MINUTES

MONTANA HOUSE OF REPRESENTATIVES
54th LEGISLATURE - REGULAR SESSION

COMMITTEE ON SELECT HEALTH CARE

Call to Order: By **CHAIRMAN SCOTT ORR**, on January 12, 1995, at 3:10 P.M.

ROLL CALL

Members Present:

Rep. Scott J. Orr, Chairman (R)
Rep. Carley Tuss, Vice Chairman (D)
Rep. John Johnson (D)
Rep. Thomas E. Nelson (R)
Rep. Bruce T. Simon (R)
Rep. Liz Smith (R)

Members Excused: REP. BEVERLY BARNHART
REP. ROYAL JOHNSON
REP. BETTY LOU KASTEN
REP. DICK SIMPKINS
REP. CAROLYN SQUIRES

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:

CHAIRMAN ORR collected the remaining contributions for the coffee, tea and cocoa fund.

CHAIRMAN ORR announced that this is the last of the informational sessions for the Select Health Care Committee's knowledge. The guest speakers today are **Mr. Charles Butler, Jr./Ms. Tanya Ask, Blue Cross & Blue Shield,** and **Ms. Claudia Clifford, State Auditor's Office.**

Mr. Butler, Vice President, Blue Cross & Blue Shield of Montana, said that they administer benefits to 235,000 Montanans. About two sessions ago, they insured about 200,000 Montanans. "We have grown and continue to grow, and we're proud to be a Montana company employing about 600+ people in the state of Montana." Blue Cross & Blue Shield is larger than many of their competitors because they solely serve the state of Montana.

Mr. Butler announced that he would like to address:
Insurance Reform
Preexisting Conditions
Portability
Purchasing Pools
Managed Care
Premium Deductible
Medical Savings Account
Expanding Medicaid
Caring Program For Children
Mr. Butler provided written testimony. **EXHIBIT 1-PART A**

Mr. Butler pointed out that there are about 16,000 people in the state of Montana who have selected HMO of Montana for their coverage.

Ms. Claudia Clifford, State Auditor's Office, Health Care Policy Specialist, announced she worked with the Small Employer Availability Act that was part of SB 285, and passed by the last legislative session. **EXHIBIT 2, PART A**

Ms. Clifford discussed the Small Employer Availability Act, how this act works, some of the definitions and terms heard in the debates. This is important because there will be proposals coming before this committee that expand on the tenants of the Small Employer Availability Act.

Ms. Clifford stated that the Small Employer Availability Act "essentially directed the **State Auditor's Office** to appoint the Benefit Plan Committee." The Benefit Plan Committee took six months to design the Basic and Standard Plans. **Ms. Clifford** stated that any insurance that stays in the market to sell insurance to small groups in Montana are required to sell both the Basic and Standard Plans. "A small group under the Act is defined as having between 3 and 25 employees who work 30 hours or more a week." The Benefit Plan Committee proposed to Mark O'Keefe a proposal for the Standard and Basic Plans. **EXHIBIT 2, PART B**

The bar graph shows what the Benefit Plan Committee proposed be adopted into rule. **EXHIBIT 2, PART B, SIDE 2** The Standard Plan would be offered by all companies, and all of the benefits in the Standard Plan would be exactly the same in each company, accordingly, so that a consumer could "comparison shop" for the best bargain for identical benefits. The Basic Plan is any plan that has fewer benefits than the Standard Plan. The Underwritten Plan is anything that has more benefits than the Standard Plan. Standard Plans and every Basic Plan must be issued when application is made for coverage. Application for a plan that is richer in benefits than the Standard Plan, could be medically underwritten; conversely, it could be less expensive. By law, however, if you are rejected, you must be given an opportunity to

apply for coverage in the underwritten plans that you would not be turned down for.
The small employer buys the plans from an insurance agent. They can only buy from a carrier that is certified as a Small Group Carrier. The carrier must offer a Basic and a Standard Plan. Over the last six months, 31 companies have written the State Auditor's office stating that they would like to be Small Group Carriers. Six of those companies have submitted satisfactory Basic and Standard Plans and are currently marketing them. **EXHIBIT 2, PART A, PAGE 6**

Ms. Clifford stated that some companies have written stating that they want out of the Small Group Market. "Almost all of them never were in the Small Group Market, they weren't marketing, and they'd even written us letters to the effect that we weren't in the market and we don't intend to be in the market...By law, they can come into the market whenever they want to if they haven't previously been selling, and there is no penalty, and we encourage them to come into the market if they want to."

{Tape: 1; Side: 2; Approx. Counter: ; Comments: .}

Ms. Clifford stated that there are six companies that were previously in the market, that are dropping out of the market. Those are Montana Medical Benefit Plan (MMBP), Nationwide, Woodmen Accidental Life, PM Group Life, Pacific Mutual, and Guardian Life. "You probably haven't heard of five of these very much because the total business that they did in the state was less than 2 per cent of the market."

REP. TOM NELSON stated that he is a general agent for two of those companies, and stated that "two of them don't, never have, and never will sell health insurance." **REP. NELSON** wished to emphasize this point before the committee to refute the impression that we're losing a lot of carriers.

Ms. Clifford confirmed that they are losing a very small fraction of the market. The major companies have all declared their intent to stay within the market.

Ms. Clifford discussed the following terms: guaranteed issue, portability, preexisting condition, conversion, mandated benefit, list billing. **EXHIBIT 2, PART B, SIDE 1**

REP. NELSON was concerned about those circumstances where an individual was changing jobs and have a policy which has a rider (exclusion) condition covering the individual for everything except a certain illness.

Ms. Clifford responded that the Auditor's Office is confronting that legal question with a number of companies. Technically speaking current law does not negate the Small Group Reform

measures, which state that rider can only be in effect for 12 months.

REP. NELSON wanted to know if that policy was in effect prior to December 7.

Ms. Clifford responded, "yes, Sir."

Ms. Clifford cited **EXHIBIT 2, PART C** when discussing mandated benefits.

REP. BETTY LOU KASTEN wanted to confirm that the basic policy excludes mandated benefits.

Ms. Clifford responded that the statute allowed the Benefit Plan Committee and the Commissioner to adopt a Basic Plan that excluded the mandated benefits. The committee struggled with that debate a long time. They had an actuary and testimony from insurance companies; essentially the information said to us that the value on a premium of a mandated benefits was about 7 or 8 per cent and some people estimated 10 per cent of the cost of a policy. The committee felt that they did not have time to thoroughly debate all of the mandated benefits and the value of them, so they kept the mandated benefits because it only meant a reduction in premium of 7 or 8 per cent. The committee recommends that if the legislatures don't like the mandated benefits, that the legislatures take them out of statute. They allowed the flexibility in how it would affect Basic and Standard Plans. If the mandated benefits are taken out of statute, they will also automatically come out of the Basic and Standard Plan.

REP. KASTEN wanted to know if all plans must include maternity benefits.

Ms. Clifford responded, "yes," because of the nongender insurance statute.

REP. KASTEN confirmed that the Basic Plan can be less, but it must include everything in the state statutes.

Ms. Clifford answered, "that is correct." The companies can have whatever deductibles and benefits, however the minimum benefits must include all of the state-mandated benefits. More than one Basic Plan can be offered, ie., Blue Cross & Blue Shield has several Basic Plans.

REP. BRUCE SIMON cited **EXHIBIT 2, PART B, SIDE 2** under the Standard Plan (includes all State Mandated Benefits). **REP. SIMON** wanted to know if, by referencing the rules, were all of these things included in the rules or does the plan just say that the plans must include any benefits that are outlined in statute. **EXHIBIT 2, PART D**

Ms. Clifford responded that anything in statute is in the Basic Plan. In the Standard Plan some of those benefits are reiterated in the rules because, for example: well-child care being part of the Preventive Care package is included in the Standard Plan thus requiring first dollar coverage. "I would say our office would definitely have to consider that a significant move by the legislature that we should take it out or at least consider that it has to be taken out of the Standard Plan."

REP. DICK SIMPKINS wanted to clarify whether or not we actually need the enumerated benefits in the Standard Plan, "so that we say that you have the freedom and list all of the various carriers that you can possibly go to." **EXHIBIT 2, PART C**

Ms. Clifford responded, "no. Just as referenced by the statute."

REP. SIMON wanted to know if the Standard Plan specifically "calls for the offering of maternity coverage and if it did, why did we do that since it's already been incorporated like the rest of them."

Ms. Clifford responded that "the court had not ruled on that prior to the work of the Benefit Plan committee."

REP. SIMON asked if maternity is specifically in the plan.

Ms. Clifford answered, "yes. It is, as obstetrical care and prenatal care."

REP. NELSON referred to the graph. **EXHIBIT 2, PART B, SIDE 2**
REP. NELSON noted that the Standard Plan has a $250 deductible, $500 family deductible, the Basic Plan has fewer benefits than the Standard Plan. **REP. NELSON** wanted to know if he bought a plan identical to the Standard Plan, with the $500 deductible, would that be defined as a Basic Plan. The only difference is more deductible.

Ms. Clifford answered, "yes."

REP. NELSON referring to **EXHIBIT 2, PART B, SIDE 2** noted that the Underwritten Policies have more benefits than the Standard Plan. **REP. NELSON** stated that he assumes "that all Underwritten Policies cannot have more than a $250 deductible, and that's not logical, but that's how I read it."

Ms. Clifford responded that "the small exception might be that it has some coverage benefit that's so rich internally. Remember that it is a formula that weights benefits." There is a possibility that it looks fairly like a Standard Plan, but it has a 30 per cent co-payment, which is less of a benefit, but then it has some internal benefit that is very rich.

REP. NELSON wanted to know if an Underwritten Policy could have more than a $250 deductible.

Ms. Clifford answered "right." You get a $100 deductible as a medically underwritten.

REP. NELSON stated that "nobody is going to buy a $250 deductible in the marketplace. They all buy at least a $1000 anymore, because that's all they can afford."

Ms. Clifford stated that "those would be Basic Plans."

REP. NELSON said, "or Underwritten Plans, either way."

Ms. Clifford answered, "not likely. Most of the Underwritten Plans, remember, have to be richer in benefits."

REP. NELSON stated, "we're going to have a citizens' revolt over that right there, I can guarantee you. In other words, what I hear you telling me that when I as an agent sell group insurance I'm going to have to tell my prospective client that he has to buy at least a $250 deductible policy. Am I incorrect?"

Ms. Clifford responded, "that would be true. If you want a plan that is medically underwritten, then the likelihood would be that the deductible would be $250 or less."

REP. NELSON said, "not 'or less' because nobody offers a policy that I'm aware of with anything smaller than $250."

Ms. Clifford responded that "Blue Cross & Blue Shield has, I think, 2 or 3 policies that are nonbasic, nonstandard, or medically underwritten." **Ms. Clifford** stated, "if you're concerned that there are some underwritten plans on the market, there are. They have been submitted to our office."

REP. NELSON responded, "right. There aren't many employers that are going to pay premiums on a policy with just a $250 deductible to pay. Most of them are going to buy a $1000 deductible. And, I understand you to tell me that they can't do that unless they buy the Basic Plan."

Ms. Clifford answered, "unless they buy the Basic Plan, that's correct." **Ms. Clifford** stated that maybe she wasn't communicating something and that she would go over this with **REP. NELSON** after the meeting.

Ms. Clifford stated that there is a cost to guarantee issue. The Montana Association of Life Underwriters brought up the point: if you're going to have a cost of guarantee issue, if the cost is spread across more policies a spectrum of policies that are guaranteed issue is created. That cost is then spread out and it doesn't increase all the costs of these policies as much. If only two policies are guarantee issue, one Basic Plan and one Standard Plan, then they become very expensive policies. Only the groups with sick people are attracted to purchasing those policies and there is a problem with the rates. This has been

the experience in the few states that are ahead of Montana in the process of implementing, who only have one Basic and one Standard; they haven't said a whole variety of plans can be guarantee issue."

Ms. Clifford stated that they had a very good insurance agent on the Benefit Plan committee, and he was concerned that he didn't want the companies to rewrite all of their products. .He suggested to "allow a lot of products to be on the market as Basic Plans and preserve a lot of things that are currently sold that are good products that people already like."

CHAIRMAN ORR suggested that after **REP. NELSON** and **Ms. Clifford** discuss this, that they report back to the Select Health Care Committee.

Ms. Clifford discussed list billing. **EXHIBIT 2, PART B, SIDE 1** **Ms. Clifford** stressed that to allow list billing would create a significant loophole in guaranteed issue.

Ms. Clifford discussed the Montana Small Employer Health Reinsurance Program. **EXHIBIT 2, PART A** "Montana set up a reinsurance program that in essence is guaranteed issue to companies." It is set up as a "non-profit, sort of quasi-governmental program in it's own realm."

REP. SIMON wanted to know based on the rates for reinsurance for companies, as well as individuals, whether or not the projected amount is going to be sufficient to cover, or if it is not what the assessment might be.

Ms. Clifford introduced **Margaret Miksch, State Auditor's Office, Life and Health Actuary,** to comment on whether these rates are designed purposely to cover all costs or to just look at the needs of the program.

Ms. Miksch responded that in the first year it is really hard to tell.

REP. SIMON asked if the assessment would go against all companies that do business, excluding ERISA and companies that are providing coverage for governmental employees.

Ms. Clifford answered, "absolutely. If you're only doing individual coverage or if you're only doing large group coverage that premium is still accessible." The exemptions under current law are for State Employee Plan, University Plan, and any self-funded disability insurance plan provided by a political subdivision of the state. Self-funded meaning you're self-insured, you do not have an insurance product. So, it is a self-insured political subdivision of the state."

Ms. Clifford stated that they did write in the rules that provided ways that employees could opt out of coverage. "We

basically said that if you had other kinds of coverage, and the employee gets to determine whether or not that's adequate coverage for themselves, then you could opt out. Essentially, you have to have other coverage, or if the employee's contribution (what the employee has to pay for the insurance) exceeds 7.5 per cent of their adjusted gross income and is a financial burden, they could opt out, or if in transferring to this policy for some reason" you have to go through a waiting period that causes undue burden you could opt out. It does not allow an individual to opt out just because they are a healthy individual who says that they do not want the coverage.

Ms. Clifford stated that a copy of the rules are available that were passed and adopted. **EXHIBIT 2, PART D**

Ms. Clifford discussed the survey on Small Business Health Insurance Reform. **EXHIBIT 2, PART A, PAGE 3**

REP. SIMON wanted to know if a company goes out in the marketplace and sells Small Group Insurance to 100 people, the premiums that the employer of those companies are charged is an agreed upon premium.

Ms. Clifford responded that although the law has in it some rating reform "there are reforms to the current rating system which does restrict the rates in what is called rate compression, and it is fairly complicated." The more current model of rating reform is contained in the proposal that will come before you that is in the Purchasing Pool for Montana. **EXHIBIT 1, PART G, JANUARY 3, 1995**

REP. SIMON sought clarification that the employers who purchase the insurance product are told what the employees are going to be charged, or they're going to be charged on the behalf of their employees to purchase health insurance, based on either the Standard Policy or the Basic Policy.

Ms. Clifford stated, "they receive quotes."

REP. SIMON confirmed that they "are given a finite premium, that this is what the premium is going to pay for."

Ms. Clifford answered, "that is correct. That is how it's supposed to work."

REP. SIMON gives an example of insurance company selling insurance to a small company. If the insurance company insures 100 people, and since it is guarantee issue, the insurance company finds that three people that are high risk. Can the insurance company then go to the Reinsurance Pool and buy reinsurance for those few to cover for the three high risk people. But, the insurance company loses the money that they have to pay the Reinsurance Pool for the reinsurance.

Ms. Clifford responds, "that's right. You can't raise the person's rates."

REP. SIMON restates, "you can't raise the rates." It is a matter of making some judgements "whether or not the risks involved with those three individuals is high enough that it is better to "eat the difference to stop my loss. Because if I leave them in the pool and I have a loss, I'm really going to get hammered." Let's say the insurance company buys the coverage from the Reinsurance Pool for the three individuals; and other insurance companies are, also, buying from this Reinsurance Pool to lay off some of their risk into that pool, but they pay a premium for it. If there is not enough money to cover those losses in that Reinsurance Pool, then there is an assessment that goes to a broader group of health care insurance companies that, "also, get drawn in to help cover if there is a gap." **REP. SIMON** wanted to confirm if that is "really how this whole thing works."

Ms. Clifford responded that is correct.

VICE CHAIR CARLEY TUSS handed out a copy of the current health care bills that will be heard in the Select Health Care Committee. As new bills are added we will get updated copies.

ADJOURNMENT

Adjournment: 4:38 P.M.

SCOTT ORR, CHAIRMAN

VIVIAN REEVES, Secretary

SO/vr

HOUSE OF REPRESENTATIVES

Select Committee on Health Care

ROLL CALL DATE Jan. 12, 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			✓

EXHIBIT 1 - Part A
DATE Jan. 12, 1995
HB

HEALTH CARE COMMITTEE

MONTANA HOUSE OF REPRESENTATIVES

Testimony of: Charles Butler, Jr.
Vice President, Government & Public Relations
Blue Cross and Blue Shield of Montana

January 12, 1995

Thank you for the invitation to talk with you today about insurance reform, including preexisting conditions, portability of coverage, and purchasing pools; managed care; deductibility of insurance premiums; medical saving accounts; and expanding Medicaid and the Caring Program for Children to provide health care for more needy kids.

Much of what you have heard about in your initial meetings and those to follow will relate to the insurance piece of health care reform, the access piece. As Dorothy Bradley said last Tuesday, so many of our reforms relate to insurance because that's the way we pay for most of our health care, and the cost is what's driving this whole discussion.

INSURANCE REFORMS/MARKET DRIVEN

Blue Cross and Blue Shield of Montana was a major proponent of the small group market insurance reforms incorporated in SB285. The reason the insurance industry was such a strong supporter of reform in itself was to address very strong vocal criticism of the insurance industry practices.

In many cases, these reforms require all health insurers to live by new ways of doing business.

- First, we must take all comers. The idea of guaranteed issue was included in legislation at the federal level supported by Senator Burns and, as you heard the other day, the law passed in '93 was based on the health project recommendations of former Governor Stan Stephens and Senator Max Baucus. There is no more cherry-picking. If cherry-picking is to be condoned, even more sick people will be without insurance.

- Second, it's portable and you only need to meet preexisting conditions once as long as you are continuously covered.

- You have guaranteed renewability as long as you pay your premium. In other words, you can't be dropped because you've used a lot of care.

- Lastly, rating practices have been modified to narrow the differences between the highest and lowest prices that are charged for benefits.

It was with the full knowledge and support of most members of the Insurance Access Committee that Governor Stephens included these provisions in his proposal for health care reform. These changes have been enacted by thirty-eight other states, including many of our neighbors like Wyoming, North Dakota, and Idaho.

EXHIBIT 1A
DATE 1-12-95

CONSUMERS' BENEFIT

Why did we support these industry practices? We have supported them because it is the right thing to do. The changes were driven by the market. A few have argued otherwise, but the beneficiaries are literally thousands of Montanans working in small businesses and their families.

A couple of real life examples: One agent reported in the last week he has had people in two small groups benefit by the portability provision--they don't have to meet another preexisting waiting period. A couple of other agents have seen modest rate decreases in the neighborhood of 20 percent for small groups with high-risk individuals, such as diabetes. These groups may have in the past paid family rates monthly in excess of $700.

These insurance reforms became fully operational only a month ago. We believe we would be doing a terrible disservice to the thousands of Montanans who stand to benefit from these reforms if we turned and ran from all or any one of them. There would also be a market disruption as we again change the contracts of 25,000 Montanans, which were just changed.

INSURANCE REFORM CHANGES

This is not to say that there should not be some changes made in the way the laws were implemented. Over the past year we worked with the Insurance Commissioner and his staff on implementation of the law and believe a few changes should be made to more accurately reflect legislative intent.

Those changes include:

1) Removal of mandates from the basic plan as laid out in the enabling legislation. The idea was to allow the market to design less costly, more affordable coverage options without the constraints of existing mandated benefits.

2) Since this law created no individual or employer mandate of coverage, insurance companies should be allowed to cover groups even if one individual waives coverage. An administrative rule now precludes this.

3) Clarify that there is no prior approval of insurance rates. There was no delegation of that authority in the law, but it appeared in the rate process.

AFFORDABILITY AND MANAGED CARE

The insurance reforms you have already passed will help to make health insurance more available to more Montanans. However, the reforms, as we and others including the State Auditor have said, do not address affordability and the rising costs of care.

Market forces are at work, however, to both better manage the costs and utilization of services. We would encourage you to support these efforts, just as the Health Care Authority

has done, and reject proposals that would interfere with these market-driven programs.

The market driven programs of which I speak include two newly licensed provider-based health maintenance organizations - one in the Flathead, the other in Yellowstone County - that join our HMO Montana in the marketplace. This is the idea of coordinated health care--coordinating delivery through physicians working with their patients and with prepaid health benefits.

By more coordination of care, utilization of services can be better managed. In HMO Montana, the days per 1,000 of hospitalization for Montanans enrolled in the program has been about 280 compared to our other business which runs about 380. The cost of hospitalization is significantly less as well. Approximately $6,000 versus $3,400 in 1993.

INDIVIDUAL CHOICES OF PLANS AND PHYSICIANS

We will compete on a number of factors, including service, availability of providers, product design, and price. These managed care programs were developed in each case with the assistance of physicians, other health care providers, and consumers who recognized the importance of preventive health care benefits being added to the regular benefit package before it was popular and before any such less-comprehensive mandates were added by statute.

HMO Montana contracts with about 250 Montana physicians throughout the state to coordinate the care of the thousands of Montanans who have voluntarily chosen this managed care health plan for themselves and their families.

Consumers are not forced into these programs. They voluntarily choose them. As you can see, consumers who do choose the managed care plan have a wide choice of HMO doctors.

In his presentation the other day, Larry Bartlett said that the best way to control costs is by managing utilization of services. That is precisely what HMO Montana and the provider-based managed care competitors to HMO Montana are doing. In order to make health care more affordable, we've got to let these market-based programs work.

To quote an article in the January 2, 1995, AMA *American Medical News* "Reform 1995: It hasn't gone away; it's just gone private and the market forces driving reforms are not gentle with physicians and hospitals." The article then raises a question about the impact on providers and gives an answer: "Will market-driven health system reforms be tougher on physicians? That depends in part on how physicians prepare for and adapt to managed care, cost controls, integration, outcome measurement, and other market-driven changes."

The same article offers several suggestions to providers concerned about their future and these market changes: "Much of what's driving market-driven reform is the inefficiency, waste, and duplication in the health care system. Being more efficient is not enough; you have to be prepared to document it. Payors want evidence that you are practicing more efficiently and are providing superior outcomes. After all, they're the ones paying the bills."

EXHIBIT 1A
DATE 1-12-95

ANTICONSUMER PROPOSALS

Blue Cross and Blue Shield of Montana and other payors have spent considerable time and devoted extensive resources to the creation of networks of doctors and other health providers. These networks save consumers substantial dollars, but they are being threatened by an anticonsumer, antimarket proposal which would force payors to send checks directly to providers, even when the provider chooses not to participate in a network that benefits his or her patients.

For instance, our member provider programs began with doctors and hospitals in 1940's. Today there are more than 2,000 health care providers voluntarily contracting with us. Through these contractual arrangements, those Montanans we serve saved over $9 million in out-of-pocket costs last year alone.

- Those providers who participate in these networks are listed in a provider directory that is distributed to our customers.
- Those professional providers who participate agree to accept reimbursement as payment in full. They are, of course, free to collect any copayment or deductible.
- Those who participate submit claims for their patients and are paid directly by us.
- Some providers choose not to participate. That is their choice and their right. However, some of those folks now want to change some of the rules to benefit themselves at the expense of their patients.

Their plan is to require insurers to send payment to them. They can still bill balances, which those who choose to participate cannot do. In addition, they want to change the state lien law that was amended a couple of sessions ago to include health insurers. They now want to mandate that any provider who submits a lien against their patients' insurance shall also be paid directly and allowed to still bill balances.

Another bill being discussed - the so-called Patient Protection Act is a misnomer. Many of the protections are already included in several other pieces of legislation passed over the last several years -- rigouous HMO licensing standards and Utilization Review standard filing requirements. The rest of the proposal is aimed at short-circuiting utilization management, the only market-based cost containment mechanism shown to have a real impact on patients' health care costs.

These two proposals shift the burden of costs even more squarely onto the backs of consumers even as we discuss ways to contain costs and make health care more affordable.

MEDICAL SAVINGS ACCOUNTS

I would now like to address medical savings accounts. We recognize the desire to pass legislation that would make it possible to create medical savings accounts for Montanans. Some Montanans may benefit from this relatively unproven idea.

As you develop language to allow for MSAs, we would urge consideration of a few issues:

1) Establishment of fiscal intermediary qualifications.

2) Establishment of a definition of health care services for which these dollars could be used, such as office visits, prescription drugs, eyeglasses. Other items, such as therapeutic visits to Phoenix for a cold weather break would probably not be an eligible expense. Will insurance premiums be a covered expense?

3) Establishment of criteria for withdrawal of funds after a certain threshold level has been reached, or in the event of financial emergencies.

VOLUNTARY PURCHASING POOLS

One of the criticisms of the original purchasing pool or alliance idea was the bureaucracy which was established, a bureaucracy which not only would add administrative burdens, but also costs to the purchase of health care.

The idea of banding together for the purchase of insurance under health reform proposals is to provide smaller groups with volume purchasing power, both in negotiating financially attractive arrangements with providers such as our networks I've just described and in cutting administrative charges by insurers for establishing and maintaining small group coverage. The larger the group, in theory, the more people over whom fixed costs can be spread.

Groups entering pool arrangements may give up certain freedoms for these benefits, such as moving in and out of the pool to beat prices in the pool. The choice of products available in the pool will also be more limited because to provide that administrative savings, a fixed menu of products is available.

There are a number of legislative approaches available from very complex models, such as California and Florida, to more market-based approaches, such as South Carolina. Perhaps the simplest approach would be to amend the definition of group disability insurance to include any group of employers. (33-22-501, MCA)

HIGH-RISK POOL

The Montana Comprehensive Health Association was established in 1985 as a subsidized mechanism for coverage available to individuals who, because of significant health problems, could not purchase individual coverage in the marketplace.

Individuals who worked for an employer with group coverage were not originally contemplated, because the concept of group coverage is that all members of a group can be covered via the group coverage. When premiums for this limited coverage are not sufficient to cover the claims incurred, an assessment is levied against all health insurers in the state based on premium volume written.

What has happened, however, has been the dumping of sick employees or sick family members of employees into MCHA, if they could even afford this coverage. The pool was not originally designed to be a sick pool for insurers to avoid the true risk of the groups they write. Risk avoidance is not the purpose of insurance, and is NOT good public policy. The idea of discriminating against certain employees in the benefit packages offered by their employers based on their health status, which means potentially greater benefits for healthy employees, we think is also NOT good public policy.

To then subsidize potentially lesser benefits via a claims paid or a sick peoples tax is a tax on these same people to pay their subsidy.

To allow "dumping" by any group allows self-funded groups to receive subsidies under the current mechanism primarily from individuals and small group employers.

In Minnesota the assessment is $40 million for their pool.

CARING PROGRAM

Another means of expanding access to health care benefits is the potential incorporation of the Caring Program for Children. The Caring Program is a Foundation that pays for health care services for children who do not qualify for government assistance and whose families can't afford health insurance.

ADDITIONAL ITEMS

There are several other items which we were asked to address:

- Tort Reform - Blue Cross and Blue Shield of Montana has included tort reform as part of our recommendations for general health care finance and delivery reform.

- Administrative Simplification - We support ongoing simplification efforts such as electronic claims submission, which by its very nature encompasses common claims forms, speeds up the processing of claims and improves information feed back. In December,as an example, 55 percent of our physician claims and almost 80 percent of hospital claims on the private side of our business were received electronically.

- Preexisting Conditions

- Portability of Coverage - We support waiver of preexisting condition clauses for individuals who have been continuously covered with comparable benefits. That

portability of coverage has been incorporated in the small group availability net for a portion of the market. In addition we allow portability within Blue Cross and Blue Shield from product to product.

- Deductibility - Blue Cross and Blue Shield of Montana supports full deductibility for individual insurance premiums as has been allowed for group coverage for some time.

- Data and Pricing Information - It is imperative that price and quality information be readily available and understandable for consumers to be able to make wise purchasing decisions. We support the ongoing efforts of the Health Care Authority, Montana Hospital Rate Review System, the Montana Hospital Association and the Montana - Wyoming Foundation to begin making some of these types of information more generally available.

SUMMARY

Blue Cross and Blue Shield of Montana has been advancing health care reform and has participated in its evolution most recently with major changes since 1987. Many of the areas you are addressing we have publicly promoted. As Governor Racicot said last week and again last night, the "Change" issue will be with us for many years to come.

GOVERNOR'S HEALTH CARE FOR MONTANANS

STEERING COMMITTEE

EXHIBIT 1 - Part B

DATE Jan. 12-1995

HB

STAN STEPHENS, GOVERNOR

JULIA E. ROBINSON, CHAIRPERSON

STATE OF MONTANA

REPRESENTATIVE FRED THOMAS HD 62 | BOB FRAZIER | NANCY ELLERY | RICK HARDEN | GREGORY DAINES

HELENA, MONTANA

September 15, 1992

To: Persons Interested in Health Care

From: Julia Robinson, Chair

It is my pleasure to present to you the Final Report of the Steering Committee for Phase II of Health Care for Montanans. The report contains recommendations on the following:

Montana Health Care Commission

Establish an Electronic Claims Processing System

Insurance for Low Income and Working Poor

Health Insurance Reform

Tax Deductions for Health Insurance Premiums

Family Practice Residency Program

Financial Incentives for Rural Health Professionals

Addressing Physician Liability

Encourage Priorities for Professional Education

Single Point of Access for Community Based Long Term Care

Develop Infrastructure for Telemedicine Demonstration Program

Prevention and Wellness

Health care issues in Montana will be discussed at the Governor's Conference on Health Care on October 7th. There will be legislative work groups on health care the morning of the 8th. Both health care meetings will be held at the Billings Holiday Inn.

The Steering Committee and I hope to see you there.

HEALTH CARE FOR MONTANANS

GOVERNOR'S HEALTH CARE FOR MONTANANS PHASE II

REPORT TO THE GOVERNOR

Prepared for
Governor Stan Stephens
and
Lt. Governor Dennis Rehberg

September 15, 1992

Prepared by the Health Care for Montanans
Steering Committee
Julia E. Robinson, Chair

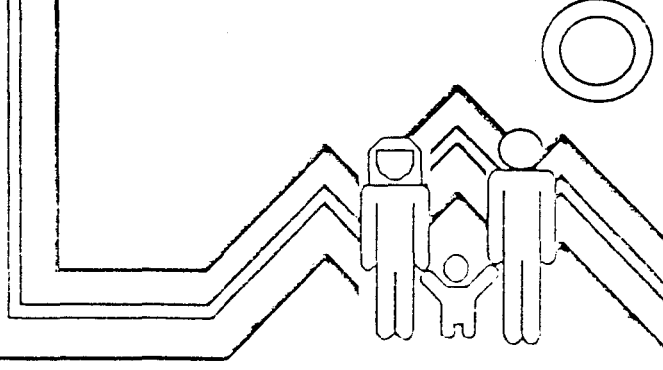

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EXHIBIT 1B
DATE 1-12-95

HEALTH CARE FOR MONTANANS

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GOVERNOR'S HEALTH CARE FOR MONTANANS

The Twelve Points of Phase II

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Benefits of the Twelve Points of Health Care for Montanans

ISSUES ADDRESSED:

PROPOSAL:	Improved Coordination & Efficiency	Cost Control	Prevent Cost Shifting	Improve Access & Coverage	Improve Rural Health Assess
Montana Health Care Commission	✓	✓		✓	✓
Single Billings System	✓	✓			
The Montana Basic Health Plan			✓	✓	✓
Health Insurance Reform	✓		✓	✓	
Uniform Application of Tax Deductions			✓	✓	
Family Practice Residency Program				✓	✓
Financial Incentives for Rural Professionals				✓	✓
Addressing Physician Liability		✓		✓	✓
Priority for Professional Education	✓			✓	✓
Single Point of Access for Long Term Care	✓	✓		✓	✓
Development of Telemedicine	✓	✓			✓
Prevention & Wellness	✓	✓			

EXHIBIT 13
DATE 1-12-95

GOVERNOR'S HEALTH CARE FOR MONTANANS

Improving the Effectiveness of Health Insurance

EXHIBIT 1B
DATE 1-12-95

POINT 4: HEALTH INSURANCE REFORM

PROBLEM: A majority of Montanans are employed by small employers. In recent years many factors have combined to make buying and keeping health insurance a difficult situation. One seriously ill employee can now cause a group to lose its coverage and not be able to purchase coverage elsewhere. Abusive rating practices by some insurers have led to employers losing coverage and in some cases actually terminating a high risk employee in order to keep a plan. Employers do not understand the rating practices of some insurance companies and do not have the time or expertise to learn them. Employers often do not know from year-to-year whether they will still be insured.

Many self-employed individuals and others face very similar problems in the individual policy market.

Highly skilled and motivated workers are not advancing because of the fear of losing insurance when they change employers. This loss could result because they are uninsurable or are subject to pre-existing condition exclusions.

Shopping for health insurance is difficult for small employers and individuals as the configuration of plans varies widely, making comparison difficult.

RECOMMENDATION: Enact comprehensive insurance reform. This reform would be based on the National Association of Insurance Commissioners "Small Employer Health Insurance Availability Model Act" for small employers with similar provisions extended to individual policies. This recommendation does not call for a word-for-word adoption of the act. The legislation needs to be tailored to Montana's needs and designed to maintain certain plan delivery services in Montana's small service market.

The act would apply to insurance provided to employers of 25 or less. The community rating and portability provisions would also be extended to the marketing of individual policies. Major provisions include:

Guaranteed Issue: All small employer groups (3 to 25 employees) would have the right to obtain basic benefits level private health insurance regardless of the health risk presented by such a group. In order to accomplish this, all carriers participating in the small employer market must guarantee coverage to all small employer applicants. The insurance policy must guarantee coverage for all employees in a given group. A carrier could not exclude individu-

als presenting high medical risks from a group, nor could the carrier charge such high risk individuals a higher premium rate than the remainder of the group.

Guaranteed Renewability: A carrier could not cancel coverage of a group and/or individuals within a group at renewal time because of the deterioration of the health of one or more individuals within the group. A carrier could discontinue a policy only for the nonpayment of premiums, fraud or misrepresentation, or noncompliance with plan provisions or eligibility requirements. A carrier could elect leaving the Montana market, but in such circumstances could not re-enter the market for a period of five years.

Portability: Once an employee or dependent satisfied the pre-existing conditions restrictions of a health benefits plan, such a person would not have to meet new pre-existing conditions restrictions for similar benefits when changing jobs or when the small employer switches carriers. Such protection would exist even when a period of time (not to exceed thirty days) had elapsed between termination of the previous coverage and commencement of employment by the new employer. Importantly, these recommendations provide broad portability for individuals moving into the small employer market. Any health benefit plan providing the basic benefits level from any source - Medicare, Medicaid, individual policy or group policy (including self-funded employer plans), regardless of employer size -- would qualify as previous coverage for purposes of eliminating pre-existing conditions restrictions for the new coverage.

Community Rating: Appropriate limits should be imposed on premium rate variations for groups similar in geography, demographic composition, class of business and plan design. However, allowing such variations within limits constitutes an equitable and responsible approach to public policy. Under these recommendations, premium rates for dissimilar classes of business would not vary by more than 20% between the mid-point rate of the lowest class and the mid-point rate of the highest class. Premium rates for similar groups would not vary by more than 30% from the mid-point rate for that class of business. A particular group's year-to-year premium increase could exceed the carrier's year-to-year increase in that carrier's lowest new business rate by no more than 15%.

These recommendations provide a rate band slightly wider than that proposed in the NAIC model. We anticipate carriers will, in order to protect their financial solvency, tend to rate "from the top down." We believe this wider rate band may lessen the price disruption experienced in the lower priced end of the current

market. Future legislatures could further compress this rate band if appropriate to address future market concerns.

Basic Benefit Plan: These recommendations propose creation of a Health Benefit Plan Committee comprised of representatives of small employers and employees, carriers, health care providers and insurance producers. This committee would develop the basic benefits plan which all carriers participating in the small employer market must guarantee issuance to all small employer applicants. The plans developed by the committee must include cost containment features.

Disproportionate Risk Protection: Since carriers are required to accept and keep groups, some carriers will receive a disproportionate share of higher risk groups and individuals. To spread this risk evenly and fairly there are several methods of redistribution. The working group on insurance reform recommended a reinsurance pool with part of the cost supplemented by outside funding sources. The Steering Committee chose a different method, called the allocation method, because the Committee could not identify a funding source for the reinsurance method.

This report describes the three available options. The allocation option is the endorsed option. The other options are both reinsurance mechanisms, one with outside funding and one funded entirely within the small insurance market:

1. Allocation Mechanism If an employer is rejected by two or more carriers as too high a risk, the employer is then assigned by an arbitrary allocation method to a carrier. The assigned carrier must accept and cover the group. Over time, the allocation process measures the actual costs of allocated groups. The allocation quotas are adjusted to "even" out the impact on carriers. There is a possibility with this method that some carriers may not be solvent enough to absorb too many high risks while waiting for a future, lower allocation to even out the risk. There is also a concern that this method might label higher risk groups as "second class citizens" because of the need for rejections before allocation.

2. Reinsurance Mechanism (with outside funding) As proposed by the working group on insurance reform:

> "In order for the recommendations outlined above to work, carriers participating in the small employer market must have access to a reinsurance mechanism for both individuals and groups. Carri-

ers choosing to cede entire groups to the reinsurance mechanism would pay a reinsurance premium of no more than 150% of the adjusted average market premium. Carriers choosing to cede individuals to the reinsurance mechanism would pay a reinsurance premium for any such individual of no more than 500% of the adjusted average market premium. Even for those insured ceded to the reinsurance pool, carriers would retain a liability up to $15,000 per year for each reinsured person. Unlike the NAIC model, we believe funding for any losses incurred by the reinsurance mechanism should go beyond assessments against only small employer market premiums. We believe the policy makers should identify a broader-based source of funding to address this societal problem."

3. Reinsurance Mechanism (without outside funding) This method is the same as number 2 above but does not contain an outside funding source.

These insurance reforms are not intended to reduce overall health care costs. They are intended to stop the increasing number of small employers who are dropping insurance or losing insurance. This will help reduce bad debt being passed on to insured employers by employers who have dropped their coverage.

The recommendation to adopt these provisions carries a warning that effective medical cost control measures must be enacted at the same time. There will be premium rate increases to generally healthier groups or individuals. The increases are estimated to be between 5 - 10%. Savings from cost controls would help offset these increases. Insurance purchasers need to be educated that along with the increases comes the security of knowing that they will not be canceled or have large premium increases when they or a member of the group becomes seriously ill.

LEGISLATIVE INITIATIVE: Yes

COST: No general fund cost.

EXHIBIT 1B
DATE 1-12-95

POINT 5: PROVIDE FOR UNIFORM APPLICATION OF TAX DEDUCTIONS FOR HEALTH INSURANCE PREMIUMS

BACKGROUND: Individuals who are privately insured receive health insurance through several financing methods. They either receive all or some of their insurance through their employer, or they buy it themselves as self-employed individuals, or they purchase individual policies. How their insurance is obtained and who pays the premiums determines who receives what tax credits or deductions and how much. Our current system does not treat all insurance premium payers equally.

Insurance premiums paid by businesses are fully deductible either as credits or expense deductions. Self-employed individuals receive a 25% credit. Insurance premiums paid by individuals are not deductible unless their total medical expenses exceed 7.5% of their income. Fortunately most people do not reach 7.5%. Unfortunately, and unfairly, they also receive no tax advantage.

Some individuals do receive full exemption from taxes on their premiums if they are insured by a plan that allows premiums to be paid with pre-tax dollars. They, however, lose some flexibility in choosing this option.

While there is debate as to the effects of allowing 100% deductibility of premiums, it is only fair to give equal credit to all persons paying insurance premiums, regardless of how the payments are made.

RECOMMENDATION: To promote tax equity and to encourage the purchase of insurance, which reduces bad debt cost shifting, tax laws need to be amended. The amendment should allow 100% full deductibility to any individual who pays insurance premiums. The three groups of individuals affected by this change are self-employed persons, those who purchase private individual policies, and those where the employee's share of employer provided insurance is paid with taxable income.

While we cannot change federal tax law we can change state law. Perhaps these changes will not result in significant increases in the number of insured individuals, but they will at least provide fairness in taxation.

LEGISLATIVE INITIATIVE: Yes

COST: Loss of income tax revenue to general fund is estimated at a low of $500,000 and possibly up to $1,200,000 per year.

Providing Basic Health Insurance Committee

Representative Fred Thomas, Chair
Stevensville, MT

Terry Frison
Department of SRS

Garth Trusler
Blue Cross/Blue Shield

Larry Akey
Life Underwriters

Dana Headapohl, M.D.

LuAnn McLain, President
Mental Health Association of Montana

Senator Ethel Harding
Polson, MT

Dave Evenson, Director of Benefits
Montana University System

Representative Jessica Stickney
Miles City, Mt

Dick Brown
Montana Hospital Association

Representative Tom Nelson
Billings, MT

Ed Grogan, President/CEO
Montana Medical Benefit Plan

Rob Hunter, CEO
EBMS

Mission:
The committee will study new approaches to expanding the number of individuals and businesses covered by basic health insurance. Focus of the committee's work will be on risk pools, self-insurance, reinsurance of small groups and approaches developed by other states.

(a) place the insurer in violation of the laws of this state; or

(b) cause the financial impairment of the insurer to the extent that further transaction of insurance by the insurer injures or is hazardous to its policyholders or to the public.

(2) Subsection (1) does not apply to a premium increase necessitated by a state or federal law, court decision, or rule adopted by an agency of competent jurisdiction of the state or federal government.

History: En. Sec. 2, Ch. 699, L. 1991.

33-22-108 and 33-22-109 reserved.

33-22-110. Preexisting conditions. (1) 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) 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.

History: En. Sec. 34, Ch. 451, L. 1993.

33-22-111. Policies to provide for freedom of choice of practitioners — professional practice not enlarged. (1) All policies of disability insurance, including individual, group, and blanket policies, must provide that the insured has full freedom of choice in the selection of any licensed physician, physician assistant-certified, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, licensed professional counselor, acupuncturist, or nurse specialist as specifically listed in 37-8-202 for treatment of any illness or injury within the scope and limitations of the person's practice. Whenever the policies insure against the expense of drugs, the insured has full freedom of choice in the selection of any licensed and registered pharmacist.

(2) This section may not be construed as enlarging the scope and limitations of practice of any of the licensed professions enumerated in subsection (1). This section may not be construed as amending, altering, or repealing any statutes relating to the licensing or use of hospitals.

History: (1)En. Sec. 1, Ch. 172, L. 1967; amd. Sec. 1, Ch. 402, L. 1971; Sec. 40-4108, R.C.M. 1947; (2)En. Sec. 2, Ch. 172, L. 1967; Sec. 40-4109, R.C.M. 1947; R.C.M. 1947, 40-4108, 40-4109; amd. Sec. 1, Ch. 258, L. 1981; amd. Sec. 20, Ch. 303, L. 1981; amd. Sec. 4, Ch. 324, L. 1981; amd. Sec. 1, Ch. 179, L. 1983; amd. Sec. 1, Ch. 302, L. 1985; amd. Sec. 14, Ch. 572, L. 1985; amd. Sec. 1, Ch. 606, L. 1987; amd. Sec. 39, Ch. 83, L. 1989; amd. Sec. 18, Ch. 97, L. 1989; amd. Sec. 1, Ch. 362, L. 1991; amd. Sec. 1, Ch. 628, L. 1993.

Compiler's Comments

1993 Amendment: Chapter 628 near beginning of first sentence of (1), after "blanket policies", deleted "and all policies insuring the payment of compensation under the Workers' Compensation Act"; and made minor changes in style. Amendment effective July 1, 1993.

Retroactive Applicability: Section 17, Ch. 628, L. 1993, provided: "Because of the decision in Wieland v. St. Compensation Mutual Insurance Fund, WCC No. 9208-6554, there is a conflict between the interpretation of 33-22-111 and Rule 24.29.1403, Administrative Rules of Montana, implementing 39-71-704, upheld in Garland v. Anaconda Co., 177 Mont. 240 (1978), upon which workers' compensation medical benefits were premised, the legislature, in order to resolve the conflict through the curative legislation in [section 1] [33-22-111], intends that [section 1] [33-22-

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Chapter Cross-References

Jurisdiction of providers of health care benefits, Title 33, ch. 1, part 11.

Comprehensive health association and plan, Title 33, ch. 22, part 15.

Licenses — discrimination in issuance prohibited, 49-3-204.

Living will declaration — not required as condition for insurance coverage, 50-9-205.

Living wills — effect on insurance, 50-9-205.

Part 1
General Provisions

33-30-101. Definitions. As used in this chapter, the following definitions apply:

(1) "Health service corporation" means a nonprofit corporation organized or operating for the purposes of establishing and operating a nonprofit plan or plans under which prepaid hospital care, medical-surgical care, and other health care and services, or reimbursement therefor, may be furnished to a member or beneficiary.

(2) "Health services" means the health care and services provided by hospitals or other health care institutions, organizations, associations, or groups and by doctors of medicine, osteopathy, dentistry, chiropractic, optometry, and podiatry; nursing services; licensed acupuncturist services; licensed social worker, licensed professional counselor, or psychologist; medical appliances, equipment, and supplies; drugs, medicines, ambulance services, and other therapeutic services and supplies.

(3) "Membership contract" means any agreement, contract, or certificate by which a health service corporation describes the health services or benefits provided to its members or beneficiaries.

History: En. 40-5901 by Sec. 1, Ch. 319, L. 1975; R.C.M. 1947, 40-5901(1) thru (3); amd. Sec. 14, Ch. 544, L. 1983; amd. Sec. 3, Ch. 606, L. 1987; amd. Sec. 2, Ch. 362, L. 1991.

Cross-References

Board of social work examiners, 2-15-1854.

Nonprofit corporations, Title 35, ch. 2.

Licensing — medical professions, Title 37.

Qualifications and licensing of social workers, Title 37, ch. 22.

33-30-102. Application of this chapter — construction of other related laws. (1) All health service corporations heretofore or hereafter organized are subject to the provisions of this chapter. In addition to the provisions contained in this chapter, other chapters and provisions of this title apply to health service corporations as follows: 33-17-212 through 33-17-214 and chapters 1, 15, 18, 19, and 22, except 33-22-111.

(2) A law of this state other than the provisions of this chapter applicable to health service corporations shall be construed in accordance with the fundamental nature of a health service corporation, and in the event of a conflict between that law and the provisions of this chapter, the latter shall prevail.

History: En. 40-5902 by Sec. 2, Ch. 319, L. 1975; R.C.M. 1947, 40-5902; amd. Sec. 3, Ch. 558, L. 1987.

Cross-References

Insurance Code — exception for health service corporations, 33-1-102.

Applicable provisions of Insurance Code: Administrative penalty for failure to pay promptly, 33-18-233.

Insurance information and privacy protection, 33-19-104.

Medicare Supplement Insurance Minimum Standards, 33-22-903.

33-30-103. Purposes of health service corporation. A health service corporation may be organized for the purposes of:

(1) (a) establishing and operating a voluntary, nonprofit plan or plans under which health services, or reimbursement therefor, are furnished to persons who become members or beneficiaries; or

(b) acting as agent or intermediary for other health service corporations, for governmental body or agency, or for other corporations, associations, partnerships, or individuals in the field of health care and services; and

(2) research, education, or related activity to further objects within the purview of this chapter.

History: En. 40-5903 by Sec. 3, Ch. 319, L. 1975; R.C.M. 1947, 40-5903.

33-30-104. No profit organization may be a health service corporation. No group, association, or organization created for or engaged in business or activity for profit, provision for the incorporation of which is made by any of the corporation laws of this state, may be organized or operated, directly or indirectly, as a health service corporation under this chapter.

History: En. 40-5904 by Sec. 4, Ch. 319, L. 1975; R.C.M. 1947, 40-5904.

Cross-References

Nonprofit corporations, Title 35, ch. 2.

33-30-105. Examination of a health service corporation. (1) If the commissioner believes a health service corporation is unable or potentially unable to fulfill its contractual obligations to its members, the commissioner may conduct an examination of that corporation.

(2) In addition to the examination authorized in subsection (1), at least once every 4 years, the commissioner shall conduct an examination of each health service corporation to determine if the corporation is fulfilling its contractual obligations by prompt satisfaction of claims at the highest monetary level consistent with reasonable dues or fees, and that the corporation's management exercises appropriate fiscal controls, operations, and personnel policies to assure that efficient and economic administration restrains overhead costs for the benefit of its members.

(3) Each health service corporation examined, its officers, employees, and insurance producers, shall produce and make available to the commissioner or his examiners the accounts, records, documents, files, information, assets,

union has a constitution or bylaws and is formed in good faith for purposes other than that of obtaining insurance;

(b) where such persons, with or without their dependents, are issued the same form of an individual policy varying only as to amounts and kinds of coverage applied for by such persons under an arrangement whereby the premiums on such policies may be paid to the insurer periodically by the employer, with or without payroll deductions, or by the association for its members or by some designated person acting on behalf of such employer, association, or union.

(2) The term "employees" as used herein may be deemed to include the officers, managers, and employees and retired employees of the employer and the individual proprietor or partners if the employer is an individual proprietor or partnership.

History: En. Sec. 383, Ch. 286, L. 1959; R.C.M. 1947, 40-4033.

Part 5
Group Disability Insurance

33-22-501. Group disability insurance defined — eligible groups. Group disability insurance is hereby declared to be that form of disability insurance covering groups of persons as defined below, with or without one or more members of their families or one or more of their dependents, or covering one or more members of the families or one or more dependents of such groups of persons and issued upon the following bases:

(1) under a policy issued to an employer or trustees of a fund established by an employer, who shall be deemed the policyholder, insuring employees of such employer for the benefit of persons other than the employer. The term "employees" as used herein shall be deemed to include the officers, managers, and employees of the employer, the individual proprietor or partner if the employer is an individual proprietor or partnership, the officers, managers, and employees of subsidiary or affiliated corporations, the individual proprietors, partners, and employees of individuals and firms, if the business of the employer and such individual or firm is under common control through stock ownership, contract, or otherwise. The term "employees" as used herein may include retired employees. A policy issued to insure employees of a public body may provide that the term "employees" shall include elected or appointed officials. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship.

(2) under a policy issued to an association, including a labor union, which shall have a constitution and bylaws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, insuring members, employees, or employees of members of the association for the benefit of persons other than the association or its officers or trustees. The term "employees" as used herein may include retired employees.

(3) under a policy issued to the trustees of a fund established by two or more employers in the same or related industry or by one or more labor unions or by one or more employers and one or more labor unions or by an association as defined in subsection (2) above, which trustees shall be deemed the policyholder, to insure employees of the employers or members of the unions or of such association or employees of members of such association for the benefit of persons other than the employers or the unions or such association. The term "employees" as used herein may include the officers, managers, and employees of the employer and the individual proprietor or partners if the employer is an individual proprietor or partnership. The term "employees" as used herein may include retired employees. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship.

(4) under a policy issued to any person or organization to which a policy of group life insurance may be issued or delivered in this state to insure any class or classes of individuals that could be insured under such group life policy;

(5) under a policy issued to cover any other substantially similar group which, in the discretion of the commissioner, may be subject to the issuance of a group disability policy or contract.

History: En. Sec. 385, Ch. 286, L. 1959; amd. Sec. 3, Ch. 74, L. 1973; amd. Sec. 3, Ch. 83, L. 1974; R.C.M. 1947, 40-4101(intro.), (1) thru (5).

Cross-References

Hearings by Commissioner, 33-1-701.

Groups eligible for group life insurance, Title 33, ch. 20, part 11.

33-22-502. Required provisions of group policies. Each group disability insurance policy delivered or issued for delivery in this state must contain in substance the following provisions:

(1) a provision that, in the absence of fraud, all statements made by applicants or the policyholder or by an insured person shall be deemed representations and not warranties and that no statement made for the purpose of effecting insurance shall avoid such insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to such policyholder or to such person or his beneficiary;

(2) a provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group a statement in summary form of the essential features of the insurance coverage of such employee or member and to whom benefits thereunder are payable. If dependents are included in the coverage, only one certificate need be issued for each family unit.

(3) a provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy;

(4) a provision or the equivalent thereto that reads:

"Conformity with Montana statutes. The provisions of this policy conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this policy."

History: En. Sec. 386, Ch. 286, L. 1959; amd. Sec. 4, Ch. 74, L. 1973; amd. Sec. 4, Ch. 83, L. 1974; R.C.M. 1947, 40-4102(part); amd. Sec. 11, Ch. 798, L. 1991.

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Health Care Committee

January 12, 1995

Blue Cross and Blue Shield of Montana

SUPPLEMENTAL INFORMATION

Insurance Reform:

- **Senator Burns**
  - **Basicare Summary information**
- **Former Governor Stephens' Health Care for Montanans**
  - **Insurance Recommendations**

Managed Care Selection Examples:

- **Provider Network Listing**
- **HMO Fact Sheet**

Caring Program for Children:

- **Information Sheet**
- **Benefit booklet**

Statutory Provisions:

- **Preexisting Conditions**
- **Allowable group definition for health insurance**

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DATE Jan. 12, 1995
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HMO SM
Montana
P.O. Box 8004
Helena, Montana 59604
(406) 444-8250

HMO MONTANA
Montana's Only Statewide HMO
FACT SHEET

November 1994

- Became operational in March 1987 with 15 Helena physicians.
- Line of business of Blue Cross and Blue Shield of Montana.
- Primary care medical services partially capitated gatekeeper model.
- Many choices of physicians.

240 Personal Care Physicians (internists, family practitioners, pediatricians, and OB-GYNS). . . . . as of November 1, 1994

15,160 Members received HMO Montana health benefits . . . . . as of November 1, 1994

HMO MONTANA MAKES A DIFFERENCE

Routine physicals covered
$10 per office visit copayment
$5 or $7 per prescription copayment
$50 emergency room copayment

1993 UTILIZATION INFORMATION

Medical Services	HMO	Traditional
HOSPITAL INPATIENT:		
Admissions per 1,000 members	78	82
Days per 1,000 members	280	379
Length of average stay	3.60	4.65
Cost per case	$ 3,402.03	$ 6,052
Cost per day	$ 945.96	$ 1,302
HOSPITAL OUTPATIENT:		
OP visits per 1,000 members	745	573
Cost per case	$ 212.68	$ 398

201TAO03.1M

"BASICARE" HEALTH ACCESS AND COST CONTROL ACT

Senator Conrad Burns, Senator Nancy Landon Kassebaum, Senator John Danforth

February 1993

EXHIBIT 1 - Part G
DATE Jan. 12, 1995
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KEY COMPONENTS:

* Simplifies the insurance market around a single uniform benefits package (BasiCare) that every insurer must offer and that every American will carry.

* The BasiCare package will be a required offering of all private health insurance carriers and will be carried by all Americans. No insurance company will be permitted to offer any non-BasiCare plans that duplicate BasiCare benefits, although they may sell supplemental policies for persons wishing additional coverage.

* The content of the BasiCare benefits package will be determined by an independent expert commission. As under the current military base-closing system, Congress will have the power to vote up or down on the commission's recommendations, but not to amend them.

* BasiCare will be subject to strict rules protecting beneficiaries from discriminatory rating and underwriting based on health status.

* Health care costs will be controlled by placing binding annual limits on the maximum allowable rate of increase in BasiCare premiums, as well as through administrative standardization of the single BasiCare package.

* Firm limits on annual BasiCare cost growth will create strong motivation for new efficiency in the health care delivery system, primarily through expanded development of coordinated systems of care negotiated between providers and insurers.

* Health care access for the uninsured will be addressed by offering low-income persons non-transferable vouchers for the purchase of BasiCare coverage. This system will replace and expand upon the current Medicaid program.

* Medicare will also be gradually assimilated into BasiCare, and long-term care coverage will be included in the BasiCare package.

* Financing will be obtained through (a) appropriation of existing Medicaid expenditures, (b) limiting the current 100 percent tax deduction and exclusion for employer health benefit contributions to the cost of a BasiCare package, and (c) a limited draw from the current Social Security payroll tax, not to exceed 1 percent of the tax.

* The plan also includes malpractice reform, a significant expansion of low-income community health care services, and measures to increase the number of health professionals in underserved rural areas.

SUMMARY OF PROVISIONS:

A. CREATION OF BASICARE:

1. Congress will determine the broad foundations of the BasiCare package, but it will not be directly responsible for the details of the plan's composition. Among the foundations that Congress will require, however, will be:

   a. Basic hospitalization coverage;

   b. Basic outpatient services;

   c. Protection against catastrophic out-of-pocket costs;

   d. Coverage against extraordinary long-term care costs; and

   e. Coverage for preventive care services of significant proven and recognized value in averting serious and costly medical conditions.

2. Actual development of the BasiCare package will be conducted by an eight-member independent, expert commission. Half of the members will be appointed by the President and the other half by the congressional leadership. All will serve on a full-time basis for staggered five-year terms.

3. The commission will define a benefit plan which, in its judgment, represents a minimum but fair coverage package. At its discretion, the commission may recommend limited variation in plan structure to accommodate delivery of BasiCare services in a managed care setting, provided that such variation does not compromise the basic uniformity of the national BasiCare package.

4. As under the current system for closing military bases, Congress will have the power to approve or disapprove the commission's recommendations, but only as an un-amendable package. The purpose of this mechanism is to help assure that the process of developing the benefit package is not unduly distorted by political pressure.

5. The BasiCare commission will have authority to make adjustments in the plan's content, as needed, to reflect changes in technology or in the nation's health needs. It will also have significant oversight responsibility for the health care system as a whole.

6. The commission will be charged with ongoing oversight of the quality of health care delivery--particularly as the system reacts to implementation of the new BasiCare structure. The commission will be required to factor findings on quality into any recommendations it makes to Congress on the content or the cost of the BasiCare package. It will also be authorized to contract with local and regional entities for the collection and dissemination of health care quality, cost-effectiveness, and patient-satisfaction data to consumers.

EXHIBIT 16
DATE 1-12-95

B. BASICARE'S ROLE IN THE INSURANCE MARKET:

1. All insurers in the health insurance market will be required to offer BasiCare and to accept its conditions.

2. Insurers will be barred from selling non-BasiCare policies that duplicate BasiCare benefits in any way. Supplemental policies, however, will be allowed (see Section F. below). Such supplemental policies will be permitted to cover only those benefits not covered by BasiCare.

3. When the program is fully implemented, BasiCare policies will be subject to strict rating and underwriting rules aimed at assuring availability and curbing risk selection. These will include:

   a. Guaranteed Issue and Renewal: Insurers will be limited in applying pre-existing condition restrictions on the issuance of policies and will have to guarantee acceptance of all small groups and individuals wishing to purchase coverage. Similar standards will also be applied to policy renewal.

   b. Community Rating: Insurers will be required to set rates on the same terms to all BasiCare policyholders, both group members and individuals. Adjustments in community rating will be permitted for the age of enrollee, but will be held within limits, which will narrow over time. Community rating will apply both to group and individual policies.

   c. Portability: Persons will no longer have to fear lack of access to coverage due to a change in employment.

4. Insurers failing to comply with the above reforms will be subject to a federal excise tax on gross premium income.

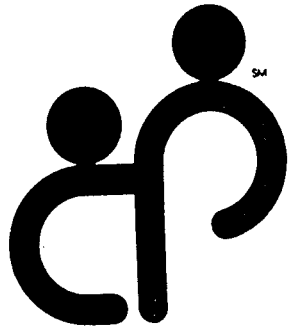
5. All persons will be required to carry a BasiCare policy, either through a group or individually. Low-income persons will receive direct public assistance for the cost of such coverage (see Section C. below).

6. Employers will not be permitted to discriminate against employees based on health status.

7. Self-insured groups will be permitted to continue self-insuring, provided they can demonstrate that: 1) they are offering a BasiCare-equivalent benefit plan that adheres to all of BasiCare's conditions, 2) they can show that their costs do not differ substantially from those of insured BasiCare plans, and 3) they can demonstrate sufficient financial reserves to assure solvency and protection of patient benefits.

8. "Stop/loss" coverage sold to self-insured groups will also have to follow the same rating, issue, and renewal standards specified for BasiCare (see above).

EXHIBIT 1- Part H
DATE Jan. 12, 1995
HB



CARING PROGRAM FOR CHILDREN℠

℠ Service Mark of Blue Cross of Western Pennsylvania
℠ Service Mark of Blue Cross and Blue Shield of Montana

- BENEFIT BOOKLET -

Sponsored and administered by
Blue Cross and Blue Shield of Montana

(booklet)

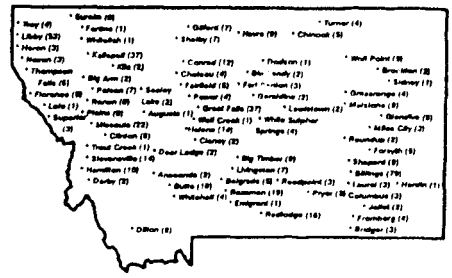
CARING PROGRAM FOR CHILDREN

℠ Service Mark of Blue Cross of Western Pennsylvania

EXHIBIT 1 - Part I
DATE Jan. 12, 1995
HB

CARING PROGRAM CHILDREN

From 1/1/93 to 1/1/95



The Caring Program for Children provides primary and preventive health benefits to eligible Montana children. The Caring Program is a cooperative effort of participating physicians, hospitals, other health care providers, contributors, and Blue Cross and Blue Shield of Montana which administers the program.

Eligible Children

Current enrollment as of January 1, 1995	399
Total number of children served	576
Estimated number of Montana children who could benefit from Caring Program services	14,000

Montana Providers Participating in the Caring Program

Physicians	627
Hospitals	43
Physician Assistants	36
Nurse Specialists	23

Contributions

The Caring Program for Children received contributions from a variety of sources including fundraisers, private foundations, United Ways, and numerous Montana businesses and individuals.

** Total Contributions Received $141,193.00
(as of December 31, 1994)
(Plus matching funds from Blue Cross and Blue Shield of Montana)

United Way Support

* United Way of Lewis and Clark County
* United Way of Cascade County
* United Way of Hill County
* United Way of Silver Bow County
* United Way of Flathead County

CPC.LTR/1012

P.O. Box 872 • Helena, MT 59624-0872 • Telephone: (406) 444-8400

Sponsored by The Caring Foundation of Montana, Inc.
Blue Cross and Blue Shield of Montana

PROVIDER NETWORK LISTING

EXHIBIT 1- Part J
DATE Jan. 12, 1995
HB

Making The Most of THE BLUES®

(booklet)

BlueCross BlueShield of Montana

EXHIBIT 2 Part A
DATE Jan. 12, 1995
HB

Small Business Health Insurance Reform

Small Employer Health Insurance Availability Act

The Small Employer Health Insurance Availability Act, passed by the 1993 Montana Legislature, is based on a model act designed by the National Association of Insurance Commissioners and adopted in similar form by 33 other states.

The NAIC developed the model act in consultation with insurers and agent associations, consumer groups and small business representatives.

Small business health insurance reforms, contained in Senate Bill 285, were tailored to the Montana market by state lawmakers. The small business health insurance reforms were, in essence, an industry solution to problems faced by small businesses that couldn't, for one reason or another, get health insurance. The act is a private-sector solution to a private-sector problem.

"I'm no insurance expert," Bozeman businesswoman Sunny Mavor told the Bozeman **Daily Chronicle,** ***"but it looks to me like it's a step in a good direction."***

The reforms are backed by such groups as the Health Insurance Association of America, Blue Cross Blue Shield of Montana, National Federation of Independent Business/Montana, Independent Insurance Agents Association of Montana, Montana Association of Life Underwriters, National Association of Independent Insurers, Montanans for Universal Health Care and the Montana Hospital Association.

Elements of Reform

Small business health insurance reform is designed to make health insurance more available to Montana's small businesses (with between 3 and 25 employees working 30 or more hours a week).

The legislation authorized State Auditor Mark O'Keefe, as insurance commissioner, to appoint the five-member Health Benefit Plan Committee. The committee, with input from the public, health-care providers, insurance industry, small business representatives and consumer groups, was charged with designing standard and basic health benefit packages that can be marketed on a ***voluntary*** basis to the state's small businesses. ***(Businesses are not required to participate in this program.)***

Goals of reform include:

- ❒ Promoting availability of health insurance, regardless of a business' health status or claims experience;
- ❒ Preventing abusive rating practices and requiring disclosure of rating practices to purchasers;
- ❒ Providing for renewability of coverage;
- ❒ Limiting use of preexisting condition exclusions; and
- ❒ Improving the overall fairness and efficiency of the small employer health insurance market.

Standard and Basic Plans

The Health Benefit Plan Committee designed two health benefit plans: a basic (lower-cost) plan and a standard plan. Both plans include all state-mandated benefits and maternity coverage.

Portability and Guaranteed Issue

The plans provide for *portability* of coverage and *guaranteed issue*. That means that people aren't subject to preexisting condition waiting periods if they have had previous coverage and sign up for a small business health insurance plan *(portability)*; and insurers can't reject a group or any eligible individual for coverage because of health history or for any other reason *(guaranteed issue)*.

Insurers offering basic and standard plans are required to accept all groups, including groups that formerly couldn't get health insurance for their employees. Companies can still underwrite other health plans.

Free Market Approach

The committee designed specific benefits to be in every standard plan sold by insurers. The committee recommended a free-market approach to basic plans, allowing insurers to offer a variety of products. The Montana basic plans would allow many current policies to serve as basic plans, thereby ensuring portability of coverage and guaranteed issue.

The committee also devised a package of preventive-care benefits based on medical knowledge and common sense. This package, contained in the standard plan, includes well-child care beyond the age of two, age-appropriate checkups, appropriate care linked to family medical history and maternity care reimbursed as a preventive care item rather than as an illness.

How the Plans Work

Since December 1994, all small business insurance carriers offer the single standard plan and at least one basic plan. Policies are not sold by the state; they are sold by private insurers that participate in this market. Businesses are not required to buy this insurance.

Businesses can continue their current policies, which may qualify as basic plans, or apply for other plans. The new law provides more choices.

Notice of cancellation of policies must be given at least 180 days prior to termination of coverage. The insurance commissioner will assist small employers whose policies have been cancelled under certain conditions in finding replacement coverage.

Special Features

☞ Employers and consumers can renew their coverage -- renewability is guaranteed -- unless they fail to pay premiums, commit fraud, or make misrepresentations.

☞ Premium rate increases will be capped, and premium variations limited. Rates no longer will be based on the health status of employees, or dependents, in the group.

☞ Pre-existing condition exclusions will be limited: Pre-existing conditions will be covered after 12 months, and if an individual is transferring from another health insurance policy, no pre-existing condition exclusion period will apply.

Standard Plan Provisions

The standard plan must offer maternity benefits and all state-mandated benefits.

It will include:

❒ An annual deductible of $250 for an individual, $500 for family coverage;

❒ Coinsurance payments, after the deductible is met, of 20 percent for the insured;

❒ Maximum out-of-pocket expenses of $1,250 a year for individuals and $2,500 per family;

❒ Maximum lifetime benefits of $1 million;

❒ 20-percent coinsurance payments for the insured for prescription drugs;

❒ First-dollar coverage (no deductible or copayment) for a package of preventive-care services, such as well-child care from birth to age 20, prenatal care, mammographies, pap smears, health exams, health counseling, and age-appropriate physical exams;

❒ Four visits a year to a practitioner of choice, with patient copayment limited to $25 per visit; and

❒ Policies issued to any group that applies.

Basic Plan Provisions

Any health benefit plan that has benefits that cost less than the benefits of a standard plan will qualify as a basic health benefit plan.

All basic (lower-cost) plans must include maternity benefits and all state-mandated benefits.

Under this approach, employers and consumers can select from a variety of basic plans and shop for the deductible, coinsurance, and maximum out-of-pocket levels that meet their particular needs.

The theory behind the basic plan is to allow the free market to dictate the components of the policies.

All basic plans will be issued to any group that applies for one.

Other Plans for Small Businesses

Insurers still can underwrite some plans, meaning they can accept or reject applicants based on a person's or group's health status.

These plans must be richer in benefits than the standard plan.

Montana Small Employer Health Reinsurance Program

Because small business health insurance reform requires insurance carriers to provide coverage (guaranteed issue) to all eligible employees and dependents, a program was established to guarantee insurers a source of reinsurance. (Reinsurance is an agreement between two or more insurance companies by which the risk of loss is proportioned.)

The Montana Small Employer Health Reinsurance Program consists of a nine-member board with representatives from the five insurance companies that write the most small business health insurance in Montana. A sixth insurance company is represented along with a small employer, a consumer, and a health care provider.

This board sets premium rates for reinsurance. If premiums do not cover program costs, the board can assess all health insurance carriers doing business in Montana. Assessments are based on a carrier's line of business for large-group, small-group and individual health insurance coverage. Exempt from assessment are health plans for state employees and the university system, and self-funded health insurance plans provided by a political subdivision of the state. (Connecticut, which had one of the first reinsurance programs in the nation, has assessed carriers a fraction of 1 percent of the $515 million base in the last 3.5 years.)

Administrative work for the reinsurance program is handled by Travelers Insurance Co., which performs similar duties for reinsurance programs in 18 other states.

EXHIBIT 2A
DATE 1-12-95

Montana Business Health Coverage Survey

Small Business Health Insurance Reform on Target, Survey Reveals

A survey conducted in the summer of 1994 confirmed what the 1993 Legislature and Montana Insurance Department only presumed to know -- that small businesses are less likely to provide health insurance coverage to employees than large businesses.

The statewide survey, conducted by the State Auditor's Office in conjunction with the state Department of Labor and Industry, found that less than half -- 47 percent -- of small businesses (between 3 and 25 employees) surveyed said they provided health insurance coverage to their workers. Meanwhile, 83 percent of large businesses (26 or more employees) reported they provided health insurance coverage to their workers.

The survey also revealed that health insurance costs are higher for small businesses.

Highlights

Percent of Large and Small Businesses Offering Health Insurance Coverage

Small Employers	47%
Large employers	83%

Percent of Each Class of Firms That Offer Insurance Coverage

500 employees or more	88.9%
100 to 499 employees	90.6%
26 to 100 employees	81.1%
3 to 25 employees	47%

Other survey highlights:

- ☐ The lack of health insurance generally is more concentrated in lower-wage, seasonal industries that employ part-time workers;
- ☐ Eighty-nine small firms and 40 large firms reported being refused group health insurance coverage by insurance companies in the last five years (employees working for small firms were almost four times more likely to be denied coverage by insurers than those working for large firms);
- ☐ Health insurance premiums for all businesses surveyed rose 8.5 percent faster than the rate of inflation over the last five years;
- ☐ 38.4 percent of small firms reported making some type of coverage contribution for employees, compared with 73.7 percent of large firms reporting making some type of coverage contribution; and
- ☐ Small firms pay more in premiums than large firms, with the average monthly insurance premium for individual health employee coverage for 1994 at $176.15 for small businesses, compared with $149.85 for large businesses.

The survey was conducted by the state labor department's Research and Analysis Bureau, which handles statistical research for Montana and the U.S. Bureau of Labor Statistics. The survey has a margin of error of 1.5 percent.

Surveys were sent to 7,807 of the 25,166 private industry employers in Montana. Two mailings of the survey were sent. Phone follow-up was done to clarify some of the data items.

5,919 responses were received, including duplicate responses. After duplicates were deleted, usable responses totaled 4,949.

Small Business Insurance Reform in Other States

Small business health insurance reform is not an effort unique to Montana. About 34 states have adapted the National Association of Insurance Commissioner's model small group act to their particular circumstances.

As the National Underwriter magazine noted in a November 14, 1994 report on U.S. health care, "For the past several years small group insurance reform has been at the forefront of states' efforts to expand access to health insurance coverage." The Intergovernmental Health Policy Project at the George Washington University notes that almost every state has enacted some form of small business health insurance reform. And, as experts point out, the reform is intended to remedy problems with insurance coverage availability, not affordability.

Since May 1991, Connecticut has been working with small business health insurance reform. 8,963 Connecticut small businesses, previously uninsured, had purchased small group plans as of June 1994, and sales remained strong among 44 of 48 small group carriers surveyed.

The surrounding states of Idaho, North Dakota, South Dakota and Wyoming all have instituted some sort of small business health insurance reforms similar to Montana's.

Commonly Asked Questions About Small Business Health Insurance Reform

Q. Will this reform cause rates to skyrocket and prompt healthy individuals to drop coverage?
A. Hopefully, not. This legislation was designed by the National Association of Insurance Commissioners, in close consultation with insurance companies and agent groups, as a way to help more small businesses get health insurance coverage. Rates in this market will no longer be based on the health status of individuals in the group, so some groups will see rates go down. Overall, rates may go up slightly to cover the costs of guaranteed issue. One major Montana insurer estimates the cost of guaranteed issue to be eight percent of premium.

Q. The law allows basic plans to be exempt from any or all of the mandated benefits. Why were all the mandated benefits left in basic plans?
A. In designing the basic plan, the Health Benefit Plan Committee carefully considered the issue of exempting the basic plan from the mandated benefits. The committee's actuary estimated the cost of the mandated benefits to be eight percent of premium. The committee felt that the Legislature had passed the mandated benefit laws for good reason. Basic and standard plans were designed with the flexibility that if the Legislature repeals or adds a mandated benefit, it will automatically change the plans.

Q. Can a small employer offer individual policies to employees?
A. No, a small business must buy a small group policy. The practice of companies selling individual policies through an employer has been stopped to prevent insurance companies from "cherrypicking" the healthy individuals. However, individuals who work for small businesses can always directly buy an individual policy.

Q. Is an employer required to offer coverage to ***every*** employee if a small group plan is purchased?
A. No. Coverage must be offered to employees who work 30 hours or more a week and the dependents of these employees. Employers decide whether to make the insurance available to anyone else. Some insurance companies have their own restrictions on coverage for part-time employees.

Q. Are dependents guaranteed coverage through small group plans?
A. Yes, the dependents of employees who work 30 hours or more a week will not be turned down for insurance. If they have previous coverage when changing to a small group plan, no waiting periods for preexisting conditions will apply.

Q. Will only a small portion of Montana employees have to pay the costs related to the reinsurance program?
A. No. The costs of the reinsurance program are paid through premiums from insurance companies that choose to buy the reinsurance coverage. Assessments on insurance companies pay for costs not covered by premiums. Insurance carriers are assessed based on their total premiums from individual, large and small group health insurance sales, which is a broad assessment base.

EXHIBIT 2A
DATE 1-12-95

Q. Can a small business buy health insurance plans other than the standard and basic policies?
A. Yes. Insurance carriers can offer health plans that they continue to "underwrite." Applicants can be refused coverage for these plans, but must be offered basic and standard plans as an alternative.

Q. Does this reform make insurance coverage of abortion a new mandated benefit?
A. No. Mandated benefits are separate laws that affect all policies sold in the state. Coverage of abortion is part of the standard plan, but it is the only plan that must include this benefit. Consumers who object to this benefit can purchase a policy with out the benefit.

Q. How does a small business qualify?
A. Any business with between three and 25 employees who work 30 hours or more a week qualifies for a small group health insurance policy and cannot be refused. Not every employee must enroll, but insurance companies are allowed to have minimum participation requirements set by the carrier.

Q. Do mandatory maternity benefits have anything to do with this reform?
A. No. The Montana Supreme Court ruled 7-0 in December 1993 that under the state's nongender insurance law it is discriminatory to exclude maternity benefits or have a separate rider policy for that coverage under a major medical insurance policy. Like all policies sold in Montana, maternity benefits are included in the basic and standard plans.

Q. Is there a minimum amount employers must contribute to paying the premium for small group plans?
A. The law does not require a minimum contribution from employers, but some insurance companies do, which is permissible.

Q. Can a small group stay on the health insurance plan acquired before the reform went into effect?
A. Yes. The law does not require small businesses to buy the new basic and standard plans.

For more information, call the Montana Insurance Department at 444-2040 in Helena, or 1-800-332-6148.

INSURANCE COMPANIES DECLARED TO BE IN SMALL GROUP MARKET

These are the insurers declared to be participating in the small business health insurance market in Montana. Those certified as small group carriers currently can offer insurance plans to small businesses. Those companies that are not yet certified may not have submitted policies to the Montana Insurance Department or their policies are being reviewed.

Company *(31 companies to date)*	Certified as Small Group Carrier as of 1/9/95
Aetna Life Insurance Co.	
American Chambers Life Insurance Co.	
American National Insurance Co.	
Bankers United Life Assurance Co.	
Best Life Assurance Company of California	
Blue Cross Blue Shield of Montana & HMO	X
Celtic Life Insurance Co.	
Centennial Life Insurance Co.	
Continental Life and Accident	
CUNA Mutual Insurance Society	
Fortis Benefits Insurance Co.	
Glacier Community Health Plan Inc.	
Golden Rule Insurance Co.	
Home Life Financial Assurance Corp.	X
John Alden Life Insurance Co.	X
John Hancock Mutual Life Insurance	
Life Investors Insurance Co of America	
Monumental Life Insurance Co	
National Group Life Insurance Co.	
New York Life Insurance Co.	X
PFL Life Insurance Co.	
Pioneer Life Insurance Company of Illinois	
Principal Mutual Life Insurance Co.	
Security Life Insurance Company of America	
Time Insurance Co.	X
Travelers Insurance Co.	X
United of Omaha Life Insurance Co.	
United World Life Insurance Co.	
Universe Life Insurance Co.	
Western Mutual Insurance Co.	
Yellowstone Community Health Plan	

EXHIBIT 2 Part B, Side 1
DATE Jan. 12, 1995
HB

INSURANCE TERMS RELATED TO HEALTH CARE REFORM

GUARANTEED ISSUE: All eligible people in a group are guaranteed to be issued insurance if they apply. No one can be turned down for any reason. Under the small business health insurance reform law, all employees who work 30 hours or more, and their dependents, are guaranteed health coverage if the employer applies for a group policy. The eligible employees and dependents can decline coverage for specific reasons. All small group basic and standard plans are guaranteed issue. Guaranteed issue prevents the practice of "cherry-picking" healthy groups or individuals by insurance companies.

PORTABILITY: Generally, portability of coverage means that person who is changing jobs will incur no or few penalties in relation to their health insurance. In small business health insurance reform, portability of coverage is provided in the sense that anyone who has had previous health insurance coverage current to 30 days before they apply for a small group policy will not have a waiting period for preexisting conditions. With the reform, coverage is portable when a person moves to a small group policy, but coverage is not portable when they leave a small group and seek individual or large-group insurance. Sometimes the term portability of coverage is used to mean that a person retains the same health care policy even if they change jobs, as with an individual policy.

PREEXISTING CONDITION: By law, (33-22-110 MCA), preexisting condition refers to a health condition for which medical advice or treatment was recommended or received before the effective date of an insurance policy. Insurance companies can only "look back" five years to determine what is a preexisting condition. This law allows insurance companies to exclude coverage or impose a "waiting period" of up to 12 months for preexisting conditions. For small group policies, a waiting period cannot be imposed if someone has had qualifying previous coverage current to 30 days before they apply for a new policy.

CONVERSION: Stipulated in 33-22-508 MCA, conversion rights provide an opportunity for a person to get an individual policy when terminated from a job. The person must have been covered by a group plan for at least three months and not have another major medical policy. Application for a conversion policy must be made within 31 days after termination of group coverage. Rates for conversion policies are usually very high.

MANDATED BENEFIT: The term mandated benefit refers to an insurance benefit which, by law, must be included in every individual or group policy. There is nothing in law that labels a set of statutes as "the mandated benefits." The Insurance Commissioner compiled a list he deems as mandated benefits. The small business health insurance reform law allowed basic plans to be exempt from mandated benefits, but the Health Benefit Plan Committee and the Insurance Commissioner chose to include the mandated benefits in the basic plan.

LIST BILLING: List billing is an arrangement with employers to deduct premium payments from employee paychecks for individual policies. Small business health insurance reform eliminates list billing and requires small employers to get group policies. The reason for this is to prevent insurance companies from "cherry-picking" healthy individuals in a group by issuing them individual policies and avoiding people with poor health. To allow list billing would create a significant loophole in guaranteed issue.

Bar Graph →

Bar Graph

EXHIBIT 2 Part B, Side 2
DATE Jan. 12, 1995
HB

Small Business Health Insurance Policies for Montana Employers with 3-25 Employees who work 30 or more hours a week

Underwritten Policies

More benefits than Standard Plan

Standard Plan

$250 Annual Individual Deductible, $500 Family Deductible
$1,250 annual maximum Out of Pocket per Individual
$2,500 annual maximum Out of Pocket per Family
20% Coinsurance Payments for Individual
Maximum Lifetime Benefits of $1 million
(Includes all State Mandated Benefits)

Basic Plans

Fewer benefits than Standard Plan
(Includes all State Mandated Benefits)

EXHIBIT 2, Part C
DATE Jan. 12, 1995
HB

STATE AUDITOR
STATE OF MONTANA

Mark O'Keefe
STATE AUDITOR

COMMISSIONER OF INSURANCE
COMMISSIONER OF SECURITIES

MANDATED BENEFITS
AS DETERMINED BY THE MONTANA STATE AUDITOR

Definition (Adopted from the work of legislature's Joint Interim Subcommittee on Mandated Benefits)

> A "mandated benefit" is defined as a mandated health care coverage, the mandated offering of a health care coverage, or mandated coverage of a health care provider. Mandated benefits by definition include freedom of choice of practitioners, covered benefits (includes mandated options and benefits limited to certain types of policies), and extended coverages.

The following statutes are by the above definition mandated benefits as determined by the Montana State Auditor and Insurance Commissioner:

A. FREEDOM OF CHOICE OF PRACTITIONERS

33-22-111 **Policies to provide freedom of choice of practitioners.** Requires insurers to pay for services of: physicians, certified physician assistants, dentists, osteopaths, chiropractors, optometrists, podiatrists, psychologists, licensed social workers, licensed professional counselors, acupuncturists, and nurse specialists, acting within the scope of their license.

33-22-114 **Coverage required for services provided by physician assistants-certified.**

33-22-125 **Independent chiropractic physical examination or review of records.** Requires a review of denied claims for chiropractic care by a Montana chiropractor. The insured bears the cost of the review unless the decision is reversed, then the insurer pays the claim and the cost of the review.

B. COVERED BENEFITS

33-22-131 **Coverage for phenylketonuria treatment.** Some individuals are born with phenylalanine disorders. These individuals cannot eat protein in the usual manner, as it may cause brain damage. This provision requires insurers to cover the cost of food supplements and physician supervision of the condition.

33-22-132 **Coverage for mammography examinations.** This Section of code covers up to $70 for mammograms for insureds starting at age 35 and based on a schedule thereafter.

33-22-303, 33-22-512, 33-20-1014 **Coverage for well child care.** Policies must pay for well child care through age 2 without imposing the deductible based on a schedule of examinations, immunizations, developmental assessment, and anticipatory guidance.

33-22-703 **Coverage of mental illness, alcoholism, and drug abuse.** This law establishes minimum payments a company may use for charges related to mental illness, alcoholism, and drug abuse.

Alcoholism and drug abuse inpatient benefits are $4000 in any 24 month period and $8000 in lifetime benefits.

Outpatient benefits for mental illness, alcoholism, and drug abuse in a year are $1000.

Inpatient mental illness treatment may not be limited to less than 30 days.

33-22-1001, 33-22-1002 **Definition of home health care and availability of coverage for home health care.** "Home health care" is defined as services provided by a licensed home health agency to an insured in his place of residence that is prescribed by the insured's attending physician as part of a written plan of care and includes nursing, home health aide services, physical therapy, occupational therapy, speech therapy, hospice service, medical supplies and equipment suitable for use in the home, and medically necessary personal hygiene, grooming, and dietary assistance. Home health care benefits must be made available under group insurance policies.

C. EXTENDED COVERAGE

33-22-130 **Coverage for adopted children from time of placement - preexisting conditions.** Requires insurers to allow adopted children to be added to the group as dependents from the time of placement without preexisting conditions.

33-22-301, 33-22-504, 33-30-1001 **Coverage of newborns.** Newborns are covered from the moment of birth for 31 days if either or both of the parents are covered under the policy. The insured must notify the company and pay any premium due for the newborn within 31 days of birth.

33-22-304, 33-22-506, 33-30-1004 **Continuation of coverage for handicapped.** Policies which cover dependents must extend coverage beyond the usual age of termination if the individual is handicapped.

33-22-305 through 311 **305. Individual family disability insurance continuity of coverage. 306. Purpose. 307. Continuity of coverage. 308. Form of coverage - requirements - evidence of insurability - preexisting conditions. 309. Notice. 310. Nonduplication. 311.**

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Overinsurance. The Individual Family Disability Insurance continuation of Coverage Act provides that a covered family member under an individual family disability insurance policy, if that person exercises the right, is entitled to continuity of coverage upon the death of the named insured, the divorce, annulment of marriage, or any other condition that would otherwise terminate coverage. The carrier is not required to issue a converted policy if the applicant has other similar coverage, or is eligible for similar coverage in a group, is provided similar coverage under any statute, is covered by a government plan.

33-22-503 **Continuation of benefits to dependents.** A group policy may provide for continuation of benefits for family members or dependents after the death of a person in the group.

33-22-507 **Continuing group coverage after reduction of work schedule.** A person covered by a group policy may for a period of one year, with the consent of the employer or the trustees, continue coverage, at the same premium charged other members of the group of the same risk category, during his employment despite any reduction of his regular work schedule below the minimum time required to qualify for membership in the group.

33-22-508 **Conversion on termination of eligible.** A person who has been insured under a group policy for at least three months and who is not insured under another major medical disability insurance policy is entitled to an individual policy on himself, his family members, and his dependents if his group coverage ceases because of termination of his employment or of his membership in the class eligible for coverage or because the employer discontinued the group policy without providing for other group coverage if application is made within 31 days after termination of the group coverage.

33-22-509 **Preexisting conditions.** A converted policy may not exclude as a pre-existing condition any condition covered by the group contract, including pregnancy.

33-22-510 **Insured family - conversion entitlement.** The conversion privilege is also available to:

- the surviving spouse and children upon the death of the employee or member;
- the spouse of the employee or member upon termination of the spouse, by reason of ceasing to be a qualified family member, while the employee or member remains under the group policy, including children whose coverage under the group policy terminates at the same time; or
- a child upon termination of his coverage by reason of ceasing to be a qualified family member under the group plan.

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Sub-Chapter 50

Small Employer Health Insurance Rules

6.6.5001 DEFINITIONS For the purposes of this sub-chapter, the following terms have the following definitions:

(1) "Act" means the Montana Small Employer Health Insurance Availability Act.

(2) "Adjusted gross income" means gross income minus deductions recognized by the Internal Revenue Code.

(3) "Associate member of an employee organization" means any individual who participates in an employee benefit plan, as defined in 29 U.S.C. 1002(1), that is a multiemployer plan, as defined in 29 U.S.C. 1002(37A), other than the following:

(a) An individual (or the eligible dependent of such individual) who is employed by a participating employer within a bargaining unit covered by at least one of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained; or

(b) An individual who is a present or former employee (or an eligible dependent of such employee) of the sponsoring employee organization, of an employer who is or was a party to at least one of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained, or of the employee benefit plan, or of a related plan.

(4) "Case management" means the process of planning and coordinating care and services to meet the individual needs of eligible employees and eligible dependents. Case management includes assessment, care coordination and referral, case planning, and monitoring.

(5) "Coinsurance" means the percentage of eligible charges which the insurer must pay, after the deductible is met.

(6) "Copayment" means a fixed dollar amount or percentage of eligible charges which the insured must pay for each service after a deductible, if any, is met.

(7) "Deductible" means the dollar amount of eligible charges which the insured must pay in an annual benefit period before any benefits are payable by the insurer.

(8) "Eligible dependent" means any dependent defined in 33-22-1803, MCA, including a common law spouse, or any child who qualifies as a dependent under the Internal Revenue Code.

(9) "High risk pregnancy" means a pregnancy, the outcome of which is considered to be at high risk as determined by the case manager, based upon the following factors:

(a) Age 19 or younger and 35 or older;

(b) Medical factors which indicate the potential for a poor pregnancy outcome;

(c) Physical disability or mental impairment;

(d) Abuse of alcohol or drugs by the patient and/or someone in the person's immediate environment; and

(e) Psychosocial factors, including emotional and social needs.

(10) "Lifetime maximum benefit" means maximum total benefits paid by the insurer throughout the life of the policy.

(11) "Maximum annual out-of-pocket" means the total amount of eligible charges paid by the insured as copayments and deductible in an annual benefit period.

(12) "New entrant" means an eligible employee, or the dependent of an eligible employee, who becomes part of an employer group after the initial period for enrollment in a health benefit plan.

(13) "Risk characteristic" means the health status, claims experience, duration of coverage, or any similar characteristic related to the health status or experience of a small employer group or of any member of a small employer group.

(14) "Risk load" means the percentage above the applicable base premium rate that is charged by a small employer carrier to a small employer to reflect the risk characteristics of the small employer group. (History: Sec. 33-1-313 and 33-22-1822 MCA; IMP, Sec. 33-22-1802, 33-22-1803, and 33-22-1812 MCA; NEW, 1994 MAR p. 1990, Eff. 6/10/94; AMD, 1994 MAR p. 2926, Eff. 11/11/94.)

6.6.5002 and 6.6.5003 reserved.

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6.6.5004 APPLICABILITY, SCOPE, AND TRANSITION

(1) Except as provided in (2) and ARM 6.6.5062, these rules apply to any health benefit plan, whether provided on a group or individual basis, which:

(a) Meets one or more of the conditions set forth in 33-22-1804, MCA; and

(b) Provides coverage to one or more employees of a small employer located in this state, without regard to whether the policy or certificate was issued in this state.

(2) Except as set forth in (3), the provisions of these rules do not apply to an individual health insurance policy delivered or issued for delivery prior to the effective date of these rules.

(3) A carrier that provides individual health insurance policies to one or more of the employees of a small employer must be considered a small employer carrier and must be subject to the provisions of these rules with respect to such policies if the small employer contributes directly or indirectly to the premiums for the policies and the carrier is aware or should have been aware of such contribution. An indirect contribution is any contribution which benefits the employee monetarily. For the purpose of this rule, payroll deductions, list billed premium payments, and employer contributions to premiums paid through cafeteria plans, as defined in section 125 of the Internal Revenue Code, must be regarded as employer contributions.

(a) Any carrier that has a list billed premium payment arrangement with a small employer after the effective date of these rules shall do one of the following:

(i) cease using a list billing to bill individuals;

(ii) renew coverage; or

(iii) withdraw from the market, in accordance with the procedures in 33-22-1810, MCA.

(4) In the case of a carrier that provides individual health insurance policies to one or more employees of a small employer, the small employer must be considered to be an eligible small employer, and the small employer carrier must be subject to 33-22-1811, MCA, relating to availability of coverage, if:

(a) The small employer has from 3 to 25 employees who work 30 hours or more a week;

(b) The small employer contributes directly or indirectly to the premiums charged by the carrier; and

(c) The carrier is aware or should have been aware of the contribution by the employer.

(5) These rules apply to all health benefit plans provided to small employers or to the employees of small employers, without regard to whether the health benefit plans are offered under, or provided through, a group policy or trust arrangement of any size sponsored by an association or employer contributions to premiums paid through cafeteria plans, as defined in section 125 of the Internal Revenue Code, unless excepted by 33-22-1803(25), MCA, or unless the plan constitutes both a multiple employer welfare arrangement as defined by section 29 USCS 1002(40)(A) and an employee welfare benefit plan under section 29 USCS 1002(1).

(6) An individual health insurance policy is not subject to the provisions of these rules solely because the policyholder elects a deduction under section 162(l) of the Internal Revenue Code, entitled "special rules for health insurance costs of self-employed individuals."

(7) If the small employer is issued a health benefit plan under the terms of the act, these rules must continue to apply to the health benefit plan in the case that the small employer subsequently employs more than 25 eligible employees. A carrier providing coverage to such an employer shall, within 60 days of becoming aware that the employer has more than 25 eligible employees, but no later than the anniversary date of the employer's health benefit plan, notify the employer that the protections provided under the act and these rules must cease to apply to the employer if such employer fails to renew its current health benefit plan or elects to enroll in a different health benefit plan.

(8) If a health benefit plan is issued to an employer that is not a small employer as defined in the act, but subsequently the employer becomes a small employer, these rules must not apply to the existing health benefit plan. The carrier providing a health benefit plan to such an employer must not become a small employer carrier under these rules solely because the carrier continues to provide coverage under the existing health benefit plan to the employer.

(9) A carrier providing coverage to an employer described in (7) shall, within 60 days of becoming aware that the employer has 3 to 25 eligible employees, notify the employer of the options and protections available to the employer under the act, including the employer's option to purchase a small employer health benefit plan from any small employer carrier.

(10) If a small employer has employees in more than one state, these rules must apply to any health benefit plans issued to the small employer if:

(a) The majority of eligible employees of such small employer are employed in this state or

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(b) If no state contains a majority of the eligible employees of the small employer, the primary business location of the small employer is in this state.

(c) In determining whether the laws of this state or another state apply to a health benefit plan issued to a small employer described in (9), the provisions of (9) apply as of the date the health benefit plan was issued to the small employer for the period that the health benefit plan remains in effect.

(d) If a health benefit plan is subject to these rules, these rules must apply to all individuals covered under the health benefit plan, whether they reside in this state or in another state.

(11) A carrier that is not operating as a small employer carrier in this state is not subject to the provisions of these rules solely because a small employer that was issued a health benefit plan in another state by that carrier moves to this state, until coverage is renewed, extended or modified. However, such a carrier shall, within 60 days of becoming aware that the employer has moved to this state, notify the employer of the options and protections available to the employer under the act, including the employer's option to purchase a small employer health benefit plan from any small employer carrier authorized to do business in this state.

(History: Sec. 33-1-313 and 33-22-1822 MCA; IMP, Sec. 33-22-1802, 33-22-1808, and 33-22-1812 MCA; NEW, 1994 MAR p. 1528, Eff. 6/10/94.)

6.6.5005 through 6.6.5007 reserved.

6.6.5008 COVERED SERVICES OF POLICIES UNDER STANDARD PLAN

(1) Policies of insurance offered under the standard health benefit plan contemplated by 33-22-1812, MCA, must provide the following coverage for medically necessary services, subject to the deductible, coinsurance, copayment, maximum out-of-pocket, and lifetime maximum benefit levels, unless specifically exempted herein:

(a) Coverage of inpatient hospital services, including but not limited to, semi-private room and board, intensive care services, and all other related hospital services.

(b) Coverage of outpatient hospital services.

(c) Coverage for hospital emergency room, services, subject to a $75 copayment, if the insured is not admitted to the hospital. This copayment may not be applied toward the deductible or the maximum annual out-of-pocket.

(d) Coverage for obstetrical care delivery services, including services of physicians, certified nurse midwives and other nurse specialists, physician assistants, costs of delivery room, and other medically necessary services directly associated with the delivery.

(e) Coverage for services of physicians and other health care professionals, subject to the freedom of choice of practitioners of 33-22-111, MCA, except as provided in 33-30-102(1), MCA.

(i) Services of nutritionists, speech pathologists, audiologists, occupational therapists, and physical therapists, within limitations of other provisions of this plan, must be covered, if referred by a licensed medical doctor (MD), doctor of osteopathy (DO), or other provider if within the scope of practice as determined by the provider's licensing board and practice act.

(f) Coverage for medical nutrition services deemed medically necessary, including nutrition assessment and counseling for the following disease conditions. Costs must be reimbursed for nutrition consultations at a total cost of no more than $240 per benefit period, unless with prior approval of insurer:

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

(g) Coverage for home health care under a plan written by an MD, DO, or other provider if within the scope of practice as determined by the provider's licensing board and practice act, when there is a cost savings compared to alternative services, as evidenced by an agreement between the referring practitioner, patient, and insurer, that home health care is desirable and cost-effective.

(h) Coverage for chiropractic services not exceeding 24 treatments per year, unless an additional 11 visits are approved by the insurer, provided that the maximum covered charge must not exceed $25 per treatment.

(i) Coverage for the following mental health services in accordance with 33-22-703, MCA:

(i) mental illness;

(ii) alcoholism; and

(iii) drug abuse.

(j) Services for alcoholism and drug abuse will be covered if they meet the criteria set forth in the American Society of Addictive Medicine.

(k) Coverage of only drugs available by a prescription, which includes formularies and generic brand prescription drugs and contraceptives prescribed for the treatment of a medical problem and not solely for contraceptive purposes.

(l) Coverage for diagnostic X-ray and laboratory services.

(m) Coverage for ambulance transportation to nearest facility where necessary care is available.

(n) Coverage for rental of durable medical equipment, and coverage for purchase of such equipment in cases where purchase of the equipment would be more cost-effective.

(o) Coverage for radiation therapy and chemotherapy.

(p) Coverage for state licensed hospice services, when the insured's life expectancy is determined by an MD or DO, to be six months or less.

(2) Coverage for all usual, customary, and reasonable charges related to medically necessary services rendered, as defined by the small employer carrier includes as follows:

(a) Charges in excess of this standard are not required to be included in the calculations under 6.6.5004 and 6.6.5008, unless otherwise excepted in section 33-30-102(1), MCA.

(b) The benefits provided shall be coordinated pursuant to ARM 6.6.2401 to 6.6.2405.

(c) Coverage for all statutory mandated benefits, including, but not limited to those mandated by 33-22-114, MCA, (services of physician's assistants - certified); 33-22-125, MCA (independent chiropractic examination and review); 33-22-130, MCA (treatment of adopted children); 33-22-131, MCA (phenylketonuria treatment); 33-22-301, 33-22-504, and 33-30-1001, MCA (newborns); 33-22-304, 33-22-506, and 33-30-1004, MCA (continuation of coverage for the handicapped); 33-22-305 through 311, MCA (the Individual Family Disability Insurance Continuation of Coverage Act); 33-22-503, MCA (regarding continuation of benefits to dependents); 33-22-507, MCA (regarding continuing group coverage after reduction of work schedule); 33-22-508, MCA (regarding conversion on termination of eligibility); 33-22-509, MCA (regarding imposition of pre-existing conditions to a converted policy covered by a group contract); and 33-22-510, MCA (insured family-conversion entitlement). (History: Sec. 33-1-313 and 33-22-1822 MCA; IMP, Sec. 33-22-1802 and 33-22-1812 MCA; NEW, 1994 MAR p. 1528, Eff. 6/10/94; AMD, 1994 MAR p. 2926, Eff. 11/11/94.)

6.6.5009 through 6.6.5011 reserved.

6.6.5012 COVERED PREVENTIVE CARE AND HEALTH MAINTENANCE SERVICES OF POLICIES UNDER STANDARD PLAN (1) Policies of insurance offered under the standard health benefit plan contemplated by 33-22-1812, MCA, must provide full coverage of all costs of the following preventive care services, provided that no charges for such services may be subject to deductible or copayment requirements:

(a) The following preventive care for low risk, asymptomatic adults:

(i) Coverage for one health examination and related counseling every 1-5 years, including current health history and counseling for tobacco and substance abuse, nutrition, exercise, sexual behavior, injury prevention, and dental care.

(ii) Coverage of age-appropriate physical examinations, including, for ages 19-39, 1 exam every 5 years; for ages 40-49, 1 exam every 3 years; and for ages 50 and above, 1 exam every 1 to 2 years.

(iii) Coverage for mammography examinations as contemplated by 33-22-132, MCA.

(iv) Coverage for 3 consecutive normal pap smear tests following the onset of sexual activity, and subsequent tests every 3 years until age 65.

(v) Coverage of 1 cholesterol test every 5 years beginning at age 35.

(vi) Coverage of 1 stool test for occult blood (colon cancer) every 1 to 2 years beginning at age 50.

(vii) Coverage for 1 flexible sigmoidoscopy every 5 years beginning at age 50.

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(viii) Coverage for annual flu shots after age 65.

(ix) Coverage for 1 pneumococcal vaccine after age 65.

(x) Coverage for 1 diphtheria/tetanus booster shot every 10 years following the initial series of shots.

(b) The following preventive care for children from birth to age 18:

(i) From birth through 2 years of age, coverage for well child care should follow the mandated benefits set forth in 33-22-303, 33-22-512, and 33-30-1014, MCA.

(ii) From age 3 through 18 years of age, coverage for interval health history and physical examinations conducted or performed by an MD, DO, or other provider if within the scope of practice as determined by the provider's licensing board and practice act, at intervals recommended by the american academy of pediatrics (AAP).

(iii) Coverage for immunizations of eligible dependents following schedules recommended by the AAP.

(c) The following reproductive health care:

(i) Family planning services, including contraception planning;

(ii) Pregnancy related services, including prenatal care; and

(iii) "Risk appropriate" prenatal care following medicaid guidelines. Risk appropriate prenatal care includes payment for case management for high risk pregnant individuals.

(d) Policies of insurance offered under the standard health benefit plan contemplated by 33-22-1812, MCA, must provide full coverage, after a copayment of $25 per consultation, for 4 visits per year to health care providers as listed under 33-22-111 and 33-22-114, MCA, of the patient's choice, except as provided in 33-30-102(1), MCA. This coverage must not be subject to deductible or coinsurance provision, but must be subject to a copayment of $25 per consultation and be applied toward meeting the out-of-pocket limit. This benefit must cover professional service fees only, and not the cost of tests, medications, or other items.

(2) In the event an individual's coverage changes from one benefit plan to another or from one carrier to another, the new benefit plan or the new carrier may count preventive care services paid for by prior carriers and benefit plans in determining whether a particular service or visit is covered.

(History: Sec. 33-1-313 and 33-22-1822 MCA; IMP, Sec. 33-22-1802 and 33-22-1812 MCA; NEW, 1994 MAR p. 1990, Eff. 6/10/94; AMD, 1994 MAR p. 2926, Eff. 11/11/94.)

6.6.5013 through 6.6.5015 reserved.

6.6.5016 SERVICES THAT MAY BE EXCLUDED FROM COVERAGE UNDER THE STANDARD PLAN (1) Policies of insurance offered under the standard health benefit plan contemplated by 33-22-1812, MCA, may exclude the following health care services from coverage:

(a) Cosmetic surgery unless performed to correct functional impairment or defects caused by disease, trauma, or previous therapeutic processes;

(b) Diagnosis or treatment of infertility, when infertility is the only diagnosis;

(c) Treatment of temporomandibular joint syndrome, except medically necessary surgery on the temporomandibular joint;

(d) Eyeglasses, contact lenses, hearing aids, or any examination or fitting related to these devices except that such health care services must be offered as optional coverage;

(e) Eye refractive surgery, including radial keratotomy, unless the corrected vision in the operated eye is worse than 20/70 prior to surgery and can be corrected to 20/70 or better only by surgery;

(f) Routine foot care;

(g) Sex change surgery;

(h) Skilled nursing facility, except as recommended by case management;

(i) Experimental and investigational treatment;

(j) All services and supplies resulting from any illness or injury which occurs in the course of employment when the employer has elected or is required by law to obtain coverage for such under state or federal workers' compensation laws, occupational disease laws, or similar legislation, including employees' compensation or liability laws of the United States and applies to all services and supplies resulting from a work-related illness or injury even though:

(i) Coverage under the government legislation provides benefits for only a portion of the services incurred;

(ii) Your employer has failed to obtain such coverage required by law;

(iii) The member waives his or her rights to such coverage or benefits;

(iv) The member fails to file a claim within the filing period allowed by law for such benefits;

(v) The member fails to comply with any other provision of the law to obtain such coverage or benefits; or

(vi) The member was permitted to elect not to be covered by the Workers' Compensation Act but failed to properly make such election effective.

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(A) This exclusion will not apply if an employer was not required and did not elect to be covered under any Workers' Compensation, occupational disease laws, or employer's liability acts of any state, country, or the United States.

(B) This exclusion will not apply if the workers' compensation insurer has denied benefits and claimant is pursuing redress through mediation, a contested case hearing, or a court, and no decision has been made on the case. If the workers' compensation coverage agrees to pay the claim, then the small employer carrier will be reimbursed for all expenses paid on the claim.

(k) Expenses that are or, without litigation could be, recovered through any federal, state, county, or municipal law, other than medicaid;

(l) Services for which there would be no charge in the absence of insurance;

(m) Services provided by immediate family members;

(n) Losses which are due to war or any act of war, whether declared or undeclared;

(o) Dental services, except for tumors or injury to the natural teeth and gums, except that such service shall be offered as optional coverage;

(p) Services and supplies not administered or ordered by an MD, DO, nurse specialist, or other covered professional.

(2) The commissioner may authorize any other exclusion which he deems to be consistent with the intent of the standard plan provisions contained in these rules. (History: Sec. 33-1-313 and 33-22-1822 MCA; IMP, Sec. 33-22-1802 and 33-22-1812 MCA; NEW, 1994 MAR p. 1528, Eff. 6/10/94.)

6.6.5017 through 6.6.5019 reserved.

6.6.5020 DEDUCTIBLE CHARGES, COINSURANCE, MAXIMUM ALLOWABLE OUT-OF-POCKET CHARGES, AND LIFETIME MAXIMUM BENEFIT LEVEL UNDER THE STANDARD PLAN (1) Policies of insurance offered under the standard health benefit plan contemplated by 33-22-1812, MCA, must provide an annual deductible of $250 per person and $500 per family. Such deductible must be applicable to all benefits, except as specifically exempted by these rules.

(2) Policies of insurance offered under the standard health benefit plan contemplated by 33-22-1812, MCA, must have a coinsurance in which the insurer must pay 80% of eligible expenses after the deductible is met, except as specifically exempted by these rules.

(3) Policies of insurance offered under the standard health benefit plan contemplated by 33-22-1812, MCA, must provide maximum annual out-of-pocket charges of $1,250 per person and $2,500 per family. Such policies must also provide that, after the annual out-of-pocket limit is met, the insurer will pay 100% of all medically necessary charges up to the lifetime maximum benefit level.

(4) Policies of insurance offered under the standard health benefit plan contemplated by 33-22-1812, MCA, must provide a lifetime maximum benefit of $1,000,000. (History: Sec. 33-1-313 and 33-22-1822 MCA; IMP, Sec. 33-22-1802 and 33-22-1812 MCA; NEW, 1994 MAR p. 1528, Eff. 6/10/94.)

6.6.5021 through 5.5.5023 reserved.

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6.6.5024 HMO COST SHARING SCHEDULE AND EXCEPTION TO STANDARD PLAN PROVISIONS (1) Standard plans offered by HMOs must comply with ARM 6.6.5008, 6.6.5012, 6.6.5016, and 6.6.5020, HMO plans may require that all services provided in ARM 6.6.5008 and 6.6.5012 must be rendered or referred by a primary care provider.

(2) Standard plans offered by HMOs are exempt from the deductible charges, and coinsurance provisions of ARM 6.6.5020, but must comply with the maximum annual out-of-pocket and lifetime maximum requirements of ARM 6.6.5020. HMO plans must include the following cost sharing schedule:

INPATIENT HOSPITAL SERVICES	
Semi-Private Room and Board Charges: Copayment Per day	$200
Other Medically Necessary Hospital Charges	No copayment
OUTPATIENT HOSPITAL SERVICES	
Outpatient Therapy	$15 copayment
Other Non-emergency	No copayment
HOSPITAL EMERGENCY ROOM	
If admitted to the hospital	No copayment for emergency room; inpatient copayment applies
If not admitted to the hospital	$75 copayment
OBSTETRICAL SERVICES	
Inpatient delivery services	$200 per day
PHYSICIANS AND OTHER MEDICAL PROFESSIONALS	
Hospital inpatient visits	No copayment
Physician office or home visits	$10 copayment
After hours visits (in- or outpatient)	$10 copayment
Referred Services	$15 copayment
MEDICAL NUTRITION SERVICES	$15 copayment $240 limit per benefit period, unless with prior approval of insurer

HOME HEALTH CARE	No copayment
CHIROPRACTIC SERVICES	
Copayment	$10 per visit
Maximum covered charge	$25 per visit
Covered treatments per year	24 visits, plus an additional 11 visits with the HMO's approval
MENTAL HEALTH SERVICES	
Inpatient	
Copayment	$200 per day
Days of covered treatment	30 days per year
Outpatient	
Copayment	$25 per visit
Maximum covered charge	$1,000 combined with substance abuse treatment
SUBSTANCE ABUSE TREATMENT	
Inpatient	
Copayment	$150 per day
Maximum covered charge	$4,000 per 24-month period
Lifetime maximum	$8,000
Outpatient	
Copayment	$25 per visit
Maximum covered charge	$1,000 combined with mental health service
PRESCRIPTION DRUGS	
Generic and brand name, if generic not available	$5 copayment
Brand name at patient's request	$5 copayment plus the difference between generic and brand name
DIAGNOSTIC X-RAY AND LABORATORY	No copayment
AMBULANCE	
Ground ambulance	$50 copayment
Air ambulance	$250 copayment

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DURABLE MEDICAL EQUIPMENT	20% copayment
RADIATION THERAPY AND CHEMOTHERAPY	20% copayment
HOSPICE SERVICE	No copayment
PREVENTIVE CARE SERVICES	
Adult preventative care	No copayment
Children preventative care	No copayment
Reproductive and prenatal health care	No copayment

(3) The health maintenance visits contemplated in ARM 6.6.5012(1)(d) do not apply to HMO plans. (History: Sec. 33-1-313 and 33-22-1822 MCA; IMP, Sec. 33-22-1802 and 33-22-1812 MCA; NEW, 1994 MAR p. 1528, Eff. 6/10/94; AMD, 1994 MAR p. 2926, Eff. 11/11/94.)

6.6.5025 through 6.6.5027 reserved.

6.6.5028 CONTRACT LANGUAGE (1) Development of contract language for policies of insurance offered under the standard health benefit plan contemplated by 33-22-1812, MCA, is the responsibility of the small employer carrier. ARM 6.6.5008, 6.6.5012, 6.6.5016, 6.6.5020, and 6.6.5024 does not define actual policy of insurance contract language. (History: Sec. 33-1-313 and 33-22-1822 MCA; IMP, Sec. 33-22-1802 and 33-22-1812 MCA; NEW 1994 MAR p. 1528, Eff. 6/10/94.)

6.6.5029 through 6.6.5031 reserved.

6.6.5032 CRITERIA OF POLICIES OFFERED UNDER BASIC PLAN (1) Any health benefit plan offered to a small employer group that has a benefit value, as calculated in ARM 6.6.5036, of less than the benefit value of the insurer's standard plan will qualify as a basic health benefit plan contemplated by 33-22-1812, MCA.

(2) Any HMO plan offered to a small employer carrier that offers fewer benefits than the insurer's standard HMO plan is subject to the commissioner's final determination, as contemplated by 33-22-1812, MCA.

(3) All basic health benefit plans and basic HMO plans contemplated by 33-22-1812, MCA, must include all benefits mandated by statute, including, but not limited to, maternity benefits contemplated by court interpretations of statutes. (History: Sec. 33-1-313 and 33-22-1822 MCA; IMP, Sec. 33-22-1802 and 33-22-1812 MCA; NEW, 1994 MAR p. 1528, Eff. 6/10/94.)

6.6.5033 through 6.6.5035 reserved.

6.6.5036 CALCULATION OF BENEFIT VALUES (1) For the purposes of determining whether a health benefit plan is a basic health benefit plan under ARM 6.6.5032, the following computations must be used, together with the values listed.

(a) The formula for calculating the benefit value is as follows:

BENEFIT VALUE = DEDUCTIBLE VALUE + COINSURANCE VALUE + LIFETIME MAXIMUM VALUE

where

DEDUCTIBLE VALUE = DEDUCTIBLE CLAIMS COST x Y x UTILIZATION(Y) / 0.8

and

COINSURANCE VALUE = COINSURANCE-STOPLOSS-PLUS-DEDUCTIBLE CLAIMS COST x {[Z x UTILIZATION(Z)] - [Y x UTILIZATION(Y)]} / 0.8.

(b) The variables for the formula must be developed in accordance with the following:

(i) COINSURANCE STOPLOSS refers to the maximum amount of annual claims to which the coinsurance is applied. For the standard plan, the COINSURANCE STOPLOSS is $5,000.

(ii) DEDUCTIBLE CLAIMS COST is the expected claims cost for a plan with a particular deductible.

(iii) COINSURANCE-STOPLOSS-PLUS-DEDUCTIBLE CLAIMS COST is the expected claim cost for a plan with a "deductible" equal to the amount of the COINSURANCE STOPLOSS plus the DEDUCTIBLE.

(iv) LIFETIME MAXIMUM VALUE is the dollar adjustment to the expected claims cost for a particular lifetime maximum amount.

(v) UTILIZATION(Y) and UTILIZATION(Z) each refer to a factor to apply to the expected claims cost to adjust for expected utilization of a plan with a coinsurance level Y or Z.

(vi) Y is the coinsurance percent applied to claims, up to the amount of the coinsurance stoploss annually.

(vii) Z is the coinsurance percent applied to claims above the coinsurance stoploss (usually 100%).

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(c) The calculation of the benefit value must be made as follows:

(i) Determine the deductible claims cost. (Table I) _____

(ii) Determine the value of Y, as a decimal. (coinsurance percentage) _____

(iii) Determine the value of utilization(Y). (Table II) _____

(iv) Determine Y x utilization(Y). (line [ii] x line [iii]) _____

(v) Determine the deductible value. (line [i] x line [iv] / 0.8) _____

(vi) Determine the coinsurance-stoploss-plus-deductible. (Coinsurance stoploss amount + deductible amount.) _____

(vii) Determine the coinsurance-stoploss-plus-deductible claims cost. (Interpolate the claims costs in Table I corresponding to the deductibles immediately bounding the coinsurance-stoploss-plus-deductible) _____

(viii) Determine the value of Z, as a decimal. (usually, but not always, 1.0) _____

(ix) Determine the value of utilization(Z) (Table II) _____

(x) Determine Z x utilization(Z). (line [viii] x line [ix]) _____

(xi) Determine the coinsurance value. (line [vii] x (line [x] - line [iv]) / 0.8) _____

(xii) Determine the lifetime-maximum value. (Table III) _____

(xiii) Determine the benefit value. (line [v] + line [xi] + line [xii]) _____

(d) The following tables must be used in calculating benefit values under this rule:

Table I - Claim Costs by Deductible Amount *

Deductible Amount	Claims Cost	Deductible Amount	Claims Cost	Deductible Amount	Claims Cost
0	$124.83	$ 750	$ 89.29	$ 10,000	$ 24.92
100	119.43	1,000	79.77	15,000	20.56
150	116.82	1,500	68.70	20,000	17.38
200	114.23	2,000	60.42	25,000	15.11
250	111.65	2,500	53.69	50,000	9.36
300	109.08	5,000	35.21	100,000	5.38
500	98.81	7,500	30.07	150,000	2.87

Table II - Utilization Rate by Coinsurance *

Coinsurance	Utilization Rate	Coinsurance	Utilization Rate
100%	1.14	70%	0.93
95%	1.10	65%	0.91
90%	1.07	60%	0.89
85%	1.03	55%	0.87
80%	1.	50% or less	0.86
75%	0.97		

Table III - Lifetime-Maximum Values by Lifetime Maximum Amount *

Lifetime Maximum Amount	Lifetime Maximum Value
$5,000,000 or more	$ 0.23
2,000,000	0.17
1,000,000	0.00
750,000	-0.28
500,000	-0.55
250,000	-1.78
100,000	-7.67
50,000	-13.34
25,000	-21.54

* Values were constructed by the Montana Insurance Department, using the 1994 Tillinghast Group Medical Insurance Rate Manual as a reference.

(e) Calculations must be made for each health benefit plan offered by the carrier and compared to the benefit value of the standard health benefit plan. The standard plan's benefit value, calculated from the formula in (c) and the values in (d), is $126.40.

(2) In instances wherein some benefits under the proposed basic health care plan are of significantly higher value than those offered under the small employer carrier's standard health benefit plan, and increase the overall value of the basic plan above the overall value of the carrier's standard plan, the carrier must file complete documentation justifying the plan's proposed classification with the commissioner.

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(3) A benefit value for HMO plans cannot be calculated using the formula described in (1)(a). The benefit value and certification as standard or basic HMO plans will be determined by the department. (History: Sec. 33-1-313 and 33-22-1822 MCA; IMP, Sec. 33-22-1802, 33-22-1809, and 33-22-1812 MCA; NEW, 1994 MAR p. 1528, Eff. 6/10/94; AMD, 1994 MAR p. 2926, Eff. 11/11/94.)

6.6.5037 through 6.6.5039 reserved.

6.6.5040 COST CONTAINMENT FEATURES OF BASIC AND STANDARD PLANS (1) All basic health benefit plans and standard health benefit plans offered to small employers in this state must include at least two of the following cost containment features acceptable to the commissioner:

(a) A patient education and assistance program that provides guidance for seeking appropriate medical care, including written materials and phone call-in services;

(b) A program for management of acute and long-term care to determine appropriate cost-effective treatment, which must include an agreement to the treatment plan by the patient, family or authorized representative, the treating health care provider, and the insurer;

(c) A program for primary care providers and referrals, such as a health maintenance organization style of delivery of care, in which each patient has a primary care provider who makes all referrals to other providers;

(d) A program for review of health care services for patients to determine the medical necessity or appropriateness of service, consistent with 33-32-102(4), MCA;

(e) A preferred provider agreement between health care providers and the insurer, which may limit the amount a provider may charge an insured for service, as well as the amount a provider may be reimbursed; or

(f) The selective contracting with hospitals, physicians, and other health care providers as defined in 33-22-1701 through 33-22-1707, 33-30-302, AND 33-31-221, MCA. (History: Sec. 33-1-313 and 33-22-1822 MCA; IMP, Sec. 33-22-1802 and 33-22-1812 MCA; NEW, 1994 MAR p. 1528, Eff. 6/10/94; AMD, 1994 MAR p. 2926, Eff. 11/11/94.)

6.6.5041 through 6.6.5043 reserved.

6.6.5044 FILING AND APPROVAL OF BASIC AND STANDARD PLANS (1) All small employer carriers shall file all of the standard health benefit plans that they market or intend to market in this state which have not been previously filed with the commissioner. Each such plan must be filed with the commissioner for prior approval as a standard health benefit plan. Each filing shall include a statement that the policy has not previously been filed and approved in this state.

(2) All small employer carriers which already market health benefit plans previously filed with the commissioner which qualify as standard plans according to the requirements of ARM 6.6.5008 through 6.6.5024 shall file each plan with the commissioner for prior approval as a standard health benefit plan. Each filing shall include a statement that the policy has previously been filed and approved in this state, and shall provide the date of approval.

(3) The commissioner shall review each filing described in (1) and (2) and grant either tentative approval, final approval, or disapproval as a standard plan to each filing within 30 days of receipt of the filing. If the commissioner grants tentative approval to the plan as a standard plan, the small employer carrier may market the plan as a standard plan, subject to (9), pending final approval or disapproval. After 30 days but no later than 120 days, the commissioner shall review each filing which had been granted tentative approval for a final decision regarding approval or disapproval of the plan as a standard health benefit plan. If a plan is disapproved as a standard health benefit plan, the commissioner shall notify the small employer carrier, in writing, of the reasons for the disapproval.

(4) All small employer carriers shall file all of the basic health benefit plans that they market or intend to market in this state which have not been previously filed with the commissioner. Each such plan must be filed with the commissioner for prior approval as a basic health benefit plan. Each filing shall include a demonstration of, and the result of, the benefit value calculation for that plan in compliance with ARM 6.6.5036. Each filing shall include a statement that the policy has not previously been filed and approved in this state.

(5) All small employer carriers which already market health benefit plans previously filed with the commissioner which qualify as basic plans according to ARM 6.6.5032 shall file each plan with the commissioner as a health benefit plan which meets the requirements of a basic health benefit plan according to the test in ARM 6.6.5036. Each filing shall include a demonstration of, and the result of, the benefit value calculation for that plan in compliance with ARM 6.6.5036. Each filing shall include a statement that the policy has previously been filed and approved in this state and shall provide the date of approval. The small employer carriers shall further state for each of these plans that either:

(a) The plan is being filed as a basic plan; or

(b) The plan is being filed as a health benefit plan which is neither a standard nor a basic plan. The filing must include complete documentation which supports this classification.

(6) All health benefit plans which are filed as basic plans as described in (4) and (5)(a) shall be reviewed by the commissioner and granted either tentative approval, final approval, or disapproval as a basic plan within 30 days of receipt of the filing. If the commissioner tentatively approves a plan as a basic plan, the small employer carrier may market the plan as such, subject to (9), pending final approval or disapproval. After 30 days but no later than 120 days, the commissioner shall review each filing which had been granted tentative approval for a final decision regarding approval or disapproval of the plan as a basic health benefit plan. If a plan is disapproved as a basic health benefit plan, the commissioner shall notify the small employer carrier, in writing, of the reasons for the disapproval.

(7) All health benefit plans which are filed as plans which qualify as basic plans according to the test in ARM 6.6.5036, but which the small employer carriers state in compliance with (5)(b) do not qualify as basic plans, shall be reviewed by the commissioner and granted tentative status either as a basic health benefit plan, a standard health benefit plan, or a health benefit plan which is neither standard nor basic, within 30 days of receipt of the filing. The small employer carrier may then market the plan as a basic plan, a standard plan, or neither a standard nor a basic plan, according to the status granted by the commissioner and subject to (9), pending a final decision by the commissioner. After 30 days but no later than 120 days the commissioner shall review each filing which had been granted tentative status for a final decision regarding approval of the plan as a basic health benefit plan, a standard health benefit plan, or a health benefit plan which is neither standard nor basic. If such plan is approved as a basic or a standard health benefit plan, the commissioner shall notify the small employer carrier, in writing, of the reasons for its classification.

(8) All small employer carriers shall refile all of the health benefit plans that they market or intend to market in this state which have been previously filed with the commissioner and which exceed the value of the standard plan according to the benefit value calculation. Each filing shall include a demonstration of, and the result of, the benefit value calculation for that plan in compliance with ARM 6.6.5036. Each filing shall include a statement that the policy has been previously filed in this state and shall inform the commissioner as to whether the plan was approved, disapproved, or filed for informational purposes only and the date of such action. The commissioner shall review each filing and, if the benefit value calculation verifies that the plan is neither standard nor basic and that the filing meets all the requirements of the Montana Code Annotated which apply, grant approval to the filing within 60 days of receipt of the filing. If the benefit value

calculation shows that the plan is actually a standard or a basic plan, the commissioner shall so notify the small employer carrier, in writing. The small employer carrier must then refile the plan as a standard or a basic health benefit plan, as classified by the commissioner.

(9) No small employer carrier may market any health benefit plans to small employers in this state, unless and until one of its basic health benefit plans and one of its standard health benefit plans have been approved by the commissioner.

(10) All small employer carriers which intend to market one or more HMO plans shall file all of the HMO plans that they intend to market in this state which have not been previously filed with the commissioner. Each such plan must be filed with the commissioner as either a standard HMO plan, a basic HMO plan, or an HMO plan that qualifies as neither a standard nor a basic HMO plan, according to ARM 6.6.5028. Each filing shall include complete documentation which justifies the small employer carrier's classification of the HMO plan as a standard HMO plan, a basic HMO plan, or neither. Each filing shall include a statement that the policy has not previously been filed and approved in this state.

(11) All small employer carriers which already market HMO plans previously filed with the commissioner shall again file each plan with the commissioner for approval as either a standard HMO plan, a basic HMO plan, or an HMO plan that qualifies as neither a standard nor a basic HMO plan, according to ARM 6.6.5032. Each filing shall include complete documentation which justifies the small employer carrier's classification of the HMO plan as a standard HMO plan, a basic HMO plan, or neither. Each filing shall include a statement that the policy has previously been filed and approved in this state, and shall provide the date of approval.

(12) The commissioner shall review each filing described in (10) and (11) and grant either tentative approval, final approval, or disapproval to each filing within 30 days of receipt of the filing. If the commissioner tentatively approves the small employer's designation of the plan, the small employer carrier may market the plan on that basis pending final approval or disapproval, subject to (14). After 30 days but no later than 120 days, the commissioner shall review each filing which had been granted a tentative approval and grant a final decision regarding approval or disapproval of the plan as a standard, basic, or neither standard nor basic HMO plan.

(13) If the commissioner's determination as to whether an HMO plan is standard, basic, or neither standard nor basic is different from the small employer carrier's determination in (10) or (11), the commissioner shall notify the small employer carrier, in writing, of the reasons for giving it a different classification. The small employer carrier shall immediately comply with the requirements of the HMO plan as classified by the commissioner. (History: Sec. 33-1-313, 33-1-501 and 33-22-1822 MCA; IMP, Sec. 33-22-1802, 33-22-1811, and 33-22-1812 MCA; NEW, 1994 MAR p. 1528, Eff. 6/10/94; AMD, 1994 MAR p. 2926, Eff. 11/11/94.)

6.6.5045 through 6.6.5049 reserved.

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6.6.5050 STATUS OF CARRIERS AS SMALL EMPLOYER CARRIERS

(1) Within 30 days after the effective date of these rules, each carrier providing health benefit plans in this state shall file a statement with the commissioner indicating whether the carrier intends to operate as a small employer carrier in this state. Status as a small employer carrier will be granted by the commissioner when the carrier has both a standard and a basic health benefit plan approved by the commissioner.

(2) Each new carrier applying for a certificate of authority to sell disability insurance in this state shall include with its application a statement whether it intends to operate as a small employer carrier in this state.

(3) Except as provided below in (4), no carrier may offer health benefit plans to small employers, or continue to provide coverage under health benefit plans previously issued to small employers in this state, unless the filing pursuant to this rule indicates that the carrier intends to operate as a small employer carrier in this state.

(4) If the filing made pursuant to this rule indicates that a carrier does not intend to operate as a small employer carrier in this state, the carrier may continue to provide coverage under health benefit plans previously issued to small employers in this state for no more than 3 years following the date that the carrier declares that it does not intend to operate as a small employer carrier in this state. Such continued small group policies must comply with the act and these rules.

(5) If a filing made pursuant to this rule indicates that a carrier does not intend to operate as a small employer carrier in this state, the carrier shall be precluded from operating as a small employer carrier in this state for a period of 5 years from the date of the filing. Upon a written request from such a carrier, the commissioner may reduce the period provided for herein, if the commissioner finds that permitting the carrier to operate as a small employer carrier would be in the best interests of the small employers in this state.

(a) Carriers who have had no small group health benefit plans in force in Montana since January 1, 1993, and file notice that the carrier does not intend to operate as a small group carrier may choose to declare intent to be a small group carrier at any time. (History: Sec. 33-1-313 and 33-22-1822 MCA; IMP, Sec. 33-22-1802, 33-22-1812, and 33-22-1814 MCA; NEW, 1994 MAR p. 1528, Eff. 6/10/94; AMD, 1994 MAR p. 2926, Eff. 11/11/94.)

6.6.5051 through 6.6.5053 reserved.

6.6.5054 APPLICATION TO REENTER STATE (1) A carrier that has been prohibited from writing coverage for small employers in this state pursuant to 33-22-1810(1)(g), MCA, may not resume offering health benefit plans to small employers in this state until the carrier has applied to the commissioner to be reinstated as a small employer carrier and the application has been granted by the commissioner.

(2) In the case of a small employer carrier doing business in only one established geographic service area of the state, if the small employer carrier elects not to renew a health benefit plan under 33-22-1810(1)(f), MCA, the small employer carrier may be prohibited from offering health benefit plans to small employers in any part of the service area for a period of 5 years. In addition, the small employer carrier must not offer health benefit plans to small employers in any other geographic area of the state without the prior approval of the commissioner. (History: Sec. 33-1-313 and 33-22-1822 MCA; IMP, Sec. 33-22-1802, 33-22-1810, and 33-22-1812 MCA; NEW, 1994 MAR p. 1528, Eff. 6/10/94.)

6.6.5055 through 6.6.5057 reserved.

6.6.5058 REQUIREMENT TO INSURE ENTIRE GROUPS (1) Small employer carriers that offer coverage to small employers shall offer to provide coverage to each eligible employee and to each dependent. Except as provided in (2), such small employer carriers shall provide the same health benefit plan to each such eligible employee and dependent.

(2) Small employer carriers may offer the employees of a small employer the option of choosing among any health plans which have been chosen by the employer. Except as provided in 33-22-1811(3), MCA, with respect to exclusions for pre-existing conditions, the choice among benefit plans may not be limited, restricted, or conditioned based upon the risk characteristics of the employees or their dependents.

(3) Except as provided in (4), small employer carriers may not issue health benefit plans to small employers unless the health benefit plans cover all eligible employees and all eligible dependents as defined in 33-22-1803, MCA, and ARM 6.6.5001.

(4) Small employer carriers may issue health benefit plans to small employers that exclude eligible employees or eligible dependents, as defined in 33-22-1803, MCA, and ARM 6.6.5001, only if one of the following applies:

(a) The excluded individuals have coverage under health benefit plans or other health benefit arrangement that provide benefits equal to or greater than the benefits provided under the health benefit plan offered by the employer as determined by the eligible employee or dependent;

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(b) The excluded individuals do not have risk characteristics or other attributes that would cause the carriers to make decisions with respect to premiums or eligibility for a health benefit plan that are adverse to the small employer;

(c) The premium contribution to be paid by the eligible employee would have exceeded 7.5% of the adjusted gross income of the eligible employee and the employee decides not to be covered. The decision not to be covered for this reason is exclusively that of the employee; or

(d) An employee shows that, in changing policies, the 12-month waiting period in pre-existing conditions would be unduly burdensome to the employee. Whether the waiting period imposes such a burden is a decision that only the employee may make. Employers shall refrain from influencing their employees' decisions.

(5) Small employer carriers shall require each small employer that applies for coverage, as part of the application process, to provide a complete list of eligible employees and eligible dependents. The list must include a statement showing how much the employer is contributing to each employee's premiums. The small employer carrier shall require the small employer to provide appropriate supporting documentation, such as a W-2 Summary Wage and Tax Form, to verify the information required under this paragraph.

(6) Small employer carriers shall secure waivers with respect to each eligible employee and each eligible dependent who declines an offer of coverage under a health benefit plan provided to a small employer for the reasons given in (4). Such waivers must be signed by the eligible employees on behalf of such employee or the dependent of such employee and must certify that the individual who declined coverage was informed of the availability of coverage under the health benefit plan. The waiver form must require that the reason for declining coverage be stated on the form and must include a written warning of the penalties imposed on late enrollees. Waivers must be maintained by the small employer carrier for a period of 6 years.

(a) Small employer carriers shall obtain, with respect to each individual who submits a waiver under (4), information sufficient to establish that the waiver is permitted.

(7) Small employer carriers may not issue coverage to any small employer if the carrier is unable to obtain the list required under (5), a waiver required under (6) or the information required under (6)(a).

(a) Small employer carriers may not offer coverage to any small employer if the carrier, or a producer for such carrier, has reason to believe that the small employer or producer has induced or pressured an eligible employee, or dependent of an eligible employee, to decline coverage due to the individual's risk characteristics.

(b) Prior to submitting an application for coverage with the carrier on behalf of a small employer, each involved producer shall notify his or her small employer carrier of any circumstances that would indicate that the small employer has induced or pressured an eligible employee or eligible dependent, to decline coverage due to the individual's risk characteristics.

(8) New entrants to a small employer group must be offered an opportunity to enroll in the health benefit plan currently held by such group by the end of six months of employment. Any new entrant that does not exercise the opportunity to enroll in the health benefit plan within the period provided by the small employer carrier may be treated as a late enrollee by the carrier, provided that the time within which to enroll in the health benefit plan extends at least 30 days after the date the new entrant is notified of his or her opportunity to enroll. If a small employer carrier has offered more than one health benefit plan to a small employer group pursuant to (2), the new entrant must be offered the same choice of health benefit plans as the other members of the group.

(a) New entrants to a group must be accepted for coverage by the small employer carrier without any restrictions or limitations on coverage related to the risk characteristics of the employees or their dependents, except that a carrier may exclude coverage for pre-existing medical conditions, consistent with the provisions of 33-22-1811(3), MCA.

(b) Small employer carriers may assess a risk load to the new entrants' premium rate consistent with the requirements of 33-22-1809, MCA. The risk loads must be the same risk load charged to the small employer group immediately prior to acceptance of the new entrant into the group.

(9) In the case of an eligible employee, or eligible dependent, who, prior to the effective date of 33-22-1811, MCA, was excluded from coverage or denied coverage by a small employer carrier in the process of providing a health benefit plan to an eligible small employer, the small employer carrier shall provide an opportunity for the eligible employee or eligible dependent, to enroll in the health benefit plan currently held by the small employer.

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(a) Small employer carriers may require any individual who requests enrollment under this subsection to sign a statement indicating that such individual sought coverage under the group contract, other than as a late enrollee, and that the coverage was not offered to the individual.

(b) The opportunity to enroll must meet the following requirements:

(i) The opportunity to enroll must begin on the effective date of 33-22-1811, MCA, and continue for a period of at least 6 months.

(ii) Eligible employees and eligible dependents who are provided an opportunity to enroll pursuant to this subsection must be treated as new entrants. Premium rates related to such individuals must be set in accordance with (8).

(iii) The terms of coverage offered to an individual described in (9) may exclude coverage for pre-existing medical conditions for a period not to exceed 12 months, if the health benefit plan currently held by the small employer contains such an exclusion, provided that the exclusion period must be reduced by the number of days between the date the individual was excluded or denied coverage and the date coverage is provided to the individual pursuant to this provision.

(iv) Small employer carriers shall provide written notice at least 45 days prior to the opportunity to enroll provided in (9) to each small employer insured under a health benefit plan offered by such carrier. The notice must clearly describe the rights granted under this subsection to employees and dependents who were previously excluded from or denied coverage and the process for enrollment of such individuals in the employer's health benefit plan. (History: Sec. 33-1-313 and 33-22-1822 MCA; IMP, Sec. 33-22-1802, 33-22-1811, and 33-22-1812 MCA; NEW, 1994 MAR p. 1528, Eff. 6/10/94; AMD, 1994 MAR p. 2926, Eff. 11/11/94.)

6.6.5059 reserved.

6.6.5060 COVERAGE THROUGH ASSOCIATIONS (1) Associations providing health insurance to small groups must comply with this act and its regulations. Associations are exempt from this act only if they do not deny coverage to any member of the association or any employee of its members who apply for coverage as part of a group.

(2) Associations must apply to the department for this exemption and submit evidence that their policies are guaranteed issue.

(3) Associations that have received exemption must provide guaranteed issue policies by January 1, 1995.

(4) Associations must provide an open enrollment period of 60 days to all employees of member groups currently enrolled with the association's health care plan except those employees previously denied coverage as late enrollees. A notice regarding the open enrollment period must be sent to all member organizations currently enrolled in the association's health care plan, instructing employers to notify employees of the open enrollment period. (History: Sec. 33-1-313, 33-1-501 and 33-22-1822 MCA; IMP, Sec. 33-22-1802 and 33-22-1803 MCA; NEW, 1994 MAR p. 2926, Eff. 11/11/94; AMD, 1995 MAR P. , Eff. 1/13/94.)

6.6.5061 reserved.

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6.6.5062 RESTORATION OF COVERAGE (1) Except as provided in (2), a small employer carrier shall, as a condition of continuing to transact business in this state with small employers, offer to provide a health benefit plan as described in (3) to any small employer whose coverage was terminated or not renewed by such small employer carrier after July 1, 1993.

(2) The offer required under (1) must not be required with respect to a health benefit plan that was not renewed if:

(a) The health benefit plan was not renewed for reasons set forth in 33-22-1810, MCA; or

(b) The nonrenewal was a result of the small employer voluntarily electing coverage under a different health benefit plan.

(3) The offer made under (1) must be made no later than 30 days after a carrier indicates its intention to operate as a small employer carrier in this state pursuant to ARM 6.6.5050. Small employers must be given at least 60 days to accept an offer made pursuant to (1). If the employer accepts the offer of coverage, the carrier must provide the plan offered. A health benefit plan provided to a terminated small employer pursuant to (1) must meet the following conditions:

(a) The health benefit plan must contain benefits that are identical to the benefits in the health benefit plan that was terminated or nonrenewed.

(b) The health benefit plan must not be subject to any waiting periods, including exclusion periods for pre-existing conditions, or other limitations on coverage that exceed those contained in the health benefit plan that was terminated or nonrenewed. In applying such exclusions or limitations, the health benefit plan must be treated as if it were continuously in force from the date it was originally issued to the date that it is restored pursuant to this rule and 33-22-1814, MCA.

(c) The health benefit plan must not be subject to any provision that restricts or excludes coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

(d) The health benefit plan must provide coverage to all employees who are eligible employees as of the date the plan is restored. The carrier shall offer coverage to each dependent of such eligible employees.

(e) The premium rate for the health benefit plan must be no more than the premium rate charged to the small employer on the date the health benefit plan was terminated or nonrenewed; provided that, if the number or case characteristics of the eligible employees, or their dependents, of the small employer has changed between the date the health benefit plan was terminated or nonrenewed and the date that it is restored, the carrier may adjust the premium rates to reflect any changes in case characteristics of the small employer. If the carrier has increased premium rates for other similar groups with similar coverage to reflect general increases in health care costs and utilization, the premium rate may further be adjusted to reflect the lowest such increase given to a similar group. The premium rate for the health benefit plan may not be increased to reflect any changes in risk characteristics of the small employer group until one year after the date the health benefit plan is restored. Any such increase must be subject to the provisions of 33-22-1809, MCA.

(4) The health benefit plan under (3) must not be eligible for reinsurance under the provisions of 33-22-1818 and 33-22-1819, MCA, except that the carrier may reinsure new entrants to the health benefit plan who enroll after the restoration of coverage. (History: Sec. 33-1-313 and 33-22-1822 MCA; IMP, Sec. 33-22-1802, 33-22-1809, 33-22-1812, and 33-22-1814 MCA; NEW 1994 MAR p. 1528, Eff. 6/10/94.)

6.6.5063 through 6.6.5065 reserved.

6.6.5066 QUALIFYING PREVIOUS AND QUALIFYING EXISTING COVERAGES (1) For the purposes of 33-22-1811(3)(b), MCA, an individual must be considered to have qualifying previous coverage with respect to a particular service if the previous policy, certificate, or other benefit arrangement covering such individual met the definition of qualifying previous coverage contained in 33-22-1803(21), MCA, if such previous coverage retained essentially the same benefits or provided increased benefits and provided benefits with respect to the service.

(2) If a waiting period for pre-existing conditions is to be applied, the small employer carrier shall ascertain the source of previous or existing coverage of each eligible employee and each dependent of an eligible employee at the time such employee or dependent initially enrolls in the health benefit plan provided by the small employer carrier. The small employer carrier may contact the source of previous or existing coverage to resolve any questions about the benefits or limitations related to such previous or existing coverage.

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(3) In cases referred to in 33-22-1810(2), MCA, the replacement coverage for small employers must not have pre-existing conditions applied to benefits comparable to those in the employer's previous coverage. The previous coverage in such cases must be considered qualifying previous coverage.
(History: Sec. 33-1-313 and 33-22-1822 MCA; IMP, Sec. 33-22-1802, 33-22-1810, 33-22-1811, and 33-22-1812 MCA; NEW, 1994 MAR p. 1528, Eff. 6/10/94.)

6.6.5067 through 6.6.5069 reserved.

6.6.5070 CONSIDERATION OF TRADE, OCCUPATION, OR INDUSTRY IN DECIDING WHETHER TO OFFER COVERAGE (1) Except as provided in this rule, small employer carriers may not consider the trade or occupation of the employees of a small employer, or the industry or type of business in which the small employer is engaged, in determining whether to issue or continue to provide coverage to the small employer.

(a) Small employer carriers may use industry as a case characteristic in establishing premium rates, subject to 33-22-1809(1)(f), MCA.

(b) Small employer carriers may consider trade, occupation or industry as part of the eligibility criteria for a class of business, subject to 33-22-1811(1)(b)(ii), MCA.

(History: Sec. 33-1-313 and 33-22-1822 MCA; IMP, Sec. 33-22-1802, 33-22-1809, 33-22-1811, and 33-22-1812 MCA; NEW, 1994 MAR p. 1528, Eff. 6/10/94.)

6.6.5071 through 6.6.5073 reserved.

6.6.5074 RESTRICTIVE RIDERS (1) A restrictive rider, endorsement, or other provision that would violate 33-22-1811(3)(e)(ii), MCA, and that was in force on the effective date of these rules may not remain in force beyond the first anniversary date following the effective date of these rules. Small employer carriers shall provide written notice to those small employers whose coverage will be changed pursuant to these rules at least 30 days prior to the required change to the health benefit plan. (History: Sec. 33-1-313 and 33-22-1822 MCA; IMP, Sec. 33-22-1802, 33-22-1811, and 33-22-1812 MCA; NEW, 1994 MAR p. 1528, Eff. 6/10/94.)

6.6.5075 through 6.6.5077 reserved.

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(i) A general description of the benefits contained in each such plan;

(ii) A price quote for each such plan; and

(iii) Written advice as to how the small employer may enroll in such plans.

(b) The written information must be provided within the time periods provided in (4) directly to the small employer and can be delivered through an authorized producer.

(c) Price quotes required under this subsection must be for the lowest-priced basic and standard health benefit plan for which the small employer is eligible. Availability of other basic and standard plans must be described in the price quotes.

(7) Small employer carriers may not require, as a condition to the offer or sale of a health benefit plan to small employers, that the small employer purchase or qualify for any other insurance product or service.

(8) Carriers offering individual and group health benefit plans in this state must be responsible for determining whether the plans are subject to the requirements of the act and these rules.

(9) No later than March 1 of each year, all small employer carriers shall file with the commissioner, the following information related to health benefit plans issued by them to small employers in this state:

(a) The number of small employers that were issued health benefit plans in the previous calendar year, indicating the number of newly issued plans and the number of renewals;

(b) The number of small employers that were issued basic health benefit plans and the number of small employers that were issued standard health benefit plans in the previous calendar year, arranged separately, showing the number of newly issued plans and the number of renewals as to each class of business;

(c) The number of small employer health benefit plans in force in each county of the state as of December 31 of the previous calendar year;

(d) The number of small employer health benefit plans that were voluntarily not renewed by small employers in the previous calendar year;

(e) The number of small employer health benefit plans that were terminated or nonrenewed, for reasons other than nonpayment of premium, by the carrier in the previous calendar year; and

(f) The number of small employer health benefit plans that were issued to small employers that were uninsured for at least the 3 months prior to issue. (History: Sec. 33-1-313 and 33-22-1822 MCA; IMP, Sec. 33-22-1802, 33-22-1812, and 33-22-1813 MCA; NEW, 1994 MAR p. 1528, Eff. 6/10/94; AMD, 1994 MAR p. 2926, Eff. 11/11/94.)

6.6.5079 through 6.6.5081 reserved.

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6.6.5082 ESTABLISHMENT OF CLASSES OF BUSINESS (1) Every small employer carrier that establishes more than one class of business pursuant to 33-22-1808, MCA, shall maintain on file for inspection by the commissioner the following information with respect to each class of business so established:

(a) A description of each criterion employed by the carrier, or any of its agents, for determining membership in the class of business;

(b) A statement describing the justification for establishing the class as a separate class of business and documentation that the establishment of the class of business is intended to reflect substantial differences in expected claims experience or administrative costs related to the reasons set forth in 33-22-1808, MCA; and

(c) A statement disclosing which, if any, health benefit plans are currently available for purchase in the class and any significant limitations related to the purchase of such plans.

(2) A carrier may not directly or indirectly use group size as a criterion for establishing eligibility for a health benefit plan or for a class of business. (History: Sec. 33-1-313 and 33-22-1822 MCA; IMP, Sec. 33-22-1802, 33-22-1808, and 33-22-1812 MCA; NEW, 1994 MAR p. 1528, Eff. 6/10/94.)

6.6.5083 through 6.6.5085 reserved.

6.6.5086 TRANSITION FOR ASSUMPTIONS OF BUSINESS FROM ANOTHER CARRIER (1) No small employer carrier may transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering a small employer in this state unless:

(a) The transfer has been approved by the commissioner of the state of domicile of the assuming carrier;

(b) The transfer has been approved by the commissioner of the state of domicile of the ceding carrier;

(c) The transfer has been approved by the commissioner of this state; and

(d) The transfer otherwise meets the requirements of this rule.

(2) Any carrier domiciled in this state that proposes to assume or cede the entire insurance obligation and/or risk of one or more small employer health benefit plans from another carrier shall file a request for approval of the transfer with the commissioner at least 60 days prior to the date of the proposed assumption. The commissioner may approve the transfer if the commissioner finds that the transaction is in the best interests of the individuals insured under the health benefit plans to be transferred and is consistent with the purposes of the act and these rules. The commissioner shall not approve the transfer until at least 30 days after the date of the filing, unless the commissioner finds that the ceding carrier is in hazardous financial condition, in which case the commissioner may approve the transfer as soon as the commissioner deems reasonable after the filing.

(3) The filing required under (2) must:

(a) Describe the class of business (including any eligibility requirements) of the ceding carrier from which the health benefit plans will be ceded;

(b) State whether the assuming carrier will maintain the assumed health benefit plans as a separate class of business pursuant to (8) or will incorporate them into an existing class of business pursuant to (9). If the assumed health benefit plans will be incorporated into an existing class of business, the filing must describe the class of business of the assuming carrier into which the health benefit plans will be incorporated;

(c) State whether the health benefit plans being assumed are currently available for purchase by small employers;

(d) Describe the potential effect, if any, of the assumption on the benefits provided by the health benefit plans to be assumed;

(e) Describe the potential effect, if any, of the assumption on the premiums for the health benefit plans to be assumed; and

(f) Describe any other potential material effects of the assumption on the coverage provided to the small employers covered by the health benefit plans to be assumed.

(4) A small employer carrier required to file a request under (2) shall include an informational filing, or other such filing as may be required, with the commissioner of each state in which there are small employer health benefit plans that would be included in the transfer. The informational filing to each state may be made concurrently with the filing made under (2) and include at least the information specified in (3) for the small employer health benefit plans in that state.

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(5) No small employer carrier may transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering a small employer in this state unless it complies with the following provisions:

(a) The carrier shall provide notice to the commissioner at least 60 days prior to the date of the proposed assumption. The notice must contain the information specified in (3) for the health benefit plans covering small employers in this state.

(b) If the assumption of a class of business would result in the assuming small employer carrier being out of compliance with the limitations related to premium rates contained in 33-22-1809, MCA, the assuming carrier shall apply to the commissioner pursuant to 33-22-1809(3), MCA, for a suspension of the application of 33-22-1809(1), MCA.

(c) No assuming carrier seeking suspension of the application of 33-22-1809(1), MCA, may complete the assumption of health benefit plans covering small employers in this state unless the commissioner grants the suspension requested pursuant to (5)(b).

(d) Unless a different period is approved by the commissioner, a suspension of the application of 33-22-1809(1), MCA, must, with respect to an assumed class of business, be for no more than 15 months and, with respect to each individual small employer, must last only until the anniversary date of such employer's coverage, provided that the period with respect to an individual small employer may be extended beyond its first anniversary date for a period of up to 12 months if the anniversary date occurs within 3 months of the date of assumption of the class of business.

(6) Except as provided in (2), no small employer carrier may cede or assume the entire insurance obligation and/or risk for a small employer health benefit plan unless the transfer includes the ceding to the assuming carrier of the entire class of business which includes such health benefit plan.

(7) A small employer carrier may cede less than an entire class of business to an assuming carrier if:

(a) One or more small employers in the class has exercised their right under contract or state law to reject, either directly or by implication, the ceding of their health benefit plans to another carrier. In that instance, the transfer must include each health benefit plan in the class of business except those health benefit plans for which a small employer has rejected the proposed cession; or

(b) After a written request from the transferring carrier, the commissioner determines that the transfer of less than the entire class of business is in the best interests of the small employers insured in that class of business.

(8) Except as provided in (9), a small employer carrier that assumes one or more health benefit plans from another carrier shall maintain such health benefit plans as a separate class of business.

(9) Subject to the prior approval of the commissioner, a small employer carrier that assumes one or more health benefit plans from another carrier may exceed the limitation contained in 33-22-1808(2), MCA, due solely to such assumption for a period of no more than 15 months after the date of the assumption, provided that the carrier complies with the following provisions:

(a) Upon assumption of the health benefit plans, such health benefit plans must be maintained as separate classes of business. During the 15-month period following the assumption, each of the assumed small employer health benefit plans must be transferred by the assuming small employer carrier into a single class of business operated by the assuming small employer carrier. The assuming small employer carrier shall select the class of business into which the assumed health benefit plans will be transferred in a manner such that the transfer results in the least possible change to the benefits and rating method of the assumed health benefit plans;

(b) The transfers authorized in (9)(a) must occur, with respect to each small employer on the anniversary date of the small employer's coverage, provided that the period with respect to an individual small employer may be extended beyond its first anniversary date for a period of up to 12 months if the anniversary date occurs within 3 months of the date of the assumption of the class of business;

(c) A small employer carrier making a transfer pursuant to (9)(a) may alter the benefits of the assumed health benefit plans to conform to the benefits currently offered by the carrier in the class of business into which the health benefit plans have been transferred;

(d) The premium rate for an assumed small employer health benefit plan must not be modified by the assuming small employer carrier until the health benefit plan is transferred pursuant to (9)(a). Upon transfer, the assuming small employer carrier shall calculate a new premium rate for the health benefit plan from the rate manual established for the class of business into which the health benefit plan is transferred. In making such calculation, the risk load applied to the health benefit plan must be no higher than the risk load applicable to such health benefit plan prior to the assumption.

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(10) During the 15-month period provided in (9)(a), the transfer of small employer health benefit plans from the assumed class of business in accordance herewith may not be treated as a violation of 33-22-1809(2), MCA.

(11) Assuming carriers may not apply eligibility requirements, including minimum participation and contribution requirements, with respect to an assumed health benefit plan, or with respect to any health benefit plan subsequently offered to a small employer covered by such an assumed health benefit plan, that are more stringent than the requirements applicable to such health benefit plan prior to the assumption.

(12) The commissioner may approve a longer period of transition upon application by a small employer carrier. The application must be made within 60 days after the date of assumption of the class of business and must clearly state the justification for a longer transition period.

(13) Nothing in this rule is intended to:

(a) Reduce or diminish any legal or contractual obligation or requirement, including any obligation provided in Title 33, chapter 2, part 12, MCA, of the ceding or assuming carrier related to the transaction;

(b) Authorize a carrier that is not admitted to transact the business of insurance in this state to offer or insure health benefit plans in this state; or

(c) Reduce or diminish the protections related to an assumption reinsurance transaction provided in Title 33, chapter 2, part 12, MCA, or otherwise provided by law.

(History: Sec. 33-1-313 and 33-22-1822 MCA; IMP, Sec. 33-22-1802, 33-22-1808, 33-22-1809, and 33-22-1812 MCA; NEW, 1994 MAR p. 1528, Eff. 6/10/94.)

6.6.5087 through 6.6.5089 reserved.

6.6.5090 RATE MANUAL AND RATE RESTRICTION GUIDELINES

(1) Each small employer carrier shall develop a separate rate manual for each class of business, which must be the basis for all premium rates and new business premium rates charged to small employers by the small employer carrier. To the extent that a portion of the premium rates charged by a small employer carrier is based on the carrier's discretion, the manual must specify the criteria and factors considered by the carrier in exercising such discretion.

(2) Small employer carriers may not modify the rating method or any characteristics used in the rate manual for a class of business, until the change has been approved by the commissioner.

(a) The commissioner may approve a change to a rating method if the commissioner finds that the change is reasonable, actuarially supported, and consistent with the purposes of the act.

(b) A carrier requesting to change the rating method for a class of business shall file a request with the commissioner for authority to modify the rating method at least 30 days prior to the proposed date of the change. The filing must contain at least the following information:

(i) The reasons the change in rating method is being requested;

(ii) A complete description of each of the proposed modifications to the rating method;

(iii) A description how the proposed change in rating method would affect the premium rates currently charged to small employers in the class of business, including an estimate from a qualified actuary of the number of groups or individuals whose premium rates may change by more than 10% due to the proposed change in rating method. This estimate must include a narrative description of the types of groups and individuals whose premium rates may change by more than 10%;

(iv) A certification from a qualified actuary that the proposed rating method is based on objective and credible data and would be actuarially sound and appropriate; and

(v) A certification from a qualified actuary that the proposed change in rating method would not produce premium rates for small employers that would be in violation of 33-22-1809, MCA.

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(3) For the purpose of this rule, a change in rating method includes the following:

(a) A change in the number of case characteristics used by a small employer carrier to determine premium rates for health benefit plans in a class of business;

(b) A change in the manner or procedures by which insureds are assigned into categories for the purpose of applying a case characteristic to determine premium rates for health benefit plans in a class of business;

(c) A change in the method of allocating expenses among health benefit plans in a class of business; or

(d) A change in a rating factor with respect to any case characteristic if the change would produce a change in premium for any small employer that exceeds 10%.

(i) For the purpose of this subsection, a change in a rating factor involves the cumulative change with respect to such factor over a 12-month period.

(ii) If a small employer carrier changes rating factors with respect to more than one case characteristic in a 12-month period, the carrier shall consider the cumulative effect of all such changes in applying the 10% test under this subsection.

(4) The rate manual developed pursuant to (1) must specify the case characteristics and rate factors to be applied by the small employer carrier in establishing premium rates for each class of business.

(5) The small employer carrier shall use the same case characteristics in establishing premium rates for each health benefit plan in a class of business and shall apply them in the same manner in establishing premium rates for each such health benefit plan. Case characteristics must be applied without regard to the risk characteristics of a small employer.

(6) The rate manual developed pursuant to (1) must clearly illustrate the relationships among the base premium rates charged for each health benefit plan in the class of business. If the new business premium rate is different than the base premium rate for a health benefit plan, the rate manual must illustrate and justify the difference.

(7) Differences among base premium rates for health benefit plans must be based solely on the reasonable and objective differences in the design and benefits of the health benefit plans and may not be based in any way on the actual or expected health status or claims experience of the small employer groups that choose, or are expected to choose, a particular health benefit plan. The small employer carrier shall apply case characteristics and rate factors within each class of business in a manner that assures that premium differences among health benefit plans for identical small employer groups vary only due to reasonable and objective differences in the design and benefits of the health benefit plans, and not due to the actual or expected health status or claims experience of the small employer groups that choose, or are expected to choose, a particular health benefit plan.

(8) The rate manual developed pursuant to (1) must provide for premium rates to be developed in a two-step process. In the first step, a base premium rate must be developed for the small employer group, without regard to any risk characteristics of the group. In the second step, the resulting base premium rate may be adjusted by a risk load, subject to the provisions of 33-22-1809, MCA, to reflect the risk characteristics of the group.

(9) Premiums charged to small employers for health benefit plans must not include separate application fees, underwriting fees, or any other separate fees or charges.

(10) Small employer carriers shall allocate administrative expenses to basic and standard health benefit plans on no less favorable a basis than expenses are allocated to other health benefit plans in the class of business. The rate manual developed pursuant to (1) must describe the method of allocating administrative expenses to the health benefit plans in the class of business for which the manual was developed.

(11) Each rate manual developed pursuant to (1) must be maintained by the carrier for a period of 6 years. Updates and changes to the manual must be maintained with the manual.

(12) If group size is used as a case characteristic by a small employer carrier, the highest rate factor associated with a group size classification must not exceed the lowest rate factor associated with such a classification by more than 20%.

(13) The restrictions related to changes in premium rates in 33-22-1809(1), MCA, apply as follows:

(a) Small employer carriers shall revise their rate manuals each rating period to reflect changes in base premium rates and changes in new business premium rates.

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(b) If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate is less than, or the same as, the percentage change in the base premium rate, the change in the new business premium rate must be deemed to be a change in the base premium rate under 33-22-1809(1), MCA.

(c) If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate exceeds the percentage change in the base premium rate, the health benefit plan must be considered a health benefit plan into which the small employer carrier is no longer enrolling new small employers for the purposes of 33-22-1809(1), MCA.

(d) If, for any rating period, the change in the new business premium rate for a health benefit plan differs from the change in the new business premium rate for any other health benefit plan in the same class of business by more than 20%, the carrier shall file a statement with the commissioner which contains a complete explanation of how the respective changes in new business premium rates were established and the reason for the difference. The filing must be made within 30 days of the beginning of the rating period.

(e) Small employer carriers shall keep on file for a period of at least 6 years, all calculations used to determine all changes in base premium rates and new business premium rates for each health benefit plan for each rating period.

(14) A representative of a Taft-Hartley trust, including a carrier upon the written request of such a trust, may file a written request with commissioner for a waiver of the application of the provisions of 33-22-1809(1), MCA, with respect to such trust.

(a) Such a request must identify the provisions for which the trust is seeking the waiver and must describe, with respect to each provision, the extent to which application of such provision would:

(i) Adversely affect the participants and beneficiaries of the trust; and

(ii) Require modifications to one or more of the collective bargaining agreements under, or pursuant to, which the trust was or is established or maintained.

(b) A waiver granted hereunder may not apply to an individual who participates in the trust because the individual is an associate member of an employee organization or the beneficiary of such an individual. (History: Sec. 33-1-313 and 33-22-1822 MCA; IMP, Sec. 33-22-1802, 33-22-1809, and 33-22-1812 MCA; NEW, 1994 MAR p. 1528, Eff. 6/10/94.)

6.6.5091 through 6.6.5093 reserved.

6.6.5094 CALCULATIONS RELATING TO PREMIUM RATE RESTRICTIONS (1) The restriction in 33-22-1809(1)(a), MCA, that the index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than 20% must be tested as follows:

(a) The small employer carrier shall conduct a representative census of its business, based on all applicable case characteristics, and formulate a representative and actuarially equivalent plan of benefits for all classes of business combined.

(b) The small employer carrier shall calculate an index rate for each class of business identified in (a).

(c) The small employer carrier shall identify the class of business with the lowest index rate.

(d) The ratio of the index rate calculated for each class of business in (b) to the lowest index rate identified in (c) of this must be between 1.00 and 1.20, inclusive.

(e) Any change in the representative census or representative actuarially equivalent plan of benefits used in (a) through (d) must be specifically documented and the test must be performed on both the previous and the new census, or actuarially equivalent plan of benefits, at the time of change.

(f) Other methods may be used if the results meet the requirements of (1)(a) through (e) when the method established therein is used.

(2) The restrictions in 33-22-1809(1)(b), MCA, that, within a class, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the premium rates that could be charged for that class of business, may not vary from the index rate by more than 25%, or by more than 20% from the index rate if the conditions set forth in 33-22-1809(1)(b)(ii), MCA, are met, must be tested as follows:

(a) Using the carrier's rate manual for each class of business, the small group carrier shall calculate an index rate for each plan of benefits and for each small employer census within each class. Index rates must be based on all applicable characteristics of each small employer group within each class. Index rates must be based on all applicable characteristics of each small employer group within each class of business.

(b) For each small employer within a given class of business, the small employer carrier shall calculate the ratio of the premium rate charged the small employer during the rating period to the index rate for the census, the plan of business, and the class of business of that small employer for which an index rate was calculated in under (a).

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(c) The ratio calculated in (b) must be between .75 and 1.25, inclusive, to comply with the requirement of 33-22-1809(1)(b)(i), MCA, or between .80 and 1.20, inclusive, to comply with the requirements of 33-22-1809(1)(b)(ii), MCA.

(d) Other methods of calculation may be used if the results meet the requirements of (2)(a) through (c), when the method established therein is used.

(3) The acceptability of a proposed rate increase for health benefits plans of small employers must be determined as follows:

(a) Using the small employer carrier's rate manual, the small employer carrier shall calculate the new base premium rate for the new rating period, the actual census, and the plan of benefits for the small employer at the beginning of the new rating period.

(b) Using the rate manual, the small employer carrier shall calculate the base premium rate for the prior rating period, the actual census, and the plan of benefits for the small employer at the beginning of the prior rating period.

(c) The premium rate calculated in (a) must be divided by the premium rate calculated in (b), and the quotient must be multiplied by the gross premium in effect at the beginning of the prior rating period. The product will be the maximum renewal premium for the new rating period under 33-22-1809(1)(c)(i), MCA.

(d) The premium rate calculated in (c) may be adjusted by a percentage of the gross premium in force prior to renewal. Such percentage may consist of:

(i) A percentage to reflect the risk load, not to exceed 15% per year, prorated for the months elapsed between the previous and the new rating dates, to be determined from the small employer carrier's rate manual for the class of business; plus

(ii) Any adjustment because of a change in coverage or a change in case characteristics for the small employer, from the beginning of the prior rating period, as determined from the small employer carrier's rate manual for the class of business.

(e) The premium rate calculated in (c) must be multiplied by 1 plus the percentage in (d).

(f) The maximum renewal gross premium is the premium rate calculated in (e), if (2) is satisfied.

(g) If the resulting maximum renewal gross premium calculated in (e) does not satisfy (2), then the maximum renewal gross premium must be adjusted downward until (2) is satisfied.

(h) Other methods of calculation may be used if the results meet the requirements of (3)(a) through (g), when the method established therein is used.

(4) The requirement in 33-22-1809(1)(e), MCA, that, if a small employer uses industry as a case characteristic in establishing premium rates, the rate factor associated with any industry classification may not vary from the average of the rate factors associated with all industry classifications by more than 15% of that coverage, must be tested as follows:

(a) A small employer carrier which charges different premium rates for different industries shall include in each class's rate manual a schedule of factors which reflect the rate differential by industry.

(b) Within each class, the small employer carrier shall calculate the average of all factors which are used, or which could be used, to vary rates by industry within that class.

(c) Within each class, the lowest industry factor and the highest industry factor each may not vary from the average calculated in (b) by more than 15%. (History: Sec. 33-1-313 and 33-22-1822 MCA; IMP, Sec. 33-22-1802, 33-22-1809, and 33-22-1812 MCA; NEW, 1994 MAR p. 1528, Eff. 6/10/94.)

6.6.5095 through 6.6.5097 reserved.

6.6.5098 ANNUAL FILING OF ACTUARIAL CERTIFICATION

(1) On or before March 15 of each year after the effective date of these rules, each small employer carrier shall file with the commissioner annually an actuarial certification which complies with 33-22-1809(5)(b), MCA. The certification must include the following effect:

(a) A statement that the carrier is in compliance with Title 33, chapter 22, part 18, MCA;

(b) A statement that the rating methods of the small employer carrier are actuarially sound; and

(c) A list and description of each class of business in the state. The description shall include:

(i) The reason the distinct grouping qualifies as a class of business under 33-22-1808(1), MCA;

(ii) Whether the distinct grouping is open to new business; and

(iii) A request for approval of the additional classes in instances wherein the number of distinct groupings exceeds nine.

(d) A written description of the derivation of the representative census developed pursuant to ARM 6.6.5094 and a statement that the representative census has either changed or not changed during the period between annual filings.

(e) A written description of the derivation of the representative actuarially equivalent plan of benefits developed pursuant to ARM 6.6.5094 and a statement that the representative and actuarially equivalent plan of benefits has either changed or not changed during the period between annual filings.

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(f) A statement that the tests developed in ARM 6.6.5094 have been performed on the representative census and on the representative and actuarially equivalent plan of benefits. If the representative census, the representative and actuarially equivalent plan of benefits, or both the representative census and the representative and actuarially equivalent plan of benefits have changed, the statement must confirm that the tests have been performed on both the previous and the new definitions of the representative census and of the representative and actuarially equivalent plan of benefits.

(g) A written description of the results of each of the tests referred to in (e) and an explanation addressing the reason for changing either the definition of the representative census, the representative and actuarially equivalent plan of benefits, or both.

(2) On or before March 15 of each year after the effective date of these rules, every small employer carrier shall file with the commissioner all rates intended for use for its small employer health benefit plans within this state. Each filing must include a schedule of rates for each plan of benefits within each class of business; and each schedule of rates must contain a reference to the plan of benefits and the class of business for which the rates are charged. (History: Sec. 33-1-313 and 33-22-1822 MCA; IMP, Sec. 33-22-1802, 33-22-1808, 33-22-1809, and 33-22-1812 MCA; NEW, 1994 MAR p. 1528, Eff. 6/10/94.)

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(2) All terms or conditions of an insurance policy or subscriber contract, except those already approved by the commissioner, are subject to the prior approval of the commissioner.

(3) A plan offering prepaid dental services under this part must offer its insureds the right to obtain dental care from any licensed dental care provider of their choice, subject to the same terms and conditions imposed under subsection (1).

History: En. Sec. 6, Ch. 638, L. 1987; amd. Sec. 1, Ch. 265, L. 1989.

Cross-References

Disability insurance — freedom of choice of practitioners, 33-22-111.

Dentist participation as provider through health maintenance organization, 33-31-305.

33-22-1707. Rules. The commissioner shall promulgate rules necessary to implement the provisions of this part.

History: En. Sec. 7, Ch. 638, L. 1987.

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.

Part 18
Small Employer Health Insurance Availability Act

33-22-1801. *(Effective January 1, 1994)* **Short title.** This part may be cited as the "Small Employer Health Insurance Availability Act".

History: En. Sec. 22, Ch. 606, L. 1993.

Compiler's Comments

Effective Date: Section 47(3), Ch. 606, L. 1993, provided that this section is effective January 1, 1994.

33-22-1802. *(Effective January 1, 1994)* **Purpose.** (1) This part must be interpreted and construed to effectuate the following express legislative purposes:

(a) to promote the availability of health insurance coverage to small employers regardless of health status or claims experience;

(b) to prevent abusive rating practices;

(c) to require disclosure of rating practices to purchasers;

(d) to establish rules regarding renewability of coverage;

(e) to establish limitations on the use of preexisting condition exclusions;

(f) to provide for the development of basic and standard health benefit plans to be offered to all small employers;

(g) to provide for the establishment of a reinsurance program; and

(h) to improve the overall fairness and efficiency of the small employer health insurance market.

(2) This part is not intended to provide a comprehensive solution to the problem of affordability of health care or health insurance.

History: En. Sec. 23, Ch. 606, L. 1993.

Compiler's Comments

Effective Date: Section 47(3), Ch. 606, L. 1993, provided that this section is effective Janu 1994

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33-22-1803. *(Effective January 1, 1994)* **Definitions.** As used in this part, the following definitions apply:

(1) "Actuarial certification" means a written statement by a member of the American academy of actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of 33-22-1809, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with a specified entity or person.

(3) "Assessable carrier" means all individual carriers of disability insurance and all carriers of group disability insurance, excluding the state group benefits plan provided for in Title 2, chapter 18, part 8, the Montana university system health plan, and any self-funded disability insurance plan provided by a political subdivision of the state.

(4) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

(5) "Basic health benefit plan" means a lower cost health benefit plan developed pursuant to 33-22-1812.

(6) "Board" means the board of directors of the program established pursuant to 33-22-1818.

(7) "Carrier" means any person who provides a health benefit plan in this state subject to state insurance regulation. The term includes but is not limited to an insurance company, a fraternal benefit society, a health service corporation, a health maintenance organization, and, to the extent permitted by the Employee Retirement Income Security Act of 1974, a multiple-employer welfare arrangement. For purposes of this part, companies that are affiliated companies or that are eligible to file a consolidated tax return must be treated as one carrier, except that the following may be considered as separate carriers:

(a) an insurance company or health service corporation that is an affiliate of a health maintenance organization located in this state;

(b) a health maintenance organization located in this state that is an affiliate of an insurance company or health service corporation; or

(c) a health maintenance organization that operates only one health maintenance organization in an established geographic service area of this state.

(8) "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, provided that claims experience, health status, and duration of coverage are not case characteristics for purposes of this part.

(9) "Class of business" means all or a separate grouping of small employers established pursuant to 33-22-1808.

(10) "Committee" means the health benefit plan committee created pursuant to 33-22-1812.

(11) "Dependent" means:

(a) a spouse or an unmarried child under 19 years of age;

(b) an unmarried child, under 23 years of age, who is a full-time student and who is financially dependent on the insured;

(c) a child of any age who is disabled and dependent upon the parent as provided in 33-22-506 and 33-30-1003; or

(d) any other individual defined to be a dependent in the health benefit plan covering the employee.

(12) "Eligible employee" means an employee who works on a full-time basis and who has a normal workweek of 30 hours or more. The term includes a sole proprietor, a partner of a partnership, and an independent contractor if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer. The term does not include an employee who works on a part-time, temporary, or substitute basis.

(13) "Established geographic service area" means a geographic area, as approved by the commissioner and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

(14) "Health benefit plan" means any hospital or medical policy or certificate providing for physical and mental health care issued by an insurance company, a fraternal benefit society, or a health service corporation or issued under a health maintenance organization subscriber contract. Health benefit plan does not include:

(a) accident-only, credit, dental, vision, specified disease, medicare supplement, long-term care, or disability income insurance;

(b) coverage issued as a supplement to liability insurance, workers' compensation insurance, or similar insurance; or

(c) automobile medical payment insurance.

(15) "Index rate" means, for each class of business for a rating period for small employers with similar case characteristics, the average of the applicable base premium rate and the corresponding highest premium rate.

(16) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual was entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period was a period of at least 30 days. However, an eligible employee or dependent may not be considered a late enrollee if:

(a) the individual meets each of the following conditions:

(i) the individual was covered under qualifying previous coverage at the time of the initial enrollment;

(ii) the individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, the death of a spouse, or divorce; and

(iii) the individual requests enrollment within 30 days after termination of the qualifying previous coverage;

(b) the individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

(c) a court has ordered that coverage be provided for a spouse, minor, or dependent child under a covered employee's health benefit plan and a request for enrollment is made within 30 days after issuance of the court order.

(17) "New business premium rate" means, for each class of business for a rating period, the lowest premium rate charged or offered or that could have been charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(18) "Plan of operation" means the operation of the program established pursuant to 33-22-1818.

(19) "Premium" means all money paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

(20) "Program" means the Montana small employer health reinsurance program created by 33-22-1818.

(21) "Qualifying previous coverage" means benefits or coverage provided under:

(a) medicare or medicaid;

(b) an employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan; or

(c) an individual health insurance policy, including coverage issued by an insurance company, a fraternal benefit society, a health service corporation, or a health maintenance organization that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided that the policy has been in effect for a period of at least 1 year.

(22) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

(23) "Reinsuring carrier" means a small employer carrier participating in the reinsurance program pursuant to 33-22-1819.

(24) "Restricted network provision" means a provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to Title 33, chapter 22, part 17, or Title 33, chapter 31, to provide health care services to covered individuals.

(25) "Small employer" means a person, firm, corporation, partnership, or association that is actively engaged in business and that, on at least 50% of its working days during the preceding calendar quarter, employed at least 3 but not more than 25 eligible employees, the majority of whom were employed within this state or were residents of this state. In determining the number of eligible employees, companies are considered one employer if they:

(a) are affiliated companies;

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(b) are eligible to file a combined tax return for purposes of state taxation; or

(c) are members of an association that:

(i) has been in existence for 1 year prior to January 1, 1994;

(ii) provides a health benefit plan to employees of its members as a group; and

(iii) does not deny coverage to any member of its association or any employee of its members who applies for coverage as part of a group.

(26) "Small employer carrier" means a carrier that offers health benefit plans that cover eligible employees of one or more small employers in this state.

(27) "Standard health benefit plan" means a health benefit plan developed pursuant to 33-22-1812.

History: En. Sec. 24, Ch. 606, L. 1993.

Compiler's Comments

Effective Date: Section 47(3), Ch. 606, L. 1993, provided that this section is effective January 1, 1994.

33-22-1804. *(Effective January 1, 1994)* **Applicability and scope.** This part applies to a health benefit plan marketed through a small employer that provides coverage to the employees of a small employer in this state if any of the following conditions are met:

(1) a portion of the premium or benefits is paid by or on behalf of the small employer;

(2) an eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium; or

(3) the health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of section 106, 125, or 162 of the Internal Revenue Code.

History: En. Sec. 25, Ch. 606, L. 1993.

Compiler's Comments

Effective Date: Section 47(3), Ch. 606, L. 1993, provided that this section is effective January 1, 1994.

33-22-1805 through 33-22-1807 reserved.

33-22-1808. *(Effective January 1, 1994)* **Establishment of classes of business.** (1) A small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs that are related to the following reasons:

(a) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers.

(b) The small employer carrier has acquired a class of business from another small employer carrier.

(c) The small employer carrier provides coverage to one or more association groups that meet the requirements of 33-22-501(2).

(2) A small employer carrier may establish up to nine separate classes of business under subsection (1).

(3) The commissioner shall adopt rules to provide for a period of trans
in order for a small employer carrier to come into compliance with subsec
(2) in the case of acquisition of an additional class of business from ano
small employer carrier.

(4) The commissioner may approve the establishment of additional
ses of business upon application to the commissioner and a finding by
commissioner that the action would enhance the fairness and efficiency o
small employer health insurance market.

History: En. Sec. 26, Ch. 606, L. 1993.

Compiler's Comments

Effective Date: Section 47(3), Ch. 606, L. 1993, provided that this section is effective January 1, 1994.

33-22-1809. *(Effective January 1, 1994)* **Restrictions relatin
premium rates.** (1) Premium rates for health benefit plans under this
are subject to the following provisions:

(a) The index rate for a rating period for any class of business may
exceed the index rate for any other class of business by more than 20%.

(b) For each class of business:

(i) the premium rates charged during a rating period to small emplo
with similar case characteristics for the same or similar coverage or the r
that could be charged to the employer under the rating system for that c
of business may not vary from the index rate by more than 25% of the in
rate; or

(ii) if the Montana health care authority established by 50-4-201 cert
to the commissioner that the cost containment goal set forth in 50-4-30
met on or before January 1, 1999, the premium rates charged during a ra
period to small employers with similar case characteristics for the sam
similar coverage may not vary from the index by more than 20% of the in
rate.

(c) The percentage increase in the premium rate charged to a s
employer for a new rating period may not exceed the sum of the followin

(i) the percentage change in the new business premium rate meas
from the first day of the prior rating period to the first day of the new ra
period; in the case of a health benefit plan into which the small empl
carrier is no longer enrolling new small employers, the small employer ca
shall use the percentage change in the base premium rate, provided that
change does not exceed, on a percentage basis, the change in the new busi
premium rate for the most similar health benefit plan into which the s
employer carrier is actively enrolling new small employers;

(ii) any adjustment, not to exceed 15% annually and adjusted pro rat
rating periods of less than 1 year, because of the claims experience, he
status, or duration of coverage of the employees or dependents of the s
employer, as determined from the small employer carrier's rate manua
the class of business; and

(iii) any adjustment because of a change in coverage or a change in
case characteristics of the small employer, as determined from the s
employer carrier's rate manual for the class of business.

(a) nonpayment of the required premium;

(b) fraud or misrepresentation of the small employer or with respect to coverage of individual insureds or their representatives;

(c) noncompliance with the carrier's minimum participation requirements;

(d) noncompliance with the carrier's employer contribution requirements;

(e) repeated misuse of a restricted network provision;

(f) election by the small employer carrier to not renew all of its health benefit plans delivered or issued for delivery to small employers in this state, in which case the small employer carrier shall:

(i) provide advance notice of this decision under this subsection (1)(f) to the commissioner in each state in which it is licensed; and

(ii) at least 180 days prior to the nonrenewal of any health benefit plans by the carrier, provide notice of the decision not to renew coverage to all affected small employers and to the commissioner in each state in which an affected insured individual is known to reside. Notice to the commissioner under this subsection (1)(f) must be provided at least 3 working days prior to the notice to the affected small employers.

(g) the commissioner finds that the continuation of the coverage would:

(i) not be in the best interests of the policyholders or certificate holders; or

(ii) impair the carrier's ability to meet its contractual obligations.

(2) If the commissioner makes a finding under subsection (1)(g), the commissioner shall assist affected small employers in finding replacement coverage.

(3) A small employer carrier that elects not to renew a health benefit plan under subsection (1)(f) is prohibited from writing new business in the small employer market in this state for a period of 5 years from the date of notice to the commissioner.

(4) In the case of a small employer carrier doing business in one established geographic service area of the state, the rules set forth in this section apply only to the carrier's operations in that service area.

History: En. Sec. 28, Ch. 606, L. 1993.

Compiler's Comments

Effective Date: Section 47(3), Ch. 606, L. 1993, provided that this section is effective January 1, 1994.

33-22-1811. Availability of coverage — required plans. (1) (a) As a condition of transacting business in this state with small employers, each small employer carrier shall offer to small employers at least two health benefit plans. One plan must be a basic health benefit plan, and one plan must be a standard health benefit plan.

(b) (i) A small employer carrier shall issue a basic health benefit plan or a standard health benefit plan to any eligible small employer that applies for either plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this part.

(ii) In the case of a small employer carrier that establishes more than one class of business pursuant to 33-22-1808, the small employer carrier shall maintain and offer to eligible small employers at least one basic health ben plan and at least one standard health benefit plan in each established cl of business. A small employer carrier may apply reasonable criteria determining whether to accept a small employer into a class of busine provided that:

(A) the criteria are not intended to discourage or prevent acceptanc small employers applying for a basic or standard health benefit plan;

(B) the criteria are not related to the health status or claims experie of the small employers' employees;

(C) the criteria are applied consistently to all small employers that ap for coverage in that class of business; and

(D) the small employer carrier provides for the acceptance of all eligi small employers into one or more classes of business.

(iii) The provisions of subsection (1)(b)(ii) may not be applied to a clas business into which the small employer carrier is no longer enrolling n small businesses.

(c) The provisions of this section are effective 180 days after commissioner's approval of the basic health benefit plan and the stand health benefit plan developed pursuant to 33-22-1812, provided that if program created pursuant to 33-22-1818 is not yet operative on that date, provisions of this section are effective on the date that the program beg operation.

(2) (a) A small employer carrier shall, pursuant to 33-1-501, file the b health benefit plans and the standard health benefit plans to be used by small employer carrier.

(b) The commissioner may at any time, after providing notice and opportunity for a hearing to the small employer carrier, disapprove continued use by a small employer carrier of a basic or standard health ber plan on the grounds that the plan does not meet the requirements of this p

(3) Health benefit plans covering small employers must comply with following provisions:

(a) A health benefit plan may not, because of a preexisting condit deny, exclude, or limit benefits for a covered individual for losses incu more than 12 months following the effective date of the individual's cover A health benefit plan may not define a preexisting condition more restricti than 33-22-110, except that the condition may be excluded for a maximu 12 months.

(b) A health benefit plan must waive any time period applicable preexisting condition exclusion or limitation period with respect to partic services for the period of time an individual was previously covere qualifying previous coverage that provided benefits with respect to t services if the qualifying previous coverage was continuous to a date not than 30 days prior to the submission of an application for new coverage. subsection (3)(b) does not preclude application of any waiting period plicable to all new enrollees under the health benefit plan.

(c) A health benefit plan may exclude coverage for late enrollees fo months or for an 18-month preexisting condition exclusion, provided th both a period of exclusion from coverage and a preexisting condition exclu

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carrier's net health insurance premium derived from health benefit plans issued in this state in the previous calendar year.

History: En. Sec. 30(1)-(3), Ch. 606, L. 1993.

Compiler's Comments

Effective Date: Section 47(4), Ch. 606, L. 1993, provided that this section is effective July 1, 1993.

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 p to recover any premiums and penalties for, on behalf of, or agains program or any reinsuring carriers;

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

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

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

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

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

(h) to the extent permitted by federal law and in accordance with sul tion (8)(c), make annual fiscal yearend assessments against assessable riers and make interim assessments to fund claims incurred by the prog and

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

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

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

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

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

(d) (i) The program may not reimburse a reinsuring carrier with res to the claims of a reinsured employee or dependent until the carrier incurred an initial level of claims for the employee or dependent of $5,00 a calendar year for benefits covered by the program. In addition, the rein ing carrier is responsible for 20% of the next $100,000 of benefit payme during a calendar year and the program shall reinsure the remainde reinsuring carrier's liability under this subsection (d)(i) may not exce maximum limit of $25,000 in any calendar year with respect to any reinsu individual.

(ii) The board annually shall adjust the initial level of claims and m mum limit to be retained by the carrier to reflect increases in costs utilization within the standard market for health benefit plans within

status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employer;

(ii) encouraging or directing small employers to seek coverage from another carrier because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employer.

(b) The provisions of subsection (2)(a) do not apply with respect to information provided by a small employer carrier or producer to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

(3) (a) Except as provided in subsection (3)(b), a small employer carrier may not, directly or indirectly, enter into any contract, agreement, or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employer.

(b) Subsection (3)(a) does not apply with respect to a compensation arrangement that provides compensation to a producer on the basis of the percentage of a premium, provided that the percentage may not vary because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic area of the small employer.

(4) A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to a producer, if any, for the sale of a basic or standard health benefit plan.

(5) A small employer carrier may not terminate, fail to renew, or limit its contract or agreement of representation with a producer for any reason related to the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employers placed by the producer with the small employer carrier.

(6) A small employer carrier or producer may not induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

(7) Denial by a small employer carrier of an application for coverage from a small employer must be in writing and must state the reason or reasons for the denial.

(8) The commissioner may adopt rules setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

(9) (a) A violation of this section by a small employer carrier or a producer is an unfair trade practice under 33-18-102.

(b) If a small employer carrier enters into a contract, agreement, or other arrangement with an administrator who holds a certificate of registration pursuant to 33-17-603 to provide administrative, marketing, or other services related to the offering of health benefit plans to small employers in this state, the administrator is subject to this section as if the administrator were a small employer carrier.

History: En. Sec. 35, Ch. 606, L. 1993.

Compiler's Comments

Effective Date: Section 47(3), Ch. 606, L. 1993, provided that this section is effective January 1, 1994.

33-22-1814. *(Effective January 1, 1994)* **Restoration of terminated coverage.** The commissioner may promulgate rules to require small employer carriers, as a condition of transacting business with small employers in this state after January 1, 1994, to reissue a health benefit plan to any small employer whose health benefit plan has been terminated or not renewed by the carrier after July 1, 1993. The commissioner may prescribe the terms for the reissuance of coverage that the commissioner finds are reasonable and necessary to provide continuity of coverage to small employers.

History: En. Sec. 36, Ch. 606, L. 1993.

Compiler's Comments

Effective Date: Section 47(3), Ch. 606, L. 1993, provided that this section is effective January 1, 1994.

33-22-1815 through 33-22-1817 reserved.

33-22-1818. Small employer carrier reinsurance program — board membership. (1) There is a nonprofit entity to be known as the Montana small employer health reinsurance program.

(2) (a) The program must operate subject to the supervision and control of the board. The board consists of nine members appointed by the commissioner plus the commissioner or the commissioner's designated representative, who shall serve as an ex officio member of the board.

(b) (i) In selecting the members of the board, the commissioner shall include representatives of small employers, small employer carriers, and other qualified individuals, as determined by the commissioner. At least six of the members of the board must be representatives of small employer carriers, one from each of the five small employer carriers with the highest annual premium volume derived from health benefit plans issued to small employers in Montana in the previous calendar year and one from the remaining small employer carriers. One member of the board must be a person licensed, certified, or otherwise authorized by the laws of Montana to provide health care in the ordinary course of business or in the practice of a profession. One member of the board must be a small employer who is not active in the health care or insurance fields. One member of the board must be a representative of the general public who is employed by a small employer and is not employed in the health care or insurance fields.

(ii) The initial board members' terms are as follows: one-third of the members shall serve a term of 1 year; one-third of the members shall serve a term of 2 years; and one-third of the members shall serve a term of 3 years. Subsequent board members shall serve for a term of 3 years. A board member's term continues until that member's successor is appointed.

(iii) A vacancy on the board must be filled by the commissioner. The commissioner may remove a board member for cause.

(3) Within 60 days of July 1, 1993, and on or before March 1 of each year after that date, each assessable carrier shall file with the commissioner the

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carrier's net health insurance premium derived from health benefit plans issued in this state in the previous calendar year.

History: En. Sec. 30(1)-(3), Ch. 606, L. 1993.

Compiler's Comments

Effective Date: Section 47(4), Ch. 606, L. 1993, provided that this section is effective July 1, 1993.

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 p to recover any premiums and penalties for, on behalf of, or agains program or any reinsuring carriers;

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

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

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

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

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

(h) to the extent permitted by federal law and in accordance with sul tion (8)(c), make annual fiscal yearend assessments against assessable riers and make interim assessments to fund claims incurred by the prog and

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

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

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

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

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

(d) (i) The program may not reimburse a reinsuring carrier with res to the claims of a reinsured employee or dependent until the carrier incurred an initial level of claims for the employee or dependent of $5,00 a calendar year for benefits covered by the program. In addition, the rein ing carrier is responsible for 20% of the next $100,000 of benefit paym during a calendar year and the program shall reinsure the remainde reinsuring carrier's liability under this subsection (d)(i) may not exce maximum limit of $25,000 in any calendar year with respect to any reinsu individual.

(ii) The board annually shall adjust the initial level of claims and m mum limit to be retained by the carrier to reflect increases in costs utilization within the standard market for health benefit plans within

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 review the methodology established under subsection (6)(a), including the system of classification and any rating factors, to ensure 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 the 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 after receipt by the assessable carrier of written notice of the assessment. A 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.

(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.

History: En. Sec. 30(4)-(15), Ch. 606, L. 1993.

EXHIBIT 2E
DATE 1-12-95

Compiler's Comments
Effective Date: Section 47(4), Ch. 606, L. 1993, provided that this section is effective July 1, 1993.

33-22-1820. Periodic market evaluation — report. The board, in consultation with members of the committee, shall study and report at least every 3 years to the commissioner on the effectiveness of this part. The report must analyze the effectiveness of this part in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the small employer health insurance markets. The report must address whether carriers and producers are fairly and actively marketing or issuing health benefit plans to small employers in fulfillment of the purposes of this part. The report may contain recommendations for market conduct or other regulatory standards or action.

History: En. Sec. 32, Ch. 606, L. 1993.

Compiler's Comments
Effective Date: Section 47(4), Ch. 606, L. 1993, provided that this section is effective July 1, 1993.

33-22-1821. Waiver of certain laws. A law that requires the inclusion of a specific category of licensed health care practitioners and a law that requires the coverage of a health care service or benefit do not apply to a basic health benefit plan delivered or issued for delivery to small employers in this state pursuant to this part but do apply to a standard health benefit plan delivered or issued for delivery to small employers in this state pursuant to this part.

History: En. Sec. 33, Ch. 606, L. 1993.

Compiler's Comments
Effective Date: Section 47(4), Ch. 606, L. 1993, provided that this section is effective July 1, 1993.

33-22-1822. Administrative procedure. The commissioner shall adopt rules in accordance with the Montana Administrative Procedure Act to implement and administer this part.

History: En. Sec. 34, Ch. 606, L. 1993.

Compiler's Comments
Effective Date: Section 47(4), Ch. 606, L. 1993, provided that this section is effective July 1, 1993.

EXHIBIT 3
DATE Jan. 12, 1995
HB

HOUSE SELECT COMMITTEE ON HEALTH CARE

1. Expanded Access to Health Care Coverage and Services

Major Issues:

- Expand coverage for low-income pregnant mothers and children?
- Tax deductability of insurance premiums?
- Improve access to services?

Bill No.	Sponsor	Title
HB 39	Rep. Dan Harrington	Increase Minimum Wage with Employer Option
HB 86	Rep. Robert Raney	Allow Individual Income Tax Deduction for Actual Amount of Medical Expenses
SB 62	Sen. Steve Doherty	Allow Individual Income Tax Deduction for Medical Insurance Premiums
SB 74	Sen. Steve Doherty	Allow Individual Income Tax Deduction for Actual Expenses for Prescriptions
LC 109	Rep. Roger Debruycker	Contract by SRS for Studies on Insurance for Mental Care
LC 183	Sen. Dorothy Eck	Expand Medicaid for Pregnant Women and Children
LC 209	Sen. Mignon Waterman	Long-Term Care Reform
LC 566	Rep. Thomas Nelson	Allow Income Tax Deduction for Medical Insurance Premiums
LC 742	Sen. Judy Jacobson	Expand Health Care Access
LC 1012	Rep. Brad Molnar	Incentives for Doctors in Certain Areas
LC 1092	Rep. Bill Carey	Health Security Act
LC 1167	Rep. John Bolinger	WAMI Funds as Loan
LC 1196	Rep. Carley Tuss	Reimbursement for Respiratory Care

2. Health Insurance Market Reforms

Major Issues:

- Repeal small group reform?
- Repeal and start over?
- Modify small group reform using existing statuatory framework?

Bill No.	Sponsor	Title
LC 743	Sen. Judy Jacobson	Insurance Market Reforms
LC 896	Sen. Larry Baer	Revise Health Care Authority Laws; Repeal Small Employer Health Insurance
LC 923	Rep. Liz Smith	Repeal Small Employer Health Insurance Availability Act
LC 1154	Rep. Peggy Arnott	Portability of Insurance
LC 1157	Rep. Scott Orr	Revise Preexisting Condition Coverage
LC 1253	Sen. Rick Holden	Revise Health Insurance Associations Law
LC 1264	Rep. Thomas Nelson	Multiple Employer Welfare Arrangements
LC 1272	Sen. Chris Christiaens	Standardized Claim Reporting Form
LC 1278	Sen. Steve Benedict	Repeal Rate Laws

3. Market-Based Cost Containment

Major Issues:

- Purchasing pool authorization
- Medical Savings Accounts
- Managed care options
- Certificate of Need
- Tort reform

Bill No.	Sponsor	Title
HB 26	Rep. Diana Wyatt	Revise Medical Legal Panel Act
HB 109	Rep. John Cobb	Cap Certificate of Need for Nursing Home Beds for 3 Year Period
LC 68	Sen. Terry Klampe	Revise Medical Legal Panel Procedure
LC 69	Sen. Terry Klampe	Require Health Care Provider Notification of Financial Interest in Referral
LC 110	Rep. Roger Debruycker	Health Care Choice
LC 275	Sen. Mignon Waterman	Medicaid Estate Recoveries
LC 349	Legislative Council	Extend Certificate of Need
LC 367	Sen. Thomas Keating	Expand Coverage of Medicaid Managed Care Mental Health
LC 368	Rep. Duane Grimes	Revise Medical Malpractice Recovery Laws
LC 438	Legislative Council	Insurance Fraud Prevention
LC 581	Sen. Bruce Crippen	Revise Certificate of Need
LC 646	Rep. Bruce Simon	Medical Savings Account
LC 727	Rep. Gay Masolo	Revise Certificate of Need
LC 744	Sen. Judy Jacobson	Market Based Cost Containment
LC 992	Sen. Ken Mesaros	Equal Access to Pharmaceutical Manufacturer Discounts

LC 1011	Sen. Ethel Harding	Medicaid Fraud and Abuse Control
LC 1062	Rep. Thomas Nelson	Voluntary Purchasing Pools for Health Insurance
LC 1161	Rep. Shiell Anderson	Anti-Trust Revision

EXHIBIT 3
DATE 1-12-95

4. Health Care Delivery System and Infrastructure

Major Issues:

- Unified health care data base
- Regulatory reform
- Location and contents of Certificate of Need Program
- Future role and scope of Health Care Authority

Bill No.	Sponsor	Title
HB 78	Rep. John Cobb	Health Care Authority to Publish Reports on Health Care Fees
LC 229	Sen. Judy Jacobson	Accept Health Care Authority Report
LC 348	Legislative Council	Transfer Certificate of Need to DHES and Allow 1 Year Extension of Certificate of Need
LC 637	Rep. Royal Johnson	Revise Health Care Authority
LC 745	Sen. Judy Jacobson	Health Care System Improvements
LC 896	Sen. Larry Baer	Revise Health Care Authority Laws; Repeal Small Employer Health Insurance

Dated: 1/11/95