code commissioner.** Wherever the name of or a reference to the Montana health care authority appears in legislation enacted by the 1995 legislature to be codified in Title 50, chapter 4, part 6, the code commissioner is directed to change the reference to the department of justice."

6. Page 8, line 11.
Strike: "**instruction**"
Insert: "**instructions**"
Following: "."
Insert: "(1)"

7. Page 8, line 14.
Insert: "(2) [Section 17] is intended to be codified as an integral part of Title 50, chapter 4, part 6, and the provisions of Title 50, chapter 4, part 6, apply to [section 17]."

8. Page 8, line 20.
Strike: "11, 12, and 14"
Insert: "20, 21, and 23"

9. Page 8, line 22.
Strike: "10"
Insert: "19"

EXHIBIT 3
DATE Feb. 16, 1995
HB 511

Amendments to House Bill No. 511
First Reading Copy

Requested by Rep. Johnson
For the Select Committee on Health Care

Prepared by Susan Byorth Fox
February 13, 1995

1. Title, line 9.
Following: "AUTHORITY;"
Insert: "TRANSFERRING THE RESPONSIBILITY FOR THE HEALTH CARE DATA BASE TO THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES;"
Strike: "AND"
Insert: ","
Following: "50-1-201"
Insert: ", AND 50-4-502,"

2. Title, line 11.
Strike: "50-4-502,"

3. Page 8, line 5.
Insert: "**Section 10.** Section 50-4-502, MCA, is amended to read:
"**50-4-502. Health care data base -- information submitted ~~-- enforcement~~.** (1) The ~~authority~~ department, with advice from the health care advisory council, shall design and develop ~~and maintain~~ a ~~unified~~ health care data base ~~that enables the authority, on a statewide basis, to:~~

~~(a) determine the distribution and capacity of health care resources, including health care facilities, providers, and health care services;~~

~~(b) identify health care needs and direct statewide and regional health care policy to ensure high-quality and cost-effective health care;~~

~~(c) conduct evaluations of health care procedures and health care protocols;~~

~~(d) compare costs of commonly performed health care procedures between providers and health care facilities within a region and make the data readily available to the public; and~~

~~(e) compare costs of various health care procedures in one location of providers and health care facilities with the costs of the same procedures in other locations of providers and health care facilities~~ that includes data on health care resources and the cost and quality of health care services. The purpose of the data base is to assist in developing and monitoring the progress of incremental health care reform measures that increase access to health care services, promote cost containment, and maintain quality of care.

(2) The ~~authority~~ department shall ~~by rule require~~ work in conjunction with health care providers, health insurers, health care facilities, private entities, and entities of state and local governments to ~~file with the authority the reports, data,~~

~~schedules, statistics, and other information determined by the authority to be~~ determine the information necessary to fulfill the purposes of the data base provided in subsection (1). ~~Material to be filed with the authority may include health insurance claims and enrollment information used by health insurers.~~

~~(3) The authority may issue subpoenas for the production of information required under this section and may issue subpoenas for and administer oaths to any person. Noncompliance with a subpoena issued by the authority is, upon application by the authority, punishable by a district court as contempt pursuant to Title 3, chapter 1, part 5.~~

~~(4) The data base must:~~

~~(a) use unique patient and provider identifiers and a uniform coding system identifying health care services; and~~

~~(b) reflect all health care utilization, costs, and resources in the state and the health care utilization and costs of services provided to Montana residents in another state.~~

~~(5) Information in the data base required by law to be kept confidential must be maintained in a manner that does not disclose the identity of the person to whom the information applies. Information in the data base not required by law to be kept confidential must be made available by the authority upon request of any person.~~

~~(6)~~(3) The ~~authority~~ department shall adopt by rule a confidentiality code to ensure that information in the data base is maintained and used according to state law governing confidential health care information.

(4) The department shall make recommendations to the legislature by October 1, 1996, on the actions needed to establish the data base, including an estimate of the fiscal impact on state and local government, health care providers, health insurers, health care facilities, and private entities.
"

NEW SECTION. **Section 11. Definitions.** As used in this part, the following definitions apply:

(1) "Data base" means the health care data base created pursuant to 50-4-502.

(2) "Department" means the department of social and rehabilitation services provided for in Title 2, chapter 15, part 22.

(3) "Health care" includes both physical health care and mental health care.

(4) "Health care advisory council" means the council provided for in [sections 1 through 6].

(5) "Health care facility" means all facilities and institutions, whether public or private, proprietary or nonprofit, that offer diagnosis, treatment, and inpatient or ambulatory care to two or more unrelated persons. The term includes all facilities and institutions included in 50-5-101(19). The term does not apply to a facility operated by religious groups relying solely on spiritual means, through prayer, for healing.

(6) "Health care provider" or "provider" means a person who

is licensed, certified, or otherwise authorized by the laws of this state to provide health care in the ordinary course of business or practice of a profession.

(7) "Health insurer" means any health insurance company, health service corporation, health maintenance organization, insurer providing disability insurance as described in 33-1-207, and, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities."

4. Page 8, line 8.
Strike: "50-4-502,"

5. Page 8, line 11.
Strike: "instruction."
Insert: "instructions. (1)"

6. Page 8, line 14.
Insert: "(2) [Section 11] is intended to be codified as an integral part of Title 50, chapter 4, part 5, and the provisions of Title 50, chapter 4, part 5, apply to [section 11]."

7. Page 8, line 20.
Following: "7,"
Strike: "11, 12, and 14"
Insert: "13, 14, and 16"

8. Page 8, line 22.
Strike: "10"
Insert: "12"

EXHIBIT 4
DATE 2/16/95
HB 511

Amendments to House Bill No. 511
First Reading Copy

For the Select Committee on Health Care

Prepared by Susan Byorth Fox
February 17, 1995

1. Title, line 9.
Following: "AUTHORITY;"
Insert: "TRANSFERRING THE RESPONSIBILITY FOR THE HEALTH CARE DATA BASE TO THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES; TRANSFERRING THE RESPONSIBILITY FOR CERTIFICATES OF PUBLIC ADVANTAGE TO THE DEPARTMENT OF JUSTICE;"
Strike: "AND 50-1-201"
Insert: "50-4-502, 50-4-601, 50-4-603, 50-4-604, 50-4-609, 50-4-610, 50-4-611, AND 50-4-612,"

2. Title, line 10.
Following: line 9
Insert: "50-1-201,"
Following: "50-4-303,"
Insert: "50-4-304,"

3. Title, lines 11 and 12.
Strike: "50-4-502,"
Insert: "AND"
Following: "50-4-503,"
Strike: the remainder of line 11 through "50-4-612," on line 12

4. Page 2, line 12.
Strike: "regional board"
Following: "members"
Insert: "who represent health care planning regions and"

5. Page 2, line 28.
Strike: "The"
Strike: "A"

6. Page 7, lines 15 through 25.
Strike: section 9 in its entirety
Renumber: subsequent sections

7. Page 8, line 5.
Insert: "**Section 9.** Section 50-4-502, MCA, is amended to read:
"50-4-502. Health care data base -- information submitted ~~-- enforcement~~. (1) The ~~authority~~ department, with advice from the health care advisory council, shall design and develop ~~and maintain~~ a ~~unified~~ health care data base ~~that enables the authority, on a statewide basis, to:~~
~~(a) determine the distribution and capacity of health care resources, including health care facilities, providers, and health care services;~~
~~(b) identify health care needs and direct statewide and regional health care policy to ensure high-quality and~~

~~cost-effective health care;~~

~~(c) conduct evaluations of health care procedures and health care protocols;~~

~~(d) compare costs of commonly performed health care procedures between providers and health care facilities within a region and make the data readily available to the public; and~~

~~(e) compare costs of various health care procedures in one location of providers and health care facilities with the costs of the same procedures in other locations of providers and health care facilities~~ that includes data on health care resources and the cost and quality of health care services. The purpose of the data base is to assist in developing and monitoring the progress of incremental health care reform measures that increase access to health care services, promote cost containment, and maintain quality of care.

(2) The ~~authority~~ department shall ~~by rule require~~ work in conjunction with health care providers, health insurers, health care facilities, private entities, and entities of state and local governments to ~~file with the authority the reports, data, schedules, statistics, and other information determined by the authority to be~~ determine the information necessary to fulfill the purposes of the data base provided in subsection (1). ~~Material to be filed with the authority may include health insurance claims and enrollment information used by health insurers.~~

~~(3) The authority may issue subpoenas for the production of information required under this section and may issue subpoenas for and administer oaths to any person. Noncompliance with a subpoena issued by the authority is, upon application by the authority, punishable by a district court as contempt pursuant to Title 3, chapter 1, part 5.~~

~~(4) The data base must:~~

~~(a) use unique patient and provider identifiers and a uniform coding system identifying health care services; and~~

~~(b) reflect all health care utilization, costs, and resources in the state and the health care utilization and costs of services provided to Montana residents in another state.~~

~~(5) Information in the data base required by law to be kept confidential must be maintained in a manner that does not disclose the identity of the person to whom the information applies. Information in the data base not required by law to be kept confidential must be made available by the authority upon request of any person.~~

~~(6)~~(3) The ~~authority~~ department shall adopt by rule a confidentiality code to ensure that information in the data base is maintained and used according to state law governing confidential health care information.

(4) The department shall make recommendations to the legislature by October 1, 1996, on the actions needed to establish the data base, including an estimate of the fiscal impact on state and local government, health care providers, health insurers, health care facilities, and private entities.
"

NEW SECTION. **Section 10. Definitions.** As used in this

part, the following definitions apply:

(1) "Data base" means the health care data base created pursuant to 50-4-502.

(2) "Department" means the department of social and rehabilitation services provided for in Title 2, chapter 15, part 22.

(3) "Health care" includes both physical health care and mental health care.

(4) "Health care advisory council" means the council provided for in [sections 1 through 6].

(5) "Health care facility" means all facilities and institutions, whether public or private, proprietary or nonprofit, that offer diagnosis, treatment, and inpatient or ambulatory care to two or more unrelated persons. The term includes all facilities and institutions included in 50-5-101(19). The term does not apply to a facility operated by religious groups relying solely on spiritual means, through prayer, for healing.

(6) "Health care provider" or "provider" means a person who is licensed, certified, or otherwise authorized by the laws of this state to provide health care in the ordinary course of business or practice of a profession.

(7) "Health insurer" means any health insurance company, health service corporation, health maintenance organization, insurer providing disability insurance as described in 33-1-207, and, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities."

Section 11. Section 50-4-601, MCA, is amended to read:

"**50-4-601. Finding and purpose.** The legislature finds that the goals of controlling health care costs and improving the quality of and access to health care will be significantly enhanced in some cases by cooperative agreements among health care facilities. The purpose of this part is to provide the state, through the ~~authority~~ department, with direct supervision and control over the implementation of cooperative agreements among health care facilities for which certificates of public advantage are granted. It is the intent of the legislature that supervision and control over the implementation of these agreements substitute state regulation of facilities for competition between facilities and that this regulation have the effect of granting the parties to the agreements state action immunity for actions that might otherwise be considered to be in violation of state or federal, or both, antitrust laws."

Section 12. Section 50-4-603, MCA, is amended to read:

"**50-4-603. Certificate of public advantage -- standards for certification -- time for action by ~~authority~~ department.** (1) Parties to a cooperative agreement may apply to the ~~authority~~ department for a certificate of public advantage. The application for a certificate must include a copy of the proposed or executed agreement, a description of the scope of the cooperation contemplated by the agreement, and the amount, nature, source, and recipient of any consideration passing to any person under

the terms of the agreement.

(2) The ~~authority~~ department shall hold a public hearing on the application for a certificate before acting upon the application. The ~~authority~~ department may not issue a certificate unless the ~~authority~~ department finds that the agreement is likely to result in lower health care costs or in greater access to or quality of health care than would occur without the agreement. If the ~~authority~~ department denies an application for a certificate for an executed agreement, the agreement is void upon the decision of the ~~authority~~ department not to issue the certificate. Parties to a void agreement may not implement or carry out the agreement.

(3) The ~~authority~~ department shall deny the application for a certificate or issue a certificate within 90 days of receipt of a completed application."

Section 13. Section 50-4-604, MCA, is amended to read:

"**50-4-604. Reconsideration by ~~authority~~ department.** (1) If the ~~authority~~ department denies an application and refuses to issue a certificate, a party to the agreement may request that the ~~authority~~ department reconsider its decision. The ~~authority~~ department shall reconsider its decision if the party applying for reconsideration submits the request to the ~~authority~~ department in writing within 30 calendar days of the ~~authority's~~ department's decision to deny the initial application.

(2) The ~~authority~~ department shall hold a public hearing on the application for reconsideration. The hearing must be held within 30 days of receipt of the request for reconsideration unless the party applying for reconsideration agrees to a hearing at a later time. The hearing must be held pursuant to 2-4-604.

(3) The ~~authority~~ department shall make a decision to deny the application or to issue the certificate within 30 days of the conclusion of the hearing required by subsection (2). The decision of the ~~authority~~ department must be part of written findings of fact and conclusions of law supporting the decision. The findings, conclusions, and decision must be served upon the applicant for reconsideration."

Section 14. Section 50-4-609, MCA, is amended to read:

"**50-4-609. Revocation of certificate by ~~authority~~ department.** (1) The ~~authority~~ department shall revoke a certificate previously granted by it if the ~~authority~~ department determines that the cooperative agreement is not resulting in lower health care costs or greater access to or quality of health care than would occur in absence of the agreement.

(2) A certificate may not be revoked by the ~~authority~~ department without giving notice and an opportunity for a hearing before the ~~authority~~ department as follows:

(a) Written notice of the proposed revocation must be given to the parties to the agreement for which the certificate was issued at least 120 days before the effective date of the proposed revocation.

(b) A hearing must be provided prior to revocation if a party to the agreement submits a written request for a hearing to the ~~authority~~ department within 30 calendar days after notice is

mailed to the party under subsection (2)(a).

(c) Within 30 calendar days of receipt of the request for a hearing, the ~~authority~~ department shall hold a public hearing to determine whether or not to revoke the certificate. The hearing must be held in accordance with 2-4-604.

(3) The ~~authority~~ department shall make its final decision and serve the parties with written findings of fact and conclusions of law in support of its decision within 30 days after the conclusion of the hearing or, if no hearing is requested, within 30 days of the date of expiration of the time to request a hearing.

(4) If a certificate of public advantage is revoked by the ~~authority~~ department, the agreement for which the certificate was issued is terminated."

Section 15. Section 50-4-610, MCA, is amended to read:

"**50-4-610. Appeal.** A party to a cooperative agreement may appeal, in the manner provided in Title 2, chapter 4, part 7, a final decision by the ~~authority~~ department to deny an application for a certificate or a decision by the ~~authority~~ department to revoke a certificate. A revocation of a certificate pursuant to 50-4-609 does not become final until the time for appeal has expired. If a decision to revoke a certificate is appealed, the decision is stayed pending resolution of the appeal by the courts."

Section 16. Section 50-4-611, MCA, is amended to read:

"**50-4-611. Record of agreements to be kept.** The ~~authority~~ department shall keep a copy of cooperative agreements for which a certificate is in effect pursuant to this part. A party to a cooperative agreement who terminates the agreement shall notify the ~~authority~~ department in writing of the termination within 30 days after the termination."

Section 17. Section 50-4-612, MCA, is amended to read:

"**50-4-612. Rulemaking.** The ~~authority~~ department shall adopt rules to implement this part. The rules shall include rules:

(1) specifying the form and content of applications for a certificate;

(2) specifying necessary details for reconsideration of denial of certificates, revocations of certificates, hearings required or authorized by this part, and appeals; and

(3) to effect the active supervision by the ~~authority~~ department of agreements between health care facilities. These rules may include reporting requirements for parties to an agreement for which a certificate is in effect."

NEW SECTION. **Section 18. Definitions.** For the purposes of this part, the following definitions apply:

(1) "Certificate of public advantage" or "certificate" means a written certificate issued by the department as evidence of the department's intention that the implementation of a cooperative agreement, when actively supervised by the department, receive state action immunity from prosecution as a violation of state or federal antitrust laws.

(2) "Cooperative agreement" or "agreement" means a written agreement between two or more health care facilities for the sharing, allocation, or referral of patients; personnel; instructional programs; emergency medical services; support services and facilities; medical, diagnostic, or laboratory facilities or procedures; or other services customarily offered by health care facilities.

(3) "Department" means the department of justice provided for in Title 2, chapter 15, part 20.

(4) "Health care facility" means all facilities and institutions, whether public or private, proprietary or nonprofit, that offer diagnosis, treatment, and inpatient or ambulatory care to two or more unrelated persons. The term includes all facilities and institutions included in 50-5-101(19). The term does not apply to a facility operated by religious groups relying solely on spiritual means, through prayer, for healing."

8. Page 8, line 6.
Following: "Sections"
Insert: "50-1-201,"

9. Page 8, line 7.
Following: "50-4-303,"
Insert: "50-4-304,"

10. Page 8, lines 8 and 9.
Strike: "50-4-502,"
Insert: "and"
Following: "50-4-503,"
Strike: the remainder of line 8 through "50-4-612," on line 9

11. Page 8, line 10.
Insert: "
NEW SECTION. **Section 20. Name change -- directions to code commissioner.** Wherever the name of or a reference to the Montana health care authority appears in legislation enacted by the 1995 legislature to be codified in Title 50, chapter 4, part 6, the code commissioner is directed to change the reference to the department of justice."
Renumber: subsequent sections

12. Page 8, line 11.
Strike: "instruction."
Insert: "instructions. (1)"

13. Page 8, line 14.
Insert: "(2) [Section 10] is intended to be codified as an integral part of Title 50, chapter 4, part 5, and the provisions of Title 50, chapter 4, part 5, apply to [section 10].

(3) [Section 18] is intended to be codified as an integral part of Title 50, chapter 4, part 6, and the provisions of Title 50, chapter 4, part 6, apply to [section 18]."

EXHIBIT 4
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HB 511

14. Page 8, line 20.
Strike: "11, 12, and 14"
Insert: "20 through 22, and 24"

15. Page 8, line 22.
Strike: "10"
Insert: "19"

EXHIBIT 5
DATE Feb. 16, 1995
HB

HEALTH CARE AUTHORITY
Subcommittees

Future of the Authority	*	Betty Lou Kasten
Statement of Health Care Policy		Dick Simpkins
Data Collection		Carolyn Squires
Cost Containment		
Anti-trust		
Tort Reform		
Prevention		
Medicaid reform		
Mandates		
Disclosure (providers)		

INSURANCE REFORM

The "Amendment"	*	Liz Smith
Guaranteed Issue		Royal Johnson
Portability		Beverly Barnhart
Access to Insurance		
Purchasing Pools		
Modified Community Rating		
Guaranteed Renewal		
Pre-existing conditions		
Benefit Levels		
Simplifying paperwork		
Disclosure (insurers)		

DELIVERY SYSTEMS

Medical Savings Accounts	*	Bruce Simon
Sequential Plan		Tom Nelson
Deduction of Medical Insurance Premiums		John Johnson
Deduction of Medical Expenses		
Long Term Care		
Wellness Program		
Family Practice Residency		

EXHIBIT 6
DATE 2/16/95
HB 533

Amendments to House Bill No. 533
First Reading Copy

For the Select Committee on Health Care

Prepared by David S. Niss
February 16, 1995

1. Title, line 7.
Strike: "AND"

2. Title, line 8.
Following: "MCA"
Insert: "; AND PROVIDING A DELAYED EFFECTIVE DATE AND AN APPLICABILITY DATE"

3. Page 1.
Following: line 13
Insert: "(1) "Block of business" means an individual disability insurance policy certificate or contract product type written and sold by a health care insurer to a defined set of individuals. All individuals covered by the type of policy or contract are considered to be within the block of business."

Renumber: subsequent subsections

4. Page 1, line 14.
Strike: "health care insurer as defined in 33-22-125"
Insert: "disability insurer, a health service corporation, or a health maintenance organization"

5. Page 1, line 27.
Strike: "standard health benefit plan referred to in 33-22-1811 and 33-22-1812"
Insert: "plan being applied for"

6. Page 1, line 30.
Following: "benefit society"
Insert: ", that provides benefits similar to or exceeding the plan being applied for"

7. Page 2, line 3.
Strike: **"Portability of insurance required."**
Insert: **"Waiver of preexisting condition exclusion."**

8. Page 2, line 7.
Strike: "effective"
Following: "date of"
Insert: "application for"

9. Page 2, lines 14 and 15.
Strike: "by premium" on line 14 through "state" on line 15
Insert: "across the block of business"

10. Page 3.
Following: line 18
Insert: "NEW SECTION. **Section 6. Applicability.** [This act] applies to a policy, certificate, or contract of disability insurance and a health service membership contract entered into or renewed on or after [the effective date of this act].

NEW SECTION. **Section 7. {standard} Effective date.** [This act] is effective January 1, 1996."

EXHIBIT 7
DATE 2/16/95
HB 405

Amendments to House Bill No. 405
First Reading Copy

Requested by Representative Tom Nelson
For the Select Committee on Health Care

Prepared by Susan Byorth Fox
February 15, 1995

1. Title, line 5.
Strike: "SMALL EMPLOYER"

2. Page 1, line 30.
Strike: "that obtains"
Insert: "that has been organized and is maintained in good faith for purposes other than that of obtaining"
Following: "insurance"
Strike: ","
Insert: "or of"

3. Page 2, line 17.
Strike: "of small employers"
Insert: "or to the member employers of a voluntary purchasing pool"

4. Page 2, line 22.
Strike: **"for small employers"**

5. Page 2, line 23.
Strike: "small employers"
Insert: "disability insurance purchasers"

6. Page 2, line 25.
Strike: "one thousand"
Insert: "1,000"

7. Page 2, line 26.
Following: "membership."
Insert: "The voluntary purchasing pool shall accept for membership any small employers and may accept for membership any employers with more that 25 eligible employees that otherwise meet the requirements for membership."

8. Page 2, line 27.
Page 3, line 7.
Page 3, line 19.
Strike: "small"

9. Page 3, lines 1 through 5.
Strike: subsection (4) in its entirety
Renumber: subsequent subsections

10. Page 3, line 6.
Strike: "under all plans offered through the group"

11. Page 3, line 11.
Page 3, line 12.
Page 3, line 14.
Page 3, line 18.
Following: "policies"
Insert: ", certificates,"

12. Page 3, line 13.
Following: "member"
Strike: "small"
Following: "subject to"
Strike: the remainder of line 13
Insert: "the provisions of this part."

13. Page 3, lines 20 and 21.
Strike: subsection (8) in its entirety
Insert: "(7) A person marketing disability insurance policies, certificates, or contracts for a voluntary purchasing pool must be licensed as an insurance producer."

14. Page 3, line 24.
Strike: "5" in both places
Insert: "18" in both places

EXHIBIT 8
DATE 2/16/95
HB 446

Amendments to House Bill No. 446
First Reading Copy

Requested by Representative Scott Orr
For the Select Committee on Health Care

Prepared by Susan Byorth Fox
February 15, 1995

1. Title, line 5.
Strike: "INDIVIDUAL"

2. Title, line 6.
Strike: "33-22-101"
Insert: "33-22-110"
Following: "; AND"
Strike: through "MCA"
Insert: "PROVIDING AN IMMEDIATE EFFECTIVE DATE AND A RETROACTIVE APPLICABILITY DATE"

3. Page 1, line 10 through page 2, line 17.
Strike: sections 1 through 3 in their entirety
Insert: "**Section 1.** Section 33-22-110, MCA, is amended to read:

"33-22-110. Preexisting conditions. (1) ~~A~~ Except as provided in subsection (2), a policy or certificate of disability insurance may not exclude coverage for a condition for which medical advice or treatment was recommended by or received from a provider of health care services unless the condition occurred within 5 years preceding the effective date of coverage of an insured person. The condition may only be excluded for a maximum of 12 months.

(2) A health benefit plan may exclude coverage or limit benefits for a preexisting condition for a maximum of 12 months. A health benefit plan may not define a preexisting condition more restrictively than:

(a) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the 3 years preceding the effective date of coverage of the insured person;

(b) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the 3 years preceding the effective date of coverage of the insured person; or

(c) a pregnancy existing on the effective date of coverage of the insured person.

(3) For purposes of subsection (2), a "health benefit plan" means a hospital-incurred or medical expense-incurred policy or certificate, a subscriber contract, or a contract of insurance provided by a health service corporation or a health maintenance subscriber contract.

(4) An insurer may use an application form designed to elicit the complete health history of an applicant and, on the basis of the answers on that application, perform underwriting in accordance with the insurer's established underwriting standards."

NEW SECTION. **Section 2. Riders.** Except for a policy issued under chapter 22, part 18, a policy of disability insurance may exclude coverage for specific conditions through the use of elimination riders. Except for a policy of disability income insurance, a condition excluded by an elimination rider may be excluded for a period not to exceed 5 years from the effective date of coverage of the insured person."
Renumber: subsequent sections

4. Page 3, line 26.
Strike: "[section 2]"
Insert: "33-22-110(2)"

5. Page 5, line 6.
Strike: section 5 in its entirety
Insert: "
NEW SECTION. **Section 4. Retroactive applicability.** [Section 2] applies retroactively, within the meaning of 1-2-109, to policies, certificates, or contracts of disability insurance issued prior to [the effective date of this act], except for policies, certificates, or contracts issued under Title 33, chapter 22, part 18.

NEW SECTION. **Section 5. Effective date.** [This act] is effective on passage and approval."
Renumber: subsequent section

6. Page 5, line 8.
Strike: "Sections 1 and"
Insert: "Section"
Strike: "are"
Insert: "is"

7. Page 5, line 9.
Following: "chapter 22," in both places
Insert: "part 1,"

EXHIBIT 9
DATE Feb. 16, 1995
HB 466

Amendments to House Bill No. 466
First Reading Copy

For the Select Committee on Health Care

Prepared by David S. Niss
February 16, 1995

1. Page 14, line 10.
Strike: "and"

2. Page 14, line 11.
Following: "diabetics"
Insert: "; (v) services of a speech pathologist and audiologist covered under a case management plan of care as directed by a referring physician; and

(w) medically necessary nutrition services covered under a case management plan of care as directed by a referring physician, including assessment and counseling for the following conditions:

(i) diabetes mellitus;
(ii) renal disease;
(iii) high-risk pregnancy;
(iv) malnutrition;
(v) high-risk pediatrics;
(vi) cardiovascular disease;
(vii) cancer;
(viii) gastrointestinal disease; and
(ix) eating disorders"

EXHIBIT 10
DATE Feb. 16, 1995
HB 466

Amendments to House Bill No. 466
First Reading Copy

Requested by Sen. Nelson
For the Select Committee on Health Care

Prepared by David S. Niss
February 16, 1995

1. Page 1, line 27.
Strike: "including"
Insert: "excluding"

2. Page 2, lines 10 and 11.
Following: "corporation," on line 10
Insert: "and"
Strike: ", and," on line 10 through "arrangement" on line 11

EXHIBIT 11
DATE Feb. 16, 1995
HB 466

Amendments to House Bill No. 466
First Reading Copy

For the Select Committee on Health Care

Prepared by David S. Niss
February 16, 1995

1. Title, line 11.
Following: "PLANS;"
Insert: "REQUIRING AN ANNUAL ACTUARIAL REVIEW OF THE SMALL EMPLOYER CARRIER REINSURANCE PROGRAM; LIMITING THE ASSESSMENT ON ASSESSABLE CARRIERS WHO ARE NOT SMALL EMPLOYER CARRIERS;"

2. Title, line 12.
Following: "33-22-1811,"
Insert: "33-22-1819,"

3. Page 14.
Following: line 25
Insert: "**Section 7** Section 33-22-1819, MCA, is amended to read:

"**33-22-1819. Program plan of operation -- treatment of losses -- exemption from taxation.** (1) Within 180 days after the appointment of the initial board, the board shall submit to the commissioner a plan of operation and may at any time submit amendments to the plan necessary or suitable to ensure the fair, reasonable, and equitable administration of the program. The commissioner may, after notice and hearing, approve the plan of operation if the commissioner determines it to be suitable to ensure the fair, reasonable, and equitable administration of the program and if the plan of operation provides for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation is effective upon written approval by the commissioner.

(2) If the board fails to submit a suitable plan of operation within 180 days after its appointment, the commissioner shall, after notice and hearing, promulgate and adopt a temporary plan of operation. The commissioner shall amend or rescind any temporary plan adopted under this subsection at the time a plan of operation is submitted by the board and approved by the commissioner.

(3) The plan of operation must:

(a) establish procedures for the handling and accounting of program assets and money and for an annual fiscal reporting to the commissioner;

(b) establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;

(c) establish procedures for reinsuring risks in accordance with the provisions of this section;

(d) establish procedures for collecting assessments from assessable carriers to fund claims incurred by the program;

(e) establish procedures for allocating a portion of premiums collected from reinsuring carriers to fund administrative expenses incurred or to be incurred by the program; and

(f) provide for any additional matters necessary for the implementation and administration of the program.

(4) The program has the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals. In addition, the program may:

(a) enter into contracts as are necessary or proper to carry out the provisions and purposes of this part, including the authority, with the approval of the commissioner, to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(b) sue or be sued, including taking any legal actions necessary or proper to recover any premiums and penalties for, on behalf of, or against the program or any reinsuring carriers;

(c) take any legal action necessary to avoid the payment of improper claims against the program;

(d) define the health benefit plans for which reinsurance will be provided and to issue reinsurance policies in accordance with the requirements of this part;

(e) establish conditions and procedures for reinsuring risks under the program;

(f) establish actuarial functions as appropriate for the operation of the program;

(g) appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in operation of the program, policy and other contract design, and any other function within the authority of the program;

(h) to the extent permitted by federal law and in accordance with subsection (8)(c), make annual fiscal yearend assessments against assessable carriers and make interim assessments to fund claims incurred by the program; and

(i) borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default are legal investments for carriers and may be carried as admitted assets.

(5) A reinsuring carrier may reinsure with the program as provided for in this subsection (5):

(a) With respect to a basic health benefit plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a basic or standard health benefit plan.

(b) A small employer carrier may reinsure an entire employer group within 60 days of the commencement of the group's coverage under a health benefit plan.

(c) A reinsuring carrier may reinsure an eligible employee or dependent within a period of 60 days following the commencement of coverage with the small employer. A newly eligible employee or dependent of the reinsured small employer

may be reinsured within 60 days of the commencement of coverage.

(d) (i) The program may not reimburse a reinsuring carrier with respect to the claims of a reinsured employee or dependent until the carrier has incurred an initial level of claims for the employee or dependent of $5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier is responsible for 20% of the next $100,000 of benefit payments during a calendar year and the program shall reinsure the remainder. A reinsuring carrier's liability under this subsection (d)(i) may not exceed a maximum limit of $25,000 in any calendar year with respect to any reinsured individual.

(ii) The board annually shall adjust the initial level of claims and maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment may not be less than the annual change in the medical component of the consumer price index for all urban consumers of the United States department of labor, bureau of labor statistics, unless the board proposes and the commissioner approves a lower adjustment factor.

(e) A small employer carrier may terminate reinsurance with the program for one or more of the reinsured employees or dependents of a small employer on any anniversary of the health benefit plan.

(f) A small employer group health benefit plan in effect before January 1, 1994, may not be reinsured by the program until January 1, 1997, and then only if the board determines that sufficient funding sources are available.

(g) A reinsuring carrier shall apply all managed care and claims-handling techniques, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

(6) (a) As part of the plan of operation, the board shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology must include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology must provide for the development of base reinsurance premium rates that must be multiplied by the factors set forth in subsection (6)(b) to determine the premium rates for the program. The base reinsurance premium rates must be established by the board, subject to the approval of the commissioner, and must be set at levels that reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard health benefit plan, adjusted to reflect retention levels required under this part.

(b) Premiums for the program are as follows:

(i) An entire small employer group may be reinsured for a rate that is one and one-half times the base reinsurance premium rate for the group established pursuant to this subsection (6).

(ii) An eligible employee or dependent may be reinsured for a rate that is five times the base reinsurance premium rate for the individual established pursuant to this subsection (6).

(c) The board ~~periodically~~ shall annually review the methodology established under subsection (6)(a), including the system of classification and any rating factors, to ensure that it is actuarially sound and that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology that are subject to the approval of the commissioner.

(d) The board may consider adjustments to the premium rates charged by the program to reflect the use of effective cost containment and managed care arrangements.

(7) If a health benefit plan for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued must meet the requirements relating to premium rates set forth in 33-22-1809.

(8) (a) Prior to March 1 of each year, the board shall determine and report to the commissioner the program net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(b) To the extent permitted by federal law, each assessable carrier shall share in any net loss of the program for the year in an amount equal to the ratio of the total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery by each assessable carrier divided by the total premiums earned in the previous calendar year from health benefit plans delivered or issued for delivery by all assessable carriers in the state.

(c) The board shall make an annual determination in accordance with this section of each assessable carrier's liability for its share of the net loss of the program and, except as otherwise provided by this section, make an annual fiscal yearend assessment against each assessable carrier to the extent of that liability. If approved by the commissioner, the board may also make interim assessments against assessable carriers to fund claims incurred by the program. Any interim assessment must be credited against the amount of any fiscal yearend assessment due or to be due from an assessable carrier. Payment of a fiscal yearend or interim assessment is due within 30 days of receipt by the assessable carrier of written notice of the assessment. An assessable carrier that ceases doing business within the state is liable for assessments until the end of the calendar year in which the assessable carrier ceased doing business. The board may determine not to assess an assessable carrier if the assessable carrier's liability determined in accordance with this section does not exceed $10.

(d) An assessable carrier who is not a small employer carrier is not subject to an assessment of more than 5% of its underwriting profit on a line of insurance offered by the carrier.

(9) The participation in the program as reinsuring carriers; the establishment of rates, forms, or procedures; or any other joint collective action required by this part may not be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers,

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either jointly or separately.

(10) The board, as part of the plan of operation, shall develop standards setting forth the minimum levels of compensation to be paid to producers for the sale of basic and standard health benefit plans. In establishing the standards, the board shall take into consideration the need to ensure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide ongoing service to small employers, the levels of compensation currently used in the industry, and the overall costs of coverage to small employers selecting these plans.

(11) The program is exempt from taxation.

(12) On or before March 1 of each year, the commissioner shall evaluate the operation of the program and report to the governor and the legislature in writing the results of the evaluation. The report must include an estimate of future costs of the program, assessments necessary to pay those costs, the appropriateness of premiums charged by the program, the level of insurance retention under the program, the cost of coverage of small employers, and any recommendations for change to the plan of operation."

{*Internal References to 33-22-1819: x33-22-1803*}

Renumber: subsequent sections

HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Select Comm on Health Care COMMITTEE BILL NO. _____

DATE 2/16/95 SPONSOR(S) _____

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NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Jean McDonald	MHAM.			

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