HOUSE BILL 86

Introduced by Boharski

12/09 Introduced
12/09 Referred to Business and Economic Development
12/09 First Reading
12/09 Fiscal Note Requested
12/10 Hearing
12/10 Tabled in Committee
12/13 Fiscal Note Received
12/13 Fiscal Note Printed

House BILL NO. 86

INTRODUCED BY Wm E Boharski

A BILL FOR AN ACT ENTITLED: "AN ACT REVISING THE SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT; REVISING DEFINITIONS; DELAYING THE EFFECTIVE DATE OF CERTAIN REQUIREMENTS OF THE ACT; REDUCING APPROPRIATIONS TO THE STATE AUDITOR'S OFFICE; REQUIRING AN ACTUARIAL EVALUATION AND REPORT TO THE LEGISLATURE; AMENDING SECTIONS 33-22-1803 AND 33-22-1811, MCA, AND SECTION 1, CHAPTER 550, LAWS OF 1993; AND PROVIDING AN EFFECTIVE DATE."

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

Section 1. Section 33-22-1803, MCA, is amended to read:

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

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

LC 0151/01

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

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

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

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

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

(7) "Carrier" means any person who provides a health benefit plan in this state subject to state insurance regulation. The term includes but is not limited to an insurance company, a fraternal benefit society, a health

HB 86
INTRODUCED BILL

service corporation, a health maintenance organization, and, to the extent permitted by the Employee Retirement Income Security Act of 1974, a multiple-employer welfare arrangement. For purposes of this part, companies that are affiliated companies or that are eligible to file a consolidated tax return must be treated as one carrier, except that the following may be considered as separate carriers:

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

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

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

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

(9) "Class of business" means all or a separate

grouping of small employers established pursuant to 33-22-1808.

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

(11) "Dependent" means:

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

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

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

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

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

(13) "Established geographic service area" means a geographic area, as approved by the commissioner and based on the carrier's certificate of authority to transact

insurance in this state, within which the carrier is authorized to provide coverage.

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

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

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

(c) automobile medical payment insurance.

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

(16) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period during which the individual was entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period was a period of at least 30 days. However,

an eligible employee or dependent may not be considered a late enrollee if:

(a) the individual meets each of the following conditions:

(i) the individual was covered under qualifying previous coverage at the time of the initial enrollment;

(ii) the individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, the death of a spouse, or divorce; and

(iii) the individual requests enrollment within 30 days after termination of the qualifying previous coverage;

(b) the individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

(c) a court has ordered that coverage be provided for a spouse, minor, or dependent child under a covered employee's health benefit plan and a request for enrollment is made within 30 days after issuance of the court order.

(17) "New business premium rate" means, for each class of business for a rating period, the lowest premium rate charged or offered or that could have been charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health

benefit plans with the same or similar coverage.

(18) "Plan of operation" means the operation of the program established pursuant to 33-22-1818.

(19) "Premium" means all money paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

(20) "Program" means the Montana small employer health reinsurance program created by 33-22-1818.

(21) "Qualifying previous coverage" means benefits or coverage provided under:

(a) medicare or medicaid;

(b) an employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan; or

(c) an individual health insurance policy, including coverage issued by an insurance company, a fraternal benefit society, a health service corporation, or a health maintenance organization that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided that the policy has been in effect for a period of at least 1 year.

(22) "Rating period" means the calendar period for which premium rates established by a small employer carrier are

assumed to be in effect.

(23) "Reinsuring carrier" means a small employer carrier participating in the reinsurance program pursuant to 33-22-1819.

(24) "Restricted network provision" means a provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to Title 33, chapter 22, part 17, or Title 33, chapter 31, to provide health care services to covered individuals.

(25) "Small employer" means a person, firm, corporation, partnership, or association that is actively engaged in business and that, on at least 50% of its working days during the preceding calendar quarter, employed at least 3 but not more than 25 eligible employees, the majority of whom were employed within this state or were residents of this state. In determining the number of eligible employees, companies are considered one employer if they:

(a) are affiliated companies;

(b) are eligible to file a combined tax return for purposes of state taxation; or

(c) are members of an association that:

(i) has been in existence for 1 year prior to January 1, 1994;

(ii) provides a health benefit plan to employees of its members as a group; and

(iii) does not deny coverage to any member of its association or any employee of its members who applies for coverage as part of a group.

(26) "Small employer carrier" means a carrier that offers health benefit plans that cover eligible employees of one or more small employers in this state.

(27) "Standard health benefit plan" means a health benefit plan developed pursuant to 33-22-1812."

Section 2. Section 33-22-1811, MCA, is amended to read:

"**33-22-1811. Availability of coverage -- required plans.** (1) (a) As a condition of transacting business in this state with small employers, each small employer carrier shall offer to small employers at least two health benefit plans. One plan must be a basic health benefit plan, and one plan must be a standard health benefit plan.

(b) (i) A small employer carrier shall issue a basic health benefit plan or a standard health benefit plan to any eligible small employer that applies for either plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this part.

(ii) In the case of a small employer carrier that establishes more than one class of business pursuant to

33-22-1808, the small employer carrier shall maintain and offer to eligible small employers at least one basic health benefit plan and at least one standard health benefit plan in each established class of business. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business, provided that:

(A) the criteria are not intended to discourage or prevent acceptance of small employers applying for a basic or standard health benefit plan;

(B) the criteria are not related to the health status or claims experience of the small employers' employees;

(C) the criteria are applied consistently to all small employers that apply for coverage in that class of business; and

(D) the small employer carrier provides for the acceptance of all eligible small employers into one or more classes of business.

(iii) The provisions of subsection (1)(b)(ii) may not be applied to a class of business into which the small employer carrier is no longer enrolling new small businesses.

(c) The provisions of this section are effective 180 days after the commissioner's approval of the basic health benefit plan and the standard health benefit plan developed pursuant to 33-22-1812~~,--provided--that~~. However, if the

program created pursuant to 33-22-1818 is not yet operative on that date, the provisions of this section are effective on the date that the program begins operation. If the commissioner approves the basic health benefit plan before July 1, 1995, or if the program created pursuant to 33-22-1818 becomes operative before July 1, 1995, then this section is effective July 1, 1995.

(2) (a) A small employer carrier shall, pursuant to 33-1-501, file the basic health benefit plans and the standard health benefit plans to be used by the small employer carrier.

(b) The commissioner may at any time, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a basic or standard health benefit plan on the grounds that the plan does not meet the requirements of this part.

(3) Health benefit plans covering small employers must comply with the following provisions:

(a) A health benefit plan may not, because of a preexisting condition, deny, exclude, or limit benefits for a covered individual for losses incurred more than 12 months following the effective date of the individual's coverage. A health benefit plan may not define a preexisting condition more restrictively than 33-22-110, except that the condition

may be excluded for a maximum of 12 months.

(b) A health benefit plan must waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to those services if the qualifying previous coverage was continuous to a date not less than 30 days prior to the submission of an application for new coverage. This subsection (3)(b) does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

(c) A health benefit plan may exclude coverage for late enrollees for 18 months or for an 18-month preexisting condition exclusion, provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period may not exceed 18 months from the date the individual enrolls for coverage under the health benefit plan.

(d) (i) Requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, must be applied uniformly among all small employers that have the same number of eligible employees and that apply

for coverage or receive coverage from the small employer carrier.

(ii) A small employer carrier may vary the application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(e) (i) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier may not offer coverage only to certain individuals in a small employer group or only to part of the group, except in the case of late enrollees as provided in subsection (3)(c).

(ii) A small employer carrier may not modify a basic or standard health benefit plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

(4) (a) A small employer carrier may not be required to offer coverage or accept applications pursuant to subsection (1) in the case of the following:

(i) to a small employer when the small employer is not physically located in the carrier's established geographic service area;

(ii) to an employee when the employee does not work or reside within the carrier's established geographic service area; or

(iii) within an area where the small employer carrier reasonably anticipates and demonstrates to the satisfaction of the commissioner that it will not have the capacity within its established geographic service area to deliver service adequately to the members of a group because of its obligations to existing group policyholders and enrollees.

(b) A small employer carrier may not be required to provide coverage to small employers pursuant to subsection (1) for any period of time for which the commissioner determines that requiring the acceptance of small employers in accordance with the provisions of subsection (1) would place the small employer carrier in a financially impaired condition."

NEW SECTION. **Section 3. Actuarial evaluation and report required.** The commissioner of insurance shall conduct an actuarial evaluation of the effect of 33-22-1811(3) on insurance premiums for small employer health benefit plans offered or to be offered in this state. The evaluation must include an estimate of the effect on insurance premiums of each of the requirements set forth in 33-22-1811(3). The commissioner of insurance shall prepare a written report of the results of the evaluation and present the report to the

54th legislature in the manner required by 5-11-210.

Section 4. Section 1, Chapter 550, Laws of 1993, is amended to read:

"Section 1. **Appropriations.** (1) If Senate Bill No. 285 is passed and approved, the department of health and environmental sciences is appropriated $750,000 of general fund money in fiscal year 1994 and $750,000 of general fund money in fiscal year 1995 for the health care authority.

(2) If Senate Bill No. 285 is passed and approved, the state auditor's office is appropriated ~~$178,385~~ $89,192 of general fund money in fiscal year 1994 and ~~$163,817~~ $81,908 of general fund money in fiscal year 1995."

NEW SECTION. **Section 5.** **Effective date.** [This act] is effective January 1, 1994.

-End-

STATE OF MONTANA - FISCAL NOTE
Form BD-15
In compliance with a written request, there is hereby submitted a Fiscal Note for HB0086, as introduced.

DESCRIPTION OF PROPOSED LEGISLATION: An act revising the small employer health insurance availability act; revising definitions; delaying the effective date of certain requirements of the act; reducing appropriations to the State Auditor's Office.

ASSUMPTIONS:
1. The small employers benefit board and the reinsurance board will complete their plans by June 30, 1995, rather than by July 1994.
2. Rules for the basic health benefit plan and the standard health benefit plan, the operational reinsurance pool plan, and the rate restriction plan will not be adopted in the 1995 biennium.
3. The additional actuarial FTE in the State Auditor's Office will not be filled during the 1995 biennium. The FTE and personal services funding will be eliminated to meet the proposed reduction in appropriations.
4. The actuarial report mandated in Section 3 of the bill cannot be completed during the 1995 biennium because data is needed for health care plans delayed beyond July 1, 1995, by the delayed effective date. If the delayed effective date were removed, such a study would cost between $35,000 and $50,000.
5. The bill reduces general fund appropriations in the State Auditor's Office for the Health Care Authority by 50% each year.

FISCAL IMPACT:
State Auditor's Office - Health Care Authority:

	FY '94			FY '95		
Expenditures:	Current Law	Proposed Law	Difference	Current Law	Proposed Law	Difference
FTE	2.00	1.00	(1.00)	2.00	1.00	(1.00)
Personal Services	107,217	33,884	(73,333)	109,200	34,882	(74,318)
Operating Expenses	68,600	52,740	(15,860)	54,617	47,026	(7,591)
Equipment	2,568	2,568	0	0	0	0
Total	178,385	89,192	(89,193)	163,817	81,908	(81,909)
Funding:						
General Fund (01)	178,385	89,192	(89,193)	163,817	81,908	(81,909)

EFFECT ON COUNTY OR OTHER LOCAL REVENUES OR EXPENDITURES:
None.

LONG-RANGE EFFECTS OF PROPOSED LEGISLATION:
None.

David Lewis 12-8

DAVID LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

Wm E Boharski 12-13-93

WILLIAM E. BOHARSKI, PRIMARY SPONSOR DATE
Fiscal Note for HB0086, as introduced

HB 86