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 SENATE

March 4, 1985	Introduced and referred to Committee on Public Health, Welfare and Safety.
March 14, 1985	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 HOUSE

March 25, 1985	Received from Senate.
April 8, 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.
	Reported correctly enrolled.

HOUSE BILL NO. 817

INTRODUCED BY Kitselman, Cole, Jacobson, Winslow, Hayne, Kennedy

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 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."

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

Section 1. Definitions. As used in [sections 1 through 12], the following definitions apply:

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

(2) "Association plan" means a policy of insurance coverage offered by the association through the lead 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 has been a resident for at least 1 year immediately preceding application for coverage under the association plan; and

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

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

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

INTRODUCED BILL HB 817

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 within
14 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;
19 (4) conduct periodic audits to assure the general
20 accuracy of the financial data submitted by the lead carrier
21 and the association; and
22 (5) undertake, directly or through contracts with
23 other persons, studies or demonstration projects to develop
24 awareness of the benefits of [sections 1 through 12] so that
25 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 the
18 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 procedures
25 for 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).

Section 4. Association board of directors -- organization. (1) There is a board of directors of the 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.

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

$ 100,000 -- $ 4,999,999	1 vote
5,000,000 -- 9,999,999	2 votes
10,000,000 -- 14,999,999	3 votes

15,000,000 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].

Section 5. Minimum benefits of association plan. The association through the association plan shall offer a policy that provides at least the benefits of a qualified 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 it otherwise meets the requirements of Title 33, chapters 15, 22, 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 to the other provisions of this section, be equal to at least 80% of the covered expenses required by this section in excess of an annual deductible that does not exceed $1,000 per person. The coverage must include a limitation of $5,000 per person on the total annual out-of-pocket expenses for services covered under this section. Coverage must be

1 subject to a maximum lifetime benefit, but such maximums may
2 not be less than $100,000.
3 (2) Covered expenses must be the usual and customary
4 charges for the following services and articles when
5 prescribed by a physician or other licensed health care
6 professional provided for in 33-22-111:
7 (a) hospital services;
8 (b) professional services for the diagnosis or
9 treatment of injuries, illness, or conditions, other than
10 dental;
11 (c) use of radium or other radioactive materials;
12 (d) oxygen;
13 (e) anesthetics;
14 (f) diagnostic x-rays and laboratory tests, except as
15 specifically provided in subsection (3);
16 (g) services of a physical therapist;
17 (h) transportation provided by licensed ambulance
18 service to the nearest facility qualified to treat the
19 condition;
20 (i) oral surgery for the gums and tissues of the mouth
21 when not performed in connection with the extraction or
22 repair of teeth or in connection with TMJ;
23 (j) rental or purchase of medical equipment, which
24 shall be reimbursed after the deductible has been met at the
25 rate of 50%, up to a maximum of $1,000;

1 (k) prosthetics, other than dental;
2 (l) services of a licensed home health agency, up to a
3 maximum of 180 visits per year; and
4 (m) necessary care and treatment of mental illness,
5 alcoholism, and drug addiction, as provided in 33-22-703.
6 (3) (a) Covered expenses for the services or articles
7 specified in this section do not include:
8 (i) drugs requiring a physician's prescription;
9 (ii) services of a nursing home;
10 (iii) home and office calls, except as specifically
11 provided in subsection (2);
12 (iv) rental or purchase of durable medical equipment,
13 except as specifically provided in subsection (2);
14 (v) the first $20 of diagnostic x-ray and laboratory
15 charges in each 14-day period;
16 (vi) oral surgery, except as specifically provided in
17 subsection (2);
18 (vii) that part of a charge for services or articles
19 which exceeds the prevailing charge in the locality where
20 the service is provided; or
21 (viii) care that is primarily for custodial or
22 domiciliary purposes which would not qualify as eligible
23 services under medicare.
24 (b) Covered expenses for the services or articles
25 specified in this section do not include charges for:

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

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

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

(iv) confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as 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 is received from the board of directors of the association;

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

(viii) pregnancy, except complications of pregnancy;

(ix) routine well baby care;

(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 endangered if the fetus were carried to term;

(xiii) weight modification or modification of the body to improve the mental or emotional well-being of an insured;

(xiv) artificial insemination or treatment for infertility; or

(xv) breast augmentation or reduction.

Section 7. Certification of qualified plan. Upon application by the association or the lead carrier for certification of a plan of health coverage as a qualified plan for the purposes of [sections 1 through 12], 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 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

1 largest insurers with the largest individual qualified plan
2 of insurance in force in this state. The premium rates of
3 the five insurers used to establish the premium rates for
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
8 qualified plans or actuarial equivalent plans offered by
9 each insurer, the rates charged by the insurer for each type
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 payment of the association plan premium to the lead carrier.
18 (2) Not less than 90% of the association plan premiums
19 paid to the lead carrier may be used to pay claims and not
20 more than 10% may be used for payment of the lead carrier's
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

1 expenses of the association plan or be allocated to reduce
2 association plan premiums.
3 (4) Each participating member of the association shall
4 share the losses due to claims expenses of the association
5 plan for plans issued or approved for issuance by the
6 association and shall share in the operating and
7 administrative expenses incurred or estimated to be incurred
8 by the association incident to the conduct of its affairs.
9 Claims expenses of the association plan that exceed the
10 premium payments allocated to the payment of benefits are
11 the liability of the association members. Association
12 members shall share in the claims expenses of the
13 association plan and operating and administrative expenses
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;
18 (b) the total disability premium received by all
19 association members from or on behalf of Montana residents,
20 as determined by the commissioner.
21 (5) The association shall make an annual determination
22 of each association member's liability, if any, and may make
23 an annual fiscal yearend assessment if necessary. The
24 association may also, subject to the approval of the
25 commissioner, provide for interim assessments against the

1 association members as may be necessary to assure the
2 financial capability of the association in meeting the
3 incurred or estimated claims expenses of the association
4 plan and operating and administrative expenses of the
5 association until the association's next annual fiscal
6 yearend assessment. Payment of an assessment is due within
7 30 days of receipt by an association member of a written
8 notice of a fiscal yearend or interim assessment. Failure
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
12 disability insurance business within the state remains
13 liable for assessments through the calendar year during
14 which disability insurance business ceased. The association
15 may decline to levy an assessment against an association
16 member if the assessment, as determined pursuant to this
17 section, would not exceed $10.
18 (6) Any annual fiscal yearend or interim assessment
19 levied against an association member may be offset, in an
20 amount equal to the assessment paid to the association,
21 against the premium tax payable by that association member
22 pursuant to 33-2-705 for the year in which the annual fiscal
23 yearend or interim assessment is levied. The department of
24 revenue shall, each year the legislature meets in regular
25 session, on or before January 15, report to the legislature

1 the total amount of premium tax offset claimed by
2 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

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
5 forms from members of the association, including the lead
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
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] and shall indicate that the claim
25 was paid by the association plan. Each claim payment must

1 include information specifying the procedure involved in the
2 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
7 administrative, printing, claims administration, management,
8 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
11 substantiate the lead carrier's cost reports consistent with
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

1 television, as well as publication in appropriate state
2 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.
8 (3) All licensed disability insurance agents may
9 engage in the selling or marketing of qualified association
10 plans. The lead carrier shall pay an agent's referral fee of
11 $25 to each licensed disability insurance agent who refers
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.
16 (4) An insurer, society, or health service corporation
17 that rejects or applies underwriting restrictions to an
18 applicant for disability insurance must notify the applicant
19 of the existence of the association plan, requirements for
20 being accepted in it, and the procedure for applying to it.
21 Section 12. Enrollment by eligible person. (1) The
22 association plan must be open for enrollment by eligible
23 persons. An eligible person may enroll in the plan by
24 submission of a certificate of eligibility to the lead
25 carrier. The certificate must provide:

1 (a) the name, address, and age of the applicant and
2 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
11 to comply with the requirements of subsection (1) or forward
12 the eligible person a notice of acceptance and billing
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 application, if the applicant
16 otherwise complies with [sections 1 through 12].
17 (3) An eligible person may not purchase more than one
18 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

1 individual, family, or group policy during the year
2 immediately preceding the filing of an application for
3 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.

-End-

STATE OF MONTANA

REQUEST NO. FNN 423-85

FISCAL NOTE

Form BD-15

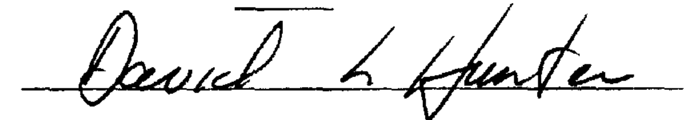
In compliance with a written request received February 13, 19 85 , there is hereby submitted a Fiscal Note for House Bill 817 pursuant to Title 5, Chapter 4, Part 2 of the Montana Code Annotated (MCA). Background information used in developing this Fiscal Note is available from the Office of Budget and 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, 1985

FN10:B/1

HB 817

Request No. FNN423-85
Form BD-15 Page 2

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.

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

SECOND READING
HB 817

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 MONTANA 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."

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

Section 1. Definitions. As used in [sections 1 through ~~12~~ 13], the following definitions apply:

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

(2) "Association plan" means a policy of insurance coverage offered by the association through the lead 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].

Montana Legislative Council

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

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

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

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

(8) "Preexisting condition" means any condition for

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 certified by the commissioner as providing the minimum benefits required by [section 6] or the actuarial equivalent of those benefits~~ 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 OR A THIRD PARTY ADMINISTRATOR, HEALTH CARE SERVICES 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.

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

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

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

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

lead carrier, including the association plan coverage and 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~~ 13] so that the residents of this state may best avail themselves of the health care benefits provided by [sections 1 through ~~12~~ 13].

Section 3. Comprehensive health association -- mandatory membership. (1) There is established a NONPROFIT LEGAL ENTITY TO BE KNOWN AS THE MONTANA comprehensive health association with participating membership consisting of all insurers, 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.

(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.

(3) The association may:

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

(b) sue or be sued;

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

(d) establish administrative and accounting procedures for 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).

Section 4. Association board of directors -- organization. (1) There is a board of directors of the 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

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

(2) Each of the seven board members representing the association members is entitled to A WEIGHTED AVERAGE vote, in person or by proxy, based on the association member's annual MONTANA premium volume~~,~~. ~~in--accordance--with--the following-schedule:~~

~~$---100,000----$-4,999,999---------------------------1-vote~~

~~--5,000,000------9,999,999---------------------------2-votes~~

~~-10,000,000-----14,999,999---------------------------3-votes~~

~~-15,000,000-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].

Section 5. Minimum benefits of association plan. The association through the association plan shall offer a policy that provides at least the benefits of a qualified 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

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

(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:

(a) hospital services;

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

(c) use of radium or other radioactive materials;

(d) oxygen;

(e) anesthetics;

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

specifically provided in subsection (3);

(g) services of a physical therapist;

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

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

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

(k) prosthetics, other than dental; AND

(l) services of a licensed home health agency, up to a maximum of 180 visits per year~~;--and~~

~~(m)--necessary--care--and--treatment-of-mental-illness, alcoholism,-and-drug-addiction,-as-provided-in-33-22-703.~~

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

(i) drugs requiring a physician's prescription;

(ii) services of a nursing home;

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

(iv) rental or purchase of durable medical equipment, except as specifically provided in subsection (2);

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

charges in each 14-day period;

(vi) oral surgery, except as specifically provided in subsection (2);

(vii) that part of a charge for services or articles which exceeds the prevailing charge in the locality where the service is provided; or

(viii) care that is primarily for custodial or domiciliary purposes which would not qualify as eligible services under medicare.

(b) Covered expenses for the services or articles specified in this section do not include charges for:

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

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

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

(iv) confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as 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---is received-from-the-board-of-directors-of-the-association~~;

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

(viii) pregnancy, except complications of pregnancy;

(ix) routine well baby care;

(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 endangered if the fetus were carried to term;

(xiii) weight modification or modification of the body to improve the mental or emotional well-being of an insured;

(xiv) artificial insemination or treatment for infertility; or

(xv) breast augmentation or reduction.

Section 7. Certification of qualified plan. Upon application by the association or the lead carrier for

certification of a plan of health coverage as a qualified plan for the purposes of [sections 1 through ~~12~~ 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 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 the five insurers used to establish the premium rates for each type of coverage offered by the association must be determined by the commissioner from information provided annually by all insurers at the request of the commissioner. The information requested must include the number of qualified plans or actuarial equivalent plans offered by each insurer, the rates charged by the insurer for each type of plan offered by the insurer, and any other information the commissioner considers necessary. The ~~commissioner~~ ASSOCIATION shall utilize generally acceptable actuarial principles and structurally compatible rates.

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

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.

(2) Not less than ~~90%~~ 88% of the association plan 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 lead carrier's direct and indirect expenses as specified in [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 association plan premiums.

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

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

(a) the association member's total disability insurance premium received from or on behalf of Montana 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 association members as may be necessary to assure the financial capability of the association in meeting the incurred or estimated claims expenses of the association plan and operating and administrative expenses of the association until the association's next annual fiscal yearend assessment. Payment of an assessment is due within 30 days of receipt by an association member of a written notice of a fiscal yearend or interim assessment. Failure by a contributing member to tender to the association the assessment within 30 days is grounds for termination of membership. An association member that ceases to do disability insurance business within the state remains 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 levied against an association member may be offset, in an amount equal to the assessment paid to the association, against the premium tax payable by that association member pursuant to 33-2-705 for the year in which the annual fiscal yearend or interim assessment is levied. The ~~department of revenue~~ INSURANCE COMMISSIONER shall, each year the legislature meets in regular session, on or before January 15, report to the legislature the total amount of premium tax offset claimed by association members during the preceding biennium.

Section 10. Administration of association plan -- rules. (1) Any member of the association may submit to the commissioner policies to be proposed to serve as the association plan. The commissioner shall prescribe by rule 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.

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

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

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

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 and the commissioner on a semiannual basis a report of the operation of the association plan. The association must determine the specific information to be contained in the report prior to the effective date of the association plan.

(6) The lead carrier shall pay all claims pursuant to [sections 1 through ~~12~~ 13] and shall indicate that the claim was paid by the association plan. Each claim payment must include information specifying the procedure involved in the event a dispute over the amount of payment arises.

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

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 under [sections 1 through ~~12~~ 13], an ~~agent of~~ INDEPENDENT CONTRACTOR FOR the association and is ~~civilly~~ INDIVIDUALLY liable for its actions, subject to the laws of this state.

Section 11. Solicitation of eligible persons. (1) The association, pursuant to a plan approved by the commissioner, shall disseminate appropriate information to the residents of this state regarding the existence of the association plan and the means of enrollment. Means of communication may include use of the press, radio, and television, as well as publication in appropriate state offices and publications.

(2) The association shall devise and implement means of maintaining public awareness of [sections 1 through ~~12~~ 13] and shall administer [sections 1 through ~~12~~ 13] in a manner which facilitates public participation in the 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 that rejects or applies underwriting restrictions to an applicant for disability insurance must notify the applicant of the existence of the association plan, requirements for being accepted in it, and the procedure for applying to it.

Section 12. Enrollment by eligible person. (1) The association plan must be open for enrollment by eligible persons. An eligible person may enroll in the plan by submission of a certificate of eligibility to the lead carrier. The certificate must provide:

(a) the name, address, and age of the applicant and 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;

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

information. Insurance is effective ~~immediately-upon-receipt of--the--first--month's--association--plan--premium--and--is retroactive--to--the--date--of-application,-if-the-applicant otherwise-complies-with-[sections-1-through-12]~~ ON THE FIRST OF THE MONTH FOLLOWING ACCEPTANCE.

(3) An eligible person may not purchase more than one 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 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 STATE IMMEDIATELY TERMINATES ELIGIBILITY FOR RENEWAL OF COVERAGE UNDER THE ASSOCIATION PLAN.

SECTION 13. LIABILITY OF ASSOCIATION MEMBERSHIP. NO MEMBER OF THE ASSOCIATION IS LIABLE FOR THE ACTIONS OF THE ASSOCIATION OR ITS LEAD CARRIER.

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

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

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

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

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

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

-End-

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

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

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

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

It is intended that the association board of directors

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

THIRD READING
HB 817

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 MONTANA 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."

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

Section 1. Definitions. As used in [sections 1 through ~~12~~ 13], the following definitions apply:

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

(2) "Association plan" means a policy of insurance coverage offered by the association through the lead 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].

Montana Legislative Council

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

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

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

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

(8) "Preexisting condition" means any condition for

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 certified-by--the--commissioner--as--providing--the--minimum benefits-required-by-[section-6]-or-the-actuarial-equivalent of--those--benefits~~ 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 OR A THIRD PARTY ADMINISTRATOR, HEALTH CARE SERVICES 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.

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

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

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

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

lead carrier, including the association plan coverage and 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~~ 13] so that the residents of this state may best avail themselves of the health care benefits provided by [sections 1 through ~~12~~ 13].

Section 3. Comprehensive health association -- mandatory membership. (1) There is established a NONPROFIT LEGAL ENTITY TO BE KNOWN AS THE MONTANA comprehensive health association with participating membership consisting of all insurers, 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.

(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.

(3) The association may:

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

(b) sue or be sued;

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

(d) establish administrative and accounting procedures for 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).

Section 4. Association board of directors -- organization. (1) There is a board of directors of the 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.

(2) Each of the seven board members representing the association members is entitled to A WEIGHTED AVERAGE vote, in person or by proxy, based on the association member's annual MONTANA premium volume~~,~~. ~~in--accordance--with--the following-schedule:~~

~~$---100,000----$-4,999,999-------------------------1-vote-~~

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(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].

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

(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:

(a) hospital services;

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

(c) use of radium or other radioactive materials;

(d) oxygen;

(e) anesthetics;

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

specifically provided in subsection (3);

(g) services of a physical therapist;

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

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

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

(k) prosthetics, other than dental; AND

(l) services of a licensed home health agency, up to a maximum of 180 visits per year~~;--and~~

~~(m)--necessary--care--and--treatment--of--mental--illness,--alcoholism,--and--drug--addiction,--as--provided--in--33-22-703~~.

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

(i) drugs requiring a physician's prescription;

(ii) services of a nursing home;

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

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charges in each 14-day period;

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(viii) care that is primarily for custodial or domiciliary purposes which would not qualify as eligible services under medicare.

(b) Covered expenses for the services or articles specified in this section do not include charges for:

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

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

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

(iv) confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as 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---is received-from-the-board-of-directors-of-the-association~~;

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

(viii) pregnancy, except complications of pregnancy;

(ix) routine well baby care;

(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 endangered if the fetus were carried to term;

(xiii) weight modification or modification of the body to improve the mental or emotional well-being of an insured;

(xiv) artificial insemination or treatment for infertility; or

(xv) breast augmentation or reduction.

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

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

(a) the association member's total disability insurance premium received from or on behalf of Montana 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 association members as may be necessary to assure the financial capability of the association in meeting the incurred or estimated claims expenses of the association plan and operating and administrative expenses of the association until the association's next annual fiscal yearend assessment. Payment of an assessment is due within 30 days of receipt by an association member of a written notice of a fiscal yearend or interim assessment. Failure by a contributing member to tender to the association the assessment within 30 days is grounds for termination of membership. An association member that ceases to do disability insurance business within the state remains 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 levied against an association member may be offset, in an amount equal to the assessment paid to the association, against the premium tax payable by that association member pursuant to 33-2-705 for the year in which the annual fiscal yearend or interim assessment is levied. The ~~department-of revenue~~ INSURANCE COMMISSIONER shall, each year the legislature meets in regular session, on or before January 15, report to the legislature the total amount of premium tax offset claimed by association members during the preceding biennium.

Section 10. Administration of association plan -- rules. (1) Any member of the association may submit to the commissioner policies to be proposed to serve as the association plan. The commissioner shall prescribe by rule 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.

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

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

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

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 and the commissioner on a semiannual basis a report of the operation of the association plan. The association must determine the specific information to be contained in the report prior to the effective date of the association plan.

(6) The lead carrier shall pay all claims pursuant to [sections 1 through ~~12~~ 13] and shall indicate that the claim was paid by the association plan. Each claim payment must include information specifying the procedure involved in the event a dispute over the amount of payment arises.

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

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 under [sections 1 through ~~12~~ 13], an ~~agent of~~ INDEPENDENT CONTRACTOR FOR the association and is ~~civilly~~ INDIVIDUALLY liable for its actions, subject to the laws of this state.

Section 11. Solicitation of eligible persons. (1) The association, pursuant to a plan approved by the commissioner, shall disseminate appropriate information to the residents of this state regarding the existence of the association plan and the means of enrollment. Means of communication may include use of the press, radio, and television, as well as publication in appropriate state offices and publications.

(2) The association shall devise and implement means of maintaining public awareness of [sections 1 through ~~12~~ 13] and shall administer [sections 1 through ~~12~~ 13] in a manner which facilitates public participation in the 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 that rejects or applies underwriting restrictions to an applicant for disability insurance must notify the applicant of the existence of the association plan, requirements for being accepted in it, and the procedure for applying to it.

Section 12. Enrollment by eligible person. (1) The association plan must be open for enrollment by eligible persons. An eligible person may enroll in the plan by submission of a certificate of eligibility to the lead carrier. The certificate must provide:

(a) the name, address, and age of the applicant and 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;

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

information. Insurance is effective ~~immediately-upon-receipt of--the--first--month's--association--plan--premium--and--is retroactive--to--the--date--of-application,-if-the-applicant otherwise-complies-with-[sections-1-through-12]~~ ON THE FIRST OF THE MONTH FOLLOWING ACCEPTANCE.

(3) An eligible person may not purchase more than one 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 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 STATE IMMEDIATELY TERMINATES ELIGIBILITY FOR RENEWAL OF COVERAGE UNDER THE ASSOCIATION PLAN.

SECTION 13. LIABILITY OF ASSOCIATION MEMBERSHIP. NO MEMBER OF THE ASSOCIATION IS LIABLE FOR THE ACTIONS OF THE ASSOCIATION OR ITS LEAD CARRIER.

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

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

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

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

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

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

-End-

SENATE

STANDING COMMITTEE REPORT

MARCH 13, 19 85

MR. PRESIDENT

We, your committee on PUBLIC HEALTH, WELFARE AND SAFETY

having had under consideration HOUSE BILL No. 817

THIRD reading copy (BLUE)
color

HEALTH INSURANCE POOLING ACT

KITSELMAN (HAGER)

Respectfully report as follows: That HOUSE BILL No. 817

be amended as follows:

1. Title, line 11.
Following: line 10.
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,"

~~DO PASS~~

~~DO NOT PASS~~ AND AS AMENDED BE CONCURRED IN

SENATOR JUDY JACOBSON Chairman.

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

REFERENCE BILL
HB 817

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

Montana Legislative Council

1 (4) "Eligible person" means an individual who:
2 (a) is a resident of this state and ~~has--been-a~~
3 ~~resident--for--at--least--1---year---immediately---preceding~~
4 ~~application~~ APPLIES 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
8 benefits by at least two insurers, societies, or health
9 service corporations, or has had a restrictive rider or
10 preexisting conditions limitation, which limitation is
11 required by at least two insurers, societies, or health
12 service corporations, which has the effect of substantially
13 reducing coverage from that received by a person considered
14 a standard risk.
15 (5) "Health service corporation" means a corporation
16 operating pursuant to Title 33, chapter 30, and offering or
17 selling contracts of disability insurance.
18 (6) "INSURANCE ARRANGEMENT" MEANS ANY PLAN, PROGRAM,
19 CONTRACT, OR OTHER ARRANGEMENT TO THE EXTENT NOT EXEMPT FROM
20 INCLUSION BY VIRTUE OF THE PROVISIONS OF THE FEDERAL
21 EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 UNDER WHICH
22 ONE OR MORE EMPLOYERS, UNIONS, OR OTHER ORGANIZATIONS
23 PROVIDE TO THEIR EMPLOYEES OR MEMBERS, EITHER DIRECTLY OR
24 INDIRECTLY THROUGH A TRUST OF A THIRD-PARTY ADMINISTRATOR,
25 HEALTH CARE SERVICES OR BENEFITS OTHER THAN THROUGH AN

INSURER.

~~(6)~~(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.

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

~~(8)~~(9) "Preexisting condition" means any condition for 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)~~(10) "Qualified plan" means ~~those--health--benefit plans-certified-by-the-commissioner-as-providing-the-minimum benefits-required-by-[section-6]-or-the-actuarial-equivalent of--those--benefits~~ ~~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-OR-A-THIRD-PARTY-ADMINISTRATOR,-HEALTH-CARE-SERVICES OR--BENEFITS--OTHER--THAN--THROUGH--AN-INSURER,~~ THOSE HEALTH BENEFIT PLANS CERTIFIED BY THE COMMISSIONER AS PROVIDING THE MINIMUM BENEFITS REQUIRED BY SECTION 6 OR THE ACTUARIAL

EQUIVALENT OF THOSE BENEFITS.

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

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

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

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

(3) approve the selection of the lead carrier by the association and approve the association's contract with the lead carrier, including the association plan coverage and 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~~ 13] so that the residents of this state may best avail themselves of the health care benefits provided by [sections 1 through ~~12~~ 13].

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

LEGAL ENTITY TO BE KNOWN AS THE MONTANA comprehensive health association with participating membership consisting of all insurers, INSURANCE ARRANGEMENTS, 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.

(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.

(3) The association may:

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

(b) sue or be sued;

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

(d) establish administrative and accounting procedures for 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).

Section 4. Association board of directors -- organization. (1) There is a board of directors of the 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.

(2) Each of the seven board members representing the association members is entitled to A WEIGHTED AVERAGE vote, in person or by proxy, based on the association member's annual MONTANA premium volume~~,~~. ~~in--accordance--with--the following-schedule:~~

~~$---100,000----$-4,999,999----------1-vote-~~

~~--5,000,000------9,999,999----------2-votes~~

~~-10,000,000-----14,999,999----------3-votes~~

~~-15,000,000-or-more-----------------4-votes~~

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

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
6 association in accordance with [section 9].
7 Section 5. Minimum benefits of association plan. The
8 association through the association plan shall offer a
9 policy that provides at least the benefits of a qualified
10 plan as required by [section 6].
11 Section 6. Qualified plan -- minimum benefits. A plan
12 of health coverage must be certified as a qualified plan if
13 it otherwise meets the requirements of Title 33, chapters
14 15, 22 <u>EXCEPTING PART 7</u>, and 30, and other laws of this
15 state, whether or not the policy is issued in this state,
16 and meets or exceeds the following minimum standards:
17 (1) The minimum benefits for an insured must, subject
18 to the other provisions of this section, be equal to at
19 least 80% of the covered expenses required by this section
20 in excess of an annual deductible that does not exceed
21 $1,000 per person. The coverage must include a limitation of
22 $5,000 per person on the total annual out-of-pocket expenses
23 for services covered under this section. Coverage must be
24 subject to a maximum lifetime benefit, but such maximums may
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
3 prescribed by a physician or other licensed health care
4 professional provided for in 33-22-111:
5 (a) hospital services;
6 (b) professional services for the diagnosis or
7 treatment of injuries, illness, or conditions, other than
8 dental;
9 (c) use of radium or other radioactive materials;
10 (d) oxygen;
11 (e) anesthetics;
12 (f) diagnostic x-rays and laboratory tests, except as
13 specifically provided in subsection (3);
14 (g) services of a physical therapist;
15 (h) transportation provided by licensed ambulance
16 service to the nearest facility qualified to treat the
17 condition;
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;
24 (k) prosthetics, other than dental; <u>AND</u>
25 (l) services of a licensed home health agency, up to a

maximum of 180 visits per year~~;--and~~

~~(m)--necessary--care--and--treatment-of-mental-illness, alcoholism,-and-drug-addiction,-as-provided-in-33-22-703~~.

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

(i) drugs requiring a physician's prescription;

(ii) services of a nursing home;

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

(iv) rental or purchase of durable medical equipment, except as specifically provided in subsection (2);

(v) the first $20 of diagnostic x-ray and laboratory charges in each 14-day period;

(vi) oral surgery, except as specifically provided in subsection (2);

(vii) that part of a charge for services or articles which exceeds the prevailing charge in the locality where the service is provided; or

(viii) care that is primarily for custodial or domiciliary purposes which would not qualify as eligible services under medicare.

(b) Covered expenses for the services or articles specified in this section do not include charges for:

(i) care or for any injury or disease either arising out of an injury in the course of employment and subject to

a workers' compensation or similar law, ~~for--which--benefits are---payable---without---regard--to--fault--under--coverage statutorily-required-to-be-contained-in-any-motor-vehicle-or other---liability----insurance----policy----or----equivalent self-insurance,--or~~ for which benefits are payable under another policy of disability insurance or medicare;

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

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

(iv) confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as 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---is received-from-the-board-of-directors-of-the-association~~;

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

(viii) pregnancy, except complications of pregnancy;

(ix) routine well baby care;

(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 endangered if the fetus were carried to term;

(xiii) weight modification or modification of the body to improve the mental or emotional well-being of an insured;

(xiv) artificial insemination or treatment for infertility; or

(xv) breast augmentation or reduction.

Section 7. Certification of qualified plan. Upon application by the association or the lead carrier for certification of a plan of health coverage as a qualified plan for the purposes of [sections 1 through ~~12~~ 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 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

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

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

(2) Not less than ~~90%~~ 88% of the association plan 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 lead carrier's direct and indirect expenses as specified in [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

1 association plan premiums.
2 (4) Each participating member of the association shall
3 share the losses due to claims expenses of the association
4 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 premium payments allocated to the payment of benefits are
10 the liability of the association members. Association
11 members shall share in the claims expenses of the
12 association plan and operating and administrative expenses
13 of the association in an amount equal to the ratio of:
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

1 financial capability of the association in meeting the
2 incurred or estimated claims expenses of the association
3 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 30 days of receipt by an association member of a written
7 notice of a fiscal yearend or interim assessment. Failure
8 by a contributing member to tender to the association the
9 assessment within 30 days is grounds for termination of
10 membership. An association member that ceases to do
11 disability insurance business within the state remains
12 liable for assessments through the calendar year during
13 which disability insurance business ceased. The association
14 may decline to levy an assessment against an association
15 member if the assessment, as determined pursuant to this
16 section, would not exceed $10.
17 (6) Any annual fiscal yearend or interim assessment
18 levied against an association member may be offset, in an
19 amount equal to the assessment paid to the association,
20 against the premium tax payable by that association member
21 pursuant to 33-2-705 for the year in which the annual fiscal
22 yearend or interim assessment is levied. The ~~department-of~~
23 ~~revenue~~ INSURANCE COMMISSIONER shall, each year the
24 legislature meets in regular session, on or before January
25 15, report to the legislature the total amount of premium

tax offset claimed by association members during the preceding biennium.

Section 10. Administration of association plan -- rules. (1) Any member of the association may submit to the commissioner policies to be proposed to serve as the association plan. The commissioner shall prescribe by rule 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. The board of directors of the association shall prepare appropriate specifications and bid forms and may solicit bids from licensed administrators and the members of the association for the purpose of selecting the lead carrier. The selection of the lead carrier must be based upon criteria established by the board of directors.

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

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

(4) The lead carrier shall provide all eligible persons involved in the association plan an individual 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 and the commissioner on a semiannual basis a report of the operation of the association plan. The association must determine the specific information to be contained in the report prior to the effective date of the association plan.

(6) The lead carrier shall pay all claims pursuant to [sections 1 through ~~12~~ 13] and shall indicate that the claim was paid by the association plan. Each claim payment must

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

(7) The lead carrier must be reimbursed from the association plan premiums received for its direct and indirect expenses. Direct and indirect expenses include a prorated reimbursement for the portion of the lead carrier's administrative, printing, claims administration, management, and building overhead expenses, which are assignable to the maintenance and administration of the association plan. The association must approve cost accounting methods to substantiate the lead carrier's cost reports consistent with generally accepted accounting principles. Direct and 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 under [sections 1 through ~~12~~ 13], an ~~agent of~~ INDEPENDENT CONTRACTOR FOR the association and is ~~civilly~~ INDIVIDUALLY liable for its actions, subject to the laws of this state.

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

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

(2) The association shall devise and implement means of maintaining public awareness of [sections 1 through ~~12~~ 13] and shall administer [sections 1 through ~~12~~ 13] in a manner which facilitates public participation in the 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 that rejects or applies underwriting restrictions to an applicant for disability insurance must notify the applicant of the existence of the association plan, requirements for being accepted in it, and the procedure for applying to it.

Section 12. Enrollment by eligible person. (1) The association plan must be open for enrollment by eligible persons. An eligible person may enroll in the plan by submission of a certificate of eligibility to the lead carrier. The certificate must provide:

(a) the name, address, and age of the applicant and 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;

(c) written evidence that he fulfills all of the elements of an eligible person, as defined in [section 1]; 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 information. Insurance is effective ~~immediately-upon-receipt of--the--first--month's--association--plan--premium--and--is retroactive--to--the--date--of--application,-if-the-applicant otherwise-complies-with-[sections-1-through-12]~~ ON THE FIRST OF THE MONTH FOLLOWING ACCEPTANCE.

(3) An eligible person may not purchase more than one 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

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 STATE IMMEDIATELY TERMINATES ELIGIBILITY FOR RENEWAL OF COVERAGE UNDER THE ASSOCIATION PLAN.

SECTION 13. LIABILITY OF ASSOCIATION MEMBERSHIP. NO MEMBER OF THE ASSOCIATION IS LIABLE FOR THE ACTIONS OF THE ASSOCIATION OR ITS LEAD CARRIER.

Section 14. Extension of authority. Any existing authority of the commissioner of insurance to make rules on the subject of the provisions of this act is extended to the provisions of this act.

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

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

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

1 this act is effective July 1, 1985.

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

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