HOUSE BILL 399

Introduced by Grimes, et al.

1/30	Introduced
1/30	Referred to Business & Economic Development
1/30	First Reading
2/09	Hearing
2/09	Tabled in Committee

House BILL NO. 399

INTRODUCED BY Grimes
Mrighaine Grady Weeding HARP Anderson Russell Bartlett

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING THE MONTANA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION PLAN; EXCLUDING FROM THE ASSOCIATION PLAN'S COVERAGE ANY RESIDENT 65 YEARS OF AGE OR OLDER WHO IS ELIGIBLE FOR ANY OTHER FORM OF DISABILITY INSURANCE OR HEALTH SERVICE BENEFITS, ANY PERSON WHO FAILS TO PAY THE POLICY PREMIUM OR WHO RECEIVES MEDICARE, DISABILITY, OR OTHER HEALTH SERVICE BENEFITS OR BENEFITS UNDER THE MONTANA MEDICAID PROGRAM, OR ANY PERSON WHO MOVES OUTSIDE MONTANA; CREATING AS AN UNFAIR TRADE PRACTICE THE INDUCEMENT OF A PERSON INTO AN ASSOCIATION PLAN FOR THE PURPOSE OF AVOIDING AN EMPLOYER'S GROUP HEALTH INSURANCE COVERAGE; EXEMPTING ASSOCIATION PLANS FROM THE PROHIBITION AGAINST DENYING OR REDUCING BENEFITS BECAUSE OF PUBLIC MEDICAL ASSISTANCE ELIGIBILITY; PROVIDING IMMUNITY FROM LIABILITY FOR THE BOARD OF DIRECTORS OF THE COMPREHENSIVE HEALTH PLAN; AND AMENDING SECTIONS 27-1-732, 33-22-113, 33-22-1501, AND 33-22-1521, MCA."

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

NEW SECTION. **Section 1.** **Limitations on eligibility.** A person who purchases a policy of insurance under 33-22-1516, ceases to be eligible for the association plan if the

person:

(1) becomes eligible for the Montana medicaid program or medicare;

(2) fails to pay the premium on the policy purchased under 33-22-1516;

(3) changes residence to a state other than Montana; or

(4) enrolls under another disability insurance policy or plan for health service benefits, except that the person may maintain the association plan during any waiting period for preexisting conditions established under any new disability insurance policy or plan for health service benefits. However, if an association plan is maintained during a waiting period for preexisting conditions on a newly purchased disability insurance policy or plan for health service benefits, the association plan may coordinate the benefits with the new policy or plan and the benefits of the association plan are always secondary to the benefits under the newly purchased policy or plan.

NEW SECTION. **Section 2.** **Unfair referral to plan.** An insurer, insurance agent, insurance broker, or third-party administrator may not refer an individual employee or the employee's dependent to the association plan or arrange for an individual employee or the employee's dependent to apply to the association plan for the purposes of separating the employee or the employee's dependent from group health

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insurance coverage provided in connection with the employee's employment.

NEW SECTION. **Section 3.** Unfair referral to comprehensive plan. A referral in violation of [section 2] is an unfair trade practice under this chapter.

Section 4. Section 27-1-732, MCA, is amended to read:

"27-1-732. Immunity of nonprofit corporation officers, directors, and volunteers. (1) No An officer, director, or volunteer of a nonprofit corporation is not individually liable for any action or omission made in the course and scope of his the person's official capacity on behalf of the nonprofit corporation. This section does not apply to liability for willful or wanton misconduct. The immunity granted by this section does not apply to the liability of a nonprofit corporation.

(2) For purposes of this section, "nonprofit corporation" means:

(a) an organization exempt from taxation under section 501(c) of the Internal Revenue Code of 1954; or

(b) a corporation or organization which is eligible for or has been granted by the department of revenue tax exempt status under the provisions of 15-31-102; or

(c) the comprehensive health association created under Title 33, chapter 22, part 15."

Section 5. Section 33-22-113, MCA, is amended to read:

"33-22-113. Disability insurance coverage of persons eligible for public medical assistance. (1) No Except as provided in subsection (2), a disability insurance policy providing hospital, medical, or surgical expense benefits delivered or issued for delivery in this state on or after July 1, 1979, may not contain any provision denying or reducing such benefits for the reason that the person insured is eligible for or receiving public medical assistance provided under Title 53, chapter 2.

(2) This section does not apply to comprehensive health association plans created under Title 33, chapter 22, part 15."

Section 6. Section 33-22-1501, MCA, is amended to read:

"33-22-1501. Definitions. As used in this part, the following definitions apply:

(1) "Association" means the comprehensive health association created by 33-22-1503.

(2) "Association plan" means a policy of insurance coverage that is offered by the association and that is certified by the association as required by 33-22-1521.

(3) "Association plan premium" means the charge determined pursuant to 33-22-1512 for membership in the association plan based on the benefits provided in 33-22-1521.

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

(a) is a resident of this state and applies for coverage under the association plan; and

(b) unless the individual's eligibility is waived by the association, has, within 6 months prior to the date of application, 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;

(c) is under the age of 65; and

(d) is not eligible for any other form of disability insurance or health service benefits or for medicare or the Montana medicaid program.

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

(6) "Insurance arrangement" means any plan, program, contract, or other arrangement to the extent not exempt from inclusion by virtue of the provisions of the federal Employee Retirement Income Security Act of 1974 under which one or more employers, unions, or other organizations provide to their employees or members, either directly or

indirectly through a trust of a third-party administrator, health care services or benefits other than through an insurer.

(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.

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

(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.

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

Section 7. Section 33-22-1521, MCA, is amended to read:

"**33-22-1521. Association plan -- minimum benefits.** A plan of health coverage must be certified as an association plan if it otherwise meets the requirements of Title 33, chapters 15, 22 (excepting part 7 and 33-22-113), and 30 (excepting 33-30-1002(5)), 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~~ the 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~~ must 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.

(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 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, including bone marrow transplants;

(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."

NEW SECTION. **Section 8.** **Codification instruction.** (1) [Sections 1 and 2] are intended to be codified as an integral part of Title 33, chapter 22, part 15, and the provisions of Title 33, chapter 22, part 15, apply to [sections 1 and 2].

(2) [Section 3] is intended to be codified as an integral part of Title 33, chapter 18, part 1, and the provisions of Title 33, chapter 18, part 1, apply to [section 3].

-End-