HOUSE BILL NO. 817

INTRODUCED BY KITSELMAN, ECK, JACOBSON, WINSLOW, HAGER, KENNERLY, THOMAS, GOULD, BERGENE, GILBERT

IN THE HOUSE

February	13,	1985		Introduced and referred to Committee on Business and Labor.
				Fiscal Note requested.
February	18,	1985		On motion by Chief Sponsor, Representatives Gould, Thomas, Bergene, and Gilbert were added as sponsors.
February	19,	1985		Fiscal Note returned.
February	20,	1985		Committee recommend bill do pass as amended. Report adopted.
				Statement of Intent attached.
				Bill printed and placed on members' desks.
February	22,	1985		Second reading, do pass.
				Considered correctly engrossed.
February	23,	1985		Third reading, passed.
				Transmitted to Senate.
			IN THE S	ENATE
March 4,	1985	5		Introduced and referred to Committee on Public Health, Welfare and Safety.
March 14,	198	35		Committee recommend bill be concurred in as amended. Report adopted.

March	18,	1985		Second reading, pass consideration.
March	21,	1985		Second reading, concurred in.
March	23,	1985		Third reading, concurred in. Ayes, 49; Noes, 0.
				Returned to House with amendments.
			IN THE H	OUSE
March	25,	1985		Received from Senate.
April	8, 3	1985		Second reading, amendments concurred in.
				On motion, rules suspended and bill placed on third reading this day.
				Third reading, amendments concurred in.
				Sent to enrolling.

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Reported correctly enrolled.

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HOUSE BILL NO. 817 1 INTRODUCED BY Kitselmon Cake Cacaleson Winterer 2 Hajer Kimmily 3 A BILL FOR AN ACT ENTITLED: "AN ACT TO PROVIDE HEALTH 4 INSURANCE COVERAGE TO CERTAIN PERSONS INELIGIBLE FOR 5 6 COVERAGE FROM TRADITIONAL PROVIDERS OF HEALTH CARE BENEFITS BY ESTABLISHING A COMPREHENSIVE HEALTH ASSOCIATION AND PLAN: 7 8 TO REQUIRE PARTICIPATION IN THE ASSOCIATION BY EACH HEALTH SERVICE CORPORATION, FRATERNAL BENEFIT SOCIETY, AND INSURER 9 10 PROVIDING HEALTH CARE BENEFITS IN THIS STATE: AND PROVIDING EFFECTIVE DATES." 11 12 13 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA: 14 Section 1. Definitions, As used in [sections 1 through 15 12], the following definitions apply: (1) "Association" means the comprehensive health 16 association created by [section 3]. 17 (2) "Association plan" means a policy of insurance 18

coverage offered by the association through the lead 19 carrier. 20

21 (3) "Association plan premium" means the charge determined pursuant to [section 8] for membership in the 22 association plan based on the benefits provided in [section 23 24 6].

(4) "Eligible person" means an individual who: 25

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1 (a) is a resident of this state and has been a 2 resident for at least 1 year immediately preceding application for coverage under the association plan; and

4 (b) within 6 months prior to the date of application, has been rejected for disability insurance or health service 5 benefits by at least two insurers, societies, or health 6 service corporations, or has had a restrictive rider or 7 8 preexisting conditions limitation, which limitation is 9 required by at least two insurers, societies, or health 10 service corporations, which has the effect of substantially reducing coverage from that received by a person considered 11 12 a standard risk.

13 (5) "Health service corporation" means a corporation operating pursuant to Title 33, chapter 30, and offering or 14 selling contracts of disability insurance. 15

16 (6) "Insurer" means a company operating pursuant to Title 33, chapter 2 or 3, and offering or selling policies 17 or contracts of disability insurance, as provided in Title 18 19 33, chapter 22.

20 (7) "Lead carrier" means the licensed administrator or insurer selected by the association to administer the 21 22 association plan.

23 (8) "Preexisting condition" means any condition for which an applicant for coverage under the association plan 24 25 received medical attention during the 5 years has

> -2- INTRODUCED BILL HB 817

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1 immediately preceding the filing of an application.

2 (9) "Qualified plan" means those health benefit plans
3 certified by the commissioner as providing the minimum
4 benefits required by [section 6] or the actuarial equivalent
5 of those benefits.

6 (10) "Society" means a fraternal benefit society 7 operating pursuant to Title 33, chapter 7, and offering or 8 selling certificates of disability insurance.

9 Section 2. Duties of the commissioner -- rules. The
10 commissioner shall:

11 (1) adopt rules to carry out the provisions and 12 purposes of [sections 1 through 12];

13 (2) supervise the creation of the association within14 the limits described in [section 3];

15 (3) approve the selection of the lead carrier by the 16 association and approve the association's contract with the 17 lead carrier, including the association plan coverage and 18 premiums to be charged;

(4) conduct periodic audits to assure the general
accuracy of the financial data submitted by the lead carrier
and the association; and

(5) undertake, directly or through contracts with
other persons, studies or demonstration projects to develop
awareness of the benefits of [sections 1 through 12] so that
the residents of this state may best avail themselves of the

1 health care benefits provided by [sections 1 through 12].

2 Section 3. Comprehensive health association --3 mandatory membership.

4 (1) There is established a comprehensive health 5 association with participating membership consisting of all 6 insurers, societies, and health service corporations 7 licensed or authorized to do business in this state. The 8 association is exempt from taxation under the laws of this 9 state, and all property owned by the association is exempt 10 from taxation.

11 (2) All participating members shall maintain their 12 membership in the association as a condition for writing 13 health care benefits policies or contracts in this state. 14 The association shall submit its articles, bylaws, and 15 operating rules to the commissioner for approval.

16 (3) The association may:

17 (a) exercise the powers granted to insurers under the18 laws of this state;

19 (b) sue or be sued;

20 (c) enter into contracts with insurers, 21 administrators, similar associations in other states, or 22 other persons for the performance of administrative 23 functions;

24 (d) establish administrative and accounting procedures25 for the operation of the association;

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(e) provide for the reinsuring of risks incurred as a
 result of issuing the coverages required by members of the
 association; and

4 (f) provide for the administration by the association 5 of policies that are reinsured pursuant to subsection 6 (3)(e).

7 Section 4. Association board of directors -8 organization. (1) There is a board of directors of the
9 association, consisting of eight individuals:

(a) one from each of the seven participating members
of the association with the highest annual premium volume of
disability insurance contracts or health service corporation
contracts, derived from or on behalf of residents in the
previous calendar year, as determined by the commissioner;
and

(b) a member at large, appointed by the commissioner
to represent the public interest, who shall serve in an
advisory capacity only.

19 (2) Each of the seven board members representing the
20 association members is entitled to vote, in person or by
21 proxy, based on the association member's annual premium
22 volume, in accordance with the following schedule:

23	\$ 100,000	\$ 4,999,999	l vote
24	5,000,000	9,999,999	2 votes
25	10,000,000	14,999,999	3 votes

1 15,000,000 or more

4 votes

2 (3) Members of the board may be reimbursed from the 3 money of the association for expenses incurred by them due 4 to their service as board members but may not otherwise be 5 compensated by the association for their services. The costs 6 of conducting the meetings of the association and its board 7 of directors must be borne by participating members of the 8 association in accordance with [section 9].

9 Section 5. Minimum benefits of association plan. The 10 association through the association plan shall offer a 11 policy that provides at least the benefits of a qualified 12 plan as required by [section 6].

13 Section 6. Qualified plan -- minimum benefits. A plan 14 of health coverage must be certified as a qualified plan if 15 it otherwise meets the requirements of Title 33, chapters 16 15, 22, and 30, and other laws of this state, whether or not 17 the policy is issued in this state, and meets or exceeds the 18 following minimum standards:

19 (1) The minimum benefits for an insured must, subject 20 to the other provisions of this section, be equal to at 21 least 80% of the covered expenses required by this section 22 in excess of an annual deductible that does not exceed 23 \$1,000 per person. The coverage must include a limitation of 24 \$5,000 per person on the total annual out-of-pocket expenses 25 for services covered under this section. Coverage must be

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1	subject to a maximum lifetime benefit, but such maximums may	<pre>l (k) prosthetics, other than dental;</pre>
2	not be less than \$100,000.	2 (1) services of a licensed home health agency, up to a
3	(2) Covered expenses must be the usual and customary	3 maximum of 180 visits per year; and
4	charges for the following services and articles when	4 (m) necessary care and treatment of mental illness,
5	prescribed by a physician or other licensed health care	5 alcoholism, and drug addiction, as provided in 33-22-703.
6	professional provided for in 33-22-111:	6 (3) (a) Covered expenses for the services or articles
7	(a) hospital services;	7 specified in this section do not include:
, 8	(b) professional services for the diagnosis or	8 (i) drugs requiring a physician's prescription;
9	treatment of injuries, illness, or conditions, other than	9 (ii) services of a nursing home;
10	dental;	<pre>10 (iii) home and office calls, except as specifically</pre>
11	(C) use of radium or other radioactive materials;	11 provided in subsection (2):
12	(d) axygen;	12 (iv) rental or purchase of durable medical equipment,
13	(e) anesthetics;	<pre>13 except as specifically provided in subsection (2);</pre>
14	(f) diagnostic x-rays and laboratory tests, except as	14 (v) the first \$20 of diagnostic x-ray and laboratory
15	specifically provided in subsection (3);	15 charges in each 14-day period;
16	(g) services of a physical therapist;	16 (vi) oral surgery, except as specifically provided in
17	(h) transportation provided by licensed ambulance	17 subsection (2);
18	service to the nearest facility qualified to treat the	18 (vii) that part of a charge for services or articles
19	condition;	19 which exceeds the prevailing charge in the locality where
20	(i) oral surgery for the gums and tissues of the mouth	20 the service is provided; or
21	when not performed in connection with the extraction or	21 (viii) care that is primarily for custodial or
22	repair of teeth or in connection with TMJ;	22 domiciliary purposes which would not qualify as eligible
23	(j) rental or purchase of medical equipment, which	23 services under medicare.
24	shall be reimbursed after the deductible has been met at the	24 (b) Covered expenses for the services or articles
25	rate of 50%, up to a maximum of \$1,000;	25 specified in this section do not include charges for:

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1 (i) care or for any injury or disease either arising out of an injury in the course of employment and subject to 2 a workers' compensation or similar law, for which benefits 3 are payable without regard to fault under coverage 4 statutorily required to be contained in any motor vehicle or 5 other liability insurance policy or equivalent 6 self-insurance, or for which benefits are payable under 7 another policy of disability insurance or medicare; 8

9 (ii) treatment for cosmetic purposes other than surgery
10 for the repair or treatment of an injury or congenital
11 bodily defect to restore normal bodily functions;

12 (iii) travel other than transportation provided by a
13 licensed ambulance service to the nearest facility qualified
14 to treat the condition;

15 (iv) confinement in a private room to the extent it is 16 in excess of the institution's charge for its most common 17 semiprivate room, unless the private room is prescribed as 18 medically necessary by a physician;

(v) services or articles the provision of which is not
within the scope of authorized practice of the institution
or individual rendering the services or articles;

(vi) organ transplants unless prior approval isreceived from the board of directors of the association;

(vii) room and board for a nonemergency admission on
 Friday or Saturday;

1 (viii) pregnancy, except complications of pregnancy;

2 (ix) routine well baby care;

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3 (x) complications to a newborn, unless no other source4 of coverage is available;

(xi) sterilization or reversal of sterilization;

6 (xii) abortion, unless the life of the mother would be7 endangered if the fetus were carried to term;

8 (xiii) weight modification or modification of the body
9 to improve the mental or emotional well-being of an insured;
10 (xiv) artificial insemination or treatment for
11 infertility; or

12 (xv) breast augmentation or reduction.

13 Section 7. Certification of qualified plan. Upon 14 application by the association or the lead carrier for 15 certification of a plan of health coverage as a qualified 16 plan for the purposes of [sections 1 through 12], the commissioner shall make a determination within 90 days as to 17 whether the plan is qualified. If determined to be 18 qualified, the plan of health coverage must be labeled as a 19 20 "qualified plan" on the front of the policy.

Section 8. Association plan premium. The association shall establish the schedule of premiums to be charged eligible persons for membership in the association plan. The schedule of premiums may not be less than 150% or more than 400% of the average premium rates charged by the five

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largest insurers with the largest individual qualified plan 1 2 of insurance in force in this state. The premium rates of the five insurers used to establish the premium rates for 3 4 each type of coverage offered by the association must be 5 determined by the commissioner from information provided 6 annually by all insurers at the request of the commissioner. 7 The information requested must include the number of qualified plans or actuarial equivalent plans offered by 8 each insurer, the rates charged by the insurer for each type ġ 10 of plan offered by the insurer, and any other information 11 the commissioner considers necessary. The commissioner shall 12 utilize generally acceptable actuarial principles and 13 structurally compatible rates.

14 Section 9. Operation of association plan. (1) Upon 15 acceptance by the lead carrier under [section 12], an 16 eligible person may enroll in the association plan by 17 paymer: of the association plan premium to the lead carrier. 18 (2) Not less than 90% of the association plan premiums 19 puid to the lead carrier may be used to pay claims and not more than 10% may be used for payment of the lead carrier's 20 21 direct and indirect expenses as specified in [section 10]. 22 (3) Any income in excess of the costs incurred by the 23 association in providing reinsurance or administrative 24 services must be held at interest and used by the 25 association to offset past and future losses due to claims

expenses of the association plan or be allocated to reduce
 association plan premiums.

3 (4) Each participating member of the association shall 4 share the losses due to claims expenses of the association plan for plans issued or approved for issuance by the 5 association and shall share in the operating and 6 administrative expenses incurred or estimated to be incurred 7 by the association incident to the conduct of its affairs. 8 Claims expenses of the association plan that exceed the 9 10 premium payments allocated to the payment of benefits are 11 the liability of the association members. Association members shall share in the claims expenses of the 12 association plan and operating and administrative expenses 13 14 of the association in an amount equal to the ratio of:

15 (a) the association member's total disability 16 insurance premium received from or on behalf of Montana 17 residents divided by;

(b) the total disability premium received by all
association members from or on behalf of Montana residents,
as determined by the commissioner.

(5) The association shall make an annual determination of each association member's liability, if any, and may make an annual fiscal yearend assessment if necessary. The association may also, subject to the approval of the commissioner, provide for interim assessments against the

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association members as may be necessary to assure the 1 2 financial capability of the association in meeting the 3 incurred or estimated claims expenses of the association plan and operating and administrative expenses of the 4 association until the association's next annual fiscal 5 yearend assessment. Payment of an assessment is due within 6 7 30 days of receipt by an association member of a written notice of a fiscal yearend or interim assessment. Failure 8 9 by a contributing member to tender to the association the 10 assessment within 30 days is grounds for termination of 11 membership. An association member that ceases to do disability insurance business within the state remains 12 liable for assessments through the calendar year during 13 14 which disability insurance business ceased. The association may decline to levy an assessment against an association 15 member if the assessment, as determined pursuant to this 16 17 section, would not exceed \$10.

(6) Any annual fiscal yearend or interim assessment 18 levied against an association member may be offset, in an 19 20 amount equal to the assessment paid to the association, against the premium tax payable by that association member 21 pursuant to 33-2-705 for the year in which the annual fiscal 22 23 yearend or interim assessment is levied. The department of revenue shall, each year the legislature meets in regular 24 25 session, on or before January 15, report to the legislature

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the total amount of premium tax offset claimed by
 association members during the preceding biennium.

3 Section 10. Administration of association plan --4 rules. (1) Any member of the association may submit to the 5 commissioner policies to be proposed to serve as the 6 association plan. The commissioner shall prescribe by rule 7 the time and manner of the submission.

8 (2) Upon the commissioner's approval of the policy 9 forms and contracts submitted, the association shall select 10 policies and contracts by a member or members of the 11 association to be the association plan. The association shall select one lead carrier to issue the qualified plans. 12 The board of directors of the association shall prepare 13 appropriate specifications and bid forms and may solicit 14 bids from licensed administrators and the members of the 15 association for the purpose of selecting the lead carrier. 16 The selection of the lead carrier must be based upon 17 criteria established by the board of directors. 18

19 (3) The lead carrier shall perform all administrative 20 and claims payment functions required by this section upon 21 the commissioner's approval of the policy forms and 22 contracts submitted. The lead carrier shall provide these 23 services for a period of at least 3 years, unless a request 24 to terminate is approved by the association and the 25 commissioner. The association and the commissioner shall

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approve or deny a request to terminate within 90 days of its 1 2 receipt. A failure to make a final decision on a request to 3 terminate within the specified period is considered an approval. The association shall invite submissions of policy 4 forms from members of the association, including the lead 5 6 carrier, 6 months prior to the expiration of each 3-year 7 period. The association shall follow the procedure provided 8 in subsection (2) in selecting a lead carrier for the subsequent 3-year period or, if a request to terminate is 9 10 approved, on or before the end of the 3-year period.

11 (4) The lead carrier shall provide all eligible
12 persons involved in the association plan an individual
13 certificate setting forth a statement as to the insurance
14 protection to which the person is entitled, the method and
15 place of filing claims, and to whom benefits are payable.
16 The certificate must indicate that coverage was obtained
17 through the association.

18 (5) The lead carrier shall submit to the association and the commissioner on a semiannual basis a report of the 19 20 operation of the association plan. The association must 21 determine the specific information to be contained in the 22 report prior to the effective date of the association plan. 23 (6) The lead carrier shall pay all claims pursuant to [sections 1 through 12] and shall indicate that the staim 24 25 was paid by the association plan. Each claim payment mest

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include information specifying the procedure involved in the
 event a dispute over the amount of payment arises.

3 (7) The lead carrier must be reimbursed from the 4 association plan premiums received for its direct and 5 indirect expenses. Direct and indirect expenses include a 6 prorated reimbursement for the portion of the lead carrier's administrative, printing, claims administration, management, я and building overhead expenses, which are assignable to the 9 maintenance and administration of the association plan. The 10 association must approve cost accounting methods to substantiate the lead carrier's cost reports consistent with 11 12 generally accepted accounting principles. Direct and 13 indirect expenses may not include costs directly related to 14 the original submission of policy forms prior to selection 15 as the lead carrier.

16 (8) The lead carrier is, when carrying out its duties 17 under [sections 1 through 12], an agent of the association 18 and is civilly liable for its actions, subject to the laws 19 of this state.

20 Section 11. Solicitation of eligible persons. (1) The 21 association, pursuant to a plan approved by the 22 commissioner, shall disseminate appropriate information to 23 the residents of this state regarding the existence of the 24 association plan and the means of enrollment. Means of 25 communication may include use of the press, radio, and

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television, as well as publication in appropriate state
 offices and publications.

3 (2) The association shall devise and implement means 4 of maintaining public awareness of [sections 1 through 12] 5 and shall administer [sections 1 through 12] in a manner 6 which facilitates public participation in the association 7 plan.

(3) All licensed disability insurance agents may 8 9 engage in the selling or marketing of qualified association 10 plans. The lead carrier shall pay an agent's referral fee of \$25 to each licensed disability insurance agent who refers 11 12 an applicant to the association plan, if the applicant is 13 accepted. The referral fees must be paid to the lead 14 carrier from money received as premiums for the association 15 plan.

(4) An insurer, society, or health service corporation 16 17 that rejects or applies underwriting restrictions to an applicant for disability insurance must notify the applicant 18 19 of the existence of the association plan, requirements for being accepted in it, and the procedure for applying to it. 20 Section 12. Enrollment by eligible person. (1) The 21 22 association plan must be open for enrollment by eligible persons. An eligible person may enroll in the plan by 23

25 carrier. The certificate must provide:

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(a) the name, address, and age of the applicant and
 length of the applicant's residence in this state;

3 (b) the name, address, and age of spouse and children,4 if any, if they are to be insured;

5 (c) written evidence that he fulfills all of the 6 elements of an eligible person, as defined in [section 1]; 7 and

(d) a designation of coverage desired.

8

9 (2) Within 30 days of receipt of the certificate, the lead carrier shall either reject the application for failing 10 to comply with the requirements of subsection (1) or forward 11 12 the eligible person a notice of acceptance and billing information. Insurance is effective immediately upon receipt 13 14 of the first month's association plan premium and is retroactive to the date of application, if the applicant 15 16 otherwise complies with [sections 1 through 12].

17 (3) An eligible person may not purchase more than one18 policy from the association plan.

19 (4) A person who obtains coverage pursuant to this 20 section may not be covered for any preexisting condition 21 during the first 12 months of coverage under the association 22 plan if the person was diagnosed or treated for that 23 condition during the 5 years immediately preceding the 24 filing of an application. This subsection does not apply to 25 a person who has had continuous coverage under an

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submission of a certificate of eligibility to the lead

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individual, family, or group policy during the year
 immediately preceding the filing of an application for
 nonelective procedures.

4 Section 13. Extension of authority. Any existing 5 authority of the commissioner of insurance to make rules on 6 the subject of the provisions of this act is extended to the 7 provisions of this act.

8 Section 14. Codification instruction. Sections 1
9 through 12 are intended to be codified as an integral part
10 of Title 33, and the provisions of Title 33 apply to
11 sections 1 through 12.

12 Section 15. Severability. If a part of this act is 13 invalid, all valid parts that are severable from the invalid 14 part remain in effect. If a part of this act is invalid in 15 one or more of its applications, the part remains in effect 16 in all valid applications that are severable from the 17 invalid applications.

18 Section 16. Effective date. (1) Except for section 5,19 this act is effective July 1, 1985.

20 (2) Section 5 is effective July 1, 1987.

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STATE OF MONTANA

REQUEST NO. FNN 423-85

FISCAL NOTE

Form BD-15

In compliance with a written request received <u>February 13</u>, <u>19</u><u>85</u>, there is hereby submitted a Fiscal Note for <u>House Bill 817</u> pursuant to Title 5, Chapter 4, Part 2 of the Montana Code Annotated (MCA). Background information used in developing this Fiscal Note is available from the Office of Budget and Program Planning, to members of the Legislature upon request.

DESCRIPTION OF PROPOSED LEGISLATION:

House Bill 817 creates a Comprehensive Health Association and plan to provide health insurance coverage to certain persons ineligible for coverage from traditional providers of health care benefits. Each Health Service Corporation, Fraternal Benefit Society and Insurer is required to participate in the association.

ASSUMPTIONS:

- 1. No revenue generated for the State. Premiums will be to cover cost of claims and association administrative costs.
- 2. Assume no additional STAFF will be required to administer the program.
- 3. Assume Financial Examiner costs for FY 1986 and every (3) three years thereafter.
- 4. Actuary required for initial start-up FY 1986 and in FY 1987; examine once every (3) three years thereafter.
- 5. Additional communication costs for biennium.
- 6. Additional hearing and rulemaking costs for FY 1986.

FISCAL	IMPACT:

Expenditures:	Existing Law	Proposed Law	Existing Law	Proposed Law
Operating	-0-	\$ 4,900	-0-	\$ 1,925
TOTAL	-0-	\$ 4,900	-0-	\$ 1,925
		······································		
Total General Fund Cost	-0	\$ 4,900	-0-	\$ 1,925

BUDGET DIRECTOR Office of Budget and Program Planning

Date: Feb 19 817

FN10:B/1

LONG-RANGE EFFECTS OF PROPOSED LEGISLATION:

Premium tax revenue to the General Fund may be impacted in future years. When claims exceed revenue raised through premiums paid by covered individuals, each insurer in the association will be assessed. That assessment can be offset against premium taxes owed to Montana.

TECHNICAL OR MECHANICAL DEFECTS OR CONFLICTS WITH EXISTING LEGISLATION:

Section 9, Paragraph (6) 1.23 and 24, Recommend change from "Department of Revenue" to "The Insurance Commissioner". Section 6 (3) (i) appears to address "no-fault" insurance which is not appropriate to Montana.

49th Legislature

HB 0817/si

APPROVED BY COMM. ON BUSINESS AND LABOR

 1
 STATEMENT OF INTENT

 2
 HOUSE BILL NO. 817

 3
 House Business and Labor Committee

 4

5 A statement of intent is required for this bill because 6 it grants rulemaking authority to the commissioner of 7 insurance for the purpose of making effective the provisions 8 and purposes of this act.

9 The purpose of this act is to establish a mechanism 10 through which adequate levels of health insurance coverages 11 can be made available to residents of this state who are 12 otherwise considered uninsurable. This bill establishes a 13 state association or pool of which all insurers, health 14 service corporations, and fraternal benefit societies 15 providing health care benefits in Montana are members.

16 It is intended that the pool coverage is the coverage of "last resort" and is not intended to duplicate coverages 17 from any other source, private or public. The mechanics of 18 the pool and its operations and functions must all be 19 established under a plan approved by the commissioner. The 20 pool is subject to the requirements of the insurance code 21 22 and has the general powers and authority of an insurer licensed to transact health insurance business in this 23 24 state.

25 It is intended that the association board of directors



1 be responsible for the day-to-day operations of the

2 association, subject to the review and approval of the

3 insurance commissioner.

-2- SECOND READING HB 817

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HOUSE BILL NO. 817 INTRODUCED BY KITSELMAN, ECK, JACOBSON, WINSLOW, HAGER, KENNERLY, THOMAS, GOULD, BERGENE, GILBERT A BILL FOR AN ACT ENTITLED: "AN ACT TO PROVIDE HEALTH INSURANCE COVERAGE TO CERTAIN PERSONS INELIGIBLE FOR COVERAGE FROM TRADITIONAL PROVIDERS OF HEALTH CARE BENEFITS BY ESTABLISHING A <u>MONTANA</u> COMPREHENSIVE HEALTH ASSOCIATION AND PLAN; TO REQUIRE PARTICIPATION IN THE ASSOCIATION BY EACH HEALTH SERVICE CORPORATION, FRATERNAL BENEFIT SOCIETY,

AND INSURER PROVIDING HEALTH CARE BENEFITS IN THIS STATE;
 AND PROVIDING EFFECTIVE DATES."

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14 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

15 Section 1. Definitions. As used in {sections 1 through 16 ±2 13}, the following definitions apply:

17 (1) "Association" means the comprehensive health18 association created by [section 3].

19 (2) "Association plan" means a policy of insurance
20 coverage offered by the association through the lead
21 carrier.

(3) "Association plan premium" means the charge
determined pursuant to [section 8] for membership in the
association plan based on the benefits provided in [section
6].

(4) "Eligible person" means an individual who:
 (a) is a resident of this state and hes-been-a
 resident-for-st-least-l--vear--immediately--preceding

4 application <u>APPLIES</u> for coverage under the association plan; 5 and

6 (b) within 6 months prior to the date of application, 7 has been rejected for disability insurance or health service benefits by at least two insurers, societies, or health 8 9 service corporations, or has had a restrictive rider or 10 preexisting conditions limitation, which limitation is required by at least two insurers, societies, or health 11 12 service corporations, which has the effect of substantially reducing coverage from that received by a person considered 13 a standard risk. 14

(5) "Health service corporation" means a corporation
operating pursuant to Title 33, chapter 30, and offering or
selling contracts of disability insurance.

18 (6) "Insurer" means a company operating pursuant to
19 Title 33, chapter 2 or 3, and offering or selling policies
20 or contracts of disability insurance, as provided in Title
21 33, chapter 22.

(7) "Lead carrier" means the licensed administrator or
insurer selected by the association to administer the
association plan.

25 (8) "Preexisting condition" means any condition for

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which an applicant for coverage under the association plan
 has received medical attention during the 5 years
 immediately preceding the filing of an application.

4 (9) "Qualified plan" means those-health-benefit-plans certified-by--the--commissioner--as--providing--the--minimum 5 benefits-required-by-fsection-61-or-the-actuarial-equivalent 6 of--those--benefits ANY PLAN, PROGRAM, CONTRACT, OR OTHER 7 ARRANGEMENT TO THE EXTENT NOT EXEMPT FROM INCLUSION BY 8 VIRTUE OF THE PROVISIONS OF THE FEDERAL EMPLOYEE RETIREMENT 9 INCOME SECURITY ACT OF 1974 UNDER WHICH ONE OR MORE 10 EMPLOYERS, UNIONS, OR OTHER ORGANIZATIONS PROVIDE TO THEIR 11 12 EMPLOYEES OR MEMBERS, EITHER DIRECTLY OR INDIRECTLY THROUGH A TRUST OR A THIRD PARTY ADMINISTRATOR, HEALTH CARE SERVICES 13 14 OR BENEFITS OTHER THAN THROUGH AN INSURER.

(10) "Society" means a fraternal benefit society
operating pursuant to Title 33, chapter 7, and offering or
selling certificates of disability insurance.

18 Section 2. Duties of the commissioner -- rules. The 19 commissioner shall:

20 (1) adopt rules to carry out the provisions and 21 purposes of [sections 1 through ¹/₂ <u>13</u>];

(2) supervise the creation of the association withinthe limits described in [section 3];

24 (3) approve the selection of the lead carrier by the25 association and approve the association's contract with the

l lead carrier, including the association plan coverage and premiums to be charged:

3 (4) conduct periodic audits to assure the general
4 accuracy of the financial data submitted by the lead carrier
5 and the association; and

6 (5) undertake, directly or through contracts with
7 other persons, studies or demonstration projects to develop
8 awareness of the benefits of (sections 1 through 12 13) so
9 that the residents of this state may best avail themselves
10 of the health care benefits provided by (sections 1 through
11 12 13).

12 Section 3. Comprehensive health association --13 mandatory membership. (1) There is established a NONPROFIT LEGAL ENTITY TO BE KNOWN AS THE MONTANA comprehensive health 14 association with participating membership consisting of all 15 16 insurers, societies, and health service corporations licensed or authorized to do business in this state. The 17 18 association is exempt from taxation under the laws of this 19 state, and all property owned by the association is exempt from taxation. 20

(2) All participating members shall maintain their
membership in the association as a condition for writing
health care benefits policies or contracts in this state.
The association shall submit its articles, bylaws, and
operating rules to the commissioner for approval.

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1	(3) The association may:	1	(b) a member
2	(a) exercise the powers granted to insurers under the	2	to represent the pub
3	laws of this state;	3	advisory capacity or
4	(b) sue or be sued;	4	(2) Each of
5	(c) enter into contracts with insurers,	5	association members
· 6	administrators, similar associations in other states, or	б	in person or by
7	other persons for the performance of administrative	7	annual <u>MONTANA</u> prem
8	functions;	8	following-schedule:
9	(d) establish administrative and accounting procedures	9	\$10070009-479
10	for the operation of the association;	10	578887888975
11	(e) provide for the reinsuring of risks incurred as a	11	-10700070001479
1 2	result of issuing the coverages required by members of the	12	-1570007000-or-more-
13	association; and	13	(3) Members o
14	(f) provide for the administration by the association	14	money of the associa
15	of policies that are reinsured pursuant to subsection	15	to their service a
16	(3)(e).	16	compensated by the a
1,7	Section 4. Association board of directors	17	of conducting the me
18	organization. (1) There is a board of directors of the	18	of directors must
19	association, consisting of eight individuals:	19	association in accor
20	(a) one from each of the seven participating members	20	Section 5. Min
21	of the association with the highest annual premium volume of	21	association through
22	disability insurance contracts or health service corporation	22	policy that provides
23	contracts, derived from or on behalf of residents in the	23	plan as required by
24	previous calendar year, as determined by the commissioner;	24	Section 6. Qua
25	and	25	of health coverage m

(b) a member at large, appointed by the commissioner to represent the public interest, who shall serve in an advisory capacity only.

-1570007000-or-more----4-votes

(3) Members of the board may be reimbursed from the money of the association for expenses incurred by them due to their service as board members but may not otherwise be compensated by the association for their services. The costs of conducting the meetings of the association and its board of directors must be borne by participating members of the association in accordance with [section 9].

20 Section 5. Minimum benefits of association plan. The 21 association through the association plan shall offer a 22 policy that provides at least the benefits of a qualified 23 plan as required by [section 6].

Section 6. Qualified plan -- minimum benefits. A plan
of health coverage must be certified as a qualified plan if

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it otherwise meets the requirements of Title 33, chapters
 15, 22 EXCEPTING PART 7, and 30, and other laws of this
 state, whether or not the policy is issued in this state,
 and meets or exceeds the following minimum standards:

(1) The minimum benefits for an insured must, subject 5 to the other provisions of this section, be equal to at 6 least 80% of the covered expenses required by this section 7 in excess of an annual deductible that does not exceed 8 \$1,000 per person. The coverage must include a limitation of 9 \$5,000 per person on the total annual out-of-pocket expenses 10 for services covered under this section. Coverage must be 11 subject to a maximum lifetime benefit, but such maximums may 12 not be less than \$100,000. 13

14 (2) Covered expenses must be the usual and customary
15 charges for the following services and articles when
16 prescribed by a physician or other licensed health care
17 professional provided for in 33-22-111:

18 (a) hospital services;

(b) professional services for the diagnosis or
treatment of injuries, illness, or conditions, other than
dental;

22 (c) use of radium or other radioactive materials;

23 (d) oxygen;

24 (e) anesthetics;

25 (f) diagnostic x-rays and laboratory tests, except as

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specifically provided in subsection (3);

2 (g) services of a physical therapist;

3 (h) transportation provided by licensed ambulance
4 service to the nearest facility qualified to treat the
5 condition;

6 (i) oral surgery for the gums and tissues of the mouth 7 when not performed in connection with the extraction or 8 repair of teeth or in connection with TMJ;

9 (j) rental or purchase of medical equipment, which 10 shall be reimbursed after the deductible has been met at the 11 rate of 50%, up to a maximum of \$1,000;

12 (k) prosthetics, other than dental; AND

13 (1) services of a licensed home health agency, up to a

14 maximum of 180 visits per year;-and

15 (m)--necessary--care--and--treatment-of-mental-illness;

16 alcoholism;-and-drug-addiction;-as-provided-in-33-22-703.

17 (3) (a) Covered expenses for the services or articles

18 specified in this section do not include:

19 (i) drugs requiring a physician's prescription;

20 (ii) services of a nursing home;

21 (iii) home and office calls, except as specifically

22 provided in subsection (2);

23 (iv) rental or purchase of durable medical equipment,

24 except as specifically provided in subsection (2);

25 (v) the first \$20 of diagnostic x-ray and laboratory

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charges in each 14-day period;	1 (iv) confinement in a private room to the extent it is
(vi) oral surgery, except as specifically provided in	2 in excess of the institution's charge for its most common
subsection (2);	3 semiprivate room, unless the private room is prescribed as
(vii) that part of a charge for services or articles	4 medically necessary by a physician;
which exceeds the prevailing charge in the locality where	5 (v) services or articles the provision of which is not
the service is provided; or	6 within the scope of authorized practice of the institution
(viii) care that is primarily for custodial or	7 or individual rendering the services or articles;
domiciliary purposes which would not qualify as eligible	8 (vi) organ transplants unlesspriorapprovalis
services under medicare.	9 received-from-the-board-of-directors-of-the-association;
(b) Covered expenses for the services or articles	10 (vii) room and board for a nonemergency admission on
specified in this section do not include charges for:	11 Friday or Saturday;
(i) care or for any injury or disease either arising	12 (viii) pregnancy, except complications of pregnancy;
out of an injury in the course of employment and subject to	<pre>13 (ix) routine well baby care;</pre>
a workers' compensation or similar law, forwhichbenefits	14 (x) complications to a newborn, unless no other source
arepayablewithoutregardtofaultundercoverage	15 of coverage is available;
statutorily-required-to-be-contained-in-any-motor-vehicle-or	<pre>16 (xi) sterilization or reversal of sterilization;</pre>
otherliabilityinsurancepolicyorequivalent	17 (xii) abortion, unless the life of the mother would be
self-insurance;or for which benefits are payable under	18 endangered if the fetus were carried to term;
another policy of disability insurance or medicare;	19 (xiii) weight modification or modification of the body
(ii) treatment for cosmetic purposes other than surgery	20 to improve the mental or emotional well-being of an insured;
for the repair or treatment of an injury or congenital	21 (xiv) artificial insemination or treatment for
bodily defect to restore normal bodily functions;	22 infertility; or
(iii) travel other than transportation provided by a	23 (xv) breast augmentation or reduction.
licensed ambulance service to the nearest facility qualified	24 Section 7. Certification of qualified plan. Upon
to treat the condition;	25 application by the association or the lead carrier for

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certification of a plan of health coverage as a qualified plan for the purposes of [sections 1 through ±2 13], the commissioner shall make a determination within 90 days as to whether the plan is qualified. If determined to be qualified, the plan of health coverage must be labeled as a "qualified plan" on the front of the policy.

Section 8. Association plan premium. The association 7 8 shall establish the schedule of premiums to be charged eligible persons for membership in the association plan. The 9 schedule of premiums may not be less than 150% or more than 10 11 400% of the average premium rates charged by the five largest insurers with the largest individual qualified plan 12 13 of insurance in force in this state. The premium rates of the five insurers used to establish the premium rates for 14 each type of coverage offered by the association must be 15 16 determined by the commissioner from information provided annually by all insurers at the request of the commissioner. 17 18 The information requested must include the number of qualified plans or actuarial equivalent plans offered by 19 each insurer, the rates charged by the insurer for each type 20 of plan offered by the insurer, and any other information 21 commissioner considers necessary. The commissioner 22 the ASSOCIATION shall utilize generally acceptable actuarial 23 24 principles and structurally compatible rates.

25 Section 9. Operation of association plan. (1) Upon

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acceptance by the lead carrier under [section 12], an 1 2 eligible person may enroll in the association plan by payment of the association plan premium to the lead carrier. 3 4 (2) Not less than 90% 88% of the association plan S premiums paid to the lead carrier may be used to pay claims and not more than $\pm 0\%$ 12% may be used for payment of the 6 7 lead carrier's direct and indirect expenses as specified in B [section 10].

9 (3) Any income in excess of the costs incurred by the 10 association in providing reinsurance or administrative 11 services must be held at interest and used by the 12 association to offset past and future losses due to claims 13 expenses of the association plan or be allocated to reduce 14 association plan premiums.

15 (4) Each participating member of the association shall share the losses due to claims expenses of the association 16 17 plan for plans issued or approved for issuance by the association and shall share in the operating and 18 administrative expenses incurred or estimated to be incurred 19 20 by the association incident to the conduct of its affairs. Claims expenses of the association plan that exceed the 21 22 premium payments allocated to the payment of benefits, are liability of the association members. Association 23 the 24 members shall share in the claims expenses of the association plan and operating and administrative expenses 25

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1 of the association in an amount equal to the ratio of:

2 (a) the association member's total disability
3 insurance premium received from or on behalf of Montana
4 residents divided by;

5 (b) the total disability premium received by all 6 association members from or on behalf of Montana residents, 7 as determined by the commissioner.

(5) The association shall make an annual determination 8 9 of each association member's liability, if any, and may make 10 an annual fiscal yearend assessment if necessary. The 11 association may also, subject to the approval of the commissioner, provide for interim assessments against the 12 association members as may be necessary to assure the 13 financial capability of the association in meeting the 14 incurred or estimated claims expenses of the association 15 plan and operating and administrative expenses of the 16 17 association until the association's next annual fiscal yearend assessment. Payment of an assessment is due within 18 30 days of receipt by an association member of a written 19 notice of a fiscal yearend or interim assessment. Failure 20 by a contributing member to tender to the association the 21 22 assessment within 30 days is grounds for termination of membership. An association member that ceases to do 23 disability insurance business within the state remains 24 25 liable for assessments through the calendar year during

which disability insurance business ceased. The association
 may decline to levy an assessment against an association
 member if the assessment, as determined pursuant to this
 section, would not exceed \$10.

(6) Any annual fiscal yearend or interim assessment 5 6 levied against an association member may be offset, in an 7 amount equal to the assessment paid to the association, against the premium tax payable by that association member 8 9 pursuant to 33-2-705 for the year in which the annual fiscal yearend or interim assessment is levied. The department-of 10 revenue INSURANCE COMMISSIONER shall, each year the 11 legislature meets in regular session, on or before January 12 15, report to the legislature the total amount of premium 13 tax offset claimed by association members during the 14 15 preceding biennium.

16 Section 10. Administration of association plan -17 rules. (1) Any member of the association may submit to the
18 commissioner policies to be proposed to serve as the
19 association plan. The commissioner shall prescribe by rule
20 the time and manner of the submission.

(2) Upon the commissioner's approval of the policy
forms and contracts submitted, the association shall select
policies and contracts by a member or members of the
association to be the association plan. The association
shall select one lead carrier to issue the qualified plans.

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1 The board of directors of the association shall prepare-2 appropriate specifications and bid forms and may solicit 3 bids from licensed administrators and the members of the 4 association for the purpose of selecting the lead carrier. 5 The selection of the lead carrier must be based upon 6 criteria established by the board of directors.

(3) The lead carrier shall perform all administrative 7 and claims payment functions required by this section upon 8 the commissioner's approval of the policy forms and 9 contracts submitted. The lead carrier shall provide these 10 services for a period of at least 3 years, unless a request 11 12 to terminate is approved by the association and the 13 commissioner. The association and the commissioner shall approve or deny a request to terminate within 90 days of its 14 receipt. A failure to make a final decision on a request to 15 16 terminate within the specified period is considered an approval. The association shall invite submissions of policy 17 18 forms from members of the association, including the lead 19 carrier, 6 months prior to the expiration of each 3-year period. The association shall follow the procedure provided 20 in subsection (2) in selecting a lead carrier for the 21 subsequent 3-year period or, if a request to terminate is 22 approved, on or before the end of the 3-year period. 23

24 (4) The lead carrier shall provide all eligible25 persons involved in the association plan an individual

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certificate setting forth a statement as to the insurance
 protection to which the person is entitled, the method and
 place of filing claims, and to whom benefits are payable.
 The certificate must indicate that coverage was obtained
 through the association.

(5) The lead carrier shall submit to the association 6 and the commissioner on a semiannual basis a report of the 7 8 operation of the association plan. The association must 9 determine the specific information to be contained in the 10 report prior to the effective date of the association plan. 11 (6) The lead carrier shall pay all claims pursuant to 12 (sections 1 through 12 13] and shall indicate that the claim 13 was paid by the association plan. Each claim payment must

14 include information specifying the procedure involved in the 15 event a dispute over the amount of payment arises.

16 (7) The lead carrier must be reimbursed from the 17 association plan premiums received for its direct and 18 indirect expenses. Direct and indirect expenses include a prorated reimbursement for the portion of the lead carrier's 19 administrative, printing, claims administration, management, 20 21 and building overhead expenses, which are assignable to the maintenance and administration of the association plan. The 22 23 association must approve cost accounting methods to 24 substantiate the lead carrier's cost reports consistent with generally accepted accounting principles. Direct and 25

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indirect expenses may not include costs directly related to
 the original submission of policy forms prior to selection
 as the lead carrier.

(8) The lead carrier is, when carrying out its duties 4 under [sections 1 through 12 13], an agent-of INDEPENDENT 5 CONTRACTOR FOR the association and is civilly INDIVIDUALLY 6 liable for its actions, subject to the laws of this state. 7 8 Section 11. Solicitation of eligible persons. (1) The 9 association, pursuant to a plan approved by the commissioner, shall disseminate appropriate information to 10 the residents of this state regarding the existence of the 11 association plan and the means of enrollment. Means of 12 communication may include use of the press, radio, and 13 television, as well as publication in appropriate state 14 15 offices and publications.

16 (2) The association shall devise and implement means
17 of maintaining public awareness of [sections 1 through 12
18 13] and shall administer [sections 1 through 12 13] in a
19 manner which facilitates public participation in the
20 association plan.

(3) All licensed disability insurance agents may
engage in the selling or marketing of qualified association
plans. The lead carrier shall pay an agent's referral fee of
\$25 to each licensed disability insurance agent who refers
an applicant to the association plan, if the applicant is

accepted. The referral fees must be paid to the lead
 carrier from money received as premiums for the association
 plan.

4 (4) An insurer, society, or health service corporation that rejects or applies underwriting restrictions to an 5 applicant for disability insurance must notify the applicant 6 of the existence of the association plan, requirements for 7 being accepted in it, and the procedure for applying to it. 8 Section 12. Enrollment by eligible person. (1) The 9 10 association plan must be open for enrollment by eligible persons. An eligible person may enroll in the plan by 11 12 submission of a certificate of eligibility to the lead carrier. The certificate must provide: 13

14 (a) the name, address, and age of the applicant and15 length of the applicant's residence in this state;

(b) the name, address, and age of spouse and children,if any, if they are to be insured;

18 (c) written evidence that he fulfills all of the 19 elements of an eligible person, as defined in (section 1); 20 and

21 (d) a designation of coverage desired.

(2) Within 30 days of receipt of the certificate, the
lead carrier shall either reject the application for failing
to comply with the requirements of subsection (1) or forward
the eligible person a notice of acceptance and billing

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information. Insurance is effective immediately-upon-receipt
 of--the--first--month's--association--plan--premium--and--is
 retroactive--to--the--date--of-application7-if-the-applicant
 otherwise-complies-with-fsections-l-through-l2] ON THE FIRST
 OF THE MONTH FOLLOWING ACCEPTANCE.

6 (3) An eligible person may not purchase more than one7 policy from the association plan.

(4) A person who obtains coverage pursuant to this B section may not be covered for any preexisting condition 9 during the first 12 months of coverage under the association 10 plan if the person was diagnosed or treated for that 11 condition during the 5 years immediately preceding the 12 filing of an application. This subsection does not apply to 13 a person who has had continuous coverage under an 14 individual, family, or group policy during the year 15 immediately preceding the filing of an application for 16 17 nonelective procedures.

 18
 (5) A CHANGE OF RESIDENCE FROM MONTANA TO ANOTHER

 19
 STATE IMMEDIATELY TERMINATES ELIGIBILITY FOR RENEWAL OF

 20
 COVERAGE UNDER THE ASSOCIATION PLAN.

 21
 SECTION 13. LIABILITY OF ASSOCIATION MEMBERSHIP, NO

 22
 MEMBER OF THE ASSOCIATION IS LIABLE FOR THE ACTIONS OF THE

 23
 ASSOCIATION OR ITS LEAD CARRIER.

24 Section 14. Extension of authority. Any existing 25 authority of the commissioner of insurance to make rules on

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the subject of the provisions of this act is extended to the provisions of this act.

3 Section 15. Codification instruction. Sections 1
4 through 12 13 are intended to be codified as an integral
5 part of Title 33, and the provisions of Title 33 apply to
6 sections 1 through 12 13.

7 Section 16. Severability. If a part of this act is 8 invalid, all valid parts that are severable from the invalid 9 part remain in effect. If a part of this act is invalid in 10 one or more of its applications, the part remains in effect 11 in all valid applications that are severable from the 12 invalid applications.

13 Section 17. Effective date. (1) Except for section 5,

14 this act is effective July 1, 1985.

15 (2) Section 5 is effective July 1, 1987.

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49th Legislature

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HB 0817/si

STATEMENT OF INTENT HOUSE BILL NO. 817 House Business and Labor Committee

5 A statement of intent is required for this bill because 6 it grants rulemaking authority to the commissioner of 7 insurance for the purpose of making effective the provisions 8 and purposes of this act.

9 The purpose of this act is to establish a mechanism 10 through which adequate levels of health insurance coverages 11 can be made available to residents of this state who are 12 otherwise considered uninsurable. This bill establishes a 13 state association or pool of which all insurers, health 14 service corporations, and fraternal benefit societies 15 providing health care benefits in Montana are members.

It is intended that the pool coverage is the coverage 16 of "last resort" and is not intended to duplicate coverages 17 18 from any other source, private or public. The mechanics of the pool and its operations and functions must all be 19 established under a plan approved by the commissioner. The 20 pool is subject to the requirements of the insurance code 21 and has the general powers and authority of an insurer 22 licensed to transact health insurance business in this 23 24 state.

It is intended that the association board of directors



1 be responsible for the day-to-day operations of the

2 association, subject to the review and approval of the

3 insurance commissioner.

-2-1 THIRD READING HB 817

HB 0817/si

1	HOUSE BILL NO. 817	· 1	(4) "Eligible person" means an individual who:
2	INTRODUCED BY KITSELMAN, ECK, JACOBSON, WINSLOW,	2	(a) is a resident of this state and has
3	HAGER, KENNERLY, THOMAS, GOULD, BERGENE, GILBERT	3	residentforatleastlyearimmediatelyp
4		4	application APPLIES for coverage under the association
5	A BILL FOR AN ACT ENTITLED: "AN ACT TO PROVIDE HEALTH	5	and
6	INSURANCE COVERAGE TO CERTAIN PERSONS INELIGIBLE FOR	6	(b) within 6 months prior to the date of appl
7	COVERAGE FROM TRADITIONAL PROVIDERS OF HEALTH CARE BENEFITS	7	has been rejected for disability insurance or health
8	BY ESTABLISHING A MONTANA COMPREHENSIVE HEALTH ASSOCIATION	8	benefits by at least two insurers, societies, or
9	AND PLAN; TO REQUIRE PARTICIPATION IN THE ASSOCIATION BY	9	service corporations, or has had a restrictive
10	EACH HEALTH SERVICE CORPORATION, FRATERNAL BENEFIT SOCIETY,	10	preexisting conditions limitation, which limitat
11	AND INSURER PROVIDING HEALTH CARE BENEFITS IN THIS STATE;	11	required by at least two insurers, societies, o
12	AND PROVIDING EFFECTIVE DATES."	12	service corporations, which has the effect of substant
13		13	reducing coverage from that received by a person co
14	BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:	14	a standard risk.
15	Section 1. Definitions. As used in [sections 1 through	15	(5) "Health service corporation" means a corp
16	$\frac{12}{12}$, the following definitions apply:	16	operating pursuant to Title 33, chapter 30, and off
17	(1) "Association" means the comprehensive health	17	selling contracts of disability insurance.
18	association created by [section 3].	18	(6) "Insurer" means a company operating pursu
19	(2) "Association plan" means a policy of insurance	19	Title 33, chapter 2 or 3, and offering or selling p
20	coverage offered by the association through the lead	20	or contracts of disability insurance, as provided in
21	carrier.	21	33, chapter 22.
22	(3) "Association plan premium" means the charge	22	(7) "Lead carrier" means the licensed administ
23	determined pursuant to [section 8] for membership in the	23	insurer selected by the association to administ
24	association plan based on the benefits provided in [section	24	association plan.
25	6].	25	(8) "Preexisting condition" means any conditi
			-1-

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a resident of this state and has--been-a --at--least--l---year---immediately---preceding PPLIES for coverage under the association plan:

hin 6 months prior to the date of application, cted for disability insurance or health service t least two insurers, societies, or health orations, or has had a restrictive rider or conditions limitation, which limitation is at least two insurers, societies, or health rations, which has the effect of substantially erage from that received by a person considered sk.

alth service corporation" means a corporation rsuant to Title 33, chapter 30, and offering or acts of disability insurance.

surer" means a company operating pursuant to chapter 2 or 3, and offering or selling policies of disability insurance, as provided in Title 2.

ad carrier" means the licensed administrator or ected by the association to administer the olan.

eexisting condition" means any condition for

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Montana Legislative Council

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which an applicant for coverage under the association plan
 has received medical attention during the 5 years
 immediately preceding the filing of an application.

(9) "Qualified plan" means those-health-benefit-plans 4 certified-by--the--commissioner--as--providing--the--minimum 5 6 benefits-required-by-fsection-6}-or-the-actuarial-equivalent of--those--benefits ANY PLAN, PROGRAM, CONTRACT, OR OTHER 7 8 ARRANGEMENT TO THE EXTENT NOT EXEMPT FROM INCLUSION BY VIRTUE OF THE PROVISIONS OF THE FEDERAL EMPLOYEE RETIREMENT 9 INCOME SECURITY ACT OF 1974 UNDER WHICH ONE OR MORE 10 EMPLOYERS, UNIONS, OR OTHER ORGANIZATIONS PROVIDE TO THEIR 11 EMPLOYEES OR MEMBERS, EITHER DIRECTLY OR INDIRECTLY THROUGH 12 13 A TRUST OR A THIRD PARTY ADMINISTRATOR, HEALTH CARE SERVICES 14 OR BENEFITS OTHER THAN THROUGH AN INSURER.

(10) "Society" means a fraternal benefit society
operating pursuant to Title 33, chapter 7, and offering or
selling certificates of disability insurance.

18 Section 2. Duties of the commissioner -- rules. The 19 commissioner shall:

20 (1) adopt rules to carry out the provisions and 21 purposes of [sections 1 through ±2 13];

(2) supervise the creation of the association withinthe limits described in [section 3];

24 (3) approve the selection of the lead carrier by the25 association and approve the association's contract with the

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lead carrier, including the association plan coverage and premiums to be charged;

3 (4) conduct periodic audits to assure the general
4 accuracy of the financial data submitted by the lead carrier
5 and the association; and

6 (5) undertake, directly or through contracts with 7 other persons, studies or demonstration projects to develop 8 awareness of the benefits of [sections 1 through ±2 13] so 9 that the residents of this state may best avail themselves 10 of the health care benefits provided by [sections 1 through 11 ±2 13].

Section 3. Comprehensive health association ----12 mandatory membership. (1) There is established a NONPROFIT 13 LEGAL ENTITY TO BE KNOWN AS THE MONTANA comprehensive health 14 association with participating membership consisting of all 15 insurers, societies, and health service corporations 16 licensed or authorized to do business in this state. The 17 association is exempt from taxation under the laws of this 18 state, and all property owned by the association is exempt 19 20 from taxation.

(2) All participating members shall maintain their
membership in the association as a condition for writing
health care benefits policies or contracts in this state.
The association shall submit its articles, bylaws, and
operating rules to the commissioner for approval.

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1	(3) The association may:	1	(b) a member at large, appointed by the commissioner
2	(a) exercise the powers granted to insurers under the	2	to represent the public interest, who shall serve in an
3	laws of this state;	3	advisory capacity only.
4	(b) sue or be sued;	4	(2) Each of the seven board members representing the
5	(c) enter into contracts with insurers,	5	association members is entitled to <u>A WEIGHTED AVERAGE</u> vote,
6	administrators, similar associations in other states, or	6	in person or by proxy, based on the association member's
7	other persons for the performance of administrative	7	annual MONTANA premium volume7. inaccordancewiththe
8	functions;	8	following-schedule:
9	(d) establish administrative and accounting procedures	9	\$ 100,000\$-4,999,999
10	for the operation of the association;	10	578887888979997999
11	(e) provide for the reinsuring of risks incurred as a	11 .	-10,000,00014,999,999
12	result of issuing the coverages required by members of the	12	-1570007000-or-more4-votes
13	association; and	13	(3) Members of the board may be reimbursed from the
14	(f) provide for the administration by the association	14 [.]	money of the association for expenses incurred by them due
15	of policies that are reinsured pursuant to subsection	15	to their service as board members but may not otherwise be
16	(3)(e).	16	compensated by the association for their services. The costs
17	Section 4. Association board of directors	17	of conducting the meetings of the association and its board
18	organization. (1) There is a board of directors of the	18	of directors must be borne by participating members of the
19	association, consisting of eight individuals:	19	association in accordance with [section 9].
20	(a) one from each of the seven participating members	20	Section 5. Minimum benefits of association plan. The
21	of the association with the highest annual premium volume of	21	association through the association plan shall offer a
22	disability insurance contracts or health service corporation	22	policy that provides at least the benefits of a qualified
23	contracts, derived from or on behalf of residents in the	23	plan as required by [section 6].
24	previous calendar year, as determined by the commissioner;	24	Section 6. Qualified plan minimum benefits. A plan
25	and	25	of health coverage must be certified as a qualified plan _ if
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it otherwise meets the requirements of Title 33, chapters
 15, 22 EXCEPTING PART 7, and 30, and other laws of this
 state, whether or not the policy is issued in this state,
 and meets or exceeds the following minimum standards:

5 (1) The minimum benefits for an insured must, subject to the other provisions of this section, be equal to at 6 7 least 80% of the covered expenses required by this section 8 in excess of an annual deductible that does not exceed \$1,000 per person. The coverage must include a limitation of 9 10 \$5,000 per person on the total annual out-of-pocket expenses 11 for services covered under this section. Coverage must be subject to a maximum lifetime benefit, but such maximums may 12 not be less than \$100,000. 13

(2) Covered expenses must be the usual and customary
charges for the following services and articles when
prescribed by a physician or other licensed health care
professional provided for in 33-22-111:

18 (a) hospital services;

(b) professional services for the diagnosis or
treatment of injuries, illness, or conditions, other than
dental;

22 (c) use of radium or other radioactive materials;

23 (d) oxygen;

24 (e) anesthetics;

25 (f) diagnostic x-rays and laboratory tests, except as

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specifically provided in subsection (3);

2 (g) services of a physical therapist;

3 (h) transportation provided by licensed ambulance
 4 service to the nearest facility qualified to treat the
 5 condition;

6 (i) oral surgery for the gums and tissues of the mouth 7 when not performed in connection with the extraction or 8 repair of teeth or in connection with TMJ:

9 (j) rental or purchase of medical equipment, which 10 shall be reimbursed after the deductible has been met at the 11 rate of 50%, up to a maximum of \$1,000;

12 (k) prosthetics, other than dental; AND

13 (1) services of a licensed home health agency, up to a

14 maximum of 180 visits per year7-and

15 (m)--necessary--care--and--treatment-of-mental-illness;

16 alcoholism7-and-drug-addiction7-as-provided-in-33-22-703.

17 (3) (a) Covered expenses for the services or articles18 specified in this section do not include:

19 (i) drugs requiring a physician's prescription;

20 (ii) services of a nursing home;

21 (iii) home and office calls, except as specifically 22 provided in subsection (2);

23 (iv) rental or purchase of durable medical equipment,

24 except as specifically provided in subsection (2);

25 (v) the first \$20 of diagnostic x-ray and laboratory

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(iv) confinement in a private room to the extent it is 1 charges in each 14-day period; in excess of the institution's charge for its most common 2 (vi) oral surgery, except as specifically provided in semiprivate room, unless the private room is prescribed as 3 4 medically necessary by a physician: (vii) that part of a charge for services or articles 5 (v) services or articles the provision of which is not within the scope of authorized practice of the institution 6 7 or individual rendering the services or articles: (viii) care that is primarily for custodial or (vi) organ transplants unless---prior---approval---is 8 received-from-the-board-of-directors-of-the-association; 9 (vii) room and board for a nonemergency admission on 10 (b) Covered expenses for the services or articles 11 Friday or Saturday; 12 (viii) pregnancy, except complications of pregnancy: (i) care or for any injury or disease either arising 13 (ix) routine well baby care; (x) complications to a newborn, unless no other source 14 15 of coverage is available; (xi) sterilization or reversal of sterilization; 16 17 (xii) abortion, unless the life of the mother would be 18 endangered if the fetus were carried to term: (xiii) weight modification or modification of the body 19 to improve the mental or emotional well-being of an insured: 20 (ii) treatment for cosmetic purposes other than surgery (xiv) artificial insemination or treatment 21 for 22 infertility; or (xv) breast augmentation or reduction. 23 (iii) travel other than transportation provided by a Section 7. Certification of qualified plan. Upon 24 application by the association or the lead carrier for 25

1

2 subsection (2); 3

đ 5 which exceeds the prevailing charge in the locality where the service is provided; or 6

7 domiciliary purposes which would not qualify as eligible 8 services under medicare. 9

10 specified in this section do not include charges for: 11

12 out of an injury in the course of employment and subject to 13 a workers' compensation or similar law, for--which--benefits 14 are---payable---Without---regard--to--fault--under--coverage 15 statutorily-required-to-be-contained-in-any-motor-vehicle-or 16 17 other---liability----insurance----policy----or----equivalent self-insurance, -- or for which benefits are payable under 18 another policy of disability insurance or medicare; 19

20 for the repair or treatment of an injury or congenital 21 22 bodily defect to restore normal bodily functions;

23 licensed ambulance service to the nearest facility qualified 24 25 to treat the condition;

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certification of a plan of health coverage as a qualified plan for the purposes of [sections 1 through ±2 13], the commissioner shall make a determination within 90 days as to whether the plan is qualified. If determined to be qualified, the plan of health coverage must be labeled as a "qualified plan" on the front of the policy.

7 Section 8. Association plan premium. The association 8 shall establish the schedule of premiums to be charged 9 eligible persons for membership in the association plan. The 10 schedule of premiums may not be less than 150% or more than 400% of the average premium rates charged by the five 11 largest insurers with the largest individual qualified plan 12 of insurance in force in this state. The premium rates of 13 14 the five insurers used to establish the premium rates for each type of coverage offered by the association must be 15 determined by the commissioner from information provided 16 annually by all insurers at the request of the commissioner. 17 The information requested must include the number of 18 qualified plans or actuarial equivalent plans offered by 19 20 each insurer, the rates charged by the insurer for each type of plan offered by the insurer, and any other information 21 22 the commissioner considers necessary. The commissioner ASSOCIATION shall utilize generally acceptable actuarial 23 principles and structurally compatible rates. 24

25 Section 9. Operation of association plan. (1) Upon

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acceptance by the lead carrier under [section 12], an
 eligible person may enroll in the association plan by
 payment of the association plan premium to the lead carrier.

4 (2) Not less than 90% <u>88%</u> of the association plan 5 premiums paid to the lead carrier may be used to pay claims 6 and not more than 10% <u>12%</u> may be used for payment of the 7 lead carrier's direct and indirect expenses as specified in 8 {section 10].

9 (3) Any income in excess of the costs incurred by the 10 association in providing reinsurance or administrative 11 services must be held at interest and used by the 12 association to offset past and future losses due to claims 13 expenses of the association plan or be allocated to reduce 14 association plan premiums.

15 (4) Each participating member of the association shall share the losses due to claims expenses of the association 16 plan for plans issued or approved for issuance by the 17 18 association and shall share in the operating and 19 administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs. 20 Claims expenses of the association plan that exceed the 21 premium payments allocated to the payment of benefits are 22 the liability of the association members. Association 23 members shall share in the claims expenses 24 of the 25 association plan and operating and administrative expenses

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1 of the association in an amount equal to the ratio of:

2 (a) the association member's total disability
3 insurance premium received from or on behalf of Montana
4 residents divided by;

5 (b) the total disability premium received by all 6 association members from or on behalf of Montana residents, 7 as determined by the commissioner.

8 (5) The association shall make an annual determination of each association member's liability, if any, and may make 9 an annual fiscal vearend assessment if necessary. The 10 association may also, subject to the approval of the 31 commissioner, provide for interim assessments against the 12 13 association members as may be necessary to assure the financial capability of the association in meeting the 14 incurred or estimated claims expenses of the association 15 plan and operating and administrative expenses of the 16 association until the association's next annual fiscal 17 vearend assessment. Payment of an assessment is due within 18 19 30 days of receipt by an association member of a written notice of a fiscal yearend or interim assessment. Failure 20 by a contributing member to tender to the association the 21 assessment within 30 days is grounds for termination of 22 membership. An association member that ceases to do 23 disability insurance business within the state remains 24 liable for assessments through the calendar year during 25

which disability insurance business ceased. The association
 may decline to levy an assessment against an association
 member if the assessment, as determined pursuant to this
 section, would not exceed \$10.

5 (6) Any annual fiscal yearend or interim assessment 6 levied against an association member may be offset, in an amount equal to the assessment paid to the association, 7 against the premium tax payable by that association member 8 pursuant to 33-2-705 for the year in which the annual fiscal 9 yearend or interim assessment is levied. The department-of 10 revenue INSURANCE COMMISSIONER shall, each year the 11 legislature meets in regular session, on or before January 12 15, report to the legislature the total amount of premium 13 tax offset claimed by association members during the 14 preceding biennium. 15

16 Section 10. Administration of association plan --17 rules. (1) Any member of the association may submit to the 18 commissioner policies to be proposed to serve as the 19 association plan. The commissioner shall prescribe by rule 20 the time and manner of the submission.

(2) Upon the commissioner's approval of the policy
forms and contracts submitted, the association shall select
policies and contracts by a member or members of the
association to be the association plan. The association
shall select one lead carrier to issue the qualified plans.

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1 The board of directors of the association shall prepare 2 appropriate specifications and bid forms and may solicit 3 bids from licensed administrators and the members of the 4 association for the purpose of selecting the lead carrier. 5 The selection of the lead carrier must be based upon 6 criteria established by the board of directors.

7 (3) The lead carrier shall perform all administrative and claims payment functions required by this section upon я 9 the commissioner's approval of the policy forms and contracts submitted. The lead carrier shall provide these 10 11 services for a period of at least 3 years, unless a request 12 to terminate is approved by the association and the 13 commissioner. The association and the commissioner shall approve or deny a request to terminate within 90 days of its 14 receipt. A failure to make a final decision on a request to 15 terminate within the specified period is considered an 16 17 approval. The association shall invite submissions of policy 18 forms from members of the association, including the lead 19 carrier, 6 months prior to the expiration of each 3-year 20 period. The association shall follow the procedure provided in subsection (2) in selecting a lead carrier for the 21 subsequent 3-year period or, if a request to terminate is 22 23 approved, on or before the end of the 3-year period.

24 (4) The lead carrier shall provide all eligible25 persons involved in the association plan an individual

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certificate setting forth a statement as to the insurance
 protection to which the person is entitled, the method and
 place of filing claims, and to whom benefits are payable.
 The certificate must indicate that coverage was obtained
 through the association.

6 (5) The lead carrier shall submit to the association and the commissioner on a semiannual basis a report of the 7 8 operation of the association plan. The association must 9 determine the specific information to be contained in the report prior to the effective date of the association plan. 10 (6) The lead carrier shall pay all claims pursuant to 11 [sections 1 through ± 2 13] and shall indicate that the claim 12 was paid by the association plan. Each claim payment must 13 14 include information specifying the procedure involved in the 15 event a dispute over the amount of payment arises.

(7) The lead carrier must be reimbursed from the 16 17 association plan premiums received for its direct and indirect expenses. Direct and indirect expenses include a 18 prorated reimbursement for the portion of the lead carrier's 19 20 administrative, printing, claims administration, management, and building overhead expenses, which are assignable to the 21 maintenance and administration of the association plan. The 22 23 association must approve cost accounting methods to substantiate the lead carrier's cost reports consistent with 24 generally accepted accounting principles. Direct and 25

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indirect expenses may not include costs directly related to
 the original submission of policy forms prior to selection
 as the lead carrier.

(8) The lead carrier is, when carrying out its duties 4 under [sections 1 through 12 13], an agent-of INDEPENDENT 5 CONTRACTOR FOR the association and is civility INDIVIDUALLY 6 liable for its actions, subject to the laws of this state. 7 Section 11. Solicitation of eligible persons. (1) The 8 association, pursuant to a plan approved by the 9 commissioner, shall disseminate appropriate information to 10 the residents of this state regarding the existence of the 11 association plan and the means of enrollment. Means of 12 communication may include use of the press, radio, and 13 television, as well as publication in appropriate state 14 offices and publications. 15

16 (2) The association shall devise and implement means 17 of maintaining public awareness of [sections 1 through $\frac{12}{12}$] 18 <u>13</u>] and shall administer [sections 1 through $\frac{12}{12}$] in a 19 manner which facilitates public participation in the 20 association plan.

(3) All licensed disability insurance agents may
engage in the selling or marketing of qualified association
plans. The lead carrier shall pay an agent's referral fee of
\$25 to each licensed disability insurance agent who refers
an applicant to the association plan, if the applicant is

accepted. The referral fees must be paid to the lead
 carrier from money received as premiums for the association
 plan.

(4) An insurer, society, or health service corporation ۵ that rejects or applies underwriting restrictions to an 5 applicant for disability insurance must notify the applicant 6 of the existence of the association plan, requirements for 7 being accepted in it, and the procedure for applying to it. 8 Section 12. Enrollment by eligible person. (1) The 9 association plan must be open for enrollment by eligible 10 persons. An eligible person may enroll in the plan by 11 submission of a certificate of eligibility to the lead 12 carrier. The certificate must provide: 13

14 (a) the name, address, and age of the applicant and
15 length of the applicant's residence in this state;

16 (b) the name, address, and age of spouse and children,17 if any, if they are to be insured;

18 (c) written evidence that he fulfills all of the
19 elements of an eligible person, as defined in [section 1];
20 and

(d) a designation of coverage desired.

(2) Within 30 days of receipt of the certificate, the
lead carrier shall either reject the application for failing
to comply with the requirements of subsection (1) or forward
the eligible person a notice of acceptance and billing

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information. Insurance is effective immediately-upon-receipt
 of--the--first--month's--association--plan--premium--and--is
 retroactive--to--the--date--of-application7-if-the-applicant
 otherwise-complies-with-fsections-1-through-127 ON THE FIRST
 OF THE MONTH FOLLOWING ACCEPTANCE.

6 (3) An eligible person may not purchase more than one7 policy from the association plan.

8 (4) A person who obtains coverage pursuant to this 9 section may not be covered for any preexisting condition 10 during the first 12 months of coverage under the association 11 plan if the person was diagnosed or treated for that condition during the 5 years immediately preceding the 12 filing of an application. This subsection does not apply to 13 a person who has had continuous coverage under an 14 individual, family, or group policy during the year 15 16 immediately preceding the filing of an application for nonelective procedures. 17

 18
 (5) A CHANGE OF RESIDENCE FROM MONTANA TO ANOTHER

 19
 STATE IMMEDIATELY TERMINATES ELIGIBILITY FOR RENEWAL OF

 20
 COVERAGE UNDER THE ASSOCIATION PLAN.

 21
 SECTION 13. LIABILITY OF ASSOCIATION MEMBERSHIP. NO

 22
 MEMBER OF THE ASSOCIATION IS LIABLE FOR THE ACTIONS OF THE

 23
 ASSOCIATION OR ITS LEAD CARRIER.

Section 14. Extension of authority. Any existing
authority of the commissioner of insurance to make rules on

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the subject of the provisions of this act is extended to the
 provisions of this act.

3 Section 15. Codification instruction. Sections 1 4 through 12 13 are intended to be codified as an integral 5 part of Title 33, and the provisions of Title 33 apply to 6 sections 1 through 12 13.

7 Section 16. Severability. If a part of this act is 8 invalid, all valid parts that are severable from the invalid 9 part remain in effect. If a part of this act is invalid in 10 one or more of its applications, the part remains in effect 11 in all valid applications that are severable from the 12 invalid applications.

13 Section 17. Effective date. (1) Except for section 5,
14 this act is effective July 1, 1985.

15 (2) Section 5 is effective July 1, 1987.

-End-

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SENATE

STANDING COMMITTEE REPORT

MARCH 13, 19.85

MR. PRESIDENT

THIRD reading copy (<u>BLUE</u>) color

HEALTH INSURANCE POOLING ACT

KITSELMAN (HAGER)

Respectfully report as follows: That...... No...817......

be amended as follows:

1. Title, line ll.
Following: line l0.
Insert: "INSURANCE ARRANGEMENT,"

2. Page 2, line 18. Following: line 17.

Insert: "(6) "Insurance arrangement" means any plan, program, contract, or other arrangement to the extent not exempt from inclusion by virtue of the provisions of the federal employee retirement income security act of 1974 under which one or more employers, unions, or other organizations provide to their employees or members, either directly or indirectly through a trust of a third party administrator, health care services or benefits other than through an insurer." Renumber: subsequent subsections

3. Page 3, lines 7 through 14. Following: "benefits" in line 7. Strike: remainder of line 7 through line 14. Insert: "those health benefit plans certified by the commissioner as providing the minimum benefits reguired by [section 6] or the acturial equivalent of those benefits."

4. Page 4, line 16.
Following: "insurers,"
Insert: "insurance arrangements,"

DOX RASSSX

RXXXXXXXX AND AS AMENDED BE CONCURRED IN

ÒR JÚDY∕ **JACOBSON** Chairman.

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HB 0817/si

1	STATEMENT OF INTENT
2	HOUSE BILL NO. 817
3	House Business and Labor Committee

4

5 A statement of intent is required for this bill because 6 it grants rulemaking authority to the commissioner of 7 insurance for the purpose of making effective the provisions 8 and purposes of this act.

9 The purpose of this act is to establish a mechanism 10 through which adequate levels of health insurance coverages 11 can be made available to residents of this state who are 12 otherwise considered uninsurable. This bill establishes a 13 state association or pool of which all insurers, health 14 service corporations, and fraternal benefit societies 15 providing health care benefits in Montana are members.

It is intended that the pool coverage is the coverage 16 of "last resort" and is not intended to duplicate coverages 17 from any other source, private or public. The mechanics of 18 19 the pool and its operations and functions must all be established under a plan approved by the commissioner. The 20 21 pool is subject to the requirements of the insurance code and has the general powers and authority of an insurer 22 licensed to transact health insurance business in this 23 24 state.

It is intended that the association board of directors

25

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be responsible for the day-to-day operations of the
 association, subject to the review and approval of the
 insurance commissioner.

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49th Legislature

HB 0817/03

1	HOUSE BILL NO. 817	1
2 ·	INTRODUCED BY KITSELMAN, ECK, JACOBSON, WINSLOW,	2
3	HAGER, KENNERLY, THOMAS, GOULD, BERGENE, GILBERT	3
4		4
5	A BILL FOR AN ACT ENTITLED: "AN ACT TO PROVIDE HEALTH	5
6	INSURANCE COVERAGE TO CERTAIN PERSONS INELIGIBLE FOR	6
7	COVERAGE FROM TRADITIONAL PROVIDERS OF HEALTH CARE BENEFITS	7
8	BY ESTABLISHING A MONTANA COMPREHENSIVE HEALTH ASSOCIATION	8
9	AND PLAN; TO REQUIRE PARTICIPATION IN THE ASSOCIATION BY	9
10	EACH HEALTH SERVICE CORPORATION, FRATERNAL BENEFIT SOCIETY,	10
11	INSURANCE ARRANGEMENT, AND INSURER PROVIDING HEALTH CARE	11
12	BENEFITS IN THIS STATE; AND PROVIDING EFFECTIVE DATES."	12
13		13
14	BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:	14
15	Section 1. Definitions. As used in [sections 1 through	15
16	12 13], the following definitions apply:	16
17	(1) "Association" means the comprehensive health	17
18	association created by [section 3].	. 18
19	(2) "Association plan" means a policy of insurance	19
20	coverage offered by the association through the lead	20
21	carrier.	21
22	(3) "Association plan premium" means the charge	22
23	determined pursuant to [section 8] for membership in the	23
24	association plan based on the benefits provided in [section	24
25	6].	25

(4) "Eligible person" means an individual who:
 (a) is a resident of this state and has--been-a
 resident--for--at--least--l--year---immediately---preceding
 application <u>APPLIES</u> for coverage under the association plan;
 and

6 (b) within 6 months prior to the date of application, 7 has been rejected for disability insurance or health service 8 benefits by at least two insurers, societies, or health 9 service corporations, or has had a restrictive rider or 0 preexisting conditions limitation, which limitation is 1 required by at least two insurers, societies, or health 2 service corporations, which has the effect of substantially 3 reducing coverage from that received by a person considered 4 a standard risk.

(5) "Health service corporation" means a corporation
operating pursuant to Title 33, chapter 30, and offering or
selling contracts of disability insurance.

(6) "INSURANCE ARRANGEMENT" MEANS ANY PLAN, PROGRAM, CONTRACT, OR OTHER ARRANGEMENT TO THE EXTENT NOT EXEMPT FROM INCLUSION BY VIRTUE OF THE PROVISIONS OF THE FEDERAL EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 UNDER WHICH ONE OR MORE EMPLOYERS, UNIONS, OR OTHER ORGANIZATIONS PROVIDE TO THEIR EMPLOYEES OR MEMBERS, EITHER DIRECTLY OR INDIRECTLY THROUGH A TRUST OF A THIRD-PARTY ADMINISTRATOR, HEALTH CARE SERVICES OR BENEFITS OTHER THAN THROUGH AN

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t6†(7) "Insurer" means a company operating pursuant to
Title 33, chapter 2 or 3, and offering or selling policies
or contracts of disability insurance, as provided in Title
33, chapter 22.

6 (7)(8) "Lead carrier" means the licensed administrator
7 or insurer selected by the association to administer the
8 association plan.

9 (8)(9) "Preexisting condition" means any condition for
10 which an applicant for coverage under the association plan
11 has received medical attention during the 5 years
12 immediately preceding the filing of an application.

(9)(10) "Qualified plan" means those--health--benefit 13 14 plans-certified-by-the-commissioner-as-providing-the-minimum 15 benefits-required-by-fsection-6]-or-the-actuarial-equivalent 16 of--those--benefits ANY--PLAN7--PROGRAM7-CONTRACT7-OR-OTHER 17 ARRANGEMENT-TO-THE--EXTENT--NOT--EXEMPT--FROM--INCLUSION--BY 18 VIRTUE--OF-THE-PROVISIONS-OF-THE-FEDERAL-EMPLOYEE-RETIREMENT 19 INCOMB--SECURITY--ACT--OF--1974--UNDER--WHICH--ONE--OR--MORE 20 EMPLOYERS7--UNIONS7--OR-OTHER-ORGANIZATIONS-PROVIDE-TO-THEIR 21 EMPLOYEES-OR-MEMBERS7-EITHER-DIRECTLY-OR-INDIRECTLY-THROUGH 22 A-TRUST-OR-A-THIRB-PARTY-ADMINISTRATOR;-HEALTH-CARE-SERVICES 23 OR--BENEFITS--OTHER--THAN--THROUGH--AN-INSURER. THOSE HEALTH 24 BENEFIT PLANS CERTIFIED BY THE COMMISSIONER AS PROVIDING THE 25 MINIMUM BENEFITS REQUIRED BY SECTION 6 OR THE ACTUARIAL

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1 EQUIVALENT OF THOSE BENEFITS.

2 (10)(11) "Society" means a fraternal benefit society
3 operating pursuant to Title 33, chapter 7, and offering or
4 selling certificates of disability insurance.

5 Section 2. Duties of the commissioner -- rules. The
6 commissioner shall:

7 (1) adopt rules to carry out the provisions and
8 purposes of [sections 1 through 12 13];

9 (2) supervise the creation of the association within
10 the limits described in [section 3];

11 (3) approve the selection of the lead carrier by the 12 association and approve the association's contract with the 13 lead carrier, including the association plan coverage and 14 premiums to be charged;

15 (4) conduct periodic audits to assure the general 16 accuracy of the financial data submitted by the lead carrier 17 and the association; and

18 (5) undertake, directly or through contracts with 19 other persons, studies or demonstration projects to develop 20 awareness of the benefits of [sections 1 through 12 13] so 21 that the residents of this state may best avail themselves 22 of the health care benefits provided by [sections 1 through 23 12 13].

Section 3. Comprehensive health association - mandatory membership. (1) There is established a NONPROFIT

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LEGAL ENTITY TO BE KNOWN AS THE MONTANA comprehensive health association with participating membership consisting of all insurers, <u>INSURANCE ARRANGEMENTS</u>, societies, and health service corporations licensed or authorized to do business in this state. The association is exempt from taxation under the laws of this state, and all property owned by the association is exempt from taxation.

8 (2) All participating members shall maintain their 9 membership in the association as a condition for writing 10 health care benefits policies or contracts in this state. 11 The association shall submit its articles, bylaws, and 12 operating rules to the commissioner for approval.

(3) The association may:

14 (a) exercise the powers granted to insurers under the15 laws of this state;

(b) sue or be sued;

13

16

17 (c) enter into contracts with insurers,
18 administrators, similar associations in other states, or
19 other persons for the performance of administrative
20 functions;

(d) establish administrative and accounting proceduresfor the operation of the association;

(e) provide for the reinsuring of risks incurred as a
result of issuing the coverages required by members of the
association; and

(f) provide for the administration by the association
 of policies that are reinsured pursuant to subsection
 (3)(e).

4 Section 4. Association board of directors --5 organization. (1) There is a board of directors of the 6 association, consisting of eight individuals:

7 (a) one from each of the seven participating members 8 of the association with the highest annual premium volume of 9 disability insurance contracts or health service corporation 10 contracts, derived from or on behalf of residents in the 11 previous calendar year, as determined by the commissioner; 12 and

(b) a member at large, appointed by the commissioner
to represent the public interest, who shall serve in an
advisory capacity only.

(3) Members of the board may be reimbursed from the

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1 money of the association for expenses incurred by them due 2 to their service as board members but may not otherwise be 3 compensated by the association for their services. The costs 4 of conducting the meetings of the association and its board 5 of directors must be borne by participating members of the association in accordance with [section 9]. 6

7 Section 5. Minimum benefits of association plan. The 8 association through the association plan shall offer a policy that provides at least the benefits of a qualified 9 10 plan as required by [section 6].

11 Section 6. Qualified plan -- minimum benefits. A plan of health coverage must be certified as a qualified plan if 12 13 it otherwise meets the requirements of Title 33, chapters 14 15, 22 EXCEPTING PART 7, and 30, and other laws of this 15 state, whether or not the policy is issued in this state, and meets or exceeds the following minimum standards: 16

17 (1) The minimum benefits for an insured must, subject to the other provisions of this section, be equal to at 18 least 80% of the covered expenses required by this section 19 20 in excess of an annual deductible that does not exceed \$1,000 per person. The coverage must include a limitation of 21 22 \$5,000 per person on the total annual out-of-pocket expenses for services covered under this section. Coverage must be 23 subject to a maximum lifetime benefit, but such maximums may 24 25 not be less than \$100,000.

1 (2) Covered expenses must be the usual and customary 2 charges for the following services and articles when prescribed by a physician or other licensed health care 3 professional provided for in 33-22-111: 4

5 (a) hospital services;

6 (b) professional services for the diagnosis or 7 treatment of injuries, illness, or conditions, other than dental; R

9 (c) use of radium or other radioactive materials;

10 (d) oxygen;

24

11 (e) anesthetics;

12 (f) diagnostic x-rays and laboratory tests, except as 13

specifically provided in subsection (3);

14 (q) services of a physical therapist;

15 (h) transportation provided by licensed ambulance service to the nearest facility qualified to treat the 16 condition: 17

18 (i) oral surgery for the gums and tissues of the mouth 19 when not performed in connection with the extraction or 20 repair of teeth or in connection with TMJ;

21 (j) rental or purchase of medical equipment, which 22 shall be reimbursed after the deductible has been met at the 23 rate of 50%, up to a maximum of \$1,000;

(k) prosthetics, other than dental; AND

25 (1) services of a licensed home health agency, up to a

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1	maximum of 180 visits per year , and	1	a workers' compensation or similar law, forwhichbenefits
2	{m}necessarycareandtreatment-of-mental-illness;	2	arepayablewithoutregardtofaultundercoverage
3	alcoholismy-and-drug-addictiony-as-provided-in-33-22-703.	3	statutorily-required-to-be-contained-in-any-motor-vehicle-or
4	(3) (a) Covered expenses for the services or articles	4	otherliabilityinsurancepolicyorequivalent
5	specified in this section do not include:	5	self-insuranceor for which benefits are payable under
6	(i) drugs requiring a physician's prescription;	6	another policy of disability insurance or medicare;
7	(ii) services of a nursing home;	7	(ii) treatment for cosmetic purposes other than surgery
8	(iii) home and office calls, except as specifically	8	for the repair or treatment of an injury or congenital
9	provided in subsection (2);	9	bodily defect to restore normal bodily functions;
10	(iv) rental or purchase of durable medical equipment,	10	(iii) travel other than transportation provided by a
11	except as specifically provided in subsection (2);	11	licensed ambulance service to the nearest facility qualified
12	(v) the first \$20 of diagnostic x-ray and laboratory	12	to treat the condition;
13	charges in each 14-day period;	13	(iv) confinement in a private room to the extent it is
14	(vi) oral surgery, except as specifically provided in	14	in excess of the institution's charge for its most common
15	subsection (2);	15	semiprivate room, unless the private room is prescribed as
16	(vii) that part of a charge for services or articles	16	medically necessary by a physician;
17	which exceeds the prevailing charge in the locality where	17	(v) services or articles the provision of which is not
18	the service is provided; or	18	within the scope of authorized practice of the institution
19	(viii) care that is primarily for custodial or	19	or individual rendering the services or articles;
20	domiciliary purposes which would not qualify as eligible	2 0 [.]	(vi) organ transplants unlesspriorapprovalis
21	services under medicare.	21	received-from-the-board-of-directors-of-the-association;
22	(b) Covered expenses for the services or articles	22	(vii) room and board for a nonemergency admission on
23	specified in this section do not include charges for:	23	Friday or Saturday;
24	(i) care or for any injury or disease either arising	24	(viii) pregnancy, except complications of pregnancy;
25	out of an injury in the course of employment and subject to	25	(ix) routine well baby care;
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(x) complications to a newborn, unless no other source
 of coverage is available;
 (xi) sterilization or reversal of sterilization;
 (xii) abortion, unless the life of the mother would be

5 endangered if the fetus were carried to term;

6 (xiii) weight modification or modification of the body
7 to improve the mental or emotional well-being of an insured;
8 (xiv) artificial insemination or treatment for
9 infertility; or

10 (xv) breast augmentation or reduction.

11 Section 7. Certification of qualified plan. Upon application by the association or the lead carrier for 12 13 certification of a plan of health coverage as a qualified plan for the purposes of [sections 1 through $\frac{1}{2}$ 13], the 14 15 commissioner shall make a determination within 90 days as to 16 whether the plan is qualified. If determined to be 17 qualified, the plan of health coverage must be labeled as a 18 "qualified plan" on the front of the policy.

Section 8. Association plan premium. The association shall establish the schedule of premiums to be charged eligible persons for membership in the association plan. The schedule of premiums may not be less than 150% or more than 400% of the average premium rates charged by the five largest insurers with the largest individual qualified plan of insurance in force in this state. The premium rates of

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the five insurers used to establish the premium rates for 1 each type of coverage offered by the association must be 2 3 determined by the commissioner from information provided 4 annually by all insurers at the request of the commissioner. 5 The information requested must include the number of 6 qualified plans or actuarial equivalent plans offered by 7 each insurer, the rates charged by the insurer for each type 8 of plan offered by the insurer, and any other information 9 the commissioner considers necessary. The commissioner ASSOCIATION shall utilize generally acceptable actuarial 10 principles and structurally compatible rates. 11

12 Section 9. Operation of association plan. (1) Upon acceptance by the lead carrier under [section 12], an 13 14 eligible person may enroll in the association plan by 15 payment of the association plan premium to the lead carrier. 16 (2) Not less than 90% 88% of the association plan 17 premiums paid to the lead carrier may be used to pay claims and not more than 10% 12% may be used for payment of the 18 19 lead carrier's direct and indirect expenses as specified in 20 [section 10].

(3) Any income in excess of the costs incurred by the association in providing reinsurance or administrative services must be held at interest and used by the association to offset past and future losses due to claims expenses of the association plan or be allocated to reduce

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l association plan premiums.

2 (4) Each participating member of the association shall 3 share the losses due to claims expenses of the association plan for plans issued or approved for issuance by the 4 5 association and shall share in the operating and administrative expenses incurred or estimated to be incurred 6 by the association incident to the conduct of its affairs. 7 Claims expenses of the association plan that exceed the 8 9 premium payments allocated to the payment of benefits are 10 the liability of the association members. Association members shall share in the claims expenses of the 11 12 association plan and operating and administrative expenses of the association in an amount equal to the ratio of: 13

14 (a) the association member's total disability 15 insurance premium received from or on behalf of Montana 16 residents divided by;

17 (b) the total disability premium received by all
18 association members from or on behalf of Montana residents,
19 as determined by the commissioner.

20 (5) The association shall make an annual determination 21 of each association member's liability, if any, and may make 22 an annual fiscal yearend assessment if necessary. The 23 association may also, subject to the approval of the 24 commissioner, provide for interim assessments against the 25 association members as may be necessary to assure the

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1 financial capability of the association in meeting the incurred or estimated claims expenses of the association 2 3 plan and operating and administrative expenses of the association until the association's next annual fiscal 4 yearend assessment. Payment of an assessment is due within 5 30 days of receipt by an association member of a written 6 7 notice of a fiscal yearend or interim assessment. Failure by a contributing member to tender to the association the 8 assessment within 30 days is grounds for termination of 9 An association member that ceases to do 10 membership. disability insurance business within the state remains 11 liable for assessments through the calendar year during 12 which disability insurance business ceased. The association 13 may decline to levy an assessment against an association 14 member if the assessment, as determined pursuant to this 15 section, would not exceed \$10. 16

17 (6) Any annual fiscal yearend or interim assessment levied against an association member may be offset, in an 18 19 amount equal to the assessment paid to the association, against the premium tax payable by that association member 20 pursuant to 33-2-705 for the year in which the annual fiscal 21 yearend or interim assessment is levied. The department-of 22 revenue INSURANCE COMMISSIONER shall, each year the 23 legislature meets in regular session, on or before January 24 25 15, report to the legislature the total amount of premium

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tax offset claimed by association members during the
 preceding biennium.

3 Section 10. Administration of association plan --4 rules. (1) Any member of the association may submit to the 5 commissioner policies to be proposed to serve as the 6 association plan. The commissioner shall prescribe by rule 7 the time and manner of the submission.

8 (2) Upon the commissioner's approval of the policy 9 forms and contracts submitted, the association shall select 10 policies and contracts by a member or members of the 11 association to be the association plan. The association 12 shall select one lead carrier to issue the qualified plans, 13 The board of directors of the association shall prepare 14 appropriate specifications and bid forms and may solicit 15 bids from licensed administrators and the members of the 16 association for the purpose of selecting the lead carrier. 17 The selection of the lead carrier must be based upon 18 criteria established by the board of directors.

19 (3) The lead carrier shall perform all administrative 20 and claims payment functions required by this section upon 21 the commissioner's approval of the policy forms and 22 contracts submitted. The lead carrier shall provide these 23 services for a period of at least 3 years, unless a request 24 to terminate is approved by the association and the 25 commissioner. The association and the commissioner shall

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1 approve or deny a request to terminate within 90 days of its 2 receipt. A failure to make a final decision on a request to 3 terminate within the specified period is considered an 4 approval. The association shall invite submissions of policy forms from members of the association, including the lead 5 carrier, 6 months prior to the expiration of each 3-year 6 7 period. The association shall follow the procedure provided 8 in subsection (2) in selecting a lead carrier for the 9 subsequent 3-year period or, if a request to terminate is 10 approved, on or before the end of the 3-year period.

11 (4) The lead carrier shall provide all eligible 12 persons involved in the association plan an individual 13 certificate setting forth a statement as to the insurance 14 protection to which the person is entitled, the method and 15 place of filing claims, and to whom benefits are payable. 16 The certificate must indicate that coverage was obtained 17 through the association.

18 (5) The lead carrier shall submit to the association 19 and the commissioner on a semiannual basis a report of the 20 operation of the association plan. The association must 21 determine the specific information to be contained in the 22 report prior to the effective date of the association plan. 23 (6) The lead carrier shall pay all claims pursuant to 24 [sections 1 through 12 13] and shall indicate that the claim was paid by the association plan. Each claim payment must 25

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include information specifying the procedure involved in the
 event a dispute over the amount of payment arises.

3 (7) The lead carrier must be reimbursed from the association plan premiums received for its direct and 4 5 indirect expenses. Direct and indirect expenses include a prorated reimbursement for the portion of the lead carrier's 6 7 administrative, printing, claims administration, management. and building overhead expenses, which are assignable to the R maintenance and administration of the association plan. The 9 10 association must approve cost accounting methods to substantiate the lead carrier's cost reports consistent with 11 12 generally accepted accounting principles. Direct and 13 indirect expenses may not include costs directly related to the original submission of policy forms prior to selection 14 15 as the lead carrier.

16 (8) The lead carrier is, when carrying out its duties 17 under [sections 1 through 12 13], an agent-of INDEPENDENT 18 CONTRACTOR FOR the association and is civility INDIVIDUALLY liable for its actions, subject to the laws of this state. 19 Section 11. Solicitation of eligible persons. (1) The 20 association, pursuant to a plan approved by the 21 commissioner, shall disseminate appropriate information to 22 the residents of this state regarding the existence of the 23 association plan and the means of enrollment. Means of 24 communication may include use of the press, radio, and 25

television, as well as publication in appropriate state
 offices and publications.

3 (2) The association shall devise and implement means
4 of maintaining public awareness of [sections 1 through ±2
5 13] and shall administer [sections 1 through ±2 13] in a
6 manner which facilitates public participation in the
7 association plan.

(3) All licensed disability insurance agents may 8 engage in the selling or marketing of qualified association 9 plans. The lead carrier shall pay an agent's referral fee of 10 \$25 to each licensed disability insurance agent who refers 11 an applicant to the association plan, if the applicant is 12 accepted. The referral fees must be paid to the lead 13 carrier from money received as premiums for the association 14 15 plan.

(4) An insurer, society, or health service corporation 16 that rejects or applies underwriting restrictions to an 17 applicant for disability insurance must notify the applicant 18 of the existence of the association plan, requirements for 19 being accepted in it, and the procedure for applying to it. 20 Section 12. Enrollment by eligible person. (1) The 21 association plan must be open for enrollment by eligible 22 persons. An eligible person may enroll in the plan by 23 submission of a certificate of eligibility to the lead 24 25 carrier. The certificate must provide:

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(a) the name, address, and age of the applicant and
 length of the applicant's residence in this state;

3 (b) the name, address, and age of spouse and children,
4 if any, if they are to be insured;

5 (c) written evidence that he fulfills all of the
6 elements of an eligible person, as defined in [section 1];
7 and

8 (d) a designation of coverage desired.

9 (2) Within 30 days of receipt of the certificate, the 10 lead carrier shall either reject the application for failing to comply with the requirements of subsection (1) or forward 11 the eligible person a notice of acceptance and billing 12 13 information. Insurance is effective immediately-upon-receipt 14 of--the--first--month-s--association--plan--premium--and--is 15 retroactive--to--the--date--of-application7-if-the-applicant otherwise-complies-with-fsections-1-through-12; ON THE FIRST 16 17 OF THE MONTH FOLLOWING ACCEPTANCE.

18 (3) An eligible person may not purchase more than one19 policy from the association plan.

(4) A person who obtains coverage pursuant to this
section may not be covered for any preexisting condition
during the first 12 months of coverage under the association
plan if the person was diagnosed or treated for that
condition during the 5 years immediately preceding the
filing of an application. This subsection does not apply to

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a person who has had continuous coverage under an
 individual, family, or group policy during the year
 immediately preceding the filing of an application for
 nonelective procedures.

(5) A CHANGE OF RESIDENCE FROM MONTANA TO ANOTHER 5 STATE IMMEDIATELY TERMINATES ELIGIBILITY FOR RENEWAL OF 6 7 COVERAGE UNDER THE ASSOCIATION PLAN. SECTION 13. LIABILITY OF ASSOCIATION MEMBERSHIP. NO 8 MEMBER OF THE ASSOCIATION IS LIABLE FOR THE ACTIONS OF THE 9 ASSOCIATION OR ITS LEAD CARRIER. 10 11 Section 14. Extension of authority. Any existing authority of the commissioner of insurance to make rules on 12 13 the subject of the provisions of this act is extended to the 14 provisions of this act.

15 Section 15. Codification instruction. Sections 1
16 through 12 13 are intended to be codified as an integral
17 part of Title 33, and the provisions of Title 33 apply to
18 sections 1 through 12 13.

19 Section 16. Severability. If a part of this act is 20 invalid, all valid parts that are severable from the invalid 21 part remain in effect. If a part of this act is invalid in 22 one or more of its applications, the part remains in effect 23 in all valid applications that are severable from the 24 invalid applications.

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Section 17. Effective date. (1) Except for section 5,

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1 this act is effective July 1, 1985.

2

(2) Section 5 is effective July 1, 1987.

-End-

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