MINUTES

MONTANA SENATE
54th LEGISLATURE - REGULAR SESSION

JOINT SELECT COMMITTEE ON HEALTH CARE

Call to Order: By **CHAIRMAN STEVE BENEDICT**, on March 16, 1995, at 6:00 p.m.

ROLL CALL

Members Present:

Sen. Steve Benedict, Chairman (R)
Rep. Scott J. Orr, Vice Chairman (R)
Sen. Dorothy Eck (D)
Sen. Mike Foster (R)
Rep. Duane Grimes (R)
Sen. Judy H. Jacobson (D)
Sen. Ken Miller (R)
Rep. Bruce T. Simon (R)
Rep. Carolyn M. Squires (D)
Rep. Carley Tuss (D)

Members Excused: None

Members Absent: None

Staff Present: Susan Fox, Legislative Council
David Niss, Legislative Council
Jennifer Gaasch, Committee Secretary

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

Committee Business Summary:

Hearing:	None
Executive Action:	SB 380, SB 322, SB 341, HB 466, HB 446, HB 533, HB 531, and SB 376.

{Tape: 1; Side: A.}

CHAIRMAN BENEDICT said it seemed like there were a lot of different philosophies when they came to this committee. He asked that those people directly involved join together and see if they could not come to a compromise. **Rick Hill** was the person who kept that group going. He said he would have **Rick Hill** walk through how the amendments would work that were being proposed and what changes would be made and the different bills that would be used as vehicles.

Rick Hill gave an overview. **(EXHIBIT #1)**

REPRESENTATIVE SIMON asked **Rick Hill** what consideration was given to the possibility that someone had a Medical Savings Account and wanted to have deductible of $1,000. He asked if they were allowed to have a higher deductible. He said in the standard plan the annual deductible was not to exceed $500 per person.

Rick Hill said in the standard plan those financial parameters would be required, but a basic plan could be offered below the standard plan where those economic criteria were different. He in a basic plan the economic criteria can be adjusted.

REP. SIMON said the uniform plan had an annual deductible not to exceed $1,000 per person. Would that person be then excluded from having a Medical Savings Account and a policy that would have higher deductible than that. If they went to the uniform plan it had to be a deductible not to exceed $1,000.

Rick Hill said the uniform plan was intended to be a standard plan that would be offered in both the group market and the Montana Comprehensive Health Association Market so that they can make a comparison. It would not preclude those people from having a Medical Savings Account because they may not only want to use that savings account to satisfy the deductible. They would want to use the account to apply to the kinds of care that are not a part of that plan because it does not have a lot of benefits.

REP. SIMON asked if those who wanted to choose to have a Medical Savings Account would probably choose another product other than the uniform plan. The uniform plan is there primarily to provide a base line for cost comparisons.

Rick Hill replied that was so. There was nothing here that would require a basic plan to be more costly than a uniform plan. The economic elements in the basic plan are more flexible, a person could go to the basic plan and do that, however that would be in the guaranteed issue market.

EXECUTIVE ACTION ON SB 322

Motion:

SENATOR MIKE FOSTER MOVED TO TABLE SB 322.

Discussion:

CHAIRMAN BENEDICT said it was a duplicate bill of another bill they had. They had some of the provisions in another bill.

Vote:

The **MOTION CARRIED UNANIMOUSLY.**

EXECUTIVE ACTION ON SB 380

Motion/Vote:

REP. SIMON MOVED TO TABLE SB 380. The **MOTION CARRIED UNANIMOUSLY.**

EXECUTIVE ACTION ON SB 341

Discussion:

Rick Hill discussed the amendments **(EXHIBIT #2).**

SEN. FOSTER said the last amendment would strike "sterilization or", he asked why that was a proposed amendment.

Rick Hill said that was on the excluded list and is now on the included list.

Motion/Vote:

REP. SIMON MOVED the amendments to SB 341. **(EXHIBIT #1)** The **MOTION CARRIED UNANIMOUSLY.**

Motion:

REP. SIMON MOVED SB 341 **DO PASS AS AMENDED.**

Discussion:

REP. GRIMES said they have limited the cost to 200%, they have expanded the benefits, would the association members pay an increased prorated amount in the association to cover increased benefits and the decreased 200% level.

Rick Hill said it would increase the premium by about $25 per month.

REP. GRIMES asked what would it do to the prorated assessment for the members.

Rick Hill referred the question to **Tanya Ask.**

Tanya Ask, representing Blue Cross and Blue Shield of Montana, said currently the premium level for the Comprehensive Health Care Association is at 200%. It is contemplated that it would remain at 200%. The assessment level has been relatively low over the last 1 ½ years so it was not contemplated that it would increase significantly with an increase in premiums.

CHAIRMAN BENEDICT said they have not gone up to the 400% cap and they have gone up to about 200% so they were going to put the cap at 200% so that the assessment could rise sometime in the future if the pressure was there.

REP. SIMON said the assessment was against all carriers of disability insurance and any assessment made against those carriers was allowed as a deduction against their premium tax.

Vote:

The **MOTION CARRIED UNANIMOUSLY.**

REP. TUSS would carry the bill on the House floor.

EXECUTIVE ACTION ON HB 466

Motion:

REP. ORR MOVED the amendments **(EXHIBIT #3 & #4)**

Discussion:

Rick Hill read and explained **(EXHIBIT #3 & #4).**

CHAIRMAN BENEDICT said there was some insertive language on page 4, #32, and the line that started with "section expenses include administrative expense, and one half the program net loss for the previous calendar year." He asked if he could explain that.

Rick Hill said the language they currently had did not provide a mechanism for recovery if the reinsurance was underestimated for the year. That would allow that any loss from the previous year could be added to the expenses and anticipate a loss in the calculation of the assessment for the next year.

CHAIRMAN BENEDICT said they would use that as a conceptual amendment because it was needed in the bill.

SEN. ECK asked if everyone was in agreement with the amendments.

Rick Hill said that everyone was in agreement with everything they have discussed so far.

REP. SIMON asked if "upon year end" of amendment #31, should be two words and not one.

Susan Fox replied that was the way it was in the bill and they were striking it so they have to show the way it was in the bill.
Vote:

The **MOTION CARRIED UNANIMOUSLY.**

Motion/Vote:

SEN. JACOBSON MOVED HB 466 **DO PASS AS AMENDED.** The **MOTION CARRIED UNANIMOUSLY.**

SEN. JACOBSON would carry the bill on the Senate floor.

EXECUTIVE ACTION ON HB 446

Discussion:

Rick Hill explained the amendments **(EXHIBIT #5).**

SEN. JACOBSON said she was still troubled about riders.

Rick Hill said a person buys insurance who has a condition that the insurance company is concerned about they can put a rider on that person's policy which would exclude that condition. A person would be insured for anything else that the policy covered, but not that condition. If they cannot put a rider on a policy it could preclude the insurance company from offering any insurance to that person.

SEN. JACOBSON said the amendments on the first page of **EXHIBIT #5**, #1 and on the second page where they are talking about riders on **EXHIBIT #5,** #7, have the same definitions. She said they could be doing something for pre-existing conditions and then the insurance companies could say that they were not covering it under pre-existing conditions they were covering it under riders because they had more flexibility under riders. Without a definition they were fixing it one place and causing trouble some where else.

CHAIRMAN BENEDICT said there was not unanimity among the group and there were a lot of different opinions of how riders should be treated and so they just let riders go.

REP. TUSS asked how riders affect portability.

Rick Hill replied the problem with portability of insurance is if a person had a rider on a policy that had a limit on that rider, and then the person went to another insurance company, would that insurance company be required to only fulfill the balance at the time of that rider, or would the rider start all over again. They could have a person with an unridered policy with one insurance company and if they went to another company and that insurance company wanted to put a rider on it would they have less insurance coverage.

REP. TUSS asked if she could characterize that riders complicate portability in the individual market.

Rick Hill said that either way they do it, it complicates it.

SEN. JACOBSON said she agreed with **Mr. Hill** that if they totally preclude riders they may preclude someone from getting an insurance policy. She said they had no difference in definition between pre-existing conditions and no limits.

REP. SIMON said if they look at amendment #7, on **EXHIBIT #5,** it says that 33-22-110 does not apply to elimination riders. He said the language on amendment #1, **EXHIBIT #5,** is codified under 33-22-110, they do not technically create a conflict between those two sections. Perhaps they need to have the word rider defined. He said the purpose of riders was to say that provision 33-22-110 say that they cannot have a pre-existing condition apply, but the price may be so high that they cannot afford it and they would choose to want to eliminate that coverage so they could make the rest of the coverage affordable to them so it was a customer choice. He said that perhaps a definition would be important.

CHAIRMAN BENEDICT asked if there was a definition of riders.

Rick Hill said that riders and pre-existing conditions deal with the same sort of circumstances. A rider is a part of the insurance contract itself and would be defined in that contract. Pre-existing conditions limitation would be an unridered pre-existing condition. If it is a riderred pre-existing condition then that would be defined.

REP. SIMON said may be they should have something in the definition section of what a rider is.

Rick Hill said that they have a definition of riders. He said an elimination rider was a division of policy which excludes coverage for a specific condition which would otherwise be covered under the policy.

CHAIRMAN BENEDICT said they would put that in conceptually.

Motion:

REP. ORR MOVED the amendments **EXHIBITS #5 and #6.**

Vote:

The **MOTION CARRIED UNANIMOUSLY.**

REP. SIMON offered a conceptual amendment to adopt the definition of riders.

Motion:

REP. SIMON MOVED to amend the bill with the definition of "elimination rider".

Discussion:

CHAIRMAN BENEDICT said that technically a rider is not part of a policy and that is why it is a rider. The language said it was part of the policy.

Rick Hill said that was not the case. That would be an amendment to the policy itself and therefore become part of the policy.

CHAIRMAN BENEDICT said the language read "elimination rider was a division of a policy".

Rick Hill said it should read "attached to a policy".

{Tape: 1; Side: B.}

Vote:

The **MOTION CARRIED UNANIMOUSLY.**

Motion/Vote:

REP. ORR MOVED HB 446 **DO PASS AS AMENDED.** The **MOTION CARRIED UNANIMOUSLY.**

SEN. MILLER would carry HB 446 on the Senate floor.

EXECUTIVE ACTION ON HB 533

Discussion:

CHAIRMAN BENEDICT said how does this bill differ from the HB 446.

Rick Hill addressed the amendments **(EXHIBIT #7 & #8).** He said they were using HB 533 as a vehicle because HB 531 would become an independent bill for disclosure. He said that HB 533 deals with portability and pre-existing conditions. The uniform plan has to address the individual market. HB 466 only deals with small group.

SEN. JACOBSON asked why they did not put pre-existing conditions and portability together.

CHAIRMAN BENEDICT said there were some different circumstances between the individual and the group market.

Rick Hill discussed the amendments. **(EXHIBIT #8)**

Motion/Vote:

REP. SQUIRES MOVED the amendments **(EXHIBIT #7 & #8).** The **MOTION CARRIED UNANIMOUSLY.**

Motion:

REP. ORR MOVED HB 533 **DO PASS AS AMENDED.**

Discussion:

SEN. MILLER asked why January 1, 1996 was the effective date?

Rick Hill replied that was a new contract year and that is the reason for the effective date.

CHAIRMAN BENEDICT said that some of the other bills did not involve contracts and just changed different provisions of law and can be effective on a normal effective date.

SEN. MILLER said that HB 446 had to do with policies and it's effective date was on passage and approval.

Larry Akey replied that the effective date fully applied to the language in the retroactivity applicability.

CHAIRMAN BENEDICT said the whole act had the effective date of passage and approval. The retroactive applicability only applies to riders and yet the effective date of the whole act is passage on approval. **CHAIRMAN BENEDICT** said that it was not necessary to change the effective date.

Vote:

The **MOTION CARRIED UNANIMOUSLY.**

SEN. MILLER would carry HB 533.

Discussion:

REP. SIMON said there are some of the bills that have undergone a lot of changes he wondered if they should have a "gray bill" copy given to the members when the bills go to the different floors.

CHAIRMAN BENEDICT said that was something he would have to discuss with the leadership and the legislative council.

EXECUTIVE ACTION ON HB 531

Discussion:

Rick Hill said they had amendments.

CHAIRMAN BENEDICT said they have taken a lot of things out of the bill to put them into other areas that they have already discussed. They will have the provider disclosure language and they have some amendments for that.

Motion/Vote:

REP. ORR MOVED the amendments. **(EXHIBIT #9)** The **MOTION CARRIED UNANIMOUSLY.**

Discussion:

CHAIRMAN BENEDICT they have taken all of the provisions out of the bill besides disclosure and they would have to decide how they wanted to handle provider disclosure. There are going to be two sets of amendments.

SEN. FOSTER said **(EXHIBIT #10)** was being passed around and he did not know if they other amendments were complementary.

Susan Fox said that **EXHIBIT #9** deals with 17-19 in a completely different way that **EXHIBITS #10 & #11** do. **EXHIBITS #10 & #11** are similar, but competing and **EXHIBIT #12** is a complementary amendment to **EXHIBIT #11.**

Motion:

SEN. FOSTER MOVED the amendments on **EXHIBIT #10.**

Discussion:

SEN. FOSTER said those amendments were agreed upon by all of the interested parties. He said it was discussing the consumer reports card. In the new section it was speaking to the Department of Social and Rehabilitation Services working with the other interested parties to design a consumer report card. He said he would like to have the Montana Health Care Advisory Council appoint a task force to do that. Currently there is no such thing to do that so on page 2, it says if HB 511 was passed then it would supersede SRS doing that. If HB 511 did not pass SRS would do that. He said the reason that "quality of care" was crossed out because there was not an answer to do that. He said that was a positive thing for the consumers and it would give the providers a chance to look at different ideas. He said on page 2, under the new section 21, was listing the members on the task force and the term "health care providers" was not included and

should be. He asked as a policy matter, should they have Legislators on that task force.

SEN. JACOBSON said that was a valid effort on the part of people. She said they were trying to set up a situation to provide data to people without an adequate data base, without adequate reporting and they would get other paper that others were not using. The Health Care Authority was going to set up a uniform data base and have uniform billing. Until they get uniform billing the data that they are getting is so un-uniform that it would not be very useful to anyone. She said that was premature.

SEN. FOSTER replied that was correct. He said by using the terms uniform data and others in the amendment they were saying they are going to have to figure out uniform data. The task force would have to address that.

CHAIRMAN BENEDICT said that the bill did not mandate those things right now. It says that the task force would figure out how to get uniform data.

SEN. JACOBSON asked how much money were they giving them to do that. The biggest piece of the Governor's budget that was turned down in the SRS budget was the formation of the data base. She said they were putting out a task to be done with no funding and that is why she was objecting.

SEN. FOSTER said they could not have a data base unless they know how they are going to get to uniformity. Once that is determined then they can move forward.

CHAIRMAN BENEDICT said that the advisory is structured so that they would be coming back to the legislature with a report prepared for the 1997 legislature which will may be include funding for the data base because they will know how the data base was needed to be set up.

SEN. JACOBSON said at the end it said "The Montana Health Care Advisory Council shall submit the task force's proposal to prepare the consumer report card by October 1, 1996."

CHAIRMAN BENEDICT replied that was going to be how to structure it.

REP. SIMON said that the Montana Health Care Authority had money in their budget to design a data base. They were told that they would be working on designing the data base and not developing a data base.

SEN. ECK said she would rather have them continue planning than to drop it. There has been some work done.

Vote:

The **MOTION CARRIED** with **SEN. JACOBSON** voting no.

Motion:

REP. SIMON said that his amendments were no longer necessary. **(EXHIBITS #11 & #12)**

Discussion:

SEN. FOSTER asked if they wanted to have the legislators on the task force.

CHAIRMAN BENEDICT said they voted on the amendments of the bill that stripped everything on the bill.

Susan Fox said that if they wanted the amendments in **EXHIBIT #10** to override just those sections that they adopted in the amendments of **EXHIBIT #9.**

David Niss said that was going to be the effect of them.

Motion/Vote:

SEN. FOSTER MOVED to add legislators to be members of the task force. The **MOTION CARRIED UNANIMOUSLY.**

Motion/Vote:

SEN. FOSTER MOVE HB 531 **DO PASS AS AMENDED.** The **MOTION CARRIED UNANIMOUSLY.**

EXECUTIVE ACTION ON HB 376

Discussion:

CHAIRMAN BENEDICT said there were amendments proposed by the State Auditor's Office and the MEWA's.

Gary Spaeth explained the amendments. **(EXHIBIT #13)**

Motion:

SEN. JACOBSON MOVED the amendments. **(EXHIBIT #13)**

Discussion:

CHAIRMAN BENEDICT said that the amendments were proposed in this form and the council would work with the drafters of the amendments to develop the exact language that fits the statute.

REP. GRIMES asked what the difference was between a certified actuarial opinion as opposed to a report.

Gary Spaeth said the difference was about $2,500. The opinion is done by the individual and the report is prepared by a firm.

REP. GRIMES asked if they would approve the actuary that did the report.

Gary Spaeth said they would work with the firm that would issue the report.

REP. GRIMES asked on the Statement of Intent it says that a Statement of Intent was required in order to address the supervision of rehabilitation and liquidation of MEWAS. He said they needed to write rules to close out MEWAS.

Gary Spaeth said that was correct.

Vote:

The **MOTION CARRIED UNANIMOUSLY.**

Motion/Vote:

REP. SIMON MOVED SB 376 **DO PASS AS AMENDED.** The **MOTION CARRIED** 9 to 1 with **REP. GRIMES** voting no.

EXHIBIT #14 was passed out at the beginning of the meeting for the committee members information.

ADJOURNMENT

Adjournment: 8:00 p.m.

SENATOR STEVE BENEDICT, Chairman

JENNIFER GAASCH, Secretary

SB/jg

MONTANA SENATE
1995 LEGISLATURE
JOINT SENATE-HOUSE SELECT COMMITTEE ON HEALTH CARE

ROLL CALL DATE 3-16-95

NAME	PRESENT	ABSENT	EXCUSED
SENATOR DOROTHY ECK	X		
SENATOR MIKE FOSTER	X		
REPRESENTATIVE DUANE GRIMES	X		
SENATOR JUDY JACOBSON	X		
SENATOR KEN MILLER	X		
REPRESENTATIVE BRUCE SIMON	X		
REPRESENTATIVE CAROLYN SQUIRES	X		
REPRESENTATIVE CARLEY TUSS	X		
REPRESENTATIVE SCOTT ORR, VICE CHAIRMAN	X		
SENATOR STEVE BENEDICT, CHAIRMAN	X		

JOINT SELECT COMMITTEE REPORT

MR. PRESIDENT:
We, your Joint Select committee on Health Care, having had under consideration HB 533 (third reading copy -- blue), respectfully report that HB 533 be amended as follows and as so amended be concurred in.

Signed: _____
Senator Steve Benedict, Chair

That such amendments read:

1. Title, line 11.
Following: "INSURER;"
Insert: "REQUIRING DISCLOSURE OF CERTAIN POLICY FEATURES AT OR BEFORE THE TIME OF APPLICATION; CREATING A LOW-COST UNIFORM HEALTH BENEFIT PLAN; CAPPING PREMIUM RATES ON CERTAIN CONVERSION POLICIES;"

2. Title, line 11.
Strike: "SECTION"
Insert: "SECTIONS"

3. Title, line 12.
Following: "33-22-101,"
Insert: "33-22-508, AND 33-30-1007,"

4. Page 1, line 19.
Following: "CONTRACT"
Strike: "PRODUCT TYPE"
Insert: "filed and approved by the commissioner pursuant to 33-1-501 and"

5. Page 1, line 20.
Strike: "TYPE OF"

6. Page 1, line 23.
Strike: "OR"
Following: "ORGANIZATION"
Insert: ", or a fraternal benefit society"

7. Page 1, line 26.
Following: "issued"
Strike: "or delivered for issue"
Insert: "for delivery"

8. Page 1, lines 27 and 28
Strike: "or" on line 27 through "individuals" on line 28

Amd. Coord. _____
Sec. of Senate _____ Senator Carrying Bill

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9. Page 1, line 29.
Strike: "self-insured" in two places
Insert: "self-funded" in two places

10. Page 2, line 8.
Following: "FOR"
Strike: the remainder of line 8 through "year"

11. Page 2, lines 11 and 12.
Following: "FOR"
Strike: the remainder of line 11 through "year" on line 12

12. Page 2, line 22.
Strike: "a group or"
Insert: "an"

13. Page 2, line 24.
Following: "charges for"
Insert: "individual"

14. Page 2, line 27.
Following: "BUSINESS"
Insert: "as defined in [section 1]"

15. Page 3, line 8.
Following: "means a"
Strike: the remainder of line 8
Insert: "disability insurer, a health service corporation, a health maintenance organization, or a fraternal benefit society."

16. Page 3, line 9.
Insert: "(3) The provisions of Title 33, chapter 1, parts 3 and 7, apply to this section."

17. Page 3, line 25.
Insert: "
NEW SECTION. **Section 5. Disclosure standards -- individual policy.** (1) In order to provide for full and fair disclosure in the sale of disability insurance, an individual disability insurance policy may not be delivered or issued for delivery in this state unless an outline of coverage is delivered to the applicant at the time the application is made.

(2) The outline of coverage must include:

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

(b) a general description of the insured's financial responsibility under the policy, including, if applicable, the

amount of the deductible, the amount or percentage of copayment, and the maximum annual out-of-pocket expenses to be paid by the insured;

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

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

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

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

(3) The outline of coverage may include any other information that the insurer considers relevant to the applicant's selection of an appropriate individual disability policy.

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

NEW SECTION. **Section 6. Disclosure standards -- group policy.** (1) In order to provide for full and fair disclosure in the sale of disability insurance, a group disability insurance policy may not be delivered or issued for delivery in this state unless an outline of coverage is delivered to the applicant at the time the application is made.

(2) The outline of coverage must include:

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

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

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

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

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

(f) a general description of the trend of premium increases or decreases for comparable policies issued by the insurer during

the preceding 5 years, if the trend data is available.

(3) If applicable, the outline of coverage must disclose that the policy does not contain coverage for mental illness or chemical dependency.

(4) The outline of coverage may include any other information that the insurer considers relevant to the applicant's selection of an appropriate group disability policy.

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

NEW SECTION. **Section 7. Disclosure standards -- health maintenance organizations.** (1) In order to provide for full and fair disclosure in the sale of disability insurance, an enrollment form or evidence of coverage may not be delivered or issued for delivery in this state by a health maintenance organization unless an outline of coverage is delivered to the applicant at the time the application is made. The outline of coverage must be filed with the commissioner as required by 33-1-501.

(2) The outline of coverage must include:

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

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

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

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

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

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

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

(4) An insurer or producer shall provide to an individual, upon request, an outline of coverage for any health benefit product marketed to the general public. The outline of coverage

provided under this subsection may exclude the statement of the estimated periodic premium to be paid by the insured.

NEW SECTION. **Section 8. Uniform health benefit plan -- individual.** (1) Each insurer or health service corporation delivering or issuing for a delivery in this state an individual disability insurance policy, certificate, or contract shall make available a uniform health benefit plan providing the benefits and services required in subsection (2).

(2) The uniform health benefit plan must:

(a) provide coverage for the services and articles required by 33-22-1521(2);

(b) pay 50% of the covered expenses in excess of an annual deductible that may not exceed $1,000 per person or $2,000 per family;

(c) include a limitation of $5,000 per person or $7,500 per family on the total annual out-of-pocket expenses for services covered; and

(d) be subject to a maximum lifetime benefit of $1 million.

NEW SECTION. **Section 9. Uniform health benefit plan -- group.** (1) Each insurer or health service corporation delivering or issuing for a delivery in this state a group disability insurance policy, certificate, or contract shall make available a uniform health benefit plan providing the benefits and services required in subsection (2).

(2) The uniform health benefit plan must:

(a) provide coverage for the services and articles required by 33-22-1521(2);

(b) pay 50% of the covered expenses in excess of an annual deductible that may not exceed $1,000 per person or $2,000 per family;

(c) include a limitation of $5,000 per person or $7,500 per family on the total annual out-of-pocket expenses for services covered; and

(d) be subject to a maximum lifetime benefit of $1 million.

NEW SECTION. **Section 10. Uniform health benefit plan -- health maintenance organization.** Each health maintenance organization delivering or issuing for a delivery in this state an enrollment form or evidence of coverage shall make available a uniform health benefit plan [providing benefit equivalency and benefit value, as defined in section 1 of House Bill No. 466] comparable to the uniform health benefit plan required in [section 8(2)].

Section 11. Section 33-22-508, MCA, is amended to read:

"**33-22-508. Conversion on termination of eligibility.** (1) A

group disability insurance policy issued or renewed after October 1, 1981, must contain a provision that if the insurance or any portion of it on a person, ~~his~~ a person's dependents, or family members covered under the policy ceases because of termination of ~~his~~ the person's employment or of ~~his~~ the person's membership in the class or classes eligible for coverage under the policy or as a result of ~~his~~ a person's employer discontinuing ~~his~~ the employer's business or as a result of ~~his~~ a person's employer discontinuing the group disability insurance policy and not providing for any other group disability insurance or plan and if the person had been insured for a period of 3 months and ~~he~~ the person is not insured under another major medical disability insurance policy or plan, ~~he~~ the person is entitled to have issued to ~~him~~ the person by the insurer, without evidence of insurability, group coverage or an individual policy issued by the insurer or, in the absence of an individual policy issued by the insurer, a group policy issued by the insurer, of hospital or medical service insurance on ~~himself~~ the person~~,~~ ~~his~~ or the person's dependents~~,~~ or family members if application for the individual policy is made and the first premium tendered to the insurer within 31 days after the termination of group coverage.

(2) The individual policy or group policy, at the option of the insured, may be on any form then customarily issued by the insurer to individual or group policyholders, with the exception of a policy the eligibility for which is determined by affiliation other than by employment with a common entity. In addition, the insurer shall make available a conversion policy as required by subsection (4).

(3) The premium on the individual policy or group policy must be at the insurer's then customary conversion rate applicable to the coverage of the individual or group policy.

(4) The insurer shall make available an individual conversion policy that provides the level of benefits provided by the insurer's lowest cost basic health benefit plan, as defined in 33-22-1803. If the insurer is not a small employer carrier under part 18, the insurer shall make available an individual conversion policy that provides equivalent benefits to a basic health benefit plan. The conversion rate may not exceed 150% of the highest rate charged for that plan."

Section 12. Section 33-30-1007, MCA, is amended to read:

"**33-30-1007. Conversion on termination of eligibility.** (1) The group hospital or medical service plan contract issued or renewed by a health service corporation after October 1, 1981, shall contain a provision that if the insurance or any portion of it on a person, ~~his~~ or a person's dependents~~,~~ or family members covered under the policy ceases because of termination of ~~his~~ the person's employment or of ~~his~~ a person's membership in the class

or classes eligible for coverage under the policy, as a result of an employer discontinuing ~~his~~ the employer's business, or as a result of an employer discontinuing the policy issued by the health service corporation and not providing for any other group disability insurance or plan, ~~such~~ a person shall, provided ~~he~~ that the person has been insured for a period of 3 months and that ~~he~~ the person is not insured under another major medical disability insurance policy or plan, be entitled to have issued to ~~him~~ the person by the insurer, without evidence of insurability, an individual policy of hospital or medical service insurance on ~~himself~~ the person~~, his~~ or the person's dependents~~,~~ or family members~~, provided application~~. Application for the individual policy ~~shall~~ must be made and the first premium tendered to the insurer within 31 days after the termination of group coverage.

(2) The individual policy shall, at the option of the insured, be on any of the forms then customarily issued by the insurer to individual policyholders with the exception of those whose eligibility is determined by their affiliation other than by employment with a particular entity. In addition, the health services corporation shall make available a conversion policy as required by subsection (4).

(3) The premium on the individual policy ~~shall~~ must be at the insurer's then customary rate applicable to the coverage of the individual policy but may not be greater than 150% of the insurer's highest group rate for a policy with the same benefits as the conversion policy.

(4) The health service corporation shall make available an individual conversion policy that provides the level of benefits provided by its lowest cost basic health benefit plan, as defined in 33-22-1803. If the insurer is not a small employer carrier under chapter 22, part 18, the insurer shall make available an individual conversion policy that provides equivalent benefits to a basic health benefit plan. The conversion rate may not exceed 150% of the highest rate charged for that plan."

NEW SECTION. **Section 13. Coordination instruction.** If House Bill No. 466 is passed and approved, then the bracketed language in [section 10], referring to benefit equivalency and benefit value, must be codified."

Renumber: subsequent sections

18. Page 3, lines 29 and 30.
Strike: "1"
Insert: "2"

19. Page 4, line 1.
Insert: "(3) [Sections 5 and 8] are intended to be codified as an integral part of Title 33, chapter 22, part 2, and the provisions of Title 33, chapter 22, part 2, apply to [sections 5 and 8].

(4) [Sections 6 and 9] are intended to be codified as an integral part of Title 33, chapter 22, part 5, and the provisions of Title 33, chapter 22, part 5, apply to [sections 6 and 9].

(5) [Sections 7 and 10] are intended to be codified as an integral part of Title 33, chapter 31, part 3, and the provisions of Title 33, chapter 31, part 3, apply to [sections 7 and 10]."

-END-

JOINT SELECT COMMITTEE REPORT

March 17, 1995

MR. PRESIDENT:

We, your Joint Select committee on Health Care, having had under consideration HB 466 (third reading copy -- blue), respectfully report that HB 466 be amended as follows and as so amended be concurred in.

Signed: _____
Senator Steve Benedict, Chair

That such amendments read:

1. Title, line 10.
Strike: "CONTINGENTLY"

2. Title, line 13.
Following: "PROGRAM;"
Strike: the remainder of line 13 through "CARRIERS;" on line 14
Insert: "CHANGING THE COMPOSITION OF THE BOARD OF THE MONTANA SMALL EMPLOYER REINSURANCE PROGRAM;"

3. Title, line 15.
Following: "33-22-1811,"
Insert: "33-22-1818,"
Strike: "CONTINGENTLY"

4. Page 1, line 29 through page 2, line 2.
Following: "all"
Strike: "individual"
Following: "insurance"
Strike: the remainder of line 29 through page 2, line 2
Insert: ", including excess of loss and stop loss disability insurance"

5. Page 2, line 7.
Strike: "["

6. Page 2, line 9.
Strike: "]"

7. Page 2, line 10.
Strike: "["
Strike: "LOWER COST"
Following: "PLAN"
Insert: "[, except a uniform health benefit plan,]"

8. Page 2, line 11.
Strike: "PURSUANT TO 33-22-1812.]"

Amd. Coord. _____
Sec. of Senate Senator Carrying Bill

Insert: "by a small employer carrier that has a lower benefit value than the small employer carrier's standard benefit plan and that provides the benefits required by [section 5]."

(6) "Benefit equivalency" means a method developed by the small employer carrier for comparing the types of health care services and articles covered under a health benefit plan with the types of health care services required to be covered under a [uniform,] basic, or standard health benefit plan.

(7) "Benefit value" means an actuarially based method developed by the small employer carrier for comparing the value of determinable contingencies covered under a health benefit plan with the value of determinable contingencies required under a [uniform,] basic, or standard health benefit plan.""
Renumber: subsequent subsections

9. Page 3, line 1.
Strike: "["
Strike: "]"

10. Page 3, lines 2 and 3.
Strike: lines 2 and 3 in their entirety

11. Page 5, line 6.
Strike: "[UNIFORM] ["
Insert: "minimum"
Following: "basic"
Strike: "]"

12. Page 5, line 9.
Strike: "[UNIFORM] ["
Insert: "minimum"
Following: "basic"
Strike: "]"

13. Page 5, line 29.
Following: "to any"
Insert: "small employer"
Following: "employee of its"
Insert: "small employer"

14. Page 6, lines 3 through 7.
Strike: lines 3 through 7 in their entirety
Insert: "(28) "Standard health benefit plan" means a health benefit plan that is developed by a small employer carrier and that contains the provisions required pursuant to [section 6]."

15. Page 6, line 18.
Following: "Code"
Insert: ", except a plan or program that is funded entirely by contributions from the employees"

16. Page 9, line 25.
Following: line 24
Insert: "(c) The filing required in subsection (5)(b) must contain the small employer carrier's benefit equivalency and benefit value."
Renumber: subsequent subsection

17. Page 10, lines 5 and 6.
Strike: "[THE" on line 5 through "] [" on line 6

18. Page 10, line 8.
Strike: "]"

19. Page 10, lines 9 and 10.
Strike: "[UNIFORM" on line 9 through "] [" on line 10
Strike: "]" on line 10

20. Page 10, line 11.
Strike: "[THE] ["
Strike: "]"

21. Page 10, lines 15 and 16.
Strike: "[A" on line 15 through "] [" on line 16

22. Page 10, line 17.
Strike: "]"

23. Page 10, line 21.
Strike: "[UNIFORM] ["
Strike: "]"

24. Page 11, line 4.
Following: line 3
Insert: "(c) A small employer carrier that elects not to comply with the requirements of subsections (1)(a) and (1)(b) may continue to provide coverage under health benefit plans previously issued to small employers in this state for a period of no more than 7 years from [the effective date of this act] if the carrier:
(i) complies with all other applicable provisions of this part, except 33-22-1810, 33-22-1813, and subsections (2) through (4) of this section; and
(ii) does not amend or alter the benefits and coverages of

the previously issued health benefit plans unless required to do so by law or rule."

25. Page 11, lines 4 and 5.
Strike: "[UNIFORM" on line 4 through "] [" on line 5

26. Page 11, line 6.
Following: "plans"
Strike: "]"

27. Page 11, lines 8 and 9.
Strike: "[UNIFORM" on line 8 through "] [" on line 9

28. Page 11, line 10.
Following: "plan"
Strike: "]"

29. Page 12, lines 6 and 7.
Strike: "[THE" on line 6 through "] [" on line 7
Following: "plan"
Strike: "]"

30. Page 15, line 10.
Insert: "

NEW SECTION. **Section 5. Benefits required in basic health benefit plan.** (1) The basic health benefit plan must provide at least the following benefits:

(a) coverage for the services and articles required by 33-22-1521(2);

(b) coverage for mental health and chemical dependency required by Title 33, chapter 22, part 7; and

(c) coverage for conversion of benefits required by 33-22-508 and 33-22-510 or by 33-30-1007.

(2) The small employer carrier may determine varying levels of deductibles, copayments, maximum annual out-of-pocket expenses, maximum lifetime benefits, and other financial cost-sharing arrangements with the insured that give the basic health benefit plan a lower benefit value than the standard health benefit plan.

(3) A basic health benefit plan provided by a health maintenance organization or a basic health benefit plan with a restricted network provision must provide a comparable level of benefits to those required by subsections (1) and (2), as determined by the benefit equivalency and benefit value.

NEW SECTION. **Section 6. Benefits required in standard benefit plan.** (1) The minimum benefits must be equal to at least 75% of the covered expenses in excess of an annual deductible

that does not exceed $500 per person or $1,000 per family. The coverage must include a limitation of $2,000 per person or $4,000 per family on the total annual out-of-pocket expenses for services covered. The coverage may be subject to a maximum lifetime benefit, but a maximum, if any, may not be less than $1 million.

(2) The commissioner may not require coverage in a standard health benefit plan for any benefit unless other provisions of Title 33, chapter 22, 30, or 31, specifically require coverage for the benefit. A small employer carrier may offer coverage for additional services and articles.

(3) A standard health benefit plan provided by a health maintenance organization or a basic health benefit plan with a restricted network provision shall provide a comparable level of benefits to those required by subsection (1), as determined by the benefit equivalency and benefit value.

Section 7. Section 33-22-1818, MCA, is amended to read:

"**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~~ four 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, and one from a disability reinsurance carrier. 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~~ a representative of a health benefit plan with a restricted network provision. 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~~ On or before March 1 of each year ~~after that date~~, each assessable carrier shall file with the commissioner the carrier's net health insurance premium derived from health benefit plans issued in this state in the previous calendar year."

"

Renumber: subsequent sections

31. Page 16, line 24.
Strike: "fiscal yearend"

32. Page 18, lines 4 and 5.
Following: "approximate"
Strike: "gross" on line 4 through "plan" on line 5
Insert: "the premiums necessary to recover one-half of the expenses for the calendar year. For purposes of this section, expenses include administrative expenses, one-half of the program net loss for the previous calendar year, and the actuarially anticipated claims to be incurred"

33. Page 18, line 23.
Following: "losses"
Insert: ", and the actuarially anticipated losses for the calendar year. The sum of one-half of the program net loss for the previous calendar year plus the anticipated net loss for the calendar year must equal the total assessment amount. If the program net loss for the previous calendar year is zero or less, the total assessment amount must equal the actuarially anticipated losses for the calendar year"

34. Page 18, lines 24 through 28.
Strike: subsection (b) in its entirety
Insert: "(b) (i) Each assessable carrier shall share in the program in an amount determined by multiplying the total assessment amount by a fraction, the numerator of which is the number of individuals in this state covered under disability insurance by the assessable carrier and the denominator of which is the number of all individuals in this state covered under disability insurance by all assessable carriers.

(ii) The board shall make a reasonable effort to ensure that

each insured individual is counted only once for the purpose of assessment. The board shall require each assessable carrier that provides excess of loss or stop loss insurance to include in its count of insured individuals all individuals whose coverage is reinsured in whole or in part, including coverage under excess or stop loss insurance. The board shall allow an assessable carrier who is an excess of loss or stop loss insurer to exclude from its count of insured individuals those who have been counted by a primary disability insurer or by a primary reinsurer.

(iii) The board shall base each assessable carrier's assessment on reports filed with the commissioner as required by 33-22-1820. The board may use any reasonable method of estimating the number of individuals insured by an assessable carrier if the specific number is unknown."

35. Page 18, line 30.
Following: "share of the"
Strike: "net loss of"
Insert: "contribution to"

36. Page 19, line 1.
Strike: "fiscal yearend"

37. Page 19, lines 2 through 4.
Strike: "If" on line 2 through "carrier." on line 4

38. Page 19, line 5.
Strike: "a fiscal yearend or interim"
Insert: "an"

39. Page 19, lines 10 and 11.
Strike: subsection (d) in its entirety
Insert: "(d) The board may establish and maintain program reserves not to exceed five times the actuarially anticipated losses for the calendar year.

(e) If the sum of the reinsurance premiums and assessments in any calendar year exceeds the sum of the administrative expenses and incurred claims for that year, the board may proportionately credit the excess to assessable carriers or it may place the excess in program reserves, subject to the limits in subsection (8)(d)."

40. Page 19, line 30.
Strike: "["

41. Page 20, line 1.
Strike: "] [, IN CONSULTATION WITH MEMBERS OF THE COMMITTEE,]"

42. Page 20, lines 11 through 17.
Following: "laws." on line 11
Strike: the remainder of line 11 through line 17
Insert: "Except as provided in [section 5], a small employer carrier may exclude any category of licensed health care practitioner and any benefit or coverage for health care services otherwise required by law or rule from a basic health benefit plan delivered or issued for delivery in this state."

43. Page 20, line 18.
Insert: "

NEW SECTION. **Section 11. Insured lives reporting requirement.** On or before February 15 of each year, each insurer providing disability insurance shall, on a form prescribed by the commissioner, report the number of Montana residents insured on February 1 under any policy of individual or group disability insurance, including stop loss or excess of loss insurance policies covering disability insurance.

NEW SECTION. **Section 12. Reentry by a carrier.** A carrier that elected to not renew all of its health benefits plans pursuant to 33-22-1810(1)(f) may notify the commissioner within 180 days of [the effective date of this act] of its intent to comply with Title 33, chapter 22, part 18."

Renumber: subsequent sections

44. Page 20, line 19.
Strike: "CONTINGENT REPEALER"
Insert: "Repealer"

45. Page 20, line 20.
Following: "repealed"
Strike: the remainder of line 20 through "531"

46. Page 20, lines 22 through 27.
Strike: section 9 in its entirety
Renumber: subsequent section

47. Page 21, line 2.
Insert: "

NEW SECTION. **Section 14. Codification instruction.** [Section 11] is intended to be codified as an integral part of Title 33, chapter 2, part 7, and the provisions of Title 33, chapter 2, part 7, apply to [section 11].

NEW SECTION. **Section 15. Coordination instruction.** If

House Bill No. 533 is passed and approved and contains a section implementing a uniform health benefit plan, then the bracketed phrases in 33-22-1803 must be included."

Renumber: subsequent section

-END-

JOINT SELECT COMMITTEE REPORT

March 17, 1995

MR. PRESIDENT:
We, your Joint Select Committee on Health Care, having had under consideration HB 446 (third reading copy -- blue), respectfully report that HB 446 be amended as follows and as so amended be concurred in.

Signed: _____
Senator Steve Benedict, Chair

That such amendments read:

1. Page 2, line 27 through page 3, line 5.
Following: "(2)"
Strike: the remainder of line 27 through page 3, line 5
Insert: "A health benefit plan 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 3 years preceding the effective date of coverage of an insured person. The condition may be excluded for a maximum of 12 months."

2. Page 3, line 6.
Strike: "hospital-incurred"
Insert: "hospital expense-incurred"

3. Page 3, line 7.
Following: "policy"
Insert: ", contract,"
Following: "certificate"
Strike: ", a subscriber contract, or a contract of insurance"
Following: "by a"
Insert: "health insurer,"

4. Page 3, line 8.
Following: "corporation"
Insert: ","
Following: "or"
Strike: "a"
Strike: "subscriber contract"
Insert: "organization"

5. Page 3, line 12.
Insert: "(5) A policy of disability income insurance may not exclude coverage for a condition for which medical advice, diagnosis, care, or treatment was recommended by or received from a provider of health care services within 5 years

Amd. Coord.
Sec. of Senate

_____
Senator Carrying Bill

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preceding the effective date of coverage of an insured person. An exclusion may not apply to a disability commencing more than 12 months from the effective date of coverage of an insured person."

6. Page 3, line 13.
Following: "RIDERS."
Insert: "(1)"

7. Page 3, line 14.
Following: "MAY"
Strike: "EXCLUDE"
Insert: "contain a provision that excludes"

8. Page 3, lines 15 through 17.
Following: "RIDERS"
Strike: the remainder of line 15 through line 17
Insert: "for conditions for which medical advice, diagnosis, care, or treatment was recommended by or received from a provider of health care services within 4 years preceding the effective date of coverage of an insured person. The provisions of 33-22-110 do not apply to elimination riders. An insured person may apply to the insurer for removal or modification of a rider, and the insurer shall respond to the application within 60 days of receipt.

(2) An insurer may not, except upon agreement by the insured, retroactively impose an elimination rider on an existing policy, certificate, or contract.

(3) "Elimination rider" means a provision attached to a policy that excludes coverage for a specific condition that would otherwise be covered under the policy."

9. Page 6, line 8.
Insert: "

NEW SECTION. **Section 4. Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications."

Renumber: subsequent sections

10. Page 6, line 12.
Following: "18."
Insert: "An insurer may not, as a result of the application of [this section], seek reimbursement for any claims previously paid. "

-END-

HOUSE STANDING COMMITTEE REPORT

March 17, 1995

Mr. Speaker: We, the committee on **Joint Select Committee on Health Care** report that **Senate Bill 341** (third reading copy -- blue) **be concurred in as amended.**

Signed: _____

Steve Benedict, Chair

Carried by: Rep. Tuss

And, that such amendments read:

1. Title, line 11.
Following: "EXCLUSION;"
Insert: "REVISING ASSOCIATION PLAN MINIMUM BENEFITS;"

2. Page 5, line 24.
Strike: "be less than 150% or more than 400%"
Insert: "exceed 200%"

3. Page 7, line 24.
Following: "(1)"
Insert: "(a)"

4. Page 7, line 25.
Strike: "80%"
Insert: "50%"

5. Page 7.
Following: line 28
Insert: "(b) One association plan must be offered with coverage for 80% of the covered expenses provided in this section in excess of an annual deductible that does not exceed $1,000 per person. This association plan must provide a maximum lifetime benefit of $500,000."

Committee Vote:
Yes 10, No 0.

621448SC.Hbk

6. Page 7, line 29.
Following: "following"
Insert: "medically necessary"

7. Page 7, line 30.
Strike: "provided for in for 33-22-111"
Insert: "and when designated in the contract"

8. Page 8, line 13.
Following: "purchase of"
Insert: "durable"

9. Page 8, line 15.
Strike: "and"

10. Page 8, line 16.
Strike: "."
Insert: ";

(m) drugs requiring a physician's prescription that are approved for use in human beings in the manner prescribed by the United States food and drug administration, covered at 50% of the expense, up to an annual maximum of $1,000;

(n) medically necessary, nonexperimental transplants of the kidney, pancreas, heart, heart/lung, lungs, liver, cornea, and high-dose chemotherapy bone marrow transplantation, limited to a lifetime maximum of $150,000, with an additional benefit not to exceed $10,000 for expenses associated with the donor;

(o) pregnancy, including complications of pregnancy;

(p) newborn infant coverage, as required by 33-22-301;

(q) sterilization;

(r) immunizations;

(s) outpatient rehabilitation therapy;

(t) foot care for diabetics;

(u) services of a convalescent home, as an alternative to hospital services, limited to a maximum of 60 days per year; and

(v) travel, other than transportation by a licensed ambulance service, to the nearest facility qualified to treat the patient's medical condition when approved in advance by the insurer."

11. Page 8, lines 18 and 19.
Strike: subsection (i) and (ii) in their entirety

Renumber: subsequent sections

12. Page 9, line 7.

Following: "condition"
Insert: ", except as provided by subsection (2)"

13. Page 9, line 13.
Strike: subsection (vi) in its entirely

Renumber: subsequent subsections

14. Page 9, line 18.
Strike: "sterilization or"

-END-

HOUSE STANDING COMMITTEE REPORT

March 17, 1995

Mr. Speaker: We, the committee on **Joint Select Committee on Health Care** report that **House Bill 531** (first reading copy -- white) **do pass as amended.**

Signed: _____

Steve Benedict, Chair

And, that such amendments read:

1. Title, lines 4 through 14.
Strike: "RELATING TO" on line 4 through "DATES" on line 14
Insert: "PROVIDING FOR THE DESIGN OF CONSUMER REPORT CARDS ON HEALTH CARE SERVICES"

2. Page 1, line 18 through page 26, line 6.
Strike: everything after the enacting clause
Insert: "

NEW SECTION. **Section 1. Consumer report cards.** (1) The department of social and rehabilitation services shall, in cooperation with consumers, employers, health insurers, hospitals, health care providers, and legislators, design a consumer report card that will enhance consumer responsibility in the use of health care services.

(2) The department of social and rehabilitation services shall, by October 1, 1996, submit to the legislature a proposal that contains the information needed to prepare the consumer report card. The information must include:

(a) uniform data, including charges, that will enable consumers to evaluate the cost of medical procedures;

(b) data about insurance plans, such as benefit and cost provisions;

(c) additional information that may assist consumers in making informed choices about their medical care; and

(d) any further applicable information generated as a result of efforts undertaken pursuant to 50-4-502.

Committee Vote:
Yes 10, No 0.

621451SC.Hbk

(3) The department of social and rehabilitation services shall also develop standards for uniform data to be provided by health insurers, hospitals, and health care providers and shall take into account the feasibility and cost-effectiveness of the standards.

(4) To the extent possible, data collected for the consumer report card must be provided by data sources that currently exist."

NEW SECTION. **Section 2. Codification instruction.** [Section 1] is intended to be codified as an integral part of Title 50, chapter 4, and the provisions of Title 50, chapter 4, apply to [section 1].

NEW SECTION. **Section 3. Coordination instruction.** (1) If House Bill No. 511 is passed and approved, [section 1(1)] must read as follows:

"(1) The Montana health care advisory council shall appoint a task force of consumers, employers, health insurers, hospitals, health care providers, and legislators to design a consumer report card that will enhance consumer responsibility in the use of health care services."

(2) If House Bill No. 511 is passed and approved, the first sentence of [section 1(2)] must read as follows:

"(2) The Montana health care advisory council shall, by October 1, 1996, submit the task force's proposal to the legislature containing the information needed to prepare the consumer report card."

(3) If House Bill No. 511 is passed and approved, [section 1(3) must read as follows:

"(3) The Montana health care advisory council shall also develop standards for uniform data to be provided by health insurers, hospitals, and health care providers and shall take into account the feasibility and cost-effectiveness of the standards."

-END-

HOUSE STANDING COMMITTEE REPORT

March 20, 1995

Mr. Speaker: We, the committee on **Joint Select Committee on Health Care** report that **Senate Bill 376** (third reading copy -- blue) **be concurred in as amended.**

Signed: _____
Steve Benedict, Chair

Carried by: Rep. Orr

And, that such amendments read:

1. Page 1.
Following: line 9
Insert: "STATEMENT OF INTENT
A statement of intent is provided for this bill because [section 8] requires the commissioner of insurance to adopt rules regarding supervision, rehabilitation, and liquidation of self-funded multiple employer welfare arrangements that fail to meet the minimum level of reserves required by [section 8]. The rules adopted by the commissioner to implement [section 8] should be consistent with Title 33, chapter 2, part 13, and should change the application of those provisions only to the extent necessary to be consistent with the purposes of this bill."

2. Page 4, line 16.
Strike: subsection (A) in its entirety

Renumber: subsequent subsections

3. Page 5, line 17.
Following: "description"
Insert: "or summary plan descriptions"

4. Page 5, line 24.
Following: "33-2-514"

Committee Vote:
Yes 9, No 1.

641208SC.Hbk

Strike: ";"
Insert: ". The commissioner may, in the commissioner's discretion, waive the requirement of an actuarial opinion and require a report by an actuarial firm."

5. Page 6, line 14.
Following: "arrangement."
Insert: "The commissioner may adopt rules regarding the supervision, rehabilitation, and liquidation of self-funded multiple employer welfare arrangements that fail to maintain the level of reserves required by this section."

6. Page 6, lines 23 and 24.
Strike: "certified actuarial report obtained by the arrangement"
Insert: "report prepared by an actuarial firm"

7. Page 7, line 13.
Following: "33-2-514"
Strike: ";"
Insert: ". The commissioner may, in the commissioner's discretion, waive the requirement of an actuarial opinion and require a report prepared by an actuarial firm and, upon a showing of good cause, may extend by 30 days the filing date for the report."

-END-

Exhibit #1
3-16-95

Insurance Reform Testimony
Rick Hill exhibit one
March 16, 1995

The issues surrounding small group reform and the Small Employer Health Insurance Availability Act go beyond one bill. The amendments I will present and explain deal with five bills:

- HB446 -- preexisting conditions
- HB466 -- small group insurance reform revisions
- HB531 -- general reform proposal
- HB533 -- general health plan revision and individual insurance market reforms
- SB341 -- Montana Comprehensive Health Association revisions

The amendments address five general areas within small group and general health insurance market reforms:

1. Benefit design
2. Reinsurance program
3. Conversion coverage
4. Disclosure/Comparison information
5. Montana Comprehensive Health Association

The issues were addressed with the intent of providing more affordable health care benefit options in the individual and group markets.

The amendments strengthen the Small Group Availability Act to address concerns that the cost of guaranteed issue is being borne solely by the small group market. They allow comparison of one uniform product from insurer to insurer. They provide a guaranteed price for a leaner benefit conversion plan, providing comparable disclosure information from one insurer to another when a consumer is shopping for health insurance, and they enhance the benefits for folks who are served by the Montana Comprehensive Health Association.

I will deal with amendments one bill at a time, but first I need to explain the health benefit plans which run throughout several of these bills. We started with the current Montana Comprehensive Health Association benefit plan, and separated it into two parts, actual benefits and financial criteria or insured financial responsibility, which means deductibles, copayment levels, lifetime maximums and the like.

Benefit Plan Explanation

An outline of all the benefit plans is attached to the testimony for your information.

Uniform Benefit Plan -- The Uniform Benefit Plan must be made available to all individuals and all groups (of 3-25 employees) by health insurers and HMOs. This plan will be non-guaranteed issue, and is designed as a low cost catastrophic benefit plan for individuals, and for small groups who want to be subject to underwriting standards.

Financial criteria for this product:

- 50/50 copayment after a $1,000 deductible per individual,
- $2,000 per family with a one million dollar lifetime maximum benefit.

Contract benefits for this product:

- hospital and physician services
- a limited prescription drug benefit.
- Rehabilitative services and a number of other (medical) goods and services are covered
- Transplants, if needed, up to $150,000 in a lifetime, plus $10,000 for donor costs.

When people who will buy this type of policy think about covering health care costs, they are thinking about the emotional and financially catastrophic events. A transplant clearly falls in that category.

The traditional mandated benefit of psychiatric and chemical dependency is not included in this benefit design, just as it is not included in the Montana Comprehensive Health Association coverage. All other mandated benefits have also been removed for the purpose of designing this low cost benefit plan, which can be medically underwritten. Again, remember this is catastrophic coverage.

The requirement that the Uniform Plan must be made available is part of the amendments to HB533. This plan is also referenced in HB466.

Montana Comprehensive Health Association Plan -- the Montana Comprehensive Health Association is a high risk pool established by the 1985 Legislature to provide health insurance for individuals, who, because of health history or conditions, could not obtain private health insurance.

The current level of benefits are enhanced under this package proposal to provide coverage for listed transplants, again with a lifetime benefit of $150,000. The Association board of directors is given the latitude to design a lower cost plan by varying the financial cost sharing arrangements with the insureds. At a minimum, the board will still provide a plan which contains the current financial cost of a $1,000 deductible with 80/20, but the maximum lifetime benefit for that option has been moved to $500,000.

The enhancement of the MCHA plan has been moved from HB531 into SB341 so it fits with other modifications proposed by the Association board.

Basic Health Benefit Plan -- Under the provisions of small group reform one standard benefit plan and at least one basic health benefit plan must be made available on a guaranteed

issue basis by all insurers writing small group insurance. The basic benefit plan approach was substantially modified from current administrative rules to allow, again, for the development of lower cost options.

Insurers may offer more than one basic plan, which is any plan with a lower level of benefits than the standard plan.

> Financial criteria -- the insurer may offer various levels of deductibles, copayment and other cost sharing arrangements.
>
> Benefits -- the basic benefit plans must contain at least the uniform plan benefits plus the mandated mental health/chemical dependency mandate plus the conversion mandate. Insurers can then add other benefits over and above these specific services and articles (such as medical supplies and equipment) as are requested by the marketplace, designing products to fit what the marketplace can afford.

Standard Health Benefit Plan -- All insurers writing coverage in the small group marketplace must provide, on a guaranteed issue basis, a standard plan which provides a greater level of benefits than basic plans.

> Financial criteria -- at least 75% of the covered expenses of the standard plan must be paid after a maximum deductible of $500 per person or $1,000 per family. Annual out of pocket expenses cannot be more than $2,000 per person or $4,000 for a family with not less than $1,000,000 lifetime benefit under the standard plan.
>
> Benefits -- the standard plan must include all of the benefits in the uniform plan plus the required benefits of the basic plan plus all other state mandates. Additional services and articles may be covered.

Both the basic and standard benefit modifications are contained in the amendments to HB 466.

Next, I would like to address what the five sets of amendments accomplish.

Amendments Overview

The amendments to HB466:

1. Redefine the basic and standard health benefit plans, both as they were set forth under the Insurance Commissioner's administrative rules and as proposed in the introduced HB466. These are the two types of guaranteed issue plans which will be offered in the small group marketplace. Definitions have been added to simplify the method whereby an HMO certifies that its plans are basic and standard. Clarification of the mandate waiver in 33-22-1821 is made as to which mandated benefits apply to which plans.

2. All language laying out a single guaranteed issue Uniform Plan and the Alternate Contingency language has been removed.

3. The reinsurance program has been rewritten to assure spreading the cost of guaranteed issue beyond the small group marketplace. The changes clearly address concerns that the cost of this reform could be borne solely on the backs of small business. At the beginning of each year the reinsurance board is to project the cost of the potential claims to the reinsurance pool. Fifty percent of that cost is to be built into the cost of the reinsurance premium paid by the small employer insurer buying the reinsurance. The other fifty percent will be paid through a premium all health insurers, health service corporations, HMOs excess and reinsurers pay based on their Montana business in the previous year.

4. Some associations provide health benefit plans to their employer members. Many association members are small employers. Association benefit compliance with the guaranteed issue requirement is clarified to fit with the same number of eligible employees as does small group reform.

5. One amendment allows insurers who were in the market prior to small group reform and who do not wish to now write new small group business to continue servicing existing clients from three to seven years. They must, however, comply with small group reform requirements for those clients. They also cannot write new groups, nor can they rewrite existing groups on new policies.

6. One amendment clarifies that employees who pay the full cost of their individual coverage through a flex benefit plan mechanism are not subject to small group reform.

House Bill 446 -- preexisting condition reform

1. Lowers the number of years an insurer can look back to determine preexisting conditions. Current law allows five. The change will now allow for only a three-year look back.

2. Clarification is made for disability income insurance to allow for conditions manifesting themselves during the first twelve months of coverage.

3. Clarifies the use of elimination riders, a mechanism whereby insurers can cover a person with a specific health condition which normally would preclude that person from getting insurance. The insurer riders out that condition, and accepts the individual for all other health conditions or incidental injuries. This has been standard practice in the marketplace, but only recently the Insurance Department said the practice was not allowed. Therefore, this amendment clarifies what has been standard practice.

4. Retroactive applicability -- important because riders have not previously been specifically addressed in Montana law, but have been an industry practice not precluded by Montana law for a number of years.

House Bill 531 -- Medisaves, Basic Plan Design, information, etc.

The amendments to this bill remove all sections but the information reporting requirements on health care facilities and providers. All other provisions are addressed in other bills, with the exception of Section 6 -- standardized claim form. That provision has been addressed for insurers through administrative rule by the Insurance Commissioner. The Health Care Advisory which is being created by HB511 should continue to pursue this for other payors, where it has jurisdiction.

House Bill 533 -- health benefit plan revision, preexisting waiver portability

1. In addition to the individual market reforms contained in this bill, insurers and HMOs will now be required to meet certain insurance product disclosure standards for prospective applicants. These standards will allow comparison of benefits, financial requirements like deductibles, potential price and underwriting characteristics, and general premium trend information. (Amendment 3, New Sections 5-7)

2. The Uniform Benefit Plan which all insurers will be required to make available to individuals and groups on an underwritten basis is defined in Amendment 3, New Sections 8-10.

3. Conversion -- for the past 14 years, individuals who leave a group insurance plan have had the right to convert to individual coverage on a guaranteed issue basis without preexisting condition applicability. The conversion right has now been expanded to include conversion to the lowest cost Basic Plan at 150% of the highest rate for that plan.

Senate Bill 341 -- Montana Comprehensive Health Association

The MCHA board had recommended some statutory changes to the current benefit plan, and has also expanded benefits where they have been able to do so. The amendments:

1. Enhance current MCHA benefits by adding coverage for listed transplants and several other services.

2. Give the board flexibility to provide more than one level of benefits, so long as it continues to offer the current $1,000 deductible, 80/20 plan with an expanded lifetime maximum of $500,000.

I can tell you from first-hand experience that this has been a grueling, time-consuming, high intensity level process by which we have reached consensus on each of these issues.

Each party has had to give considerable ground from their original positions on any number of issues.

I believe the people of Montana have been well served by the process. We have made substantial improvements in the small group insurance market as well as expanding reforms in the individual market and insurance industry as a whole.

Now that we have dealt significantly with insurance issues, I hope when you return in 1997 we can focus as much time and energy on cost issues which will continue to be at the forefront of health care and our ability to purchase insurance and health care services.

Exhibit #1a

BENEFIT DESIGN

Uniform:

Group and Individual
Nonguaranteed Issue

Financial Criteria:

(a) Pay 50% of the covered expenses in excess of an annual deductible that does not exceed $1,000 per person or $2,000 per family;
(b) Include a limitation of $5,000 per person or $7,500 per family on the total annual out-of-pocket expenses for services covered; and
(c) Be subject to a maximum lifetime benefit of $1,000,000.

Benefit Criteria:

Covered expenses must include the following medically necessary services and articles when prescribed by a physician or other health care provider as designated in the contract:

(a) hospital services;
(b) professional services for the diagnosis or treatment of injuries, illness, or conditions, other than dental;
(c) use of radium or other radioactive materials;
(d) oxygen;
(e) anesthetics;
(f) diagnostic x-rays and laboratory tests, except as specifically provided in subsection (3) (c) (i);
(g) services of a physical therapist;
(h) transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition;
(i) oral surgery for the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth or in connection with TMJ;
(j) rental or purchase of durable medical equipment, which must be reimbursed after the deductible has been met at the rate of 50 percent, up to a maximum of $1,000;
(k) prosthetics, other than dental;
(l) services of a licensed home health agency, up to a maximum of 180 visits per year;
(m) drugs requiring a physician's prescription that are approved for use in human beings in the manner prescribed by the United States Food and Drug Administration at the rate of 50 percent, up to an annual maximum of $1,000.
(n) medically necessary, nonexperimental organ transplants of the following major organs, limited to a maximum of $150,000 in a lifetime, with an additional $10,000 to be paid for costs associated with the donor:
    1. kidney
    2. pancreas
    3. heart
    4. heart/lung
    5. lung

6. liver
7. high-dosage chemothrapy/bone marrow transplantation
8. cornea

(o) pregnancy, including complications of pregnancy;
(p) newborn infant coverage as provided in 33-22-301, 33-22-504, and 33-30-1001, MCA;
(q) sterilization;
(r) immunizations;
(s) outpatient rehabilitation therapy;
(t) foot care for diabetics;
(u) services of a convalescent home, as an alternative to hospital services, limited to a maximum of 60 days per year; and
(v) travel, other than transportation provided by a licensed ambulance service, to the nearest facility qualified to treat the patient's medical condition when approved by the insurer's Medical Utilization Review Department.

BASIC

Small Group and lowest cost for conversion
Guaranteed Issue

Financial Criteria:
Lower than standard, determined by marketplace

Benefit Criteria:
Uniform Benefit Plan
Mental Health/Chemical Dependency
Conversion
Plus whatever else marketplace determines up to standard

STANDARD

Small Group
Guaranteed Issue

Financial Criteria:
(a) The minimum benefits must be equal to at least 75% of the covered expenses in excess of an annual deductible that does not exceed $500 per person or $1,000 per family.
(b) The coverage must include a limitation of $2,000 per person or $4,000 per family on the total annual out-of-pocket expenses for services covered.
(c) The coverage may be subject to a maximum lifetime benefit, but such maximums, if any, must not be less than $1,000,000.

EXHIBIT 1a
DATE 3-16-95

Benefit Criteria:
Uniform Benefit Plan
Plus all state mandates
Plus any additional benefits an insurer may decide to offer

MONTANA COMPREHENSIVE HEALTH ASSOCIATION

State-Sponsored High-Risk Pool for Individuals
Guaranteed Issue

Financial Criteria:

(a) Pay at least 50% of covered expenses in excess of an annual deductible with $1,000 annual deductible.
(b) Limitation of $5,000 annual out-of-pocket expenses for services covered.
(c) Maximum lifetime benefits of at least $100,000--the current level is $350,000.
(d) One option must be offered with coverage for 80% of the covered expenses required by this section in excess of an annual deductible that does not exceed $1,000 per person. This association plan must provide a maximum lifetime benefit of $500,000.

Benefit Criteria:

New benefits added to those already in plan are:

a) Drugs requiring a physician's prescription that are approved for use in human beings in the manner prescribed by the United States Food and Drug Administration, covered at 50% of the expense up to an annual maximum of $1,000;
b) Medically necessary, nonexperimental transplants of the kidney, pancreas, heart, heart/lung, lung, liver, cornea, and high-dosage chemotherapy/bone marrow transplantation, limited to a lifetime maximum of $150,000, with an additional benefit not to exceed $10,000 for expenses associated with the donor;
c) Pregnancy, including complications of pregnancy;
d) Newborn infant coverage, as required by 33-22-301;
e) Sterilization;
f) Immunizations;
g) Outpatient rehabilitation therapy;
h) Foot care for diabetics;
i) Services of a convalescent home, as an alternative to hospital services, limited to a maximum of 60 days per year; and
j) Travel, other than transportation provided by a licensed ambulance service, to the nearest facility qualified to treat the patient's medical condition when approved by the insurer's Medical Utilization Review Department.

Exhibit #2
3-16-95

Amendments to Senate Bill No. 341
Third Reading Copy

Requested by Sen. Benedict
For the Joint Select Committee on Health Care

Prepared by David S. Niss
March 16, 1995

1. Title, line 11.
Following: "EXCLUSION;"
Insert: "REVISING ASSOCIATION PLAN MINIMUM BENEFITS;"

2. Page 5, line 24.
Strike: "be less than 150% or more than 400%"
Insert: "exceed 200%"

3. Page 7, line 24.
Following: "(1)"
Insert: "(a)"

4. Page 7, line 25.
Strike: "80%"
Insert: "50%"

5. Page 7.
Following: line 28
Insert: "(b) One association plan must be offered with coverage for 80% of the covered expenses provided in this section in excess of an annual deductible that does not exceed $1,000 per person. This association plan must provide a maximum lifetime benefit of $500,000."

6. Page 7, line 29.
Following: "following"
Insert: "medically necessary"

7. Page 7, line 30.
Strike: "provided for in for 33-22-111"
Insert: "and when designated in the contract"

8. Page 8, line 13.
Following: "purchase of"
Insert: "durable"

9. Page 8, line 15.
Strike: "and"

10. Page 8, line 16.
Strike: "."
Insert: ";
(m) drugs requiring a physician's prescription that are approved for use in human beings in the manner prescribed by the United States food and drug administration, covered at 50% of

the expense, up to an annual maximum of $1,000;

(n) medically necessary, nonexperimental transplants of the kidney, pancreas, heart, heart/lung, lungs, liver, cornea, and high-dose chemotherapy bone marrow transplantation, limited to a lifetime maximum of $150,000, with an additional benefit not to exceed $10,000 for expenses associated with the donor;

(o) pregnancy, including complications of pregnancy;

(p) newborn infant coverage, as required by 33-22-301;

(q) sterilization;

(r) immunizations;

(s) outpatient rehabilitation therapy;

(t) foot care for diabetics;

(u) services of a convalescent home, as an alternative to hospital services, limited to a maximum of 60 days per year; and

(v) travel, other than transportation by a licensed ambulance service, to the nearest facility qualified to treat the patient's medical condition when approved in advance by the insurer."

11. Page 8, lines 18 and 19.
Strike: subsection (i) and (ii) in their entirety

Renumber: subsequent sections

12. Page 9, line 7.
Following: "condition"
Insert: ", except as provided by subsection (2)"

13. Page 9, line 13.
Strike: subsection (vi) in its entirely

Renumber: subsequent subsections

14. Page 9, line 18.
Strike: "sterilization or"

exhibit #3
3-16-95

Amendments to House Bill No. 466
Third Reading Copy

Requested by Senator Steve Benedict
For the Joint Select Committee on Health Care Issues

Prepared by Susan Byorth Fox
March 16, 1995

1. Title, line 10.
Strike: "CONTINGENTLY"

2. Title, line 13.
Following: "PROGRAM;"
Strike: the remainder of line 13 through "CARRIERS;" on line 14

3. Title, line 15.
Strike: "CONTINGENTLY"

4. Page 1, line 29 through page 2, line 2.
Following: "all"
Strike: "individual"
Following: "insurance"
Strike: the remainder of line 29 through page 2, line 2
Insert: ", including excess of loss and stop loss disability insurance"

5. Page 2, line 7.
Strike: "["

6. Page 2, line 9.
Strike: "]"

7. Page 2, line 10.
Strike: "["
Strike: "LOWER COST"
Following: "PLAN"
Insert: ", except a uniform benefit plan,"

8. Page 2, line 11.
Strike: "PURSUANT TO 33-22-1812.]"
Insert: "by a small employer carrier that has a lower benefit value than the small employer carrier's standard benefit plan and that provides the benefits required by [section 5]."

(6) "Benefit equivalency" means a method developed by the small employer carrier for comparing the types of health care services and articles covered under a health benefit plan with the types of health care services required to be covered under a uniform, basic, or standard health benefit plan.

(7) "Benefit value" means an actuarially based method developed by the small employer carrier for comparing the value of determinable contingencies covered under a health benefit plan with the value of determinable contingencies required under a uniform, basic, or standard health benefit plan.""

Renumber: subsequent subsections

9. Page 3, line 1.
Strike: "["
Strike: "]"

10. Page 3, lines 2 and 3.
Strike: lines 2 and 3 in their entirety

11. Page 5, line 6.
Strike: "[UNIFORM] ["
Insert: "minimum"
Following: "basic"
Strike: "]"

12. Page 5, line 9.
Strike: "[UNIFORM] ["
Insert: "minimum"
Following: "basic"
Strike: "]"

13. Page 5, line 29.
Following: "to any"
Insert: "small employer"
Following: "employee of its"
Insert: "small employer"

14. Page 6, lines 3 through 7.
Strike: lines 3 through 7 in their entirety
Insert: "(28) "Standard health benefit plan" means a health benefit plan that is developed by a small employer carrier and that contains the provisions required pursuant to [section 6]."

15. Page 6, line 18.
Following: "Code"
Insert: ", except a plan or program that is funded entirely by contributions from the employees"

16. Page 9, line 25.
Following: line 24
Insert: "(c) The filing required in subsection (5)(b) must contain the small employer carrier's benefit equivalency and benefit value."
Renumber: subsequent subsection

17. Page 10, lines 5 and 6.
Strike: "[THE" on line 5 through "] [" on line 6

18. Page 10, line 8.
Strike: "]"

19. Page 10, lines 9 and 10.
Strike: "[UNIFORM" on line 9 through "] [" on line 10
Strike: "]" on line 10

EXHIBIT 3
DATE 3-16-95

20. Page 10, line 11.
Strike: "[THE] ["
Strike: "]"

21. Page 10, lines 15 and 16.
Strike: "[A" on line 15 through "] [" on line 16

22. Page 10, line 17.
Strike: "]"

23. Page 10, line 21.
Strike: "[UNIFORM] ["
Strike: "]"

24. Page 11, line 4.
Following: line 3
Insert: "(c) A small employer carrier that elects not to comply with the requirements of subsections (1)(a) and (1)(b) may continue to provide coverage under health benefit plans previously issued to small employers in this state for a period of no more than 7 years from [the effective date of this act] if the carrier:

(i) complies with all other applicable provisions of this part, except 33-22-1810, 33-22-1813, and subsections (2) through (4) of this section; and

(ii) does not amend or alter the benefits and coverages of the previously issued health benefit plans unless required to do so by law or rule."

25. Page 11, lines 4 and 5.
Strike: "[UNIFORM" on line 4 through "] [" on line 5

26. Page 11, line 6.
Following: "plans"
Strike: "]"

27. Page 11, lines 8 and 9.
Strike: "[UNIFORM" on line 8 through "] [" on line 9

28. Page 11, line 10.
Following: "plan"
Strike: "]"

29. Page 12, lines 6 and 7.
Strike: "[THE" on line 6 through "] [" on line 7
Following: "plan"
Strike: "]"

30. Page 15, line 10.
Insert: "

NEW SECTION. **Section 5. Benefits required in a basic health benefit plan.** (1) The basic health benefit plan must provide at least the following benefits:

(a) coverage for the services and articles required by

33-22-1521(2);

(b) coverage for mental health and chemical dependency required by Title 33, chapter 22, part 7; and

(c) coverage for conversion of benefits required by 33-22-508 and 33-22-510 or by 33-30-1007.

(2) The small employer carrier may determine varying levels of deductibles, copayments, maximum annual out-of-pocket expenses, maximum lifetime benefits, and other financial cost-sharing arrangements with the insured that give the basic health benefit plan a lower benefit value than the standard health benefit plan.

(3) A basic health benefit plan provided by a health maintenance organization or a basic health benefit plan with a restricted network provision must provide a comparable level of benefits to those required by subsections (1) and (2), as determined by the benefit equivalency and benefit value.

NEW SECTION. **Section 6. Benefits required in a standard benefit plan.** (1) The minimum benefits must be equal to at least 75% of the covered expenses in excess of an annual deductible that does not exceed $500 per person or $1,000 per family. The coverage must include a limitation of $2,000 per person or $4,000 per family on the total annual out-of-pocket expenses for services covered. The coverage may be subject to a maximum lifetime benefit, but a maximum, if any, may not be less than $1 million.

(2) The commissioner may not require coverage in a standard health benefit plan for any benefit unless other provisions of Title 33, chapter 22, 30, or 31, specifically require coverage for the benefit. A small employer carrier may offer coverage for additional services and articles.

(3) A standard health benefit plan provided by a health maintenance organization or a basic health benefit plan with a restricted network provision shall provide a comparable level of benefits to those required by subsection (1), as determined by the benefit equivalency and benefit value."

Renumber: subsequent sections

31. Page 16, line 24.
Strike: "fiscal yearend"

32. Page 18, lines 4 and 5.
Following: "approximate"
Strike: "gross" on line 4 through "plan" on line 5
Insert: "the premiums necessary to recover one-half of the expenses for the calendar year. For purposes of this section, expenses include administrative expenses and the actuarially anticipated claims to be incurred"

33. Page 18, line 23.
Following: "losses"
Insert: ", and the actuarially anticipated losses for the calendar year. The sum of the program net loss for the previous calendar year plus the anticipated net loss for the calendar year must equal the total assessment amount. If

the program net loss for the previous calendar year is zero or less, the total assessment amount must equal the actuarially anticipated losses for the calendar year"

34. Page 18, lines 24 through 28.
Strike: subsection (b) in its entirety
Insert: "(b) (i) Each assessable carrier shall share in the program in an amount determined by multiplying the total assessment amount by a fraction, the numerator of which is the number of individuals in this state covered under disability insurance by the assessable carrier and the denominator of which is the number of all individuals in this state covered under disability insurance by all assessable carriers.

(ii) The board shall make a reasonable effort to ensure that each insured individual is counted only once for the purpose of assessment. The board shall require each assessable carrier that provides excess of loss or stop loss insurance to include in its count of insured individuals all individuals whose coverage is reinsured in whole or in part, including reinsurance under excess or stop loss insurance. The board shall allow an assessable carrier who is an excess of loss or stop loss insurer to exclude from its count of insured individuals those who have been counted by a primary disability insurer or by a primary reinsurer.

(iii) The board shall base each assessable carrier's assessment on reports filed with the commissioner as required by 33-22-1820. The board may use any reasonable method of estimating the number of individuals insured by an assessable carrier if the specific number is unknown."

35. Page 18, line 30.
Following: "share of the"
Strike: "net loss of"
Insert: "contribution to"

36. Page 19, line 1.
Strike: "fiscal yearend"

37. Page 19, lines 2 through 4.
Strike: "If" on line 2 through "carrier." on line 4

38. Page 19, line 5.
Strike: "a fiscal yearend or interim"
Insert: "an"

39. Page 19, lines 10 and 11.
Strike: subsection (d) in its entirety
Insert: "(d) The board may establish and maintain program reserves not to exceed five times the actuarially anticipated losses for the calendar year.

(e) If the sum of the reinsurance premiums and assessments in any calendar year exceeds the sum of the administrative expenses and incurred claims for that year, the board may proportionately credit the excess to assessable carriers or it

may place the excess in program reserves, subject to the limits in subsection (8)(d)."

40. Page 19, line 30.
Strike: "["

41. Page 20, line 1.
Strike: "] [, IN CONSULTATION WITH MEMBERS OF THE COMMITTEE,]"

42. Page 20, lines 11 through 17.
Strike: lines 11 through 17 in their entirety
Insert: "Except as provided in [section 5], a small employer carrier may exclude any category of licensed health care practitioner and any benefit or coverage for health care services otherwise required by law or rule from a basic health benefit plan delivered or issued for delivery in this state."

43. Page 20, line 18.
Insert: "

NEW SECTION. **Section 10. Insured lives reporting requirement.** On or before February 15 of each year, each insurer providing disability insurance shall, on a form prescribed by the commissioner, report the number of Montana residents insured on February 1 under any policy of individual or group disability insurance, including stop loss or excess of loss insurance policies covering disability insurance.

NEW SECTION. **Section 11. Reentry by a carrier.** A carrier that elected to not renew all of its health benefits plans pursuant to 33-22-1810(1)(f) may notify the commissioner within 180 days of [the effective date of this act] of its intent to comply with Title 33, chapter 22, part 18."

Renumber: subsequent sections

44. Page 20, line 19.
Strike: "CONTINGENT REPEALER"
Insert: "Repealer"

45. Page 20, line 20.
Following: "repealed"
Strike: the remainder of line 20 through "531"

46. Page 20, lines 22 through 27.
Strike: section 9 in its entirety
Renumber: subsequent section

47. Page 21, line 2.
Insert: "

NEW SECTION. **Section 13. {standard} Codification instruction.** [Section 10] is intended to be codified as an integral part of Title 33, chapter 2, part 7, and the provisions of Title 33, chapter 2, part 7, apply to [section 10]."
Renumber: subsequent section

exhibit 4
3-16-95

Amendments to House Bill No. 466
Third Reading Copy

Requested by Senator Steve Benedict
For the Joint Select Committee on Health Care Issues

Prepared by Susan Byorth Fox
March 16, 1995

1. Title, line 14.
Following: "CARRIERS;"
Insert: "CHANGING THE COMPOSITION OF THE BOARD OF THE MONTANA SMALL EMPLOYER REINSURANCE PROGRAM;"

2. Title, line 15.
Following: "33-22-1811,"
Insert: "33-22-1818,"

3. Page 15, line 10.
Insert: "

Section 5. Section 33-22-1818, MCA, is amended to read:

"**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~~ four 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, and one from a disability reinsurance carrier. 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~~ a representative of a health benefit plan with a restricted network provision. 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~~ On or before March 1 of each year ~~after that date~~, each assessable carrier shall file with the commissioner the carrier's net health insurance premium derived from health benefit plans issued in this state in the previous calendar year."

{Internal References to 33-22-1818:
33-22-1803x 33-22-1803x 33-22-1803x 33-22-1811x}

Renumber: subsequent sections

exhibit 5
3-16-95

Amendments to House Bill No. 446
Third Reading Copy

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

Prepared by Susan Byorth Fox
March 16, 1995

1. Page 2, line 27 through page 3, line 5.
Following: "(2)"
Strike: the remainder of line 27 through page 3, line 5
Insert: "A health benefit plan 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 3 years preceding the effective date of coverage of an insured person. The condition may be excluded for a maximum of 12 months."

2. Page 3, line 6.
Strike: "hospital-incurred"
Insert: "hospital expense-incurred"

3. Page 3, line 7.
Following: "policy"
Insert: ", contract,"
Following: "certificate"
Strike: ", a subscriber contract, or a contract of insurance"
Following: "by a"
Insert: "health insurer,"

4. Page 3, line 8.
Following: "corporation"
Insert: ","
Following: "or"
Strike: "a"
Strike: "subscriber contract"
Insert: "organization"

5. Page 3, line 12.
Insert: "(5) A policy of disability income insurance may not exclude coverage for a condition for which medical advice, diagnosis, care, or treatment was recommended by or received from a provider of health care services within 5 years preceding the effective date of coverage of the insured person. An exclusion may not apply to a disability commencing more than 12 months from the effective date of coverage of an insured person."

6. Page 3, line 14.
Following: "MAY"
Strike: "EXCLUDE"
Insert: "contain a provision that excludes"

7. Page 3, lines 15 through 17.
Following: "RIDERS"
Strike: the remainder of line 15 through line 17
Insert: "for conditions for which medical advice, diagnosis, care, or treatment was recommended by or received from a provider of health care services within 4 years preceding the effective date of coverage of an insured person. The provisions of 33-22-110 do not apply to elimination riders. An insured person may apply to the insurer for removal or modification of a rider, and the insurer shall respond to the application within 60 days of receipt."

8. Page 6, line 12.
Following: "18."
Insert: "An insurer under this provision may not, as a result of the application of this provision, seek reimbursement for any claims previously paid. An insurer may not, except upon agreement by the insured, retroactively impose an elimination rider on an existing policy, certificate, or contract."

exhibit 6
3-16-95

Amendments to House Bill No. 446
Third Reading Copy

Requested by Senator Benedict
For the Joint Select Committee on Health Care Issues

Prepared by Susan Byorth Fox
March 16, 1995

1. Page 6, line 8.
Insert: "

NEW SECTION. **Section 4. {standard} Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications."

Renumber: subsequent sections

Exhibit # 7
3-16-95

Amendments to House Bill No. 533
Third Reading Copy

Requested by Senator Steve Benedict
For the Joint Select Committee on Health Care Issues

Prepared by Susan Byorth Fox
March 16, 1995

1. Page 1, line 19.
Following: "CONTRACT"
Strike: "PRODUCT TYPE"
Insert: "filed and approved by the Commissioner pursuant to 33-1-501 and"

2. Page 1, line 20.
Strike: "TYPE OF"

3. Page 1, line 23.
Strike: "OR"
Following: "ORGANIZATION"
Insert: ", or a fraternal benefit society"

4. Page 1, line 26.
Following: "issued"
Strike: "or delivered for issue"
Insert: "for delivery"

5. Page 1, lines 27 and 28
Strike: lines 27 through "individuals" on line 28

6. Page 1, line 29.
Following: "self-" in two places
Strike: "insured"
Insert: "funded"

7. Page 2, line 8.
Following: "FOR"
Strike: the remainder of line 8 through "year"

8. Page 2, lines 11 and 12.
Following: "FOR"
Strike: the remainder of line 11 through "year" on line 12

9. Page 2, line 22.
Strike: "a group or"
Insert: "an"

10. Page 2, line 24.
Following: "charges for"
Insert: "individual"

11. Page 2, line 27.
Following: "BUSINESS"

Insert: "as defined in [section 1]"

12. Page 3, line 8.
Following: "means a"
Strike: the remainder of line 8
Insert: "disability insurer, a health service corporation, a health maintenance organization, or a fraternal benefit society."

13. Page 3, line 9.
Insert: "(3) The provisions of Title 33, chapter 1, parts 3 and 7 apply to this section."

14. Page 3, lines 29 and 30.
Strike: "1"
Insert: "2"

Exhibit #8
3-16-95

Amendments to House Bill No. 533
Third Reading Copy

Requested by Senator Benedict
For the Joint Select Committee on Health Care Issues

Prepared by Susan Byorth Fox
March 16, 1995

1. Title, line 11.
Following: "INSURER;"
Insert: "REQUIRING DISCLOSURE OF CERTAIN POLICY FEATURES AT OR BEFORE THE TIME OF APPLICATION; CREATING A LOW-COST UNIFORM HEALTH BENEFIT PLAN; CAPPING PREMIUM RATES ON CERTAIN CONVERSION POLICIES;"

2. Title, line 11.
Strike: "SECTION"
Insert: "SECTIONS"

3. Title, line 12.
Following: "33-22-101,"
Insert: "33-22-508, AND 33-30-1007,"

4. Page 3, line 25.
Insert: "

NEW SECTION. **Section 5. Disclosure standards -- individual policy.** (1) In order to provide for full and fair disclosure in the sale of disability insurance, an individual disability insurance policy may not be delivered or issued for delivery in this state unless an outline of coverage is delivered to the applicant at the time the application is made.

(2) The outline of coverage must include:

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

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

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

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

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

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

(3) The outline of coverage may include any other information that the insurer considers relevant to the applicant's selection of an appropriate individual disability policy.

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

NEW SECTION. **Section 6. Disclosure standards -- group policy.** (1) In order to provide for full and fair disclosure in the sale of disability insurance, a group disability insurance policy may not be delivered or issued for delivery in this state unless an outline of coverage is delivered to the applicant at the time the application is made.

(2) The outline of coverage must include:

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

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

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

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

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

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

(3) If applicable, the outline of coverage must disclose that the policy does not contain coverage for mental illness or chemical dependency.

(4) The outline of coverage may include any other information that the insurer considers relevant to the applicant's selection of an appropriate group disability policy.

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

NEW SECTION. **Section 7. Disclosure standards -- health maintenance organizations.** (1) In order to provide for full and fair disclosure in the sale of disability insurance, an enrollment form or evidence of coverage may not be delivered or issued for delivery in this state by a health maintenance organization unless an outline of coverage is delivered to the applicant at the time the application is made. The outline of coverage must be filed with the commissioner as required by 33-1-501.

(2) The outline of coverage must include:

(a) a general description of the principal benefits and

coverages provided by the policy;

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

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

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

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

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

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

(4) An insurer or producer shall provide an outline of coverage to any individual upon request.

NEW SECTION. **Section 8. Uniform health benefit plan -- individual.** (1) Each insurer or health service corporation delivering or issuing for a delivery in this state an individual disability insurance policy, certificate, or contract shall make available a uniform health benefit plan providing the benefits and services required in subsection (2).

(2) The uniform health benefit plan must:

(a) provide coverage for the services and articles required by 33-22-1521(2);

(b) pay 50% of the covered expenses in excess of an annual deductible that may not exceed $1,000 per person or $2,000 per family;

(c) include a limitation of $5,000 per person or $7,500 per family on the total annual out-of-pocket expenses for services covered; and

(d) be subject to a maximum lifetime benefit of $1 million.

NEW SECTION. **Section 9. Uniform health benefit plan -- group.** (1) Each insurer or health service corporation delivering or issuing for a delivery in this state a group disability insurance policy, certificate, or contract shall make available a uniform health benefit plan providing the benefits and services required in subsection (2).

(2) The uniform health benefit plan must:

(a) provide coverage for the services and articles required by 33-22-1521(2);

(b) pay 50% of the covered expenses in excess of an annual deductible that may not exceed $1,000 per person or $2,000 per family;

(c) include a limitation of $5,000 per person or $7,500 per family on the total annual out-of-pocket expenses for services covered; and

(d) be subject to a maximum lifetime benefit of $1 million.

NEW SECTION. **Section 10. Uniform health benefit plan -- health maintenance organization.** Each health maintenance organization delivering or issuing for a delivery in this state an enrollment form or evidence of coverage shall make available a uniform health benefit plan providing benefit equivalency and benefit value, as defined in chapter 22, part 18, comparable to the uniform health benefit plan required in [section 8(2)].

Section 11. Section 33-22-508, MCA, is amended to read:

"33-22-508. Conversion on termination of eligibility. (1) A group disability insurance policy issued or renewed after October 1, 1981, must contain a provision that if the insurance or any portion of it on a person, ~~his~~ a person's dependents, or family members covered under the policy ceases because of termination of ~~his~~ the person's employment or of ~~his~~ the person's membership in the class or classes eligible for coverage under the policy or as a result of ~~his~~ a person's employer discontinuing ~~his~~ the employer's business or as a result of ~~his~~ a person's employer discontinuing the group disability insurance policy and not providing for any other group disability insurance or plan and if the person had been insured for a period of 3 months and ~~he~~ the person is not insured under another major medical disability insurance policy or plan, ~~he~~ the person is entitled to have issued to ~~him~~ the person by the insurer, without evidence of insurability, group coverage or an individual policy issued by the insurer or, in the absence of an individual policy issued by the insurer, a group policy issued by the insurer, of hospital or medical service insurance on ~~himself~~ the person, ~~his~~ the person's dependents, or family members if application for the individual policy is made and the first premium tendered to the insurer within 31 days after the termination of group coverage.

(2) The individual policy or group policy, at the option of the insured, may be on any form then customarily issued by the insurer to individual or group policyholders, with the exception of a policy the eligibility for which is determined by affiliation other than by employment with a common entity. In addition, the insurer must make available a conversion policy as required by subsection (4).

(3) The premium on the individual policy or group policy must be at the insurer's then customary conversion rate applicable to the coverage of the individual or group policy.

(4) The insurer must make available an individual conversion policy that provides the level of benefits provided by the insurer's lowest cost basic health benefit plan under 33-22-1803(5). If the insurer is not a small employer carrier under part 18, the insurer shall make available an individual conversion policy that provides equivalent benefits to a basic health benefit plan. The conversion rate may not exceed 150% of the highest rate charged for that plan."

{*Internal References to 33-22-508:*
2-18-704x *33-22-1113x* *33-22-513x* *33-22-513x*}

Section 12. Section 33-30-1007, MCA, is amended to read:

EXHIBIT 8
DATE 3-16-95

"33-30-1007. Conversion on termination of eligibility. (1) The group hospital or medical service plan contract issued or renewed by a health service corporation after October 1, 1981, shall contain a provision that if the insurance or any portion of it on a person, ~~his~~ a person's dependents, or family members covered under the policy ceases because of termination of ~~his~~ the person's employment or of ~~his~~ a person's membership in the class or classes eligible for coverage under the policy, as a result of an employer discontinuing ~~his~~ the employer's business, or as a result of an employer discontinuing the policy issued by the health service corporation and not providing for any other group disability insurance or plan, ~~such~~ a person shall, provided ~~he~~ the person has been insured for a period of 3 months and that ~~he~~ the person is not insured under another major medical disability insurance policy or plan, be entitled to have issued to ~~him~~ the person by the insurer, without evidence of insurability, an individual policy of hospital or medical service insurance on ~~himself~~ the person, ~~his~~ the person's dependents, or family members, provided application for the individual policy ~~shall~~ must be made and the first premium tendered to the insurer within 31 days after the termination of group coverage.

(2) The individual policy shall, at the option of the insured, be on any of the forms then customarily issued by the insurer to individual policyholders with the exception of those whose eligibility is determined by their affiliation other than by employment with a particular entity. In addition, the health services corporation shall make available a conversion policy as required by subsection (4).

(3) The premium on the individual policy ~~shall~~ must be at the insurer's then customary rate applicable to the coverage of the individual policy but may not be greater than 150% of the insurer's highest group rate for a policy with the same benefits as the conversion policy.

(4) The health service corporation must make an individual conversion policy that provides the level of benefits provided by its lowest cost basic health benefit plan under 33-22-1803(5). If the insurer is not a small employer carrier under chapter 22, part 18, the insurer must make available an individual conversion policy that provides equivalent benefits to a basic health benefit plan. The conversion rate may not exceed 150% of the highest rate charged for that plan.""

{*Internal References to 33-30-1007:*
33-30-1015x *33-30-1015x* *33-30-307x*}

5. Page 4, line 1.
Insert: "(3) [Sections 5 and 8] are intended to be codified as an integral part of Title 33, chapter 22, part 2, and the provisions of Title 33, chapter 22, part 2, apply to [sections 5 and 8].

(4) [Sections 6 and 9] are intended to be codified as an integral part of Title 33, chapter 22, part 5, and the provisions of Title 33, chapter 22, part 5, apply to [sections 6 and 9].

(5) [Sections 7 and 10] are intended to be codified as an integral part of Title 33, chapter 31, part 3, and the provisions of Title 33, chapter 31, part 3, apply to [sections 7 and 10]."

Exhibit #9
3-16-95

Amendments to House Bill No. 531
First Reading Copy

Requested by Sen. Benedict
For the Joint Select Committee on Health Care

Prepared by David S. Niss
March 16, 1995

1. Title, lines 4 through 10.
Strike: "RELATING TO" on line 4 through "PLAN;" on line 10

2. Title, line 11.
Strike: "INSURERS AND"

3. Title, lines 12 through 14.
Strike: "AMENDING" on line 12 through "DATES" on line 14

4. Page 1, line 18 through line 20 on page 20.
Strike: sections 1 through 16 in their entirety

Renumber: subsequent sections

5. Page 20, line 22.
Strike: "17 through 19"
Insert: "1 and 2"

6. Page 20, lines 24 and 25.
Strike: subsections (1) and (2) in their entirety

Renumber: subsequent subsections

7. Page 20, lines 26 and 27.
Strike: "health care provider" on line 26 through "hospital." on line 27
Insert: "person who is licensed, certified, or otherwise authorized by the laws of this state to provide health care in the ordinary course of business or the practice of a profession. The term does not include a hospital."

8. Page 21, line 1.
Strike: "Insurers and health"
Insert: "Health"

9. Page 21, line 2.
Strike: "Insurers, hospitals,"
Insert: "Hospitals"

10. Page 21, line 16 through line 4 on page 22.
Strike: subsection (4) in its entirety

11. Page 22, lines 6 through 14.
Strike: section 19 in its entirety

Renumber: subsequent sections

12. Page 23, line 1 through line 18 on page 25.
Strike: sections 22 and 23 in their entirety

Renumber: subsequent sections

13. Page 25, line 20.
Following: "Sections"
Insert: "1 and"
Strike: "through 6 and 17 through"

14. Page 25, line 21.
Strike: "19"

15. Page 25, line 22.
Following: "[sections"
Insert: "1 and"
Strike: "through 6 and 17 through 19"

16. Page 25, lines 23 and 24.
Strike: subsection (2) in its entirety

Renumber: subsequent subsections

17. Page 25, lines 25 and 26.
Strike: "20"
Insert: "3"

18. Page 25, lines 27 and 28.
Strike: "21"
Insert: "4"

19. Page 26, lines 4 through 6.
Strike: section 26 in its entirety

Exhibit #10
3-16-95

Amendments to House Bill No. 531
First Reading Copy

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

Prepared by Susan Byorth Fox
March 16, 1995

1. Title, lines 10 through 12.
Following: "PLAN;" on line 10
Strike: the remainder of line 10 through "PERSON;" on line 11
Insert: "CONTINGENTLY PROVIDING FOR THE DESIGN OF CONSUMER REPORT CARDS ON HEALTH CARE SERVICES;"
Strike: "PROVIDING PENALTIES;" on line 12

2. Page 20, line 22 through page 22, line 30.
Strike: sections 17 through 21 in their entirety
Insert: "

NEW SECTION. **Section 17. Consumer report cards.** (1) The department of social and rehabilitation services shall, in cooperation with consumers, employers, hospitals, insurers, and health care providers, design a consumer report card that will enhance consumer responsibility in the use of health care services.

(2) The department of social and rehabilitation services shall submit a proposal that contains the information needed to prepare the consumer report card to the legislature by October 1, 1996. The information must include:

(a) uniform data, including charges, that will enable consumers to evaluate the cost of medical procedures ~~and the quality of care~~;

(b) data about insurance plans, such as benefit and cost provisions;

(c) additional information that may assist consumers in making informed choices about their medical care; and

(d) any further applicable information generated as a result of efforts undertaken pursuant to 50-4-502.

(3) The department of social and rehabilitation services shall also develop standards for uniform data to be provided by insurers, hospitals, and health care providers and shall take into account the feasibility and cost-effectiveness.

(4) To the extent possible, data collected for the consumer report card must be provided by data sources that currently exist."
Renumber: subsequent sections

3. Page 25, lines 20 and 21.
Following: "6"
Strike: the remainder of line 20 through "19" on line 21

4. Page 25, line 22.
Following: "6"
Strike: "and" through "19"

5. Page 25, lines 25 through 28.
Strike: lines 25 through 28 in their entirety
Insert: "(3) [Section 17] is intended to be codified as an integral part of Title 53, and the provisions of Title 53 apply to [section 17]."

6. Page 25, line 29.
Insert: "

NEW SECTION. **Section 21. Coordination instruction.** (1) If House Bill No. 511 is passed and approved, [section 17(1)] must read as follows:

"(1) The Montana health care advisory council shall appoint a task force of consumers, employers, hospitals, and insurers, to design a consumer report card that will enhance consumer responsibility in the use of health care services."

(2) If House Bill No. 511 is passed and approved, the first sentence of [section 17(2)] must read as follows:

(2) The Montana health care advisory council shall submit the task force's proposal that contains the information needed to prepare the consumer report card to the legislature by October 1, 1996."

7. Page 26, line 4.
Strike: "24, 25"
Insert: ", 20 through 22,"

8. Page 26, line 6.
Strike: "23"
Insert: "19"

Exhibit #11
3-16-95

Amendments to House Bill No. 531
First Reading Copy

Requested by Representative Simon
For the Joint Select Committee on Health Care Issues

Prepared by Susan Byorth Fox
March 16, 1995

1. Page 1, line 15.
Insert: "WHEREAS, the Department of Social and Rehabilitation Services is charged with developing a consumer report card to enhance consumer responsibility in the use of health care services; and

WHEREAS, an important element of cost data for hospitals is actual charges; and

WHEREAS, any hospital data included in a consumer report card should include actual charge data."

Exhibit# 12
3-16-95

Amendments to House Bill No. 531
First Reading Copy

Requested by Representative Simon
For the Joint Select Committee on Health Care Issues

Prepared by Susan Byorth Fox
March 15, 1995

1. Title, lines 10 through 12.
Following: "PLAN;" on line 10
Strike: the remainder of line 10 through "PERSON;" on line 11
Insert: "PROVIDING FOR THE DESIGN OF CONSUMER REPORT CARDS ON HEALTH CARE SERVICES;"
Strike: "PROVIDING PENALTIES;" on line 12

2. Page 20, line 22 through page 22, line 30.
Strike: sections 17 through 21 in their entirety
Insert: "
NEW SECTION. **Section 17. Consumer report cards.** (1) The department of social and rehabilitation services shall, in cooperation with consumers, employers, hospitals, insurers, and health care providers, design a consumer report card that will enhance consumer responsibility in the use of health care services.

(2) The department of social and rehabilitation services shall submit a proposal that contains the information needed to prepare the consumer report card to the legislature by October 1, 1996. The information must include:

(a) data that will enable consumers to evaluate the cost of medical procedures and the quality of care;

(b) data about insurance plans, such as benefit and cost provisions;

(c) additional information that may assist consumers in making informed choices about their medical care; and

(d) any further applicable information generated as a result of efforts undertaken pursuant to 50-4-502.

(3) The department of social and rehabilitation services shall also develop standards for data to be provided by insurers, hospitals, and health care providers and shall take into account the feasibility and cost-effectiveness.

(4) To the extent possible, data collected for the consumer report card must be provided by data sources that currently exist."
Renumber: subsequent sections

3. Page 25, lines 20 and 21.
Following: "6"
Strike: the remainder of line 20 through "19" on line 21

4. Page 25, line 22.
Following: "6"
Strike: "and" through "19"

5. Page 25, lines 25 through 28.

Strike: lines 25 through 28 in their entirety
Insert: "(3) [Section 17] is intended to be codified as an integral part of Title 53, and the provisions of Title 53 apply to [section 17]."

6. Page 25, line 29.
Insert: "

NEW SECTION. **Section 21. Coordination instruction.** If House Bill No. 511 is passed and approved, [section 17(1)] must read as follows:

"(1) The department of social and rehabilitation services shall, in cooperation with the Montana health care advisory council, consumers, employers, hospitals, and insurers, design a consumer report card that will enhance consumer responsibility in the use of health care services.""

7. Page 26, line 4.
Strike: "24, 25"
Insert: ", 20 through 22,"

8. Page 26, line 6.
Strike: "23"
Insert: "19"

Exhibit #13
3-16-95

CONSENSUS AMENDMENTS
House Bill 531
March 16, 1995
Joint Number Select Health Care Committee

1. Page 1
   Line 4 through line 10
   Following: "AN ACT"
   Delete: "RELATING TO" through "INSURANCE ASSOCIATION PLAN;"

   Line 11
   Delete: "INSURERS AND"

   Line 12
   Following: "PENALTIES;"
   Delete: "AMENDING SECTIONS" through line 13 "33-22-110, MCA;"

2. Page 1, Line 18 through page 20, line 20
   Delete: Sections 1 through 16

3. Page 20, lines 24 and 25
   Following: "(1)"
   Delete: "Health benefits plan" through "in 33-22-125"
   Renumber subsequent sections

4. Page 21, Line 1
   Following: "Section 18."
   Delete: "Insurers and"

5. Page 21, line 2
   Delete: "Insurers"

6. Page 21, line 16 through page 22, line 4
   Delete: Subsection (4) in its entirety

7. Page 22, lines 6 through 14
   Delete: Section 19 in its entirety

8. Page 23, lines 1 through page 25, line 18
   Delete: Sections 22 and 23

9. Page 25, lines 20 through 24
   Following: "(1)"
   Delete: "[Sections 2 through 6" through "apply to [sections 7 through 13]"

10. Page 26, line 4
Following: "[Section "
Delete: "13,"

Line 6
Following: "[Sections "
Delete: "1 through 12 and 14 through 23]"
Insert: "18, 20, and 21"

Exhibit # 13
3-16-95

Amendments to Senate Bill No. 376
Proposed Jointly by the State Auditor's Office and the MEWA's

1. Page 1, line 13.
Insert "STATEMENT OF INTENT"
A statement of intent is required for this bill because the bill does not contain any provisions regarding supervision, rehabilitation and liquidation of self funded multiple employer welfare arrangement which fail to maintain the level of reserves as are required by section 8. The rules should be consistent with the provisions of Title 33, chapter 2, part 13 and only modify those provisions to the extent necessary to be consistent with the provisions and purposes of this act.

2. Page 4, Line 16.
Strike: subsection (a) in its entirety
Renumber : subsequent subsections

3. Page 5, Line 17.
Following: "description"
Insert: "or summary plan descriptions"

4. Page 5, Line 24.
Following 33-2-514
Insert: ". The commissioner in his discretion may waive the requirement of an actuarial opinion and require a report by an actuarial firm"

5. Page 6, Line 23.
Following: "by a"
Strike: "certified actuarial report obtained by the arrangement"
Insert: "report prepared by an actuarial firm:

6. Page 7, line 12.
Following 33-2-514
Insert: ". The commissioner in his discretion may waive the requirement of an actuarial opinion and require a report prepared by an actuarial firm and upon a showing of good cause extend the filing date of the report by thirty days"

7. Page 9.
Following: line 6
Insert: "NEW SECTION. Section 15. Disclosure. Each policy issued by a self-funded multiple employer welfare arrangement must contain, in 10-point type on the front page and the declaraion page, the following notice:

"NOTICE

This policy is issued by a self-funded multiple employer welfare arrangement. A self-funded multiple employer welfare arrangement may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for a self-funded multiple employer welfare arrangement."

Exhibit #14
3-16-95

Pondera Medical Center

406-278-3211 805 Sunset Blvd. Conrad, MT 59425

Handed out at hearing was a Fax

March 15, 1995

TO: Representative Bruce Simon
Joint Select Committee on Health Care

FR: Carl Hanson, Administrator Carl

RE: HB 531

Regarding HB 531, I have two concerns that I hope you will keep in mind as you consider this bill. The first is the experience of other states that have attempted such disclosure. The second is the value of the price information to the consumer.

OTHER STATE'S EXPERIENCE

Several other states have attempted such programs of disclosure. When Utah enacted such laws, they found that the primary users of the data were other physicians and hospitals. Their interest in the information was not so much to ensure their own competitiveness, but to figure out ways to charge more for certain items. You or some of the Committee members might investigate Utah's experiences with charge disclosure.

VALUE OF PRICE INFORMATION

For as long as I can remember, this hospital has provided price information in advance to any patient who requests as much. Pondera Medical Center has found that a list of prices, or a "charge master," does not mean much to the patient. The structure of the document is based upon Medicare and Medicaid codes. It is difficult to interpret. Other states have proven that the data this bill will make available has been important only to other providers and insurance companies.

What has proven valuable to the patient is the average discharge cost for the type of procedure being considered, and the extremes that have been experienced for that procedure in the last six months. This information has been, and will be, provided to any inquiring patient.

I hope the legislature does not enact a law to require what is already being given in an understandable form to anyone who asks.

DATE March 16, 1995

SENATE COMMITTEE ON Joint Select Committee on Health Care

BILLS BEING HEARD TODAY: SB 380, SB 322, SB 341, HB 466, HB 446, HB 533, HB 531, SB 376

< ■ > PLEASE PRINT < ■ >

Name	Representing	Bill No.	Check One: Support	Check One: Oppose

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

REGISTER.F10