HOUSE BILL NO. 446

INTRODUCED BY ORR Hill Tom Miller Curtiss Josh Kerns Denny McKee Green Barnett Martinez L. Smith Jon Sonju

A BILL FOR AN ACT ENTITLED: "AN ACT PROHIBITING THE EXCLUSION OF CERTAIN PREEXISTING CONDITIONS FROM INDIVIDUAL HEALTH BENEFIT PLANS; PROVIDING DEFINITION; AMENDING SECTIONS 33-22-101 AND 33-22-1811, MCA; AND REPEALING SECTION ~~33-22-110, MCA~~."

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

NEW SECTION. **Section 1. Definition.** (1) As used in [section 2], unless the context indicates otherwise, "individual health benefit plan" means a hospital- or medical expense-incurred policy or certificate, a subscriber contract or contract of insurance provided by a prepaid hospital or medical service plan, a health maintenance organization subscriber contract issued or delivered for issue to an individual, or a discretionary group trust policy providing hospital- or medical expense-incurred coverage to individuals.

(2) The term does not include:

(a) a self-insured group health plan, a self-insured, multi-employer group health plan, a group conversion plan, or an insured group health plan;

(b) accident-only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, medicare supplement, long-term care, or disability income insurance; or

(c) coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.

NEW SECTION. **Section 2. Preexisting conditions.** An individual health benefit plan may, because of a preexisting condition, not 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. An individual health benefit plan may not define a preexisting condition more restrictively than:

(1) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the 24 months immediately preceding the effective date of coverage;

(2) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the 24 months immediately preceding the effective date of coverage; or

(3) a pregnancy existing on the effective date of coverage.

Section 3. Section 33-22-101, MCA, is amended to read:

"**33-22-101. Exceptions to scope.** Parts 1 through 4 of this chapter, except 33-22-107, ~~33-22-110~~ [section 2], 33-22-111, 33-22-114, 33-22-125, 33-22-130 through 33-22-132, and 33-22-304, do not apply to or affect:

(1) any policy of liability or workers' compensation insurance with or without supplementary expense coverage;

(2) any group or blanket policy;

(3) life insurance, endowment, or annuity contracts or supplemental contracts that contain only those provisions relating to disability insurance as:

(a) provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means; or

(b) operate to safeguard contracts against lapse or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract; or

(4) reinsurance."

Section 4. 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 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.

(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~~ [section 2].

(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 5. Repealer.** Section 33-22-110, MCA, is repealed.

NEW SECTION. **Section 6. Codification instruction.** [Sections 1 and 2] are intended to be codified as an integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [sections 1 and 2].

-END-

STATE OF MONTANA - FISCAL NOTE

Fiscal Note for HB0446, 3rd reading

DESCRIPTION OF PROPOSED LEGISLATION:
An act prohibiting the exclusion of certain preexisting conditions from health benefit plans.

ASSUMPTIONS:
1. HB446 requires changes to current contract language. There are 900 authorized disability insurance carriers of which 800 are active.
2. Carriers average five contracts per carrier. Approximately 50% of the carriers will comply with the provisions of this bill by submitting endorsements; 50% will comply by submitting new contracts. Separate endorsements would have to be filed for disability income and medical insurance. There is a $10 fee for submitting endorsements and a $25 fee for submitting new contracts. It is assumed that filings of both endorsements and contracts will be spread evenly between fiscal years.
3. Contracts must comply with the new language upon sale or renewal. Submissions will be equally divided between FY96 and FY97 because of the January 1, 1996, effective date.
4. There will be 1.00 FTE required in the rates and forms area of the Insurance Program in the State Auditor's Office to review and approve the submissions.
5. There is a duplication of estimated revenue and expenditure with HB533. Insurers will submit one set of contracts for review and pay one set of fees to comply with the provisions of both bills. **The fiscal impact already is shown in the fiscal note for HB533.**
6. If HB533 and HB446 are both passed and approved, there is no additional fiscal impact to HB446. If HB446 is passed and approved and HB533 fails, there will be additional general fund revenue of $29,000 per year and additional general fund expenses of $36,693 per year as a result of HB446.

FISCAL IMPACT:

Expenditures:
See assumption #6.

Revenues:
See assumption #6.

Dave Lewis 3-23-95

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

SCOTT ORR, PRIMARY SPONSOR DATE

APPROVED BY SELECT
COMMITTEE ON HEALTH CARE

HOUSE BILL NO. 446

INTRODUCED BY ORR, MILLER, T. NELSON, CURTISS, TASH, AHNER, DENNY, MCKEE, GREEN, BARNETT, L. SMITH, SIMON, HERRON, MARTINEZ, SOMERVILLE

A BILL FOR AN ACT ENTITLED: "AN ACT PROHIBITING THE EXCLUSION OF CERTAIN PREEXISTING CONDITIONS FROM ~~INDIVIDUAL~~ HEALTH BENEFIT PLANS; PROVIDING DEFINITION; AMENDING SECTIONS ~~33-22-101~~ 33-22-110 AND 33-22-1811, MCA; AND ~~REPEALING SECTION 33-22-110, MCA~~ PROVIDING AN IMMEDIATE EFFECTIVE DATE AND A RETROACTIVE APPLICABILITY DATE."

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

~~NEW SECTION. **Section 1. Definition.** (1) As used in [section 2], unless the context indicates otherwise, "individual health benefit plan" means a hospital or medical expense incurred policy or certificate, a subscriber contract or contract of insurance provided by a prepaid hospital or medical service plan, a health maintenance organization subscriber contract issued or delivered for issue to an individual, or a discretionary group trust policy providing hospital or medical expense incurred coverage to individuals.~~

~~(2) The term does not include:~~

~~(a) a self-insured group health plan, a self-insured, multi-employer group health plan, a group conversion plan, or an insured group health plan;~~

~~(b) accident only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, medicare supplement, long-term care, or disability income insurance; or~~

~~(c) coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.~~

~~NEW SECTION. **Section 2. Preexisting conditions.** An individual health benefit plan may, because of a preexisting condition, not 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. An individual health benefit plan may not define a preexisting condition more restrictively than:~~

~~(1) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the 24 months immediately preceding the effective date of coverage;~~

~~(2) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the 24 months immediately preceding the effective date of coverage; or~~

~~(3) a pregnancy existing on the effective date of coverage.~~

~~**Section 3.** Section 33-22-101, MCA, is amended to read:~~

~~"**33-22-101. Exceptions to scope.** Parts 1 through 4 of this chapter, except 33-22-107, 33-22-110 [section 2], 33-22-111, 33-22-114, 33-22-125, 33-22-130 through 33-22-132, and 33-22-304, do not apply to or affect:~~

~~(1) any policy of liability or workers' compensation insurance with or without supplementary expense coverage;~~

~~(2) any group or blanket policy;~~

~~(3) life insurance, endowment, or annuity contracts or supplemental contracts that contain only those provisions relating to disability insurance as:~~

~~(a) provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means; or~~

~~(b) operate to safeguard contracts against lapse or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract; or~~

~~(4) reinsurance."~~

SECTION 1. SECTION 33-22-110, MCA, IS AMENDED TO READ:

"**33-22-110. Preexisting conditions.** (1) ~~A~~ Except as provided in subsection (2), a policy or certificate of disability insurance may not exclude coverage for a condition for which medical advice or treatment was recommended by or received from a provider of health care services unless the condition occurred within 5 years preceding the effective date of coverage of an insured person. The condition may only be excluded for a maximum of 12 months.

(2) A health benefit plan may exclude coverage or limit benefits for a preexisting condition for a maximum of 12 months. A health benefit plan may not define a preexisting condition more restrictively than:

(a) a condition for which medical advice, diagnosis, care, or treatment was recommended or

received during the 3 years preceding the effective date of coverage of the insured person;

(b) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the 3 years preceding the effective date of coverage of the insured person; or

(c) a pregnancy existing on the effective date of coverage of the insured person.

(3) For purposes of subsection (2), a "health benefit plan" means a hospital-incurred or medical expense-incurred policy or certificate, a subscriber contract, or a contract of insurance provided by a health service corporation or a health maintenance subscriber contract.

(4) An insurer may use an application form designed to elicit the complete health history of an applicant and, on the basis of the answers on that application, perform underwriting in accordance with the insurer's established underwriting standards."

NEW SECTION. **SECTION 2. RIDERS.** EXCEPT FOR A POLICY ISSUED UNDER CHAPTER 22, PART 18, A POLICY OF DISABILITY INSURANCE MAY EXCLUDE COVERAGE FOR SPECIFIC CONDITIONS THROUGH THE USE OF ELIMINATION RIDERS. EXCEPT FOR A POLICY OF DISABILITY INCOME INSURANCE, A CONDITION EXCLUDED BY AN ELIMINATION RIDER MAY BE EXCLUDED FOR A PERIOD NOT TO EXCEED 5 YEARS FROM THE EFFECTIVE DATE OF COVERAGE OF THE INSURED PERSON.

Section 3. 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 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.

(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~~ ~~[section 2]~~ 33-22-110(2).

(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 5. Repealer.** Section 33-22-110, MCA, is repealed.~~

NEW SECTION. **SECTION 4. RETROACTIVE APPLICABILITY.** [SECTION 2] APPLIES RETROACTIVELY, WITHIN THE MEANING OF 1-2-109, TO POLICIES, CERTIFICATES, OR CONTRACTS OF DISABILITY INSURANCE ISSUED PRIOR TO [THE EFFECTIVE DATE OF THIS ACT], EXCEPT FOR POLICIES, CERTIFICATES, OR CONTRACTS ISSUED UNDER TITLE 33, CHAPTER 22, PART 18.

NEW SECTION. **SECTION 5. EFFECTIVE DATE.** [THIS ACT] IS EFFECTIVE ON PASSAGE AND APPROVAL.

NEW SECTION. **Section 6. Codification instruction.** [~~Sections 1 and~~ SECTION 2] ~~are~~ IS intended to be codified as an integral part of Title 33, chapter 22, PART 1, and the provisions of Title 33, chapter 22, PART 1, apply to [~~sections 1 and~~ SECTION 2].

-END-

HOUSE BILL NO. 446

INTRODUCED BY ORR, MILLER, T. NELSON, CURTISS, TASH, AHNER, DENNY, MCKEE, GREEN, BARNETT, L. SMITH, SIMON, HERRON, MARTINEZ, SOMERVILLE

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(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 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.

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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.

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(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 5. Repealer.** Section 33-22-110, MCA, is repealed.~~

NEW SECTION. **SECTION 4. RETROACTIVE APPLICABILITY.** [SECTION 2] APPLIES RETROACTIVELY, WITHIN THE MEANING OF 1-2-109, TO POLICIES, CERTIFICATES, OR CONTRACTS OF DISABILITY INSURANCE ISSUED PRIOR TO [THE EFFECTIVE DATE OF THIS ACT], EXCEPT FOR POLICIES, CERTIFICATES, OR CONTRACTS ISSUED UNDER TITLE 33, CHAPTER 22, PART 18.

NEW SECTION. **SECTION 5. EFFECTIVE DATE.** [THIS ACT] IS EFFECTIVE ON PASSAGE AND APPROVAL.

NEW SECTION. **Section 6. Codification instruction.** [~~Sections 1 and~~ SECTION 2] ~~are~~ IS intended to be codified as an integral part of Title 33, chapter 22, PART 1, and the provisions of Title 33, chapter 22, PART 1, apply to [~~sections 1 and~~ SECTION 2].

-END-

HOUSE BILL NO. 446

INTRODUCED BY ORR, MILLER, T. NELSON, CURTISS, TASH, AHNER, DENNY, MCKEE, GREEN, BARNETT, L. SMITH, SIMON, HERRON, MARTINEZ, SOMERVILLE

A BILL FOR AN ACT ENTITLED: "AN ACT PROHIBITING THE EXCLUSION OF CERTAIN PREEXISTING CONDITIONS FROM ~~INDIVIDUAL~~ HEALTH BENEFIT PLANS; PROVIDING DEFINITION; AMENDING SECTIONS ~~33-22-101~~ 33-22-110 AND 33-22-1811, MCA; AND ~~REPEALING SECTION 33-22-110, MCA~~ PROVIDING AN IMMEDIATE EFFECTIVE DATE AND A RETROACTIVE APPLICABILITY DATE."

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

NEW SECTION. ~~**Section 1. Definition.** (1) As used in [section 2], unless the context indicates otherwise, "individual health benefit plan" *means a hospital or medical expense incurred policy or certificate, a subscriber contract or contract of insurance provided by a prepaid hospital or medical service plan, a health maintenance organization subscriber contract issued or delivered for issue to an individual, or a discretionary group trust policy providing hospital or medical expense incurred coverage to individuals.*~~

~~(2) The term does not include:~~

~~(a) a self-insured group health plan, a self-insured, multi-employer group health plan, a group conversion plan, or an insured group health plan;~~

~~(b) accident only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, medicare supplement, long-term care, or disability income insurance; or~~

~~(c) coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.~~

NEW SECTION. ~~**Section 2. Preexisting conditions.** An individual health benefit plan may, because of a preexisting condition, not 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. An individual health benefit plan may not define a preexisting condition *more restrictively* than:~~

~~(1) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the 24 months immediately preceding the effective date of coverage;~~

~~(2) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the 24 months immediately preceding the effective date of coverage; or~~

~~(3) a pregnancy existing on the effective date of coverage.~~

~~**Section 3.** Section 33-22-101, MCA, is amended to read:~~

~~"**33-22-101. Exceptions to scope.** Parts 1 through 4 of this chapter, except 33-22-107, 33-22-110 [section 2], 33-22-111, 33-22-114, 33-22-125, 33-22-130 through 33-22-132, and 33-22-304, do not apply to or affect:~~

~~(1) any policy of liability or workers' compensation insurance with or without supplementary expense coverage;~~

~~(2) any group or blanket policy;~~

~~(3) life insurance, endowment, or annuity contracts or supplemental contracts that contain only those provisions relating to disability insurance as:~~

~~(a) provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means; or~~

~~(b) operate to safeguard contracts against lapse or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract; or~~

~~(4) reinsurance.~~"

SECTION 1. SECTION 33-22-110, MCA, IS AMENDED TO READ:

"**33-22-110. Preexisting conditions.** (1) ~~A~~ Except as provided in subsection (2), a policy or certificate of disability insurance may not exclude coverage for a condition for which medical advice or treatment was recommended by or received from a provider of health care services unless the condition occurred within 5 years preceding the effective date of coverage of an insured person. The condition may only be excluded for a maximum of 12 months.

(2) ~~A health benefit plan may exclude coverage or limit benefits for a preexisting condition for a maximum of 12 months. A health benefit plan may not define a preexisting condition more restrictively than:~~

~~(a) a condition for which medical advice, diagnosis, care, or treatment was recommended or~~

~~received during the 3 years preceding the effective date of coverage of the insured person;~~

~~(b) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the 3 years preceding the effective date of coverage of the insured person; or~~

~~(c) a pregnancy existing on the effective date of coverage of the insured person.~~ A HEALTH BENEFIT PLAN MAY NOT EXCLUDE COVERAGE FOR A CONDITION FOR WHICH MEDICAL ADVICE OR TREATMENT WAS RECOMMENDED BY OR RECEIVED FROM A PROVIDER OF HEALTH CARE SERVICES UNLESS THE CONDITION OCCURRED WITHIN 3 YEARS PRECEDING THE EFFECTIVE DATE OF COVERAGE OF AN INSURED PERSON. THE CONDITION MAY BE EXCLUDED FOR A MAXIMUM OF 12 MONTHS.

(3) For purposes of subsection (2), a "health benefit plan" means a ~~hospital-incurred~~ HOSPITAL EXPENSE-INCURRED or medical expense-incurred policy, CONTRACT, or certificate~~, a subscriber contract, or a contract of insurance~~ provided by a HEALTH INSURER, health service corporation, or ~~a~~ health maintenance ~~subscriber contract~~ ORGANIZATION.

(4) An insurer may use an application form designed to elicit the complete health history of an applicant and, on the basis of the answers on that application, perform underwriting in accordance with the insurer's established underwriting standards.

(5) A POLICY OF DISABILITY INCOME INSURANCE MAY NOT EXCLUDE COVERAGE FOR A CONDITION FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE, OR TREATMENT WAS RECOMMENDED BY OR RECEIVED FROM A PROVIDER OF HEALTH CARE SERVICES WITHIN 5 YEARS PRECEDING THE EFFECTIVE DATE OF COVERAGE OF AN INSURED PERSON. AN EXCLUSION MAY NOT APPLY TO A DISABILITY COMMENCING MORE THAN 12 MONTHS FROM THE EFFECTIVE DATE OF COVERAGE OF AN INSURED PERSON."

NEW SECTION. **SECTION 2. RIDERS.** (1) EXCEPT FOR A POLICY ISSUED UNDER CHAPTER 22, PART 18, A POLICY OF DISABILITY INSURANCE MAY ~~EXCLUDE~~ CONTAIN A PROVISION THAT EXCLUDES COVERAGE FOR SPECIFIC CONDITIONS THROUGH THE USE OF ELIMINATION RIDERS. ~~EXCEPT FOR A POLICY OF DISABILITY INCOME INSURANCE, A CONDITION EXCLUDED BY AN ELIMINATION RIDER MAY BE EXCLUDED FOR A PERIOD NOT TO EXCEED 5 4 YEARS FROM THE EFFECTIVE DATE OF COVERAGE OF THE INSURED PERSON.~~ FOR CONDITIONS FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE, OR TREATMENT WAS RECOMMENDED BY OR RECEIVED FROM A

PROVIDER OF HEALTH CARE SERVICES WITHIN 4 YEARS PRECEDING THE EFFECTIVE DATE OF COVERAGE OF AN INSURED PERSON. THE PROVISIONS OF 33-22-110 DO NOT APPLY TO ELIMINATION RIDERS. AN INSURED PERSON MAY APPLY TO THE INSURER FOR REMOVAL OR MODIFICATION OF A RIDER, AND THE INSURER SHALL RESPOND TO THE APPLICATION WITHIN 60 DAYS OF RECEIPT.

(2) AN INSURER MAY NOT, EXCEPT UPON AGREEMENT BY THE INSURED, RETROACTIVELY IMPOSE AN ELIMINATION RIDER ON AN EXISTING POLICY, CERTIFICATE, OR CONTRACT.

(3) "ELIMINATION RIDER" MEANS A PROVISION ATTACHED TO A POLICY THAT EXCLUDES COVERAGE FOR A SPECIFIC CONDITION THAT WOULD OTHERWISE BE COVERED UNDER THE POLICY.

Section 3. 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 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.

(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 [section 2]~~ 33-22-110(2).

(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 5. Repealer.** Section 33-22-110, MCA, is repealed.~~

NEW SECTION. **SECTION 4. SEVERABILITY.** IF A PART OF [THIS ACT] IS INVALID, ALL VALID

PARTS THAT ARE SEVERABLE FROM THE INVALID PART REMAIN IN EFFECT. IF A PART OF [THIS ACT] IS INVALID IN ONE OR MORE OF ITS APPLICATIONS, THE PART REMAINS IN EFFECT IN ALL VALID APPLICATIONS THAT ARE SEVERABLE FROM THE INVALID APPLICATIONS.

NEW SECTION. **SECTION 5. RETROACTIVE APPLICABILITY.** [SECTION 2] APPLIES RETROACTIVELY, WITHIN THE MEANING OF 1-2-109, TO POLICIES, CERTIFICATES, OR CONTRACTS OF DISABILITY INSURANCE ISSUED PRIOR TO [THE EFFECTIVE DATE OF THIS ACT], EXCEPT FOR POLICIES, CERTIFICATES, OR CONTRACTS ISSUED UNDER TITLE 33, CHAPTER 22, PART 18. AN INSURER MAY NOT, AS A RESULT OF THE APPLICATION OF [THIS SECTION], SEEK REIMBURSEMENT FOR ANY CLAIMS PREVIOUSLY PAID.

NEW SECTION. **SECTION 6. EFFECTIVE DATE.** [THIS ACT] IS EFFECTIVE ON PASSAGE AND APPROVAL.

NEW SECTION. **Section 7. Codification instruction.** [~~Sections 1 and~~ SECTION 2] ~~are~~ IS intended to be codified as an integral part of Title 33, chapter 22, PART 1, and the provisions of Title 33, chapter 22, PART 1, apply to [~~sections 1 and~~ SECTION 2].

-END-

JOINT SELECT COMMITTEE REPORT

March 17, 1995

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

Signed:_____
Senator Steve Benedict, Chair

That such amendments read:

1. Page 2, line 27 through page 3, line 5.
Following: "(2)"
Strike: the remainder of line 27 through page 3, line 5
Insert: "A health benefit plan may not exclude coverage for a condition for which medical advice or treatment was recommended by or received from a provider of health care services unless the condition occurred within 3 years preceding the effective date of coverage of an insured person. The condition may be excluded for a maximum of 12 months."

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

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

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

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

___ Amd. Coord.
___ Sec. of Senate

_____
Senator Carrying Bill

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JOINT H & S

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

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

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

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

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

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

9. Page 6, line 8.
Insert: "

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

Renumber: subsequent sections

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

-END-

FREE CONFERENCE COMMITTEE

on House Bill 446
Report No. 1, April 6, 1995

Mr. Speaker and Mr. President:

We, your Free Conference Committee met and considered **House Bill 446** and recommend as follows:

1. Page 3, line 18.
Following: "ADVICE"
Strike: ", DIAGNOSIS, CARE,"

2. Page 3, line 19.
Following: "SERVICES"
Insert: "unless the condition occurred"

And this FREE Conference Committee report be adopted.

For the House:	For the Senate:
Representative Orr	Senator Foster
Chair	Chair
Representative Kasten	Senator Eck
Representative Tuss	Senator Miller

ADOPT

REJECT

HB 446
FCCR #1
790933CC.Hbk

HOUSE BILL NO. 446

INTRODUCED BY ORR, MILLER, T. NELSON, CURTISS, TASH, AHNER, DENNY, MCKEE, GREEN, BARNETT, L. SMITH, SIMON, HERRON, MARTINEZ, SOMERVILLE

A BILL FOR AN ACT ENTITLED: "AN ACT PROHIBITING THE EXCLUSION OF CERTAIN PREEXISTING CONDITIONS FROM ~~INDIVIDUAL~~ HEALTH BENEFIT PLANS; PROVIDING DEFINITION; AMENDING SECTIONS ~~33-22-101~~ 33-22-110 AND 33-22-1811, MCA; AND ~~REPEALING SECTION 33-22-110, MCA~~ PROVIDING AN IMMEDIATE EFFECTIVE DATE AND A RETROACTIVE APPLICABILITY DATE."

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

~~NEW SECTION. Section 1. Definition. (1) As used in [section 2], unless the context indicates otherwise, "individual health benefit plan" means a hospital or medical expense-incurred policy or certificate, a subscriber contract or contract of insurance provided by a prepaid hospital or medical service plan, a health maintenance organization subscriber contract issued or delivered for issue to an individual, or a discretionary group trust policy providing hospital or medical expense-incurred coverage to individuals.~~

~~(2) The term does not include:~~

~~(a) a self-insured group health plan, a self-insured, multi-employer group health plan, a group conversion plan, or an insured group health plan;~~

~~(b) accident only, specified disease, short term hospital or medical, hospital confinement indemnity, credit, dental, vision, medicare supplement, long term care, or disability income insurance; or~~

~~(c) coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.~~

~~NEW SECTION. Section 2. Preexisting conditions. An individual health benefit plan may, because of a preexisting condition, not 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. An individual health benefit plan may not define a preexisting condition more restrictively than:~~

~~(1) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the 24 months immediately preceding the effective date of coverage;~~

REFERENCE BILL: INCLUDES FREE CONFERENCE COMMITTEE REPORT DATED 4-6-95

~~(2) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the 24 months immediately preceding the effective date of coverage; or~~

~~(3) a pregnancy existing on the effective date of coverage.~~

~~**Section 3.** Section 33-22-101, MCA, is amended to read:~~

~~**"33-22-101. Exceptions to scope.** Parts 1 through 4 of this chapter, except 33-22-107, 33-22-110 [section 2], 33-22-111, 33-22-114, 33-22-125, 33-22-130 through 33-22-132, and 33-22-304, do not apply to or affect:~~

~~(1) any policy of liability or workers' compensation insurance with or without supplementary expense coverage;~~

~~(2) any group or blanket policy;~~

~~(3) life insurance, endowment, or annuity contracts or supplemental contracts that contain only those provisions relating to disability insurance as:~~

~~(a) provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means; or~~

~~(b) operate to safeguard contracts against lapse or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract; or~~

~~(4) reinsurance."~~

SECTION 1. SECTION 33-22-110, MCA, IS AMENDED TO READ:

"**33-22-110. Preexisting conditions.** (1) ~~A~~ Except as provided in subsection (2), a policy or certificate of disability insurance may not exclude coverage for a condition for which medical advice or treatment was recommended by or received from a provider of health care services unless the condition occurred within 5 years preceding the effective date of coverage of an insured person. The condition may only be excluded for a maximum of 12 months.

(2) ~~A health benefit plan may exclude coverage or limit benefits for a preexisting condition for a maximum of 12 months. A health benefit plan may not define a preexisting condition more restrictively than:~~

~~(a) a condition for which medical advice, diagnosis, care, or treatment was recommended or~~

~~received during the 3 years preceding the effective date of coverage of the insured person;~~

~~(b) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the 3 years preceding the effective date of coverage of the insured person; or~~

~~(c) a pregnancy existing on the effective date of coverage of the insured person.~~ A HEALTH BENEFIT PLAN MAY NOT EXCLUDE COVERAGE FOR A CONDITION FOR WHICH MEDICAL ADVICE OR TREATMENT WAS RECOMMENDED BY OR RECEIVED FROM A PROVIDER OF HEALTH CARE SERVICES UNLESS THE CONDITION OCCURRED WITHIN 3 YEARS PRECEDING THE EFFECTIVE DATE OF COVERAGE OF AN INSURED PERSON. THE CONDITION MAY BE EXCLUDED FOR A MAXIMUM OF 12 MONTHS.

(3) For purposes of subsection (2), a "health benefit plan" means a ~~hospital-incurred~~ HOSPITAL EXPENSE-INCURRED or medical expense-incurred policy, CONTRACT, or certificate~~, a subscriber contract, or a contract of insurance~~ provided by a HEALTH INSURER, health service corporation, or a health maintenance ~~subscriber contract~~ ORGANIZATION.

(4) An insurer may use an application form designed to elicit the complete health history of an applicant and, on the basis of the answers on that application, perform underwriting in accordance with the insurer's established underwriting standards.

(5) A POLICY OF DISABILITY INCOME INSURANCE MAY NOT EXCLUDE COVERAGE FOR A CONDITION FOR WHICH MEDICAL ADVICE~~, DIAGNOSIS, CARE,~~ OR TREATMENT WAS RECOMMENDED BY OR RECEIVED FROM A PROVIDER OF HEALTH CARE SERVICES UNLESS THE CONDITION OCCURRED WITHIN 5 YEARS PRECEDING THE EFFECTIVE DATE OF COVERAGE OF AN INSURED PERSON. AN EXCLUSION MAY NOT APPLY TO A DISABILITY COMMENCING MORE THAN 12 MONTHS FROM THE EFFECTIVE DATE OF COVERAGE OF AN INSURED PERSON."

NEW SECTION. **SECTION 2. RIDERS.** (1) EXCEPT FOR A POLICY ISSUED UNDER CHAPTER 22, PART 18, A POLICY OF DISABILITY INSURANCE MAY ~~EXCLUDE~~ CONTAIN A PROVISION THAT EXCLUDES COVERAGE FOR SPECIFIC CONDITIONS THROUGH THE USE OF ELIMINATION RIDERS~~.~~ ~~EXCEPT FOR A POLICY OF DISABILITY INCOME INSURANCE, A CONDITION EXCLUDED BY AN ELIMINATION RIDER MAY BE EXCLUDED FOR A PERIOD NOT TO EXCEED 5 4 YEARS FROM THE EFFECTIVE DATE OF COVERAGE OF THE INSURED PERSON.~~ FOR CONDITIONS FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE, OR TREATMENT WAS RECOMMENDED BY OR RECEIVED FROM A

PROVIDER OF HEALTH CARE SERVICES WITHIN 4 YEARS PRECEDING THE EFFECTIVE DATE OF COVERAGE OF AN INSURED PERSON. THE PROVISIONS OF 33-22-110 DO NOT APPLY TO ELIMINATION RIDERS. AN INSURED PERSON MAY APPLY TO THE INSURER FOR REMOVAL OR MODIFICATION OF A RIDER, AND THE INSURER SHALL RESPOND TO THE APPLICATION WITHIN 60 DAYS OF RECEIPT.

(2) AN INSURER MAY NOT, EXCEPT UPON AGREEMENT BY THE INSURED, RETROACTIVELY IMPOSE AN ELIMINATION RIDER ON AN EXISTING POLICY, CERTIFICATE, OR CONTRACT.

(3) "ELIMINATION RIDER" MEANS A PROVISION ATTACHED TO A POLICY THAT EXCLUDES COVERAGE FOR A SPECIFIC CONDITION THAT WOULD OTHERWISE BE COVERED UNDER THE POLICY.

Section 3. 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 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.

(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~~ ~~[section 2]~~ 33-22-110(2).

(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 5. Repealer.** Section 33-22-110, MCA, is repealed.~~

NEW SECTION. **SECTION 4. SEVERABILITY.** IF A PART OF [THIS ACT] IS INVALID, ALL VALID

PARTS THAT ARE SEVERABLE FROM THE INVALID PART REMAIN IN EFFECT. IF A PART OF [THIS ACT] IS INVALID IN ONE OR MORE OF ITS APPLICATIONS, THE PART REMAINS IN EFFECT IN ALL VALID APPLICATIONS THAT ARE SEVERABLE FROM THE INVALID APPLICATIONS.

NEW SECTION. **SECTION 5. RETROACTIVE APPLICABILITY.** [SECTION 2] APPLIES RETROACTIVELY, WITHIN THE MEANING OF 1-2-109, TO POLICIES, CERTIFICATES, OR CONTRACTS OF DISABILITY INSURANCE ISSUED PRIOR TO [THE EFFECTIVE DATE OF THIS ACT], EXCEPT FOR POLICIES, CERTIFICATES, OR CONTRACTS ISSUED UNDER TITLE 33, CHAPTER 22, PART 18. AN INSURER MAY NOT, AS A RESULT OF THE APPLICATION OF [THIS SECTION], SEEK REIMBURSEMENT FOR ANY CLAIMS PREVIOUSLY PAID.

NEW SECTION. **SECTION 6. EFFECTIVE DATE.** [THIS ACT] IS EFFECTIVE ON PASSAGE AND APPROVAL.

NEW SECTION. **Section 7. Codification instruction.** [~~Sections 1 and~~ SECTION 2] ~~are~~ IS intended to be codified as an integral part of Title 33, chapter 22, PART 1, and the provisions of Title 33, chapter 22, PART 1, apply to [~~sections 1 and~~ SECTION 2].

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