

INTRODUCED BY ORR Dennis McKee House Bill No. 446
Green Barnett Curtis L. Smith John L. Linner
McGinnis John J. O'Brien John J. O'Brien

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."

10-22-10, MGA
SOMER

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 within 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~~
~~1-21~~, 33-22-111, 33-22-114, 33-22-125, 33-22-130 through 33-22-132, and 33-22-304, do not
affect:

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

(2) any group or blanket policy;

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

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

(b) operate to safeguard contracts against lapse or to give a special surrender value or special or an annuity in the event that the insured or annuitant becomes totally and permanently disabled, named 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

(ii) In the case of a small employer carrier that establishes more than one class of business pursuant to 22-1808, the small employer carrier shall maintain and offer to eligible small employers at least one health benefit plan and at least one standard health benefit plan in each established class of business.

1 A small employer carrier may apply reasonable criteria in determining whether to accept a small employer
2 into a class of business, provided that:

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

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

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

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

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

13 (c) The provisions of this section are effective 180 days after the commissioner's approval of the
14 basic health benefit plan and the standard health benefit plan developed pursuant to 33-22-1812, provided
15 that if the program created pursuant to 33-22-1818 is not yet operative on that date, the provisions of this
16 section are effective on the date that the program begins operation.

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

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

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

23 (a) A health benefit plan may not, because of a preexisting condition, deny, exclude, or limit
24 benefits for a covered individual for losses incurred more than 12 months following the effective date of
25 the individual's coverage. A health benefit plan may not define a preexisting condition more restrictively
26 than 33-22-110, except that the condition may be excluded for a maximum of 12 months [section 2].

27 (b) A health benefit plan must waive any time period applicable to a preexisting condition exclusion
28 or limitation period with respect to particular services for the period of time an individual was previously
29 covered by qualifying previous coverage that provided benefits with respect to those services if the
30 qualifying previous coverage was continuous to a date not less than 30 days prior to the submission of an

1 application for new coverage. This subsection (3)(b) does not preclude application of any waiting period
2 applicable to all new enrollees under the health benefit plan.

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

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

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

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

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

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

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

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

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

(b) A small employer carrier may not be required to provide coverage to small employers pursuant to section (1) for any period of time for which the commissioner determines that requiring the coverage 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 integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [sections 1

11

-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 323-95
DAVE LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

SCOTT ORR, PRIMARY SPONSOR DATE

Fiscal Note for HB0446, 3rd reading

HB 446

APPROVED BY SELECT
COMMITTEE ON HEALTH CARE

1 HOUSE BILL NO. 446

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

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

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

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(2) The term does not include:

18 (a) a self insured group health plan, a self insured, multi employer group health plan, a group
19 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

22 (c) coverage issued as a supplement to liability insurance, workers' compensation or similar
23 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;



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

4

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

6 "33-22-101. Exceptions to scope. Parts 1 through 4 of this chapter, except 33-22-107, 33-22-110
7 [section 2], 33-22-111, 33-22-114, 33-22-125, 33-22-130 through 33-22-132, and 33-22-304, do not
8 apply to or affect:

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

11 (2) any group or blanket policy;

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

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

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

19 (4) reinsurance."

20

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

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

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

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

1 received during the 3 years preceding the effective date of coverage of the insured person;
2 (b) a condition that would have caused an ordinarily prudent person to seek medical advice,
3 diagnosis, care, or treatment during the 3 years preceding the effective date of coverage of the insured
4 person; or
5 (c) a pregnancy existing on the effective date of coverage of the insured person.

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

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

12
13 NEW SECTION. SECTION 2. RIDERS. EXCEPT FOR A POLICY ISSUED UNDER CHAPTER 22,
14 PART 18, A POLICY OF DISABILITY INSURANCE MAY EXCLUDE COVERAGE FOR SPECIFIC CONDITIONS
15 THROUGH THE USE OF ELIMINATION RIDERS. EXCEPT FOR A POLICY OF DISABILITY INCOME
16 INSURANCE, A CONDITION EXCLUDED BY AN ELIMINATION RIDER MAY BE EXCLUDED FOR A PERIOD
17 NOT TO EXCEED 5 YEARS FROM THE EFFECTIVE DATE OF COVERAGE OF THE INSURED PERSON.

18
19 Section 3. Section 33-22-1811, MCA, is amended to read:
20 **"33-22-1811. Availability of coverage -- required plans.** (1) (a) As a condition of transacting
21 business in this state with small employers, each small employer carrier shall offer to small employers at
22 least two health benefit plans. One plan must be a basic health benefit plan, and one plan must be a
23 standard health benefit plan.

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

28 (ii) In the case of a small employer carrier that establishes more than one class of business pursuant
29 to 33-22-1808, the small employer carrier shall maintain and offer to eligible small employers at least one
30 basic health benefit plan and at least one standard health benefit plan in each established class of business.

1 A small employer carrier may apply reasonable criteria in determining whether to accept a small employer
2 into a class of business, provided that:

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

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

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

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

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

13 (c) The provisions of this section are effective 180 days after the commissioner's approval of the
14 basic health benefit plan and the standard health benefit plan developed pursuant to 33-22-1812, provided
15 that if the program created pursuant to 33-22-1818 is not yet operative on that date, the provisions of this
16 section are effective on the date that the program begins operation.

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

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

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

23 (a) A health benefit plan may not, because of a preexisting condition, deny, exclude, or limit
24 benefits for a covered individual for losses incurred more than 12 months following the effective date of
25 the individual's coverage. A health benefit plan may not define a preexisting condition more restrictively
26 than ~~33-22-110, except that the condition may be excluded for a maximum of 12 months [section 2]~~
27 33-22-110(2).

28 (b) A health benefit plan must waive any time period applicable to a preexisting condition exclusion
29 or limitation period with respect to particular services for the period of time an individual was previously
30 covered by qualifying previous coverage that provided benefits with respect to those services if the

1 qualifying previous coverage was continuous to a date not less than 30 days prior to the submission of an
2 application for new coverage. This subsection (3)(b) does not preclude application of any waiting period
3 applicable to all new enrollees under the health benefit plan.

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

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

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

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

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

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

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

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

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

1 group policyholders and enrollees.

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

6

7 ~~NEW SECTION. Section 5. Repealer. Section 33-22-110, MCA, is repealed.~~

8

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

13

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

16

17 NEW SECTION. Section 6. Codification instruction. [Sections 1 and SECTION 2] are IS intended
18 to be codified as an integral part of Title 33, chapter 22, PART 1, and the provisions of Title 33, chapter
19 22, PART 1, apply to [sections 1 and SECTION 2].

20

-END-

1

HOUSE BILL NO. 446

2

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

4

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6 CONDITIONS FROM INDIVIDUAL HEALTH BENEFIT PLANS; PROVIDING DEFINITION; AMENDING
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8 PROVIDING AN IMMEDIATE EFFECTIVE DATE AND A RETROACTIVE APPLICABILITY DATE."

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17

(2) The term does not include:

18

19 conversion plan, or an insured group health plan;

20

21 credit, dental, vision, medicare supplement, long-term care, or disability income insurance; or
22 (c) coverage issued as a supplement to liability insurance, workers' compensation or similar
23 insurance, or automobile medical payment insurance.

24

25

26 of a preexisting condition, not deny, exclude, or limit benefits for a covered individual for losses incurred
27 more than 12 months following the effective date of the individual's coverage. An individual health benefit
28 plan may not define a preexisting condition more restrictively than:

29

30 ~~diagnosis, care, or treatment during the 24 months immediately preceding the effective date of coverage;~~



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

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15 THROUGH THE USE OF ELIMINATION RIDERS. EXCEPT FOR A POLICY OF DISABILITY INCOME
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25 payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this
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10 or more classes of business.

11 (iii) The provisions of subsection (1)(b)(ii) may not be applied to a class of business into which the
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21 health benefit plan on the grounds that the plan does not meet the requirements of this part.

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

23 (a) A health benefit plan may not, because of a preexisting condition, deny, exclude, or limit
24 benefits for a covered individual for losses incurred more than 12 months following the effective date of
25 the individual's coverage. A health benefit plan may not define a preexisting condition more restrictively
26 than ~~33-22-110, except that the condition may be excluded for a maximum of 12 months [section 2]~~
27 33-22-110(2).

28 (b) A health benefit plan must waive any time period applicable to a preexisting condition exclusion
29 or limitation period with respect to particular services for the period of time an individual was previously
30 covered by qualifying previous coverage that provided benefits with respect to those services if the

1 qualifying previous coverage was continuous to a date not less than 30 days prior to the submission of an
2 application for new coverage. This subsection (3)(b) does not preclude application of any waiting period
3 applicable to all new enrollees under the health benefit plan.

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

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

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

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

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

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

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

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

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

1 group policyholders and enrollees.

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

6

7 ~~NEW SECTION. Section 5. Repealer. Section 33-22-110, MCA, is repealed.~~

8

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

13

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

16

17 NEW SECTION. Section 6. Codification instruction. [Sections 1 and SECTION 2] are IS intended
18 to be codified as an integral part of Title 33, chapter 22, PART 1, and the provisions of Title 33, chapter
19 22, PART 1, apply to [sections 1 and SECTION 2].

20

-END-

1 HOUSE BILL NO. 446

2 INTRODUCED BY ORR, MILLER, T. NELSON, CURTISS, TASH, AHNER, DENNY, MCKEE, GREEN,
3 BARNETT, L. SMITH, SIMON, HERRON, MARTINEZ, SOMERVILLE4
5 A BILL FOR AN ACT ENTITLED: "AN ACT PROHIBITING THE EXCLUSION OF CERTAIN PREEXISTING
6 CONDITIONS FROM INDIVIDUAL HEALTH BENEFIT PLANS; PROVIDING DEFINITION; AMENDING
7 SECTIONS ~~33-22-101~~ 33-22-110 AND 33-22-1811, MCA; AND REPEALING SECTION ~~33-22-110~~, MCA
8 PROVIDING AN IMMEDIATE EFFECTIVE DATE AND A RETROACTIVE APPLICABILITY DATE."

9

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

11

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

17 (2) The term does not include:

18 (a) a self insured group health plan, a self insured, multi employer group health plan, a group
19 conversion plan, or an insured group health plan;
20 (b) accident only, specified disease, short term hospital or medical, hospital confinement indemnity,
21 credit, dental, vision, medicare supplement, long term care, or disability income insurance; or
22 (c) coverage issued as a supplement to liability insurance, workers' compensation or similar
23 insurance, or automobile medical payment insurance.

24

25 NEW SECTION. Section 2. Preexisting conditions. An individual health benefit plan may, because
26 of a preexisting condition, not deny, exclude, or limit benefits for a covered individual for losses incurred
27 more than 12 months following the effective date of the individual's coverage. An individual health benefit
28 plan may not define a preexisting condition more restrictively than:29 (1) a condition that would have caused an ordinarily prudent person to seek medical advice,
30 diagnosis, care, or treatment during the 24 months immediately preceding the effective date of coverage;

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

4

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

6 **"33-22-101. Exceptions to scope. Parts 1 through 4 of this chapter, except 33-22-107, 33-22-110**
7 **[section 2], 33-22-111, 33-22-114, 33-22-125, 33-22-130 through 33-22-132, and 33-22-304, do not**
8 **apply to or affect:**

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

11 (2) any group or blanket policy;

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

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

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

19 (4) reinsurance."

20

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

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

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

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



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

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

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

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

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

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

23

24 NEW SECTION. SECTION 2. RIDERS. (1) EXCEPT FOR A POLICY ISSUED UNDER CHAPTER 22,
25 PART 18, A POLICY OF DISABILITY INSURANCE MAY EXCLUDE CONTAIN A PROVISION THAT
26 EXCLUDES COVERAGE FOR SPECIFIC CONDITIONS THROUGH THE USE OF ELIMINATION RIDERS.
27 EXCEPT FOR A POLICY OF DISABILITY INCOME INSURANCE, A CONDITION EXCLUDED BY AN
28 ELIMINATION RIDER MAY BE EXCLUDED FOR A PERIOD NOT TO EXCEED 6-4 YEARS FROM THE
29 EFFECTIVE DATE OF COVERAGE OF THE INSURED PERSON. FOR CONDITIONS FOR WHICH MEDICAL
30 ADVICE, DIAGNOSIS, CARE, OR TREATMENT WAS RECOMMENDED BY OR RECEIVED FROM A

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

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

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

9

10 **Section 3.** Section 33-22-1811, MCA, is amended to read:

11 **"33-22-1811. Availability of coverage -- required plans.** (1) (a) As a condition of transacting
12 business in this state with small employers, each small employer carrier shall offer to small employers at
13 least two health benefit plans. One plan must be a basic health benefit plan, and one plan must be a
14 standard health benefit plan.

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

19 (ii) In the case of a small employer carrier that establishes more than one class of business pursuant
20 to 33-22-1808, the small employer carrier shall maintain and offer to eligible small employers at least one
21 basic health benefit plan and at least one standard health benefit plan in each established class of business.
22 A small employer carrier may apply reasonable criteria in determining whether to accept a small employer
23 into a class of business, provided that:

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

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

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

30 (D) the small employer carrier provides for the acceptance of all eligible small employers into one

1 or more classes of business.

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

4 (c) The provisions of this section are effective 180 days after the commissioner's approval of the
5 basic health benefit plan and the standard health benefit plan developed pursuant to 33-22-1812, provided
6 that if the program created pursuant to 33-22-1818 is not yet operative on that date, the provisions of this
7 section are effective on the date that the program begins operation.

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

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

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

14 (a) A health benefit plan may not, because of a preexisting condition, deny, exclude, or limit
15 benefits for a covered individual for losses incurred more than 12 months following the effective date of
16 the individual's coverage. A health benefit plan may not define a preexisting condition more restrictively
17 than ~~33-22-110, except that the condition may be excluded for a maximum of 12 months [section 2]~~
18 33-22-110(2).

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

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

29 (d) (i) Requirements used by a small employer carrier in determining whether to provide coverage
30 to a small employer, including requirements for minimum participation of eligible employees and minimum

1 employer contributions, must be applied uniformly among all small employers that have the same number
2 of eligible employees and that apply for coverage or receive coverage from the small employer carrier.

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

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

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

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

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

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

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

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

27

28 ~~NEW SECTION. Section 5. Repealer. Section 33-22-110, MCA, is repealed.~~

29

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

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

4

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

11

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

14

15 NEW SECTION. Section 7. Codification instruction. [Sections 1 and SECTION 2] are IS intended
16 to be codified as an integral part of Title 33, chapter 22, PART 1, and the provisions of Title 33, chapter
17 22, PART 1, apply to [sections 1 and SECTION 2].

18 -END-

JOINT SELECT COMMITTEE REPORT

Page 1 of 2
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

March 17, 1995

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

Page 1 of 1

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:

Representative Orr

Chair

Representative Kasten

Representative Tuss

For the Senate:

Senator Foster

Chair

Senator Eck

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

4
5 A BILL FOR AN ACT ENTITLED: "AN ACT PROHIBITING THE EXCLUSION OF CERTAIN PREEXISTING
6 CONDITIONS FROM INDIVIDUAL HEALTH BENEFIT PLANS; PROVIDING DEFINITION; AMENDING
7 SECTIONS ~~33-22-101~~ 33-22-110 AND 33-22-1811, MCA; AND ~~REPEALING SECTION 33-22-110, MCA~~
8 PROVIDING AN IMMEDIATE EFFECTIVE DATE AND A RETROACTIVE APPLICABILITY DATE."

10 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

(e) 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;



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

4

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

6 "33-22-101. Exceptions to scope. Parts 1 through 4 of this chapter, except 33-22-107, 33-22-110
7 [section 2], 33-22-111, 33-22-114, 33-22-125, 33-22-130 through 33-22-132, and 33-22-304, do not
8 apply to or affect:

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

11 (2) any group or blanket policy;

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

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

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

19 (4) reinsurance."

20

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

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

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

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

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

2 (b) a condition that would have caused an ordinarily prudent person to seek medical advice,

3 diagnosis, care, or treatment during the 3 years preceding the effective date of coverage of the insured
4 person; or

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

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

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

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

23
24 NEW SECTION. SECTION 2. RIDERS. (1) EXCEPT FOR A POLICY ISSUED UNDER CHAPTER 22,
25 PART 18, A POLICY OF DISABILITY INSURANCE MAY EXCLUDE CONTAIN A PROVISION THAT
26 EXCLUDES COVERAGE FOR SPECIFIC CONDITIONS THROUGH THE USE OF ELIMINATION RIDERS-
27 EXCEPT FOR A POLICY OF DISABILITY INCOME INSURANCE, A CONDITION EXCLUDED BY AN
28 ELIMINATION RIDER MAY BE EXCLUDED FOR A PERIOD NOT TO EXCEED 5-4 YEARS FROM THE
29 EFFECTIVE DATE OF COVERAGE OF THE INSURED PERSON. FOR CONDITIONS FOR WHICH MEDICAL
30 ADVICE, DIAGNOSIS, CARE, OR TREATMENT WAS RECOMMENDED BY OR RECEIVED FROM A

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

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

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

9

10 **Section 3.** Section 33-22-1811, MCA, is amended to read:

11 **"33-22-1811. Availability of coverage -- required plans.** (1) (a) As a condition of transacting
12 business in this state with small employers, each small employer carrier shall offer to small employers at
13 least two health benefit plans. One plan must be a basic health benefit plan, and one plan must be a
14 standard health benefit plan.

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

19 (ii) In the case of a small employer carrier that establishes more than one class of business pursuant
20 to 33-22-1808, the small employer carrier shall maintain and offer to eligible small employers at least one
21 basic health benefit plan and at least one standard health benefit plan in each established class of business.
22 A small employer carrier may apply reasonable criteria in determining whether to accept a small employer
23 into a class of business, provided that:

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

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

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

30 (D) the small employer carrier provides for the acceptance of all eligible small employers into one

1 or more classes of business.

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

4 (c) The provisions of this section are effective 180 days after the commissioner's approval of the
5 basic health benefit plan and the standard health benefit plan developed pursuant to 33-22-1812, provided
6 that if the program created pursuant to 33-22-1818 is not yet operative on that date, the provisions of this
7 section are effective on the date that the program begins operation.

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

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

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

14 (a) A health benefit plan may not, because of a preexisting condition, deny, exclude, or limit
15 benefits for a covered individual for losses incurred more than 12 months following the effective date of
16 the individual's coverage. A health benefit plan may not define a preexisting condition more restrictively
17 than ~~33-22-110, except that the condition may be excluded for a maximum of 12 months [section 2]~~
18 33-22-110(2).

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

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

29 (d) (i) Requirements used by a small employer carrier in determining whether to provide coverage
30 to a small employer, including requirements for minimum participation of eligible employees and minimum

1 employer contributions, must be applied uniformly among all small employers that have the same number
2 of eligible employees and that apply for coverage or receive coverage from the small employer carrier.

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

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

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

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

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

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

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

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

27

28 NEW SECTION. Section 5. Repealer. Section 33-22-110, MCA, is repealed.

29

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

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

4

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

11

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

14

15 NEW SECTION. Section 7. Codification instruction. [Sections 1 and SECTION 2] are [S intended
16 to be codified as an integral part of Title 33, chapter 22, PART 1, and the provisions of Title 33, chapter
17 22, PART 1, apply to [sections 1 and SECTION 2].

18

-END-