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INTRODUCED BY House BILL NO. 466  
*Tom Nelson* *Tracie* *Miss Benedict*

A BILL FOR AN ACT ENTITLED: "AN ACT REVISING THE SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT; REVISING DEFINITIONS; CLARIFYING REIMBURSEMENT TREATMENT; REVISING RESTRICTIONS ON PREMIUM RATES; RESTRICTING THE AUTHORITY OF THE COMMISSIONER OF INSURANCE TO ADOPT RULES; PROHIBITING THE COMMISSIONER OF INSURANCE FROM REQUIRING PRIOR APPROVAL OF RATING METHODS AND PREMIUMS; DELETING EFFECTIVE DATES RELATED TO THE DEVELOPMENT OF BENEFIT PLANS AND THE COMMISSIONER'S APPROVAL OF THE PLANS; PROVIDING FOR WAIVERS OF COVERAGE BY EMPLOYEES; ELIMINATING THE HEALTH BENEFIT PLAN COMMITTEE; PROVIDING FOR THE CONTENT OF BASIC AND STANDARD HEALTH BENEFIT PLANS; AMENDING SECTIONS 33-22-1803, 33-22-1804, 33-22-1809, 33-22-1811, 33-22-1820, AND 33-22-1821, MCA; AND REPEALING SECTION 33-22-1812, MCA."

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

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

**"33-22-1803. Definitions.** As used in this part, the following definitions apply:

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

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

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

(4) "Base premium rate" means, for each class of business as to a rating period, the lowest

1 premium rate charged or that could have been charged under the rating system for that class of business  
 2 by the small employer carrier to small employers with similar case characteristics for health benefit plans  
 3 with the same or similar coverage.

4 (5) "Basic health benefit plan" means a ~~lower cost~~ health benefit plan developed pursuant to  
 5 ~~33-22-1812~~ by a small employer carrier that is a lower cost plan than the standard health benefit plan and  
 6 that provides the benefits required by [section 5].

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

8 (7) "Carrier" means any person who provides a health benefit plan in this state subject to state  
 9 insurance regulation. The term includes but is not limited to an insurance company, a fraternal benefit  
 10 society, a health service corporation, a health maintenance organization, and, to the extent permitted by  
 11 the Employee Retirement Income Security Act of 1974, a multiple-employer welfare arrangement. For  
 12 purposes of this part, companies that are affiliated companies or that are eligible to file a consolidated tax  
 13 return must be treated as one carrier, except that the following may be considered as separate carriers:

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

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

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

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

24 (9) "Class of business" means all or a separate grouping of small employers established pursuant  
 25 to 33-22-1808.

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

27 ~~(11)~~(10) "Dependent" means:

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

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

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

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

4 ~~(12)~~(11) "Eligible employee" means an employee who works on a full-time basis ~~and who has~~ with  
5 a normal workweek of 30 hours or more, except that at the sole discretion of the employer, the term may  
6 include an employee who works on a full-time basis with a normal workweek of between 20 and 40 hours  
7 as long as this eligibility criteria is applied uniformly among all of the employer's employees. The term  
8 includes a sole proprietor, a partner of a partnership, and an independent contractor if the sole proprietor,  
9 partner, or independent contractor is included as an employee under a health benefit plan of a small  
10 employer. The term does not include an employee who works on a part-time, temporary, or substitute  
11 basis.

12 ~~(13)~~(12) "Established geographic service area" means a geographic area, as approved by the  
13 commissioner and based on the carrier's certificate of authority to transact insurance in this state, within  
14 which the carrier is authorized to provide coverage.

15 ~~(14)~~(13) "Health benefit plan" means any hospital or medical policy or certificate providing for  
16 physical and mental health care issued by an insurance company, a fraternal benefit society, or a health  
17 service corporation or issued under a health maintenance organization subscriber contract. Health benefit  
18 plan does not include:

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

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

23 (c) automobile medical payment insurance.

24 ~~(15)~~(14) "Index rate" means, for each class of business for a rating period for small employers with  
25 similar case characteristics, the average of the applicable base premium rate and the corresponding highest  
26 premium rate.

27 ~~(16)~~(15) "Late enrollee" means an eligible employee or dependent who requests enrollment in a  
28 health benefit plan of a small employer following the initial enrollment period during which the individual  
29 was entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period  
30 was a period of at least 30 days. However, an eligible employee or dependent may not be considered a late

1 enrollee if:

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

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

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

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

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

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

15 ~~(17)~~(16) "New business premium rate" means, for each class of business for a rating period, the  
16 lowest premium rate charged or offered or that could have been charged or offered by the small employer  
17 carrier to small employers with similar case characteristics for newly issued health benefit plans with the  
18 same or similar coverage.

19 ~~(18)~~(17) "Plan of operation" means the operation of the program established pursuant to  
20 33-22-1818.

21 ~~(19)~~(18) "Premium" means all money paid by a small employer and eligible employees as a  
22 condition of receiving coverage from a small employer carrier, including any fees or other contributions  
23 associated with the health benefit plan.

24 ~~(20)~~(19) "Program" means the Montana small employer health reinsurance program created by  
25 33-22-1818.

26 ~~(21)~~(20) "Qualifying previous coverage" means benefits or coverage provided under:

27 (a) medicare or medicaid;

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

30 (c) an individual health insurance policy, including coverage issued by an insurance company, a

1 fraternal benefit society, a health service corporation, or a health maintenance organization that provides  
 2 benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided that the  
 3 policy has been in effect for a period of at least 1 year.

4 ~~(22)~~(21) "Rating period" means the calendar period for which premium rates established by a small  
 5 employer carrier are assumed to be in effect.

6 ~~(23)~~(22) "Reinsuring carrier" means a small employer carrier participating in the reinsurance  
 7 program pursuant to 33-22-1819.

8 ~~(24)~~(23) "Restricted network provision" means a provision of a health benefit plan that conditions  
 9 the payment of benefits, in whole or in part, on the use of health care providers that have entered into a  
 10 contractual arrangement with the carrier pursuant to Title 33, chapter 22, part 17, or Title 33, chapter 31,  
 11 to provide health care services to covered individuals.

12 ~~(25)~~(24) "Small employer" means a person, firm, corporation, partnership, or association that is  
 13 actively engaged in business and that, on at least 50% of its working days during the preceding calendar  
 14 quarter, employed at least 3 but not more than 25 eligible employees, the majority of whom were employed  
 15 within this state or were residents of this state. In determining the number of eligible employees, companies  
 16 are considered one employer if they:

- 17 (a) are affiliated companies;  
 18 (b) are eligible to file a combined tax return for purposes of state taxation; or  
 19 (c) are members of an association that:  
 20 (i) has been in existence for 1 year prior to January 1, 1994;  
 21 (ii) provides a health benefit plan to employees of its members as a group; and  
 22 (iii) does not deny coverage to any member of its association or any employee of its members who  
 23 applies for coverage as part of a group.

24 ~~(26)~~(25) "Small employer carrier" means a carrier that offers health benefit plans that cover eligible  
 25 employees of one or more small employers in this state.

26 ~~(27)~~(26) "Standard health benefit plan" means a health benefit plan that is developed pursuant to  
 27 33-22-1812 by a small employer carrier and that contains the provisions required pursuant to [section 6]."  
 28

29 **Section 2.** Section 33-22-1804, MCA, is amended to read:

30 "33-22-1804. **Applicability and scope.** (1) This part applies to a health benefit plan marketed

1 through a small employer that provides coverage to the employees of a small employer in this state if any  
 2 of the following conditions are met:

- 3 ~~(1)(a)~~ a portion of the premium or benefits is paid by or on behalf of the small employer;  
 4 ~~(2)(b)~~ an eligible employee or dependent is reimbursed, whether through wage adjustments or  
 5 otherwise, by or on behalf of the small employer for any portion of the premium; or  
 6 ~~(3)(c)~~ the health benefit plan is treated by the employer or any of the eligible employees or  
 7 dependents as part of a plan or program for the purposes of section 106, 125, or 162 of the Internal  
 8 Revenue Code.

9 (2) A payroll deduction or a list-billed premium is not a reimbursement for the purposes of  
 10 subsection (1)(b)."

11

12 **Section 3.** Section 33-22-1809, MCA, is amended to read:

13 **"33-22-1809. Restrictions relating to premium rates.** (1) Premium rates for health benefit plans  
 14 under this part are subject to the following provisions:

15 (a) The index rate for a rating period for any class of business may not exceed the index rate for  
 16 any other class of business by more than 20%.

17 (b) For each class of business:

18 (i) the premium rates charged during a rating period to small employers with similar case  
 19 characteristics for the same or similar coverage or the rates that could be charged to the employer under  
 20 the rating system for that class of business may not vary from the index rate by more than 25% of the  
 21 index rate; or

22 (ii) if the Montana health care authority established by 50-4-201 certifies to the commissioner that  
 23 the cost containment goal set forth in 50-4-303 is met on or before January 1, 1999, the premium rates  
 24 charged during a rating period to small employers with similar case characteristics for the same or similar  
 25 coverage may not vary from the index by more than 20% of the index rate.

26 (c) The percentage increase in the premium rate charged to a small employer for a new rating  
 27 period may not exceed the sum of the following:

28 (i) the percentage change in the new business premium rate measured from the first day of the  
 29 prior rating period to the first day of the new rating period; in the case of a health benefit plan into which  
 30 the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use

1 the percentage change in the base premium rate, provided that the change does not exceed, on a  
2 percentage basis, the change in the new business premium rate for the most similar health benefit plan into  
3 which the small employer carrier is actively enrolling new small employers;

4 (ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less  
5 than 1 year, because of the claims experience, health status, or duration of coverage of the employees or  
6 dependents of the small employer, as determined from the small employer carrier's rate manual for the class  
7 of business; and

8 (iii) any adjustment because of a change in coverage or a change in the case characteristics of the  
9 small employer, as determined from the small employer carrier's rate manual for the class of business.

10 (d) Adjustments in rates for claims experience, health status, and duration of coverage may not  
11 be charged to individual employees or dependents. Any adjustment must be applied uniformly to the rates  
12 charged for all employees and dependents of the small employer.

13 (e) If a small employer carrier uses industry as a case characteristic in establishing premium rates,  
14 the rate factor associated with any industry classification may not vary from the average of the rate factors  
15 associated with all industry classifications by more than 15% of that coverage.

16 (f) In the case of health benefit plans delivered or issued for delivery prior to January 1, 1994, a  
17 premium rate for a rating period may exceed the ranges set forth in subsections (1)(a) and (1)(b) until  
18 January 1, 1997. In that case, the percentage increase in the premium rate charged to a small employer  
19 for a new rating period may not exceed the sum of the following:

20 (i) the percentage change in the new business premium rate measured from the first day of the  
21 prior rating period to the first day of the new rating period; in the case of a health benefit plan into which  
22 the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use  
23 the percentage change in the base premium rate, provided that the change does not exceed, on a  
24 percentage basis, the change in the new business premium rate for the most similar health benefit plan into  
25 which the small employer carrier is actively enrolling new small employers; and

26 (ii) any adjustment because of a change in coverage or a change in the case characteristics of the  
27 small employer, as determined from the small employer carrier's rate manual for the class of business.

28 (g) A small employer carrier shall:

29 (i) apply rating factors, including case characteristics, consistently with respect to all small  
30 employers in a class of business. Rating factors must produce premiums for identical groups that differ only

1 by the amounts attributable to plan design and that do not reflect differences because of the nature of the  
2 groups. Differences among base premium rates may not be based in any way on the actual or expected  
3 health status or claims experience of the small employer groups that choose or are expected to choose a  
4 particular health benefit plan.

5 (ii) treat all health benefit plans issued or renewed in the same calendar month as having the same  
6 rating period.

7 (h) For the purposes of this subsection (1), a health benefit plan that includes a restricted network  
8 provision may not be considered similar coverage to a health benefit plan that does not include a restricted  
9 network provision.

10 ~~(i) The commissioner shall adopt rules to implement the provisions of this section and to ensure~~  
11 ~~that rating practices used by small employer carriers are consistent with the purposes of this part, including~~  
12 ~~rules that ensure that differences in rates charged for health benefit plans by small employer carriers are~~  
13 ~~reasonable and reflect objective differences in plan design, not including differences because of the nature~~  
14 ~~of the groups.~~

15 (2) A small employer carrier may not transfer a small employer involuntarily into or out of a class  
16 of business. A small employer carrier may not offer to transfer a small employer into or out of a class of  
17 business unless the offer is made to transfer all small employers in the class of business without regard to  
18 case characteristics, claims experience, health status, or duration of coverage since the insurance was  
19 issued.

20 (3) The commissioner may suspend for a specified period the application of subsection (1)(a) for  
21 the premium rates applicable to one or more small employers included within a class of business of a small  
22 employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by  
23 the commissioner either that the suspension is reasonable in light of the financial condition of the small  
24 employer carrier or that the suspension would enhance the fairness and efficiency of the small employer  
25 health insurance market.

26 (4) In connection with the offering for sale of any health benefit plan to a small employer, a small  
27 employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of each  
28 of the following:

29 (a) the extent to which premium rates for a specified small employer are established or adjusted  
30 based upon the actual or expected variation in claims costs or upon the actual or expected variation in



1 health status of the employees of small employers and the employees' dependents;

2 (b) the provisions of the health benefit plan concerning the small employer carrier's right to change  
3 premium rates and the factors, other than claims experience, that affect changes in premium rates;

4 (c) the provisions relating to renewability of policies and contracts; and

5 (d) the provisions relating to any preexisting condition.

6 (5) (a) Each small employer carrier shall maintain at its principal place of business a complete and  
7 detailed description of its rating practices and renewal underwriting practices, including information and  
8 documentation that demonstrate that its rating methods and practices are based upon commonly accepted  
9 actuarial assumptions and are in accordance with sound actuarial principles.

10 (b) Each small employer carrier shall file with the commissioner annually, on or before March 15,  
11 an actuarial certification certifying that the carrier is in compliance with this part and that the rating  
12 methods of the small employer carrier are actuarially sound. The actuarial certification must be in a form  
13 and manner and must contain information as specified by the commissioner. A copy of the actuarial  
14 certification must be retained by the small employer carrier at its principal place of business.

15 (c) A small employer carrier shall make the information and documentation described in subsection  
16 (5)(a) available to the commissioner upon request. Except in cases of violations of the provisions of this  
17 part and except as agreed to by the small employer carrier or as ordered by a court of competent  
18 jurisdiction, the information must be considered proprietary and trade secret information and is not subject  
19 to disclosure by the commissioner to persons outside of the department.

20 (6) The commissioner may not require prior approval of the rating methods used by small employer  
21 carriers or the premium rates of the health benefit plans offered to small employers."

22

23 **Section 4.** Section 33-22-1811, MCA, is amended to read:

24 **"33-22-1811. Availability of coverage -- required plans.** (1) (a) As a condition of transacting  
25 business in this state with small employers, each small employer carrier shall offer to small employers at  
26 least two health benefit plans. One plan must be a basic health benefit plan, and one plan must be a  
27 standard health benefit plan.

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

1 part.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 (iii) A small employer carrier shall secure a waiver of coverage from each eligible employee who  
26 declines, at the sole discretion of the eligible employee, an offer of coverage under a health benefit plan  
27 provided by the small employer. The waiver must be signed by the eligible employee and must certify that  
28 the employee was informed of the availability of coverage under the health benefit plan and of the penalties  
29 for late enrollment. The waiver may not require the eligible employee to disclose the reasons for declining  
30 coverage.

1           (iv) A small employer carrier may not issue coverage to a small employer if the carrier or a producer  
 2 for the carrier has evidence that the small employer induced or pressured an eligible employee to decline  
 3 coverage due to the health status or risk characteristics of the eligible employee or of the dependents of  
 4 the eligible employee.

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

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

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

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

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

19  
 20           **NEW SECTION. Section 5. Benefits required for basic health benefit plan.** (1) The basic health  
 21 benefit plan must provide at least the following benefits:

22           (a) hospital services;

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

25           (c) use of radium or other radioactive materials;

26           (d) oxygen;

27           (e) anesthetics;

28           (f) diagnostic x-rays and laboratory tests;

29           (g) services of a physical therapist;

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

- 1 the condition;
- 2 (i) oral surgery for the gums and tissues of the mouth when not performed in connection with the  
3 extraction or repair of teeth or in connection with TMJ;
- 4 (j) rental or purchase of medical equipment, which must be reimbursed after the deductible has  
5 been met at the rate of 50%, up to a maximum of \$1,000;
- 6 (k) prosthetics, other than dental;
- 7 (l) services of a licensed home health agency, up to a maximum of 180 visits per year;
- 8 (m) drugs requiring a physician's prescription that are approved for use in human beings in the  
9 manner prescribed by the United States food and drug administration;
- 10 (n) nonexperimental organ transplants of the following human organs, for which coverage may be  
11 subject to a maximum lifetime benefit for one or more transplants of not less than \$150,000:
- 12 (i) kidney;
- 13 (ii) pancreas;
- 14 (iii) heart;
- 15 (iv) heart/lung;
- 16 (v) single lung;
- 17 (vi) double lung;
- 18 (vii) liver;
- 19 (viii) bone marrow, including high dose chemotherapy and stem cell rescue;
- 20 (o) expenses of procurement of any of the organs listed in subsection (1)(n), including  
21 transportation of the surgical or harvesting team, surgical removal of the donor organ, evaluation of the  
22 donor organ, and transportation of the donor organ to the location of the operation, which may be subject  
23 to a lifetime maximum benefit by a small employer carrier for one or more transplants of not less than  
24 \$10,000;
- 25 (p) pregnancy, including complications of pregnancy;
- 26 (q) routine well-child care for children up to the age of 2;
- 27 (r) sterilization;
- 28 (s) coverage for mental illness, alcoholism, and drug addiction as provided in 33-22-701 through  
29 33-22-705, except that the coverage may be limited by a small employer carrier as follows:
- 30 (i) inpatient treatment for mental illness, alcoholism, and drug addiction may be subject to a

1 maximum yearly benefit of 21 days;

2 (ii) inpatient treatment for mental illness may be traded on a two-for-one basis for a benefit for  
3 partial hospitalization through an American partial hospitalization association program;

4 (iii) inpatient treatment for alcoholism and drug addiction may be subject to a maximum benefit of  
5 \$4,000 in any 24-month period and a maximum lifetime benefit of \$8,000;

6 (iv) outpatient treatment for mental illness may be subject to a maximum yearly limit of not less  
7 than \$2,000; and

8 (v) outpatient treatment for alcoholism and drug addiction may be subject to a maximum yearly  
9 benefit of \$1,000;

10 (t) outpatient rehabilitation therapy; and

11 (u) foot care for diabetics.

12 (2) Subject to 33-22-1821, covered expenses must be charges determined by the small employer  
13 carrier as necessary and reasonable for the covered services and articles when prescribed by a physician  
14 or other licensed health care professional recognized by the small employer carrier as acting within the  
15 scope of the professional's license.

16

17 **NEW SECTION. Section 6. Commissioner to set terms of standard health benefit plan --**  
18 **rulemaking.** The commissioner may by rule establish minimum levels for annual deductible charges,  
19 coinsurance or copayments, annual maximum out-of-pocket charges, and lifetime maximum benefits for  
20 the standard health benefit plan. The minimum levels for annual deductible charges, coinsurance or  
21 copayments, annual maximum out-of-pocket charges and lifetime maximum benefits for the standard health  
22 benefit plan established by the commissioner may be different for a health benefit plan that includes a  
23 restricted network provision than for a health benefit plan that does not include a restricted network  
24 provision. The commissioner may not require coverage in a standard health benefit plan for any benefit  
25 unless other provisions of Title 33, chapter 22, 30, or 31, specifically require coverage for the benefit.

26

27 **Section 7.** Section 33-22-1820, MCA, is amended to read:

28 **"33-22-1820. Periodic market evaluation -- report.** The board, ~~in consultation with members of the~~  
29 ~~committee,~~ shall study and report at least every 3 years to the commissioner on the effectiveness of this  
30 part. The report must analyze the effectiveness of this part in promoting rate stability, product availability,

1 and coverage affordability. The report may contain recommendations for actions to improve the overall  
2 effectiveness, efficiency, and fairness of the small employer health insurance markets. The report must  
3 address whether carriers and producers are fairly and actively marketing or issuing health benefit plans to  
4 small employers in fulfillment of the purposes of this part. The report may contain recommendations for  
5 market conduct or other regulatory standards or action."  
6

7 **Section 8.** Section 33-22-1821, MCA, is amended to read:

8 **"33-22-1821. Waiver of certain laws.** A law or rule that requires the inclusion of a specific  
9 category of licensed health care ~~practitioners~~ practitioner and a law or rule that requires the coverage of  
10 a health care service or benefit do not apply to a basic health benefit plan delivered or issued for delivery  
11 to small employers in this state pursuant to this part ~~but do apply to a standard health benefit plan delivered~~  
12 ~~or issued for delivery to small employers in this state pursuant to this part."~~

13  
14 NEW SECTION. **Section 9. Repealer.** Section 33-22-1812, MCA, is repealed.

15  
16 NEW SECTION. **Section 10. Codification instruction.** [Sections 5 and 6] are intended to be  
17 codified as an integral part of Title 33, chapter 22, part 18, and the provisions of Title 33, chapter 22, part  
18 18, apply to [sections 5 and 6].

19  
20 NEW SECTION. **Section 11. Saving clause.** [This act] does not affect rights and duties that  
21 matured, penalties that were incurred, or proceedings that were begun before [the effective date of this  
22 act].

23 -END-

STATE OF MONTANA - FISCAL NOTE

Fiscal Note for HB0466, as introduced

DESCRIPTION OF PROPOSED LEGISLATION:

A bill revising the small employer health insurance availability act; revising restrictions on premium rates; restricting the authority of the Commissioner of Insurance to adopt rules; prohibiting the Commissioner of Insurance from requiring prior approval of rating methods and premiums; deleting effective dates related to the development of benefit plans and the commissioner's approval of the plans; and eliminating the health benefit plan committee.


ASSUMPTIONS:


1. The health benefit plan committee is eliminated. The travel and honoraria expenses for the committee are no longer required. Expense savings is estimated to be \$3,000 per year for travel and \$1,000 per year for honoraria.
2. Approximately 35 pages of administrative rules related to the standard and basic plans will be repealed. The cost for repealing administrative rules is \$35 per page.
3. Twenty pages of administrative rules will be adopted by the Commissioner of Insurance setting forth the economic criteria of benefit plans. The cost for filing administrative rules is \$35 per page.
4. Present law base staff will be able to handle the administration of form filings and the other provisions of the bill.
5. The fiscal note assumptions are based upon the present law base in the Governor's Executive Budget for the Insurance Program in the State Auditor's Office. However, as of February 14, 1995, the present law base amounts associated with the small employer health insurance availability act were eliminated from the present law base by joint appropriations subcommittee action.
6. The bill has no fiscal impact on the Montana Health Care Authority.

FISCAL IMPACT:

Expenditures:

	<u>FY96</u>	<u>FY97</u>
Insurance Program:	<u>Difference</u>	<u>Difference</u>
Operating Expenses	(2,075)	(4,000)
<u>Funding:</u>		
General Fund (01)	(2,075)	(4,000)

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

  
 THOMAS E. NELSON, PRIMARY SPONSOR      DATE

Fiscal Note for HB0466, as introduced

**HB 466**



STATE OF MONTANA - FISCAL NOTE

Fiscal Note for HB0466, 3rd reading, as amended

DESCRIPTION OF PROPOSED LEGISLATION:

An act revising the small employer health insurance availability act.

ASSUMPTIONS:

1. As of March 22, 1995, HB2 (the general appropriations act) does not include funding in the State Auditor's Office for the small employer health insurance availability act. Therefore, the fiscal impact is shown in terms of the present status of HB2. The Governor's Executive Budget includes present law funding for the provisions of the act in the amounts of \$173,525 in FY96 and \$174,036 in FY97.
2. The bill is effective October 1, 1995. The present law requirements for the small employer health insurance availability act will be in statute through the first quarter of FY96.
3. The bill, as amended, repeals the requirement for the health benefit advisory committee. The committee travel and honoraria expenses will not be required. The committee incurred expenses of \$3,500 for travel and honoraria and \$1,000 for printing and postage in FY94.
4. Rating practice rules will be repealed. Enforcement duties remain and will be performed by the actuary FTE included in assumption #4.
5. It will be necessary to retain 1.00 FTE life/health actuary to approve benefit value and benefit equivalency models submitted by 45 insurance companies. It is estimated that these requirements and the enforcement duties in assumption #3 will require approximately 2,080 hours per year. The personal services costs for the actuary are \$62,160 in FY96 and \$62,324 in FY97. Comparative contract actuary services costs, at the rate of \$275 per hour, would be approximately \$572,000 each year (2,080 hours x \$275 per hour = \$572,000).
6. The additional reporting requirements required in 33-12-1810, MCA, and the present law workload maintained in the bill will require the retention of 1.00 FTE health insurance specialist; total personal services expenses for this position are \$41,615 in FY96 and \$41,728 in FY97. Based on the number of inquiries when the act first went into effect, clarification of the amended act will require extensive intervention by this position and existing insurance department staff.
7. New filings of the basic and standard plans will be required. Existing staff will be used for six months to handle this added workload.
8. Operating expenses necessary to implement this bill and maintain compliance with present law include \$27,245 in FY96 and \$24,995 in FY97 for contract services, administrative rule change fees, and rule and complaint hearings, \$19,970 each year for travel, \$9,156 each year for postage and telephone expenses, \$8,370 each year for supplies and certain printing expenses, \$1,228 each year for rent, and \$1,070 for other expenses.

(continued)

*Dave Lewis 3-22-95*  
DAVE LEWIS, BUDGET DIRECTOR      DATE  
Office of Budget and Program Planning

THOMAS NELSON, PRIMARY SPONSOR      DATE

Fiscal Note for HB0466, 3rd reading, as amended

HB 466-#2

(continued)

FISCAL IMPACT:

State Auditor's Office, Insurance Program:

Expenditures:

Present law base adjustments for continuation of the small employer health insurance availability act were not approved in HB2. The expenditures shown below are applicable to implementation of and continued compliance with provisions of the bill:

	<u>FY96</u>	<u>FY97</u>
	<u>Difference</u>	<u>Difference</u>
FTE	2.00	2.00
Personal Services	103,775	104,052
Operating Expenses	<u>67,039</u>	<u>64,789</u>
Total	170,814	168,841
<u>Funding:</u>		
General Fund (01)	170,814	168,841

APPROVED BY SELECT  
COMMITTEE ON HEALTH CARE

HOUSE BILL NO. 466

INTRODUCED BY T. NELSON, FRANKLIN, TUSS, BENEDICT

1  
2  
3  
4 A BILL FOR AN ACT ENTITLED: "AN ACT REVISING THE SMALL EMPLOYER HEALTH INSURANCE  
5 AVAILABILITY ACT; REVISING DEFINITIONS; CLARIFYING REIMBURSEMENT TREATMENT; REVISING  
6 RESTRICTIONS ON PREMIUM RATES; RESTRICTING THE AUTHORITY OF THE COMMISSIONER OF  
7 INSURANCE TO ADOPT RULES; PROHIBITING THE COMMISSIONER OF INSURANCE FROM REQUIRING  
8 PRIOR APPROVAL OF RATING METHODS AND PREMIUMS; DELETING EFFECTIVE DATES RELATED TO  
9 THE DEVELOPMENT OF BENEFIT PLANS AND THE COMMISSIONER'S APPROVAL OF THE PLANS;  
10 PROVIDING FOR WAIVERS OF COVERAGE BY EMPLOYEES; CONTINGENTLY ELIMINATING THE HEALTH  
11 BENEFIT PLAN COMMITTEE; PROVIDING FOR THE CONTENT OF BASIC AND STANDARD HEALTH  
12 BENEFIT PLANS; REQUIRING AN ANNUAL ACTUARIAL REVIEW OF THE SMALL EMPLOYER CARRIER  
13 REINSURANCE PROGRAM; LIMITING THE ASSESSMENT ON ASSESSABLE CARRIERS WHO ARE NOT  
14 SMALL EMPLOYER CARRIERS; AMENDING SECTIONS 33-22-1803, 33-22-1804, 33-22-1809,  
15 33-22-1811, 33-22-1819, 33-22-1820, AND 33-22-1821, MCA; AND CONTINGENTLY REPEALING  
16 SECTION 33-22-1812, MCA."

17

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

19

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

21 **"33-22-1803. Definitions.** As used in this part, the following definitions apply:

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

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

29 (3) "Assessable carrier" means all individual carriers of disability insurance and all carriers of group  
30 disability insurance, ~~excluding including~~ EXCLUDING the state group benefits plan provided for in Title 2,

1 chapter 18, part 8, the Montana university system health plan, and any self-funded disability insurance plan  
2 provided by a political subdivision of the state.

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

7 ~~[(5) "Basic health benefit plan" means a lower cost health benefit plan developed pursuant to  
8 33-22-1812 by a small employer carrier that is a lower cost plan than the standard health benefit plan and  
9 that provides the benefits required by (section 5).]~~

10 [(5) "BASIC HEALTH BENEFIT PLAN" MEANS A LOWER COST HEALTH BENEFIT PLAN  
11 DEVELOPED PURSUANT TO 33-22-1812.]

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

13 (7) "Carrier" means any person who provides a health benefit plan in this state subject to state  
14 insurance regulation. The term includes but is not limited to an insurance company, a fraternal benefit  
15 society, a health service corporation, AND a health maintenance organization, ~~and, to the extent permitted~~  
16 ~~by the Employee Retirement Income Security Act of 1974, a multiple employer welfare arrangement.~~ For  
17 purposes of this part, companies that are affiliated companies or that are eligible to file a consolidated tax  
18 return must be treated as one carrier, except that the following may be considered as separate carriers:

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

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

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

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

29 (9) "Class of business" means all or a separate grouping of small employers established pursuant  
30 to 33-22-1808.

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

2 [(10) "COMMITTEE" MEANS THE HEALTH BENEFIT PLAN COMMITTEE CREATED PURSUANT TO  
3 33-22-1812.]

4 ~~(11)~~(10) "Dependent" means:

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

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

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

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

11 ~~(12)~~(11) "Eligible employee" means an employee who works on a full-time basis ~~and who has with~~  
12 a normal workweek of 30 hours or more, except that at the sole discretion of the employer, the term may  
13 include an employee who works on a full-time basis with a normal workweek of between 20 and 40 hours  
14 as long as this eligibility criteria is applied uniformly among all of the employer's employees. The term  
15 includes a sole proprietor, a partner of a partnership, and an independent contractor if the sole proprietor,  
16 partner, or independent contractor is included as an employee under a health benefit plan of a small  
17 employer. The term does not include an employee who works on a part-time, temporary, or substitute  
18 basis.

19 ~~(13)~~(12) "Established geographic service area" means a geographic area, as approved by the  
20 commissioner and based on the carrier's certificate of authority to transact insurance in this state, within  
21 which the carrier is authorized to provide coverage.

22 ~~(14)~~(13) "Health benefit plan" means any hospital or medical policy or certificate providing for  
23 physical and mental health care issued by an insurance company, a fraternal benefit society, or a health  
24 service corporation or issued under a health maintenance organization subscriber contract. Health benefit  
25 plan does not include:

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

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

30 (c) automobile medical payment insurance.

1           ~~(15)~~(14) "Index rate" means, for each class of business for a rating period for small employers with  
2 similar case characteristics, the average of the applicable base premium rate and the corresponding highest  
3 premium rate.

4           ~~(16)~~(15) "Late enrollee" means an eligible employee or dependent who requests enrollment in a  
5 health benefit plan of a small employer following the initial enrollment period during which the individual  
6 was entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period  
7 was a period of at least 30 days. However, an eligible employee or dependent may not be considered a late  
8 enrollee if:

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

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

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

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

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

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

22           ~~(17)~~(16) "New business premium rate" means, for each class of business for a rating period, the  
23 lowest premium rate charged or offered or that could have been charged or offered by the small employer  
24 carrier to small employers with similar case characteristics for newly issued health benefit plans with the  
25 same or similar coverage.

26           ~~(18)~~(17) "Plan of operation" means the operation of the program established pursuant to  
27 33-22-1818.

28           ~~(19)~~(18) "Premium" means all money paid by a small employer and eligible employees as a  
29 condition of receiving coverage from a small employer carrier, including any fees or other contributions  
30 associated with the health benefit plan.

1           ~~(20)~~(19) "Program" means the Montana small employer health reinsurance program created by  
2 33-22-1818.

3           ~~(24)~~(20) "Qualifying previous coverage" means benefits or coverage provided under:

4           (a) medicare or medicaid;

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

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

11           ~~(22)~~(21) "Rating period" means the calendar period for which premium rates established by a small  
12 employer carrier are assumed to be in effect.

13           ~~(23)~~(22) "Reinsuring carrier" means a small employer carrier participating in the reinsurance  
14 program pursuant to 33-22-1819.

15           ~~(24)~~(23) "Restricted network provision" means a provision of a health benefit plan that conditions  
16 the payment of benefits, in whole or in part, on the use of health care providers that have entered into a  
17 contractual arrangement with the carrier pursuant to Title 33, chapter 22, part 17, or Title 33, chapter 31,  
18 to provide health care services to covered individuals.

19           ~~(25)~~(24) "Small employer" means a person, firm, corporation, partnership, or association that is  
20 actively engaged in business and that, on at least 50% of its working days during the preceding calendar  
21 quarter, employed at least 3 but not more than 25 eligible employees, the majority of whom were employed  
22 within this state or were residents of this state. In determining the number of eligible employees, companies  
23 are considered one employer if they:

24           (a) are affiliated companies;

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

26           (c) are members of an association that:

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

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

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

1           ~~(26)~~(25) "Small employer carrier" means a carrier that offers health benefit plans that cover eligible  
2 employees of one or more small employers in this state.

3           ~~(27)~~(26) "~~Standard~~ UNIFORM health benefit plan" means a health benefit plan that is developed  
4 pursuant to 33-22-1812 by a small employer carrier and that contains the provisions required pursuant to  
5 ~~section 6.~~ THE UNIFORM HEALTH BENEFIT PLAN (SECTION 3) AS PROVIDED IN HOUSE BILL NO. 31.]  
6 ["STANDARD HEALTH BENEFIT PLAN" MEANS A HEALTH BENEFIT PLAN DEVELOPED PURSUANT TO  
7 33-22-1812.]"

8  
9           **Section 2.** Section 33-22-1804, MCA, is amended to read:

10           **"33-22-1804. Applicability and scope.** (1) This part applies to a health benefit plan marketed  
11 through a small employer that provides coverage to the employees of a small employer in this state if any  
12 of the following conditions are met:

- 13           ~~(1)~~(a) a portion of the premium or benefits is paid by or on behalf of the small employer;
- 14           ~~(2)~~(b) an eligible employee or dependent is reimbursed, whether through wage adjustments or  
15 otherwise, by or on behalf of the small employer for any portion of the premium; or
- 16           ~~(3)~~(c) the health benefit plan is treated by the employer or any of the eligible employees or  
17 dependents as part of a plan or program for the purposes of section 106, 125, or 162 of the Internal  
18 Revenue Code.

19           (2) A payroll deduction or a list-billed premium is not a reimbursement for the purposes of  
20 subsection (1)(b)."

21  
22           **Section 3.** Section 33-22-1809, MCA, is amended to read:

23           **"33-22-1809. Restrictions relating to premium rates.** (1) Premium rates for health benefit plans  
24 under this part are subject to the following provisions:

- 25           (a) The index rate for a rating period for any class of business may not exceed the index rate for  
26 any other class of business by more than 20%.
- 27           (b) For each class of business:
  - 28           (i) the premium rates charged during a rating period to small employers with similar case  
29 characteristics for the same or similar coverage or the rates that could be charged to the employer under  
30 the rating system for that class of business may not vary from the index rate by more than 25% of the



1 index rate; or

2 (ii) if the Montana health care authority established by 50-4-201 certifies to the commissioner that  
3 the cost containment goal set forth in 50-4-303 is met on or before January 1, 1999, the premium rates  
4 charged during a rating period to small employers with similar case characteristics for the same or similar  
5 coverage may not vary from the index by more than 20% of the index rate.

6 (c) The percentage increase in the premium rate charged to a small employer for a new rating  
7 period may not exceed the sum of the following:

8 (i) the percentage change in the new business premium rate measured from the first day of the  
9 prior rating period to the first day of the new rating period; in the case of a health benefit plan into which  
10 the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use  
11 the percentage change in the base premium rate, provided that the change does not exceed, on a  
12 percentage basis, the change in the new business premium rate for the most similar health benefit plan into  
13 which the small employer carrier is actively enrolling new small employers;

14 (ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less  
15 than 1 year, because of the claims experience, health status, or duration of coverage of the employees or  
16 dependents of the small employer, as determined from the small employer carrier's rate manual for the class  
17 of business; and

18 (iii) any adjustment because of a change in coverage or a change in the case characteristics of the  
19 small employer, as determined from the small employer carrier's rate manual for the class of business.

20 (d) Adjustments in rates for claims experience, health status, and duration of coverage may not  
21 be charged to individual employees or dependents. Any adjustment must be applied uniformly to the rates  
22 charged for all employees and dependents of the small employer.

23 (e) If a small employer carrier uses industry as a case characteristic in establishing premium rates,  
24 the rate factor associated with any industry classification may not vary from the average of the rate factors  
25 associated with all industry classifications by more than 15% of that coverage.

26 (f) In the case of health benefit plans delivered or issued for delivery prior to January 1, 1994, a  
27 premium rate for a rating period may exceed the ranges set forth in subsections (1)(a) and (1)(b) until  
28 January 1, 1997. In that case, the percentage increase in the premium rate charged to a small employer  
29 for a new rating period may not exceed the sum of the following:

30 (i) the percentage change in the new business premium rate measured from the first day of the

1 prior rating period to the first day of the new rating period; in the case of a health benefit plan into which  
2 the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use  
3 the percentage change in the base premium rate, provided that the change does not exceed, on a  
4 percentage basis, the change in the new business premium rate for the most similar health benefit plan into  
5 which the small employer carrier is actively enrolling new small employers; and

6 (ii) any adjustment because of a change in coverage or a change in the case characteristics of the  
7 small employer, as determined from the small employer carrier's rate manual for the class of business.

8 (g) A small employer carrier shall:

9 (i) apply rating factors, including case characteristics, consistently with respect to all small  
10 employers in a class of business. Rating factors must produce premiums for identical groups that differ only  
11 by the amounts attributable to plan design and that do not reflect differences because of the nature of the  
12 groups. Differences among base premium rates may not be based in any way on the actual or expected  
13 health status or claims experience of the small employer groups that choose or are expected to choose a  
14 particular health benefit plan.

15 (ii) treat all health benefit plans issued or renewed in the same calendar month as having the same  
16 rating period.

17 (h) For the purposes of this subsection (1), a health benefit plan that includes a restricted network  
18 provision may not be considered similar coverage to a health benefit plan that does not include a restricted  
19 network provision.

20 ~~(i) The commissioner shall adopt rules to implement the provisions of this section and to ensure~~  
21 ~~that rating practices used by small employer carriers are consistent with the purposes of this part, including~~  
22 ~~rules that ensure that differences in rates charged for health benefit plans by small employer carriers are~~  
23 ~~reasonable and reflect objective differences in plan design, not including differences because of the nature~~  
24 ~~of the groups.~~

25 (2) A small employer carrier may not transfer a small employer involuntarily into or out of a class  
26 of business. A small employer carrier may not offer to transfer a small employer into or out of a class of  
27 business unless the offer is made to transfer all small employers in the class of business without regard to  
28 case characteristics, claims experience, health status, or duration of coverage since the insurance was  
29 issued.

30 (3) The commissioner may suspend for a specified period the application of subsection (1)(a) for

1 the premium rates applicable to one or more small employers included within a class of business of a small  
2 employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by  
3 the commissioner either that the suspension is reasonable in light of the financial condition of the small  
4 employer carrier or that the suspension would enhance the fairness and efficiency of the small employer  
5 health insurance market.

6 (4) In connection with the offering for sale of any health benefit plan to a small employer, a small  
7 employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of each  
8 of the following:

9 (a) the extent to which premium rates for a specified small employer are established or adjusted  
10 based upon the actual or expected variation in claims costs or upon the actual or expected variation in  
11 health status of the employees of small employers and the employees' dependents;

12 (b) the provisions of the health benefit plan concerning the small employer carrier's right to change  
13 premium rates and the factors, other than claims experience, that affect changes in premium rates;

14 (c) the provisions relating to renewability of policies and contracts; and

15 (d) the provisions relating to any preexisting condition.

16 (5) (a) Each small employer carrier shall maintain at its principal place of business a complete and  
17 detailed description of its rating practices and renewal underwriting practices, including information and  
18 documentation that demonstrate that its rating methods and practices are based upon commonly accepted  
19 actuarial assumptions and are in accordance with sound actuarial principles.

20 (b) Each small employer carrier shall file with the commissioner annually, on or before March 15,  
21 an actuarial certification certifying that the carrier is in compliance with this part and that the rating  
22 methods of the small employer carrier are actuarially sound. The actuarial certification must be in a form  
23 and manner and must contain information as specified by the commissioner. A copy of the actuarial  
24 certification must be retained by the small employer carrier at its principal place of business.

25 (c) A small employer carrier shall make the information and documentation described in subsection  
26 (5)(a) available to the commissioner upon request. Except in cases of violations of the provisions of this  
27 part and except as agreed to by the small employer carrier or as ordered by a court of competent  
28 jurisdiction, the information must be considered proprietary and trade secret information and is not subject  
29 to disclosure by the commissioner to persons outside of the department.

30 (6) The commissioner may not require prior approval of the rating methods used by small employer

1 carriers or the premium rates of the health benefit plans offered to small employers."

2  
3 **Section 4.** Section 33-22-1811, MCA, is amended to read:

4 **"33-22-1811. Availability of coverage -- required plans.** (1) (a) As a condition of transacting  
5 business in this state with small employers, each small employer carrier shall offer to small employers [THE  
6 UNIFORM BENEFIT PLAN (SECTION 3) AS PROVIDED IN HOUSE BILL NO. 531.] [ at least two health  
7 benefit plans. One plan must be a basic health benefit plan, and one plan must be a standard health benefit  
8 plan.]

9 (b) (i) A small employer carrier shall issue a [UNIFORM HEALTH BENEFIT PLAN (SECTION 3) AS  
10 PROVIDED IN HOUSE BILL NO. 531] [basic health benefit plan or a standard health benefit plan] to any  
11 eligible small employer that applies for [THE] [either] plan and agrees to make the required premium  
12 payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this  
13 part.

14 (ii) In the case of a small employer carrier that establishes more than one class of business pursuant  
15 to 33-22-1808, the small employer carrier shall maintain and offer to eligible small employers [A UNIFORM  
16 HEALTH BENEFIT PLAN (SECTION 3) AS PROVIDED IN HOUSE BILL NO. 531] [at least one basic health  
17 benefit plan and at least one standard health benefit plan] in each established class of business. A small  
18 employer carrier may apply reasonable criteria in determining whether to accept a small employer into a  
19 class of business, provided that:

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

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

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

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

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

30 ~~(e) The provisions of this section are effective 180 days after the commissioner's approval of the~~

1 ~~basic health benefit plan and the standard health benefit plan developed pursuant to 33-22-1812, provided~~  
2 ~~that if the program created pursuant to 33-22-1818 is not yet operative on that date, the provisions of this~~  
3 ~~section are effective on the date that the program begins operation.~~

4 (2) (a) A small employer carrier shall, pursuant to 33-1-501, file the [UNIFORM HEALTH BENEFIT  
5 PLAN (SECTION 3) AS PROVIDED IN HOUSE BILL NO. 531] [basic health benefit plans and the standard  
6 health benefit plans] to be used by the small employer carrier.

7 (b) The commissioner may at any time, after providing notice and an opportunity for a hearing to  
8 the small employer carrier, disapprove the continued use by a small employer carrier of a [UNIFORM  
9 HEALTH BENEFIT PLAN (SECTION 3) AS PROVIDED IN HOUSE BILL NO. 531] [basic or standard health  
10 benefit plan] on the grounds that the plan does not meet the requirements of this part.

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

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

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

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

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

30 (ii) A small employer carrier may vary the application of minimum participation requirements and

1 minimum employer contribution requirements only by the size of the small employer group.

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

6 (ii) A small employer carrier may not modify [THE UNIFORM HEALTH BENEFIT PLAN (SECTION 3)  
7 AS PROVIDED IN HOUSE BILL NO. 531] [a basic or standard health benefit plan] with respect to a small  
8 employer or any eligible employee or dependent, through riders, endorsements, or otherwise, to restrict or  
9 exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

10 (iii) A small employer carrier shall secure a waiver of coverage from each eligible employee who  
11 declines, at the sole discretion of the eligible employee, an offer of coverage under a health benefit plan  
12 provided by the small employer. The waiver must be signed by the eligible employee and must certify that  
13 the employee was informed of the availability of coverage under the health benefit plan and of the penalties  
14 for late enrollment. The waiver may not require the eligible employee to disclose the reasons for declining  
15 coverage.

16 (iv) A small employer carrier may not issue coverage to a small employer if the carrier or a producer  
17 for the carrier has evidence that the small employer induced or pressured an eligible employee to decline  
18 coverage due to the health status or risk characteristics of the eligible employee or of the dependents of  
19 the eligible employee.

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

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

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

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

30 (b) A small employer carrier may not be required to provide coverage to small employers pursuant

1 to subsection (1) for any period of time for which the commissioner determines that requiring the  
 2 acceptance of small employers in accordance with the provisions of subsection (1) would place the small  
 3 employer carrier in a financially impaired condition."

4

5 ~~NEW SECTION. Section 5. Benefits required for basic health benefit plan. (1) The basic health~~  
 6 ~~benefit plan must provide at least the following benefits:~~

7 ~~(a) hospital services;~~

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

10 ~~(c) use of radium or other radioactive materials;~~

11 ~~(d) oxygen;~~

12 ~~(e) anesthetics;~~

13 ~~(f) diagnostic x rays and laboratory tests;~~

14 ~~(g) services of a physical therapist;~~

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

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

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

21 ~~(k) prosthetics, other than dental;~~

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

23 ~~(m) drugs requiring a physician's prescription that are approved for use in human beings in the~~  
 24 ~~manner prescribed by the United States food and drug administration;~~

25 ~~(n) nonexperimental organ transplants of the following human organs, for which coverage may be~~  
 26 ~~subject to a maximum lifetime benefit for one or more transplants of not less than \$150,000:~~

27 ~~(i) kidney;~~

28 ~~(ii) pancreas;~~

29 ~~(iii) heart;~~

30 ~~(iv) heart/lung;~~

- 1           ~~(v) single lung;~~
- 2           ~~(vi) double lung;~~
- 3           ~~(vii) liver;~~
- 4           ~~(viii) bone marrow, including high dose chemotherapy and stem cell rescue;~~
- 5           ~~(o) expenses of procurement of any of the organs listed in subsection (1)(n), including~~  
6 ~~transportation of the surgical or harvesting team, surgical removal of the donor organ, evaluation of the~~  
7 ~~donor organ, and transportation of the donor organ to the location of the operation, which may be subject~~  
8 ~~to a lifetime maximum benefit by a small employer carrier for one or more transplants of not less than~~  
9 ~~\$10,000;~~
- 10          ~~(p) pregnancy, including complications of pregnancy;~~
- 11          ~~(q) routine well child care for children up to the age of 2;~~
- 12          ~~(r) sterilization;~~
- 13          ~~(s) coverage for mental illness, alcoholism, and drug addiction as provided in 33-22-701 through~~  
14 ~~33-22-705, except that the coverage may be limited by a small employer carrier as follows:~~
- 15           ~~(i) inpatient treatment for mental illness, alcoholism, and drug addiction may be subject to a~~  
16 ~~maximum yearly benefit of 21 days;~~
- 17           ~~(ii) inpatient treatment for mental illness may be traded on a two for one basis for a benefit for~~  
18 ~~partial hospitalization through an American partial hospitalization association program;~~
- 19           ~~(iii) inpatient treatment for alcoholism and drug addiction may be subject to a maximum benefit of~~  
20 ~~\$4,000 in any 24 month period and a maximum lifetime benefit of \$8,000;~~
- 21           ~~(iv) outpatient treatment for mental illness may be subject to a maximum yearly limit of not less~~  
22 ~~than \$2,000; and~~
- 23           ~~(v) outpatient treatment for alcoholism and drug addiction may be subject to a maximum yearly~~  
24 ~~benefit of \$1,000;~~
- 25           ~~(t) outpatient rehabilitation therapy; and~~
- 26           ~~(u) foot care for diabetics.~~
- 27          ~~(2) Subject to 33-22-1821, covered expenses must be charges determined by the small employer~~  
28 ~~carrier as necessary and reasonable for the covered services and articles when prescribed by a physician~~  
29 ~~or other licensed health care professional recognized by the small employer carrier as acting within the~~  
30 ~~scope of the professional's license.~~



1        ~~**NEW SECTION. Section 6. Commissioner to set terms of standard health benefit plan**~~  
 2 ~~**rulemaking.** The commissioner may by rule establish minimum levels for annual deductible charges,~~  
 3 ~~coinsurance or copayments, annual maximum out of pocket charges, and lifetime maximum benefits for~~  
 4 ~~the standard health benefit plan. The minimum levels for annual deductible charges, coinsurance or~~  
 5 ~~copayments, annual maximum out of pocket charges and lifetime maximum benefits for the standard health~~  
 6 ~~benefit plan established by the commissioner may be different for a health benefit plan that includes a~~  
 7 ~~restricted network provision than for a health benefit plan that does not include a restricted network~~  
 8 ~~provision. The commissioner may not require coverage in a standard health benefit plan for any benefit~~  
 9 ~~unless other provisions of Title 33, chapter 22, 30, or 31, specifically require coverage for the benefit.~~

11        **SECTION 5. SECTION 33-22-1819, MCA, IS AMENDED TO READ:**

12        **"33-22-1819. Program plan of operation -- treatment of losses -- exemption from taxation. (1)**

13        Within 180 days after the appointment of the initial board, the board shall submit to the commissioner a  
 14        plan of operation and may at any time submit amendments to the plan necessary or suitable to ensure the  
 15        fair, reasonable, and equitable administration of the program. The commissioner may, after notice and  
 16        hearing, approve the plan of operation if the commissioner determines it to be suitable to ensure the fair,  
 17        reasonable, and equitable administration of the program and if the plan of operation provides for the sharing  
 18        of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this  
 19        section. The plan of operation is effective upon written approval by the commissioner.

20        (2) If the board fails to submit a suitable plan of operation within 180 days after its appointment,  
 21        the commissioner shall, after notice and hearing, promulgate and adopt a temporary plan of operation. The  
 22        commissioner shall amend or rescind any temporary plan adopted under this subsection at the time a plan  
 23        of operation is submitted by the board and approved by the commissioner.

24        (3) The plan of operation must:

25        (a) establish procedures for the handling and accounting of program assets and money and for an  
 26        annual fiscal reporting to the commissioner;

27        (b) establish procedures for selecting an administering carrier and setting forth the powers and  
 28        duties of the administering carrier;

29        (c) establish procedures for reinsuring risks in accordance with the provisions of this section;

30        (d) establish procedures for collecting assessments from assessable carriers to fund claims incurred

1 by the program;

2 (e) establish procedures for allocating a portion of premiums collected from reinsuring carriers to  
3 fund administrative expenses incurred or to be incurred by the program; and

4 (f) provide for any additional matters necessary for the implementation and administration of the  
5 program.

6 (4) The program has the general powers and authority granted under the laws of this state to  
7 insurance companies and health maintenance organizations licensed to transact business, except the power  
8 to issue health benefit plans directly to either groups or individuals. In addition, the program may:

9 (a) enter into contracts as are necessary or proper to carry out the provisions and purposes of this  
10 part, including the authority, with the approval of the commissioner, to enter into contracts with similar  
11 programs of other states for the joint performance of common functions or with persons or other  
12 organizations for the performance of administrative functions;

13 (b) sue or be sued, including taking any legal actions necessary or proper to recover any premiums  
14 and penalties for, on behalf of, or against the program or any reinsuring carriers;

15 (c) take any legal action necessary to avoid the payment of improper claims against the program;

16 (d) define the health benefit plans for which reinsurance will be provided and to issue reinsurance  
17 policies in accordance with the requirements of this part;

18 (e) establish conditions and procedures for reinsuring risks under the program;

19 (f) establish actuarial functions as appropriate for the operation of the program;

20 (g) appoint appropriate legal, actuarial, and other committees as necessary to provide technical  
21 assistance in operation of the program, policy and other contract design, and any other function within the  
22 authority of the program;

23 (h) to the extent permitted by federal law and in accordance with subsection (8)(c), make annual  
24 fiscal yearend assessments against assessable carriers and make interim assessments to fund claims  
25 incurred by the program; and

26 (i) borrow money to effect the purposes of the program. Any notes or other evidence of  
27 indebtedness of the program not in default are legal investments for carriers and may be carried as admitted  
28 assets.

29 (5) A reinsuring carrier may reinsure with the program as provided for in this subsection (5):

30 (a) With respect to a basic health benefit plan or a standard health benefit plan, the program shall

1 reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to  
2 the level of coverage provided in a basic or standard health benefit plan.

3 (b) A small employer carrier may reinsure an entire employer group within 60 days of the  
4 commencement of the group's coverage under a health benefit plan.

5 (c) A reinsuring carrier may reinsure an eligible employee or dependent within a period of 60 days  
6 following the commencement of coverage with the small employer. A newly eligible employee or dependent  
7 of the reinsured small employer may be reinsured within 60 days of the commencement of coverage.

8 (d) (i) The program may not reimburse a reinsuring carrier with respect to the claims of a reinsured  
9 employee or dependent until the carrier has incurred an initial level of claims for the employee or dependent  
10 of \$5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier is  
11 responsible for 20% of the next \$100,000 of benefit payments during a calendar year and the program  
12 shall reinsure the remainder. A reinsuring carrier's liability under this subsection (d)(i) may not exceed a  
13 maximum limit of \$25,000 in any calendar year with respect to any reinsured individual.

14 (ii) The board annually shall adjust the initial level of claims and maximum limit to be retained by  
15 the carrier to reflect increases in costs and utilization within the standard market for health benefit plans  
16 within the state. The adjustment may not be less than the annual change in the medical component of the  
17 consumer price index for all urban consumers of the United States department of labor, bureau of labor  
18 statistics, unless the board proposes and the commissioner approves a lower adjustment factor.

19 (e) A small employer carrier may terminate reinsurance with the program for one or more of the  
20 reinsured employees or dependents of a small employer on any anniversary of the health benefit plan.

21 (f) A small employer group health benefit plan in effect before January 1, 1994, may not be  
22 reinsured by the program until January 1, 1997, and then only if the board determines that sufficient  
23 funding sources are available.

24 (g) A reinsuring carrier shall apply all managed care and claims-handling techniques, including  
25 utilization review, individual case management, preferred provider provisions, and other managed care  
26 provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

27 (6) (a) As part of the plan of operation, the board shall establish a methodology for determining  
28 premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this  
29 section. The methodology must include a system for classification of small employers that reflects the types  
30 of case characteristics commonly used by small employer carriers in the state. The methodology must

1 provide for the development of base reinsurance premium rates that must be multiplied by the factors set  
2 forth in subsection (6)(b) to determine the premium rates for the program. The base reinsurance premium  
3 rates must be established by the board, subject to the approval of the commissioner, and must be set at  
4 levels that reasonably approximate gross premiums charged to small employers by small employer carriers  
5 for health benefit plans with benefits similar to the standard health benefit plan, adjusted to reflect retention  
6 levels required under this part.

7 (b) Premiums for the program are as follows:

8 (i) An entire small employer group may be reinsured for a rate that is one and one-half times the  
9 base reinsurance premium rate for the group established pursuant to this subsection (6).

10 (ii) An eligible employee or dependent may be reinsured for a rate that is five times the base  
11 reinsurance premium rate for the individual established pursuant to this subsection (6).

12 (c) The board ~~periodically~~ shall annually review the methodology established under subsection  
13 (6)(a), including the system of classification and any rating factors, to ensure that it is actuarially sound and  
14 that it reasonably reflects the claims experience of the program. The board may propose changes to the  
15 methodology that are subject to the approval of the commissioner.

16 (d) The board may consider adjustments to the premium rates charged by the program to reflect  
17 the use of effective cost containment and managed care arrangements.

18 (7) If a health benefit plan for a small employer is entirely or partially reinsured with the program,  
19 the premium charged to the small employer for any rating period for the coverage issued must meet the  
20 requirements relating to premium rates set forth in 33-22-1809.

21 (8) (a) Prior to March 1 of each year, the board shall determine and report to the commissioner the  
22 program net loss for the previous calendar year, including administrative expenses and incurred losses for  
23 the year, taking into account investment income and other appropriate gains and losses.

24 (b) To the extent permitted by federal law, each assessable carrier shall share in any net loss of  
25 the program for the year in an amount equal to the ratio of the total premiums earned in the previous  
26 calendar year from health benefit plans delivered or issued for delivery by each assessable carrier divided  
27 by the total premiums earned in the previous calendar year from health benefit plans delivered or issued  
28 for delivery by all assessable carriers in the state.

29 (c) The board shall make an annual determination in accordance with this section of each  
30 assessable carrier's liability for its share of the net loss of the program and, except as otherwise provided

1 by this section, make an annual fiscal yearend assessment against each assessable carrier to the extent of  
2 that liability. If approved by the commissioner, the board may also make interim assessments against  
3 assessable carriers to fund claims incurred by the program. Any interim assessment must be credited  
4 against the amount of any fiscal yearend assessment due or to be due from an assessable carrier. Payment  
5 of a fiscal yearend or interim assessment is due within 30 days of receipt by the assessable carrier of  
6 written notice of the assessment. An assessable carrier that ceases doing business within the state is liable  
7 for assessments until the end of the calendar year in which the assessable carrier ceased doing business.  
8 The board may determine not to assess an assessable carrier if the assessable carrier's liability determined  
9 in accordance with this section does not exceed \$10.

10 (d) An assessable carrier who is not a small employer carrier is not subject to an assessment of  
11 more than 5% of its underwriting profit on a line of insurance offered by the carrier.

12 (9) The participation in the program as reinsuring carriers; the establishment of rates, forms, or  
13 procedures; or any other joint collective action required by this part may not be the basis of any legal  
14 action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers, either jointly  
15 or separately.

16 (10) The board, as part of the plan of operation, shall develop standards setting forth the minimum  
17 levels of compensation to be paid to producers for the sale of basic and standard health benefit plans. In  
18 establishing the standards, the board shall take into consideration the need to ensure the broad availability  
19 of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need  
20 to provide ongoing service to small employers, the levels of compensation currently used in the industry,  
21 and the overall costs of coverage to small employers selecting these plans.

22 (11) The program is exempt from taxation.

23 (12) On or before March 1 of each year, the commissioner shall evaluate the operation of the  
24 program and report to the governor and the legislature in writing the results of the evaluation. The report  
25 must include an estimate of future costs of the program, assessments necessary to pay those costs, the  
26 appropriateness of premiums charged by the program, the level of insurance retention under the program,  
27 the cost of coverage of small employers, and any recommendations for change to the plan of operation."  
28

29 **Section 6.** Section 33-22-1820, MCA, is amended to read:

30 **"33-22-1820. Periodic market evaluation -- report.** The board~~, in consultation with members of~~

1 ~~the committee,]~~ [, IN CONSULTATION WITH MEMBERS OF THE COMMITTEE,] shall study and report at  
 2 least every 3 years to the commissioner on the effectiveness of this part. The report must analyze the  
 3 effectiveness of this part in promoting rate stability, product availability, and coverage affordability. The  
 4 report may contain recommendations for actions to improve the overall effectiveness, efficiency, and  
 5 fairness of the small employer health insurance markets. The report must address whether carriers and  
 6 producers are fairly and actively marketing or issuing health benefit plans to small employers in fulfillment  
 7 of the purposes of this part. The report may contain recommendations for market conduct or other  
 8 regulatory standards or action."

9  
 10 **Section 7.** Section 33-22-1821, MCA, is amended to read:

11 **"33-22-1821. Waiver of certain laws.** A law or rule that requires the inclusion of a specific  
 12 category of licensed health care ~~practitioners~~ practitioner and a law or rule that requires the coverage of  
 13 a health care service or benefit do not apply to a basic health benefit plan delivered or issued for delivery  
 14 to small employers in this state pursuant to this part ~~[but do apply to a standard health benefit plan~~  
 15 ~~delivered or issued for delivery to small employers in this state pursuant to this part.]~~ [BUT DO APPLY TO  
 16 A STANDARD HEALTH BENEFIT PLAN DELIVERED OR ISSUED FOR DELIVERY TO SMALL EMPLOYERS  
 17 IN THIS STATE PURSUANT TO THIS PART.]"

18  
 19 **NEW SECTION. Section 8. Repealer. CONTINGENT REPEALER.** Section 33-22-1812, MCA, is  
 20 repealed CONTINGENT UPON THE PASSAGE AND APPROVAL OF HOUSE BILL NO. 531.

21  
 22 **NEW SECTION. SECTION 9. COORDINATION INSTRUCTION. IF HOUSE BILL NO. 531 IS PASSED**  
 23 **AND APPROVED, THEN THE MATERIAL IN THE FIRST SET OF BRACKETS REFERRING TO THE UNIFORM**  
 24 **HEALTH BENEFIT PLAN (SECTION 3) AS PROVIDED IN HOUSE BILL NO. 531 OR TO THE HEALTH BENEFIT**  
 25 **PLAN COMMITTEE IS TO BE CODIFIED. IF HOUSE BILL NO. 531 FAILS, THEN THE MATERIAL IN THE**  
 26 **SECOND SET OF BRACKETS REFERRING TO BASIC AND STANDARD HEALTH BENEFIT PLANS AND**  
 27 **DELETING REFERENCES TO THE HEALTH BENEFIT PLAN COMMITTEE MUST BE CODIFIED.**

28  
 29 **NEW SECTION. Section 10. Codification instruction.** ~~[Sections 5 and 6] are intended to be~~  
 30 ~~codified as an integral part of Title 33, chapter 22, part 18, and the provisions of Title 33, chapter 22, part~~

1 ~~18, apply to [sections 5 and 6].~~

2

3 NEW SECTION. **Section 10. Saving clause.** [This act] does not affect rights and duties that  
4 matured, penalties that were incurred, or proceedings that were begun before [the effective date of this  
5 act].

6

-END-

## 1 HOUSE BILL NO. 466

2 INTRODUCED BY T. NELSON, FRANKLIN, TUSS, BENEDICT

3  
4 A BILL FOR AN ACT ENTITLED: "AN ACT REVISING THE SMALL EMPLOYER HEALTH INSURANCE  
5 AVAILABILITY ACT; REVISING DEFINITIONS; CLARIFYING REIMBURSEMENT TREATMENT; REVISING  
6 RESTRICTIONS ON PREMIUM RATES; RESTRICTING THE AUTHORITY OF THE COMMISSIONER OF  
7 INSURANCE TO ADOPT RULES; PROHIBITING THE COMMISSIONER OF INSURANCE FROM REQUIRING  
8 PRIOR APPROVAL OF RATING METHODS AND PREMIUMS; DELETING EFFECTIVE DATES RELATED TO  
9 THE DEVELOPMENT OF BENEFIT PLANS AND THE COMMISSIONER'S APPROVAL OF THE PLANS;  
10 PROVIDING FOR WAIVERS OF COVERAGE BY EMPLOYEES; CONTINGENTLY ELIMINATING THE HEALTH  
11 BENEFIT PLAN COMMITTEE; PROVIDING FOR THE CONTENT OF BASIC AND STANDARD HEALTH  
12 BENEFIT PLANS; REQUIRING AN ANNUAL ACTUARIAL REVIEW OF THE SMALL EMPLOYER CARRIER  
13 REINSURANCE PROGRAM; LIMITING THE ASSESSMENT ON ASSESSABLE CARRIERS WHO ARE NOT  
14 SMALL EMPLOYER CARRIERS; AMENDING SECTIONS 33-22-1803, 33-22-1804, 33-22-1809,  
15 33-22-1811, 33-22-1819, 33-22-1820, AND 33-22-1821, MCA; AND CONTINGENTLY REPEALING  
16 SECTION 33-22-1812, MCA."

17

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

19

THERE ARE NO CHANGES IN THIS BILL AND IT WILL  
NOT BE REPRINTED. PLEASE REFER TO SECOND  
READING COPY (YELLOW) FOR COMPLETE TEXT.



JOINT SELECT COMMITTEE REPORT

Page 1 of 9  
March 17, 1995

MR. PRESIDENT:

We, your Joint Select committee on Health Care, having had under consideration HB 466 (third reading copy -- blue), respectfully report that HB 466 be amended as follows and as so amended be concurred in.

Signed:   
Senator Steve Benedict, Chair

That such amendments read:

1. Title, line 10.

Strike: "CONTINGENTLY"

2. Title, line 13.

Following: "PROGRAM;"

Strike: the remainder of line 13 through "CARRIERS;" on line 14

Insert: "CHANGING THE COMPOSITION OF THE BOARD OF THE MONTANA  
SMALL EMPLOYER REINSURANCE PROGRAM;"

3. Title, line 15.

Following: "33-22-1811,"

Insert: "33-22-1818,"

Strike: "CONTINGENTLY"

4. Page 1, line 29 through page 2, line 2.

Following: "all"

Strike: "individual"

Following: "insurance"

Strike: the remainder of line 29 through page 2, line 2

Insert: ", including excess of loss and stop loss disability  
insurance"

5. Page 2, line 7.

Strike: "[

6. Page 2, line 9.

Strike: "]"

7. Page 2, line 10.

Strike: "[


Strike: "LOWER COST"

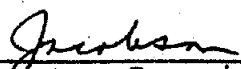
Following: "PLAN"

Insert: "[, except a uniform health benefit plan,]"

8. Page 2, line 11.

Strike: "PURSUANT TO 33-22-1812.1"

  
Amd. Coord.  
Sec. of Senate

  
Senator Carrying Bill

HB 466

JOINT H & S

Insert: "by a small employer carrier that has a lower benefit value than the small employer carrier's standard benefit plan and that provides the benefits required by [section 5]."

(6) "Benefit equivalency" means a method developed by the small employer carrier for comparing the types of health care services and articles covered under a health benefit plan with the types of health care services required to be covered under a [uniform,] basic, or standard health benefit plan.

(7) "Benefit value" means an actuarially based method developed by the small employer carrier for comparing the value of determinable contingencies covered under a health benefit plan with the value of determinable contingencies required under a [uniform,] basic, or standard health benefit plan."

Renumber: subsequent subsections

9. Page 3, line 1.

Strike: "[

Strike: "]"

10. Page 3, lines 2 and 3.

Strike: lines 2 and 3 in their entirety

11. Page 5, line 6.

Strike: "[UNIFORM] ["

Insert: "minimum"

Following: "basic"

Strike: "]"

12. Page 5, line 9.

Strike: "[UNIFORM] ["

Insert: "minimum"

Following: "basic"

Strike: "]"

13. Page 5, line 29.

Following: "to any"

Insert: "small employer"

Following: "employee of its"

Insert: "small employer"

14. Page 6, lines 3 through 7.

Strike: lines 3 through 7 in their entirety

Insert: "(28) "Standard health benefit plan" means a health benefit plan that is developed by a small employer carrier and that contains the provisions required pursuant to [section 6]."

15. Page 6, line 18.

Following: "Code"

Insert: ", except a plan or program that is funded entirely by contributions from the employees"

16. Page 9, line 25.

Following: line 24

Insert: "(c) The filing required in subsection (5)(b) must contain the small employer carrier's benefit equivalency and benefit value."

Renumber: subsequent subsection

17. Page 10, lines 5 and 6.

Strike: "THE" on line 5 through "]" on line 6

18. Page 10, line 8.

Strike: "]"

19. Page 10, lines 9 and 10.

Strike: "UNIFORM" on line 9 through "]" on line 10

Strike: "]" on line 10

20. Page 10, line 11.

Strike: "THE]"

Strike: "]"

21. Page 10, lines 15 and 16.

Strike: "A" on line 15 through "]" on line 16

22. Page 10, line 17.

Strike: "]"

23. Page 10, line 21.

Strike: "UNIFORM]"

Strike: "]"

24. Page 11, line 4.

Following: line 3

Insert: "(c) A small employer carrier that elects not to comply with the requirements of subsections (1)(a) and (1)(b) may continue to provide coverage under health benefit plans previously issued to small employers in this state for a period of no more than 7 years from [the effective date of this act] if the carrier:

(i) complies with all other applicable provisions of this part, except 33-22-1810, 33-22-1813, and subsections (2) through (4) of this section; and

(ii) does not amend or alter the benefits and coverages of

the previously issued health benefit plans unless required to do so by law or rule."

25. Page 11, lines 4 and 5.

Strike: "UNIFORM" on line 4 through "]" on line 5

26. Page 11, line 6.

Following: "plans"

Strike: "]"

27. Page 11, lines 8 and 9.

Strike: "UNIFORM" on line 8 through "]" on line 9

28. Page 11, line 10.

Following: "plan"

Strike: "]"

29. Page 12, lines 6 and 7.

Strike: "THE" on line 6 through "]" on line 7

Following: "plan"

Strike: "]"

30. Page 15, line 10.

Insert: "

**NEW SECTION.** Section 5. Benefits required in basic health benefit plan. (1) The basic health benefit plan must provide at least the following benefits:

(a) coverage for the services and articles required by 33-22-1521(2);

(b) coverage for mental health and chemical dependency required by Title 33, chapter 22, part 7; and

(c) coverage for conversion of benefits required by 33-22-508 and 33-22-510 or by 33-30-1007.

(2) The small employer carrier may determine varying levels of deductibles, copayments, maximum annual out-of-pocket expenses, maximum lifetime benefits, and other financial cost-sharing arrangements with the insured that give the basic health benefit plan a lower benefit value than the standard health benefit plan.

(3) A basic health benefit plan provided by a health maintenance organization or a basic health benefit plan with a restricted network provision must provide a comparable level of benefits to those required by subsections (1) and (2), as determined by the benefit equivalency and benefit value.

**NEW SECTION.** Section 6. Benefits required in standard benefit plan. (1) The minimum benefits must be equal to at least 75% of the covered expenses in excess of an annual deductible

that does not exceed \$500 per person or \$1,000 per family. The coverage must include a limitation of \$2,000 per person or \$4,000 per family on the total annual out-of-pocket expenses for services covered. The coverage may be subject to a maximum lifetime benefit, but a maximum, if any, may not be less than \$1 million.

(2) The commissioner may not require coverage in a standard health benefit plan for any benefit unless other provisions of Title 33, chapter 22, 30, or 31, specifically require coverage for the benefit. A small employer carrier may offer coverage for additional services and articles.

(3) A standard health benefit plan provided by a health maintenance organization or a basic health benefit plan with a restricted network provision shall provide a comparable level of benefits to those required by subsection (1), as determined by the benefit equivalency and benefit value.

**Section 7.** Section 33-22-1818, MCA, is amended to read:

**"33-22-1818. Small employer carrier reinsurance program -- board membership.** (1) There is a nonprofit entity to be known as the Montana small employer health reinsurance program.

(2) (a) The program must operate subject to the supervision and control of the board. The board consists of nine members appointed by the commissioner plus the commissioner or the commissioner's designated representative, who shall serve as an ex officio member of the board.

(b) (i) In selecting the members of the board, the commissioner shall include representatives of small employers, small employer carriers, and other qualified individuals, as determined by the commissioner. At least six of the members of the board must be representatives of small employer carriers, one from each of the ~~five~~ four small employer carriers with the highest annual premium volume derived from health benefit plans issued to small employers in Montana in the previous calendar year, and one from the remaining small employer carriers, and one from a disability reinsurance carrier. One member of the board must be a ~~person licensed, certified, or otherwise authorized by the laws of Montana to provide health care in the ordinary course of business or in the practice of a profession~~ a representative of a health benefit plan with a restricted network provision. One member of the board must be a small employer who is not active in the health care or insurance fields. One member of the board must be a representative of the general public who is employed by a small employer and is not employed in the health care or insurance fields.

(ii) The initial board members' terms are as follows: one-third of the members shall serve a term of 1 year; one-third of the members shall serve a term of 2 years; and one-third of

the members shall serve a term of 3 years. Subsequent board members shall serve for a term of 3 years. A board member's term continues until that member's successor is appointed.

(iii) A vacancy on the board must be filled by the commissioner. The commissioner may remove a board member for cause.

(3) ~~Within 60 days of July 1, 1993, and on~~ On or before March 1 of each year ~~after that date~~, each assessable carrier shall file with the commissioner the carrier's net health insurance premium derived from health benefit plans issued in this state in the previous calendar year."

"

Renumber: subsequent sections

31. Page 16, line 24.

Strike: "fiscal yearend"

32. Page 18, lines 4 and 5.

Following: "approximate"

Strike: "gross" on line 4 through "plan" on line 5

Insert: "the premiums necessary to recover one-half of the expenses for the calendar year. For purposes of this section, expenses include administrative expenses, one-half of the program net loss for the previous calendar year, and the actuarially anticipated claims to be incurred"

33. Page 18, line 23.

Following: "losses"

Insert: ", and the actuarially anticipated losses for the calendar year. The sum of one-half of the program net loss for the previous calendar year plus the anticipated net loss for the calendar year must equal the total assessment amount. If the program net loss for the previous calendar year is zero or less, the total assessment amount must equal the actuarially anticipated losses for the calendar year"

34. Page 18, lines 24 through 28.

Strike: subsection (b) in its entirety

Insert: "(b) (i) Each assessable carrier shall share in the program in an amount determined by multiplying the total assessment amount by a fraction, the numerator of which is the number of individuals in this state covered under disability insurance by the assessable carrier and the denominator of which is the number of all individuals in this state covered under disability insurance by all assessable carriers.

(ii) The board shall make a reasonable effort to ensure that

each insured individual is counted only once for the purpose of assessment. The board shall require each assessable carrier that provides excess of loss or stop loss insurance to include in its count of insured individuals all individuals whose coverage is reinsured in whole or in part, including coverage under excess or stop loss insurance. The board shall allow an assessable carrier who is an excess of loss or stop loss insurer to exclude from its count of insured individuals those who have been counted by a primary disability insurer or by a primary reinsurer.

(iii) The board shall base each assessable carrier's assessment on reports filed with the commissioner as required by 33-22-1820. The board may use any reasonable method of estimating the number of individuals insured by an assessable carrier if the specific number is unknown."

35. Page 18, line 30.  
Following: "share of the"  
Strike: "net loss of"  
Insert: "contribution to"

36. Page 19, line 1.  
Strike: "fiscal yearend"

37. Page 19, lines 2 through 4.  
Strike: "If" on line 2 through "carrier." on line 4

38. Page 19, line 5.  
Strike: "a fiscal yearend or interim"  
Insert: "an"

39. Page 19, lines 10 and 11.  
Strike: subsection (d) in its entirety  
Insert: "(d) The board may establish and maintain program reserves not to exceed five times the actuarially anticipated losses for the calendar year.  
(e) If the sum of the reinsurance premiums and assessments in any calendar year exceeds the sum of the administrative expenses and incurred claims for that year, the board may proportionately credit the excess to assessable carriers or it may place the excess in program reserves, subject to the limits in subsection (8)(d)."

40. Page 19, line 30.  
Strike: "["

41. Page 20, line 1.  
Strike: "[, IN CONSULTATION WITH MEMBERS OF THE COMMITTEE,]"

42. Page 20, lines 11 through 17.

Following: "laws." on line 11

Strike: the remainder of line 11 through line 17

Insert: "Except as provided in [section 5], a small employer carrier may exclude any category of licensed health care practitioner and any benefit or coverage for health care services otherwise required by law or rule from a basic health benefit plan delivered or issued for delivery in this state."

43. Page 20, line 18.

Insert: "

NEW SECTION. **Section 11. Insured lives reporting requirement.** On or before February 15 of each year, each insurer providing disability insurance shall, on a form prescribed by the commissioner, report the number of Montana residents insured on February 1 under any policy of individual or group disability insurance, including stop loss or excess of loss insurance policies covering disability insurance.

NEW SECTION. **Section 12. Reentry by a carrier.** A carrier that elected to not renew all of its health benefits plans pursuant to 33-22-1810(1)(f) may notify the commissioner within 180 days of [the effective date of this act] of its intent to comply with Title 33, chapter 22, part 18."

ReNUMBER: subsequent sections

44. Page 20, line 19.

Strike: "CONTINGENT REPEALER"

Insert: "Repealer"

45. Page 20, line 20.

Following: "repealed"

Strike: the remainder of line 20 through "531"

46. Page 20, lines 22 through 27.

Strike: section 9 in its entirety

ReNUMBER: subsequent section

47. Page 21, line 2.

Insert: "

NEW SECTION. **Section 14. Codification instruction.** [Section 11] is intended to be codified as an integral part of Title 33, chapter 2, part 7, and the provisions of Title 33, chapter 2, part 7, apply to [section 11].

NEW SECTION. **Section 15. Coordination instruction.** If



House Bill No. 533 is passed and approved and contains a section implementing a uniform health benefit plan, then the bracketed phrases in 33-22-1803 must be included."

Renumber: subsequent section

-END-

## 1 HOUSE BILL NO. 466

2 INTRODUCED BY T. NELSON, FRANKLIN, TUSS, BENEDICT

3  
 4 A BILL FOR AN ACT ENTITLED: "AN ACT REVISING THE SMALL EMPLOYER HEALTH INSURANCE  
 5 AVAILABILITY ACT; REVISING DEFINITIONS; CLARIFYING REIMBURSEMENT TREATMENT; REVISING  
 6 RESTRICTIONS ON PREMIUM RATES; RESTRICTING THE AUTHORITY OF THE COMMISSIONER OF  
 7 INSURANCE TO ADOPT RULES; PROHIBITING THE COMMISSIONER OF INSURANCE FROM REQUIRING  
 8 PRIOR APPROVAL OF RATING METHODS AND PREMIUMS; DELETING EFFECTIVE DATES RELATED TO  
 9 THE DEVELOPMENT OF BENEFIT PLANS AND THE COMMISSIONER'S APPROVAL OF THE PLANS;  
 10 PROVIDING FOR WAIVERS OF COVERAGE BY EMPLOYEES; ~~CONTINGENTLY~~ ELIMINATING THE HEALTH  
 11 BENEFIT PLAN COMMITTEE; PROVIDING FOR THE CONTENT OF BASIC AND STANDARD HEALTH  
 12 BENEFIT PLANS; REQUIRING AN ANNUAL ACTUARIAL REVIEW OF THE SMALL EMPLOYER CARRIER  
 13 REINSURANCE PROGRAM; LIMITING THE ASSESSMENT ON ASSESSABLE CARRIERS WHO ARE NOT  
 14 SMALL EMPLOYER CARRIERS; CHANGING THE COMPOSITION OF THE BOARD OF THE MONTANA  
 15 SMALL EMPLOYER REINSURANCE PROGRAM; AMENDING SECTIONS 33-22-1803, 33-22-1804,  
 16 33-22-1809, 33-22-1811, 33-22-1818, 33-22-1819, 33-22-1820, AND 33-22-1821, MCA; AND  
 17 CONTINGENTLY REPEALING SECTION 33-22-1812, MCA."

18  
 19 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:  
 20

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

22 **"33-22-1803. Definitions.** As used in this part, the following definitions apply:

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

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

30 (3) "Assessable carrier" means all individual carriers of disability insurance and all carriers of group

1 ~~disability insurance, excluding including~~ EXCLUDING ~~the state group benefits plan provided for in Title 2,~~  
 2 ~~chapter 18, part 8, the Montana university system health plan, and any self-funded disability insurance plan~~  
 3 ~~provided by a political subdivision of the state,~~ INCLUDING EXCESS OF LOSS AND STOP LOSS DISABILITY  
 4 INSURANCE.

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

9 ~~[(5) "Basic health benefit plan" means a lower cost health benefit plan developed pursuant to~~  
 10 ~~33-22-1812 by a small employer carrier that is a lower cost plan than the standard health benefit plan and~~  
 11 ~~that provides the benefits required by [section 5].]~~

12 [(5) "BASIC HEALTH BENEFIT PLAN" MEANS A LOWER-COST HEALTH BENEFIT PLAN], EXCEPT  
 13 A UNIFORM HEALTH BENEFIT PLAN,] DEVELOPED PURSUANT TO 33-22-1812.] BY A SMALL EMPLOYER  
 14 CARRIER THAT HAS A LOWER BENEFIT VALUE THAN THE SMALL EMPLOYER CARRIER'S STANDARD  
 15 BENEFIT PLAN AND THAT PROVIDES THE BENEFITS REQUIRED BY [SECTION 5].

16 (6) "BENEFIT EQUIVALENCY" MEANS A METHOD DEVELOPED BY THE SMALL EMPLOYER  
 17 CARRIER FOR COMPARING THE TYPES OF HEALTH CARE SERVICES AND ARTICLES COVERED UNDER  
 18 A HEALTH BENEFIT PLAN WITH THE TYPES OF HEALTH CARE SERVICES REQUIRED TO BE COVERED  
 19 UNDER A [UNIFORM,] BASIC, OR STANDARD HEALTH BENEFIT PLAN.

20 (7) "BENEFIT VALUE" MEANS AN ACTUARIALLY BASED METHOD DEVELOPED BY THE SMALL  
 21 EMPLOYER CARRIER FOR COMPARING THE VALUE OF DETERMINABLE CONTINGENCIES COVERED  
 22 UNDER A HEALTH BENEFIT PLAN WITH THE VALUE OF DETERMINABLE CONTINGENCIES REQUIRED  
 23 UNDER A [UNIFORM,] BASIC, OR STANDARD HEALTH BENEFIT PLAN.

24 ~~(6)(8)~~ "Board" means the board of directors of the program established pursuant to 33-22-1818.

25 ~~(7)(9)~~ "Carrier" means any person who provides a health benefit plan in this state subject to state  
 26 insurance regulation. The term includes but is not limited to an insurance company, a fraternal benefit  
 27 society, a health service corporation, AND a health maintenance organization, ~~and, to the extent permitted~~  
 28 ~~by the Employee Retirement Income Security Act of 1974, a multiple employer welfare arrangement.~~ For  
 29 purposes of this part, companies that are affiliated companies or that are eligible to file a consolidated tax  
 30 return must be treated as one carrier, except that the following may be considered as separate carriers:

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

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

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

7 ~~(8)(10)~~ "Case characteristics" means demographic or other objective characteristics of a small  
8 employer that are considered by the small employer carrier in the determination of premium rates for the  
9 small employer, provided that claims experience, health status, and duration of coverage are not case  
10 characteristics for purposes of this part.

11 ~~(9)(11)~~ "Class of business" means all or a separate grouping of small employers established  
12 pursuant to 33-22-1808.

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

14 ~~[(10) "COMMITTEE" MEANS THE HEALTH BENEFIT PLAN COMMITTEE CREATED PURSUANT TO~~  
15 ~~33-22-1812.]~~

16 ~~(11)(10)(12)~~ "Dependent" means:

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

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

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

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

23 ~~(12)(11)(13)~~ "Eligible employee" means an employee who works on a full-time basis ~~and who has~~  
24 with a normal workweek of 30 hours or more, except that at the sole discretion of the employer, the term  
25 may include an employee who works on a full-time basis with a normal workweek of between 20 and 40  
26 hours as long as this eligibility criteria is applied uniformly among all of the employer's employees. The  
27 term includes a sole proprietor, a partner of a partnership, and an independent contractor if the sole  
28 proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a  
29 small employer. The term does not include an employee who works on a part-time, temporary, or  
30 substitute basis.

1           ~~(13)(12)~~(14) "Established geographic service area" means a geographic area, as approved by the  
2 commissioner and based on the carrier's certificate of authority to transact insurance in this state, within  
3 which the carrier is authorized to provide coverage.

4           ~~(14)(13)~~(15) "Health benefit plan" means any hospital or medical policy or certificate providing for  
5 physical and mental health care issued by an insurance company, a fraternal benefit society, or a health  
6 service corporation or issued under a health maintenance organization subscriber contract. Health benefit  
7 plan does not include:

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

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

12           (c) automobile medical payment insurance.

13           ~~(15)(14)~~(16) "Index rate" means, for each class of business for a rating period for small employers  
14 with similar case characteristics, the average of the applicable base premium rate and the corresponding  
15 highest premium rate.

16           ~~(16)(15)~~(17) "Late enrollee" means an eligible employee or dependent who requests enrollment in  
17 a health benefit plan of a small employer following the initial enrollment period during which the individual  
18 was entitled to enroll under the terms of the health benefit plan, provided that the initial enrollment period  
19 was a period of at least 30 days. However, an eligible employee or dependent may not be considered a late  
20 enrollee if:

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

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

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

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

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

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

4 ~~(17)(16)(18)~~ "New business premium rate" means, for each class of business for a rating period,  
 5 the lowest premium rate charged or offered or that could have been charged or offered by the small  
 6 employer carrier to small employers with similar case characteristics for newly issued health benefit plans  
 7 with the same or similar coverage.

8 ~~(18)(17)~~19 "Plan of operation" means the operation of the program established pursuant to  
 9 33-22-1818.

10 ~~(19)(18)(20)~~ "Premium" means all money paid by a small employer and eligible employees as a  
 11 condition of receiving coverage from a small employer carrier, including any fees or other contributions  
 12 associated with the health benefit plan.

13 ~~(20)(19)(21)~~ "Program" means the Montana small employer health reinsurance program created  
 14 by 33-22-1818.

15 ~~(21)(20)(22)~~ "Qualifying previous coverage" means benefits or coverage provided under:

16 (a) medicare or medicaid;

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

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

23 ~~(22)(21)(23)~~ "Rating period" means the calendar period for which premium rates established by  
 24 a small employer carrier are assumed to be in effect.

25 ~~(23)(22)(24)~~ "Reinsuring carrier" means a small employer carrier participating in the reinsurance  
 26 program pursuant to 33-22-1819.

27 ~~(24)(23)(25)~~ "Restricted network provision" means a provision of a health benefit plan that  
 28 conditions the payment of benefits, in whole or in part, on the use of health care providers that have  
 29 entered into a contractual arrangement with the carrier pursuant to Title 33, chapter 22, part 17, or Title  
 30 33, chapter 31, to provide health care services to covered individuals.

1 ~~(25)(24)(26)~~ "Small employer" means a person, firm, corporation, partnership, or association that  
 2 is actively engaged in business and that, on at least 50% of its working days during the preceding calendar  
 3 quarter, employed at least 3 but not more than 25 eligible employees, the majority of whom were employed  
 4 within this state or were residents of this state. In determining the number of eligible employees, companies  
 5 are considered one employer if they:

6 (a) are affiliated companies;

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

8 (c) are members of an association that:

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

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

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

13 ~~(26)(25)(27)~~ "Small employer carrier" means a carrier that offers health benefit plans that cover  
 14 eligible employees of one or more small employers in this state.

15 ~~(27)(26)~~ "Standard UNIFORM health benefit plan" means a health benefit plan ~~that is developed~~  
 16 ~~pursuant to 33-22-1812 by a small employer carrier and that contains the provisions required pursuant to~~  
 17 ~~[section 6]. THE UNIFORM HEALTH BENEFIT PLAN (SECTION 3) AS PROVIDED IN HOUSE BILL NO. 31.~~  
 18 ~~["STANDARD HEALTH BENEFIT PLAN" MEANS A HEALTH BENEFIT PLAN DEVELOPED PURSUANT TO~~  
 19 ~~33-22-1812.]~~

20 (28) "STANDARD HEALTH BENEFIT PLAN" MEANS A HEALTH BENEFIT PLAN THAT IS  
 21 DEVELOPED BY A SMALL EMPLOYER CARRIER AND THAT CONTAINS THE PROVISIONS REQUIRED  
 22 PURSUANT TO [SECTION 6]."

23  
 24 **Section 2.** Section 33-22-1804, MCA, is amended to read:

25 **"33-22-1804. Applicability and scope. (1)** This part applies to a health benefit plan marketed  
 26 through a small employer that provides coverage to the employees of a small employer in this state if any  
 27 of the following conditions are met:

28 ~~(1)~~(a) a portion of the premium or benefits is paid by or on behalf of the small employer;

29 ~~(2)~~(b) an eligible employee or dependent is reimbursed, whether through wage adjustments or  
 30 otherwise, by or on behalf of the small employer for any portion of the premium; or

1           ~~(3)(c)~~ the health benefit plan is treated by the employer or any of the eligible employees or  
 2 dependents as part of a plan or program for the purposes of section 106, 125, or 162 of the Internal  
 3 Revenue Code, EXCEPT A PLAN OR PROGRAM THAT IS FUNDED ENTIRELY BY CONTRIBUTIONS FROM  
 4 THE EMPLOYEES.

5           (2) A payroll deduction or a list-billed premium is not a reimbursement for the purposes of  
 6 subsection (1)(b)."

7  
 8           **Section 3.** Section 33-22-1809, MCA, is amended to read:

9           **"33-22-1809. Restrictions relating to premium rates.** (1) Premium rates for health benefit plans  
 10 under this part are subject to the following provisions:

11           (a) The index rate for a rating period for any class of business may not exceed the index rate for  
 12 any other class of business by more than 20%.

13           (b) For each class of business:

14           (i) the premium rates charged during a rating period to small employers with similar case  
 15 characteristics for the same or similar coverage or the rates that could be charged to the employer under  
 16 the rating system for that class of business may not vary from the index rate by more than 25% of the  
 17 index rate; or

18           (ii) if the Montana health care authority established by 50-4-201 certifies to the commissioner that  
 19 the cost containment goal set forth in 50-4-303 is met on or before January 1, 1999, the premium rates  
 20 charged during a rating period to small employers with similar case characteristics for the same or similar  
 21 coverage may not vary from the index by more than 20% of the index rate.

22           (c) The percentage increase in the premium rate charged to a small employer for a new rating  
 23 period may not exceed the sum of the following:

24           (i) the percentage change in the new business premium rate measured from the first day of the  
 25 prior rating period to the first day of the new rating period; in the case of a health benefit plan into which  
 26 the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use  
 27 the percentage change in the base premium rate, provided that the change does not exceed, on a  
 28 percentage basis, the change in the new business premium rate for the most similar health benefit plan into  
 29 which the small employer carrier is actively enrolling new small employers;

30           (ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less



1 than 1 year, because of the claims experience, health status, or duration of coverage of the employees or  
2 dependents of the small employer, as determined from the small employer carrier's rate manual for the class  
3 of business; and

4 (iii) any adjustment because of a change in coverage or a change in the case characteristics of the  
5 small employer, as determined from the small employer carrier's rate manual for the class of business.

6 (d) Adjustments in rates for claims experience, health status, and duration of coverage may not  
7 be charged to individual employees or dependents. Any adjustment must be applied uniformly to the rates  
8 charged for all employees and dependents of the small employer.

9 (e) If a small employer carrier uses industry as a case characteristic in establishing premium rates,  
10 the rate factor associated with any industry classification may not vary from the average of the rate factors  
11 associated with all industry classifications by more than 15% of that coverage.

12 (f) In the case of health benefit plans delivered or issued for delivery prior to January 1, 1994, a  
13 premium rate for a rating period may exceed the ranges set forth in subsections (1)(a) and (1)(b) until  
14 January 1, 1997. In that case, the percentage increase in the premium rate charged to a small employer  
15 for a new rating period may not exceed the sum of the following:

16 (i) the percentage change in the new business premium rate measured from the first day of the  
17 prior rating period to the first day of the new rating period; in the case of a health benefit plan into which  
18 the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use  
19 the percentage change in the base premium rate, provided that the change does not exceed, on a  
20 percentage basis, the change in the new business premium rate for the most similar health benefit plan into  
21 which the small employer carrier is actively enrolling new small employers; and

22 (ii) any adjustment because of a change in coverage or a change in the case characteristics of the  
23 small employer, as determined from the small employer carrier's rate manual for the class of business.

24 (g) A small employer carrier shall:

25 (i) apply rating factors, including case characteristics, consistently with respect to all small  
26 employers in a class of business. Rating factors must produce premiums for identical groups that differ only  
27 by the amounts attributable to plan design and that do not reflect differences because of the nature of the  
28 groups. Differences among base premium rates may not be based in any way on the actual or expected  
29 health status or claims experience of the small employer groups that choose or are expected to choose a  
30 particular health benefit plan.

1 (ii) treat all health benefit plans issued or renewed in the same calendar month as having the same  
2 rating period.

3 (h) For the purposes of this subsection (1), a health benefit plan that includes a restricted network  
4 provision may not be considered similar coverage to a health benefit plan that does not include a restricted  
5 network provision.

6 ~~(i) The commissioner shall adopt rules to implement the provisions of this section and to ensure  
7 that rating practices used by small employer carriers are consistent with the purposes of this part, including  
8 rules that ensure that differences in rates charged for health benefit plans by small employer carriers are  
9 reasonable and reflect objective differences in plan design, not including differences because of the nature  
10 of the groups.~~

11 (2) A small employer carrier may not transfer a small employer involuntarily into or out of a class  
12 of business. A small employer carrier may not offer to transfer a small employer into or out of a class of  
13 business unless the offer is made to transfer all small employers in the class of business without regard to  
14 case characteristics, claims experience, health status, or duration of coverage since the insurance was  
15 issued.

16 (3) The commissioner may suspend for a specified period the application of subsection (1)(a) for  
17 the premium rates applicable to one or more small employers included within a class of business of a small  
18 employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by  
19 the commissioner either that the suspension is reasonable in light of the financial condition of the small  
20 employer carrier or that the suspension would enhance the fairness and efficiency of the small employer  
21 health insurance market.

22 (4) In connection with the offering for sale of any health benefit plan to a small employer, a small  
23 employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of each  
24 of the following:

25 (a) the extent to which premium rates for a specified small employer are established or adjusted  
26 based upon the actual or expected variation in claims costs or upon the actual or expected variation in  
27 health status of the employees of small employers and the employees' dependents;

28 (b) the provisions of the health benefit plan concerning the small employer carrier's right to change  
29 premium rates and the factors, other than claims experience, that affect changes in premium rates;

30 (c) the provisions relating to renewability of policies and contracts; and

1 (d) the provisions relating to any preexisting condition.

2 (5) (a) Each small employer carrier shall maintain at its principal place of business a complete and  
3 detailed description of its rating practices and renewal underwriting practices, including information and  
4 documentation that demonstrate that its rating methods and practices are based upon commonly accepted  
5 actuarial assumptions and are in accordance with sound actuarial principles.

6 (b) Each small employer carrier shall file with the commissioner annually, on or before March 15,  
7 an actuarial certification certifying that the carrier is in compliance with this part and that the rating  
8 methods of the small employer carrier are actuarially sound. The actuarial certification must be in a form  
9 and manner and must contain information as specified by the commissioner. A copy of the actuarial  
10 certification must be retained by the small employer carrier at its principal place of business.

11 (C) THE FILING REQUIRED IN SUBSECTION (5)(B) MUST CONTAIN THE SMALL EMPLOYER  
12 CARRIER'S BENEFIT EQUIVALENCY AND BENEFIT VALUE.

13 ~~(e)(D)~~ A small employer carrier shall make the information and documentation described in  
14 subsection (5)(a) available to the commissioner upon request. Except in cases of violations of the provisions  
15 of this part and except as agreed to by the small employer carrier or as ordered by a court of competent  
16 jurisdiction, the information must be considered proprietary and trade secret information and is not subject  
17 to disclosure by the commissioner to persons outside of the department.

18 (6) The commissioner may not require prior approval of the rating methods used by small employer  
19 carriers or the premium rates of the health benefit plans offered to small employers."

20  
21 **Section 4.** Section 33-22-1811, MCA, is amended to read:

22 **"33-22-1811. Availability of coverage -- required plans.** (1) (a) As a condition of transacting  
23 business in this state with small employers, each small employer carrier shall offer to small employers ~~THE~~  
24 ~~UNIFORM BENEFIT PLAN (SECTION 3) AS PROVIDED IN HOUSE BILL NO. 531.]~~ at least two health  
25 benefit plans. One plan must be a basic health benefit plan, and one plan must be a standard health benefit  
26 plan.]

27 (b) (i) A small employer carrier shall issue a ~~UNIFORM HEALTH BENEFIT PLAN (SECTION 3) AS~~  
28 ~~PROVIDED IN HOUSE BILL NO. 531.]~~ basic health benefit plan or a standard health benefit plan] to any  
29 eligible small employer that applies for ~~THE] either]~~ plan and agrees to make the required premium  
30 payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this

1 part.

2 (ii) In the case of a small employer carrier that establishes more than one class of business pursuant  
3 to 33-22-1808, the small employer carrier shall maintain and offer to eligible small employers ~~[A UNIFORM~~  
4 ~~HEALTH BENEFIT PLAN (SECTION 3) AS PROVIDED IN HOUSE BILL NO. 631]~~ at least one basic health  
5 benefit plan and at least one standard health benefit plan} in each established class of business. A small  
6 employer carrier may apply reasonable criteria in determining whether to accept a small employer into a  
7 class of business, provided that:

8 (A) the criteria are not intended to discourage or prevent acceptance of small employers applying  
9 for a ~~[UNIFORM]~~ basic or standard} health benefit plan;

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

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

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

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

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

22 (C) A SMALL EMPLOYER CARRIER THAT ELECTS NOT TO COMPLY WITH THE REQUIREMENTS  
23 OF SUBSECTIONS (1)(A) AND (1)(B) MAY CONTINUE TO PROVIDE COVERAGE UNDER HEALTH BENEFIT  
24 PLANS PREVIOUSLY ISSUED TO SMALL EMPLOYERS IN THIS STATE FOR A PERIOD OF NO MORE THAN  
25 7 YEARS FROM [THE EFFECTIVE DATE OF THIS ACT] IF THE CARRIER:

26 (I) COMPLIES WITH ALL OTHER APPLICABLE PROVISIONS OF THIS PART, EXCEPT 33-22-1810,  
27 33-22-1813, AND SUBSECTIONS (2) THROUGH (4) OF THIS SECTION; AND

28 (II) DOES NOT AMEND OR ALTER THE BENEFITS AND COVERAGES OF THE PREVIOUSLY ISSUED  
29 HEALTH BENEFIT PLANS UNLESS REQUIRED TO DO SO BY LAW OR RULE.

30 (2) (a) A small employer carrier shall, pursuant to 33-1-501, file the ~~[UNIFORM HEALTH BENEFIT~~

1 ~~PLAN (SECTION 3) AS PROVIDED IN HOUSE BILL NO. 531~~ [basic health benefit plans and the standard  
2 health benefit plans] to be used by the small employer carrier.

3 (b) The commissioner may at any time, after providing notice and an opportunity for a hearing to  
4 the small employer carrier, disapprove the continued use by a small employer carrier of a UNIFORM  
5 HEALTH BENEFIT PLAN (SECTION 3) AS PROVIDED IN HOUSE BILL NO. 531 [basic or standard health  
6 benefit plan] on the grounds that the plan does not meet the requirements of this part.

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

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

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

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

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

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

28 (e) (i) If a small employer carrier offers coverage to a small employer, the small employer carrier  
29 shall offer coverage to all of the eligible employees of a small employer and their dependents. A small  
30 employer carrier may not offer coverage only to certain individuals in a small employer group or only to part

1 of the group, except in the case of late enrollees as provided in subsection (3)(c).

2 (ii) A small employer carrier may not modify ~~THE UNIFORM HEALTH BENEFIT PLAN (SECTION 3)~~  
3 ~~AS PROVIDED IN HOUSE BILL NO. 5311~~ [a basic or standard health benefit plan] with respect to a small  
4 employer or any eligible employee or dependent, through riders, endorsements, or otherwise, to restrict or  
5 exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

6 (iii) A small employer carrier shall secure a waiver of coverage from each eligible employee who  
7 declines, at the sole discretion of the eligible employee, an offer of coverage under a health benefit plan  
8 provided by the small employer. The waiver must be signed by the eligible employee and must certify that  
9 the employee was informed of the availability of coverage under the health benefit plan and of the penalties  
10 for late enrollment. The waiver may not require the eligible employee to disclose the reasons for declining  
11 coverage.

12 (iv) A small employer carrier may not issue coverage to a small employer if the carrier or a producer  
13 for the carrier has evidence that the small employer induced or pressured an eligible employee to decline  
14 coverage due to the health status or risk characteristics of the eligible employee or of the dependents of  
15 the eligible employee.

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

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

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

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

26 (b) A small employer carrier may not be required to provide coverage to small employers pursuant  
27 to subsection (1) for any period of time for which the commissioner determines that requiring the  
28 acceptance of small employers in accordance with the provisions of subsection (1) would place the small  
29 employer carrier in a financially impaired condition."  
30

- 1        ~~NEW SECTION. Section 5. Benefits required for basic health benefit plan. (1) The basic health~~  
2 ~~benefit plan must provide at least the following benefits:~~
- 3        ~~(a) hospital services;~~
  - 4        ~~(b) professional services for the diagnosis or treatment of injuries, illness, or conditions, other than~~  
5 ~~dental;~~
  - 6        ~~(c) use of radium or other radioactive materials;~~
  - 7        ~~(d) oxygen;~~
  - 8        ~~(e) anesthetics;~~
  - 9        ~~(f) diagnostic x rays and laboratory tests;~~
  - 10       ~~(g) services of a physical therapist;~~
  - 11       ~~(h) transportation provided by licensed ambulance service to the nearest facility qualified to treat~~  
12 ~~the condition;~~
  - 13       ~~(i) oral surgery for the gums and tissues of the mouth when not performed in connection with the~~  
14 ~~extraction or repair of teeth or in connection with TMJ;~~
  - 15       ~~(j) rental or purchase of medical equipment, which must be reimbursed after the deductible has~~  
16 ~~been met at the rate of 50%, up to a maximum of \$1,000;~~
  - 17       ~~(k) prosthetics, other than dental;~~
  - 18       ~~(l) services of a licensed home health agency, up to a maximum of 180 visits per year;~~
  - 19       ~~(m) drugs requiring a physician's prescription that are approved for use in human beings in the~~  
20 ~~manner prescribed by the United States food and drug administration;~~
  - 21       ~~(n) nonexperimental organ transplants of the following human organs, for which coverage may be~~  
22 ~~subject to a maximum lifetime benefit for one or more transplants of not less than \$150,000:~~
  - 23       ~~(i) kidney;~~
  - 24       ~~(ii) pancreas;~~
  - 25       ~~(iii) heart;~~
  - 26       ~~(iv) heart/lung;~~
  - 27       ~~(v) single lung;~~
  - 28       ~~(vi) double lung;~~
  - 29       ~~(vii) liver;~~
  - 30       ~~(viii) bone marrow, including high dose chemotherapy and stem cell rescue;~~

1 ~~(o) expenses of procurement of any of the organs listed in subsection (1)(n), including~~  
 2 ~~transportation of the surgical or harvesting team, surgical removal of the donor organ, evaluation of the~~  
 3 ~~donor organ, and transportation of the donor organ to the location of the operation, which may be subject~~  
 4 ~~to a lifetime maximum benefit by a small employer carrier for one or more transplants of not less than~~  
 5 ~~\$10,000;~~

6 ~~(p) pregnancy, including complications of pregnancy;~~

7 ~~(q) routine well child care for children up to the age of 2;~~

8 ~~(r) sterilization;~~

9 ~~(s) coverage for mental illness, alcoholism, and drug addiction as provided in 33-22-701 through~~  
 10 ~~33-22-705, except that the coverage may be limited by a small employer carrier as follows:~~

11 ~~(i) inpatient treatment for mental illness, alcoholism, and drug addiction may be subject to a~~  
 12 ~~maximum yearly benefit of 21 days;~~

13 ~~(ii) inpatient treatment for mental illness may be traded on a two for one basis for a benefit for~~  
 14 ~~partial hospitalization through an American partial hospitalization association program;~~

15 ~~(iii) inpatient treatment for alcoholism and drug addiction may be subject to a maximum benefit of~~  
 16 ~~\$4,000 in any 24 month period and a maximum lifetime benefit of \$8,000;~~

17 ~~(iv) outpatient treatment for mental illness may be subject to a maximum yearly limit of not less~~  
 18 ~~than \$2,000; and~~

19 ~~(v) outpatient treatment for alcoholism and drug addiction may be subject to a maximum yearly~~  
 20 ~~benefit of \$1,000;~~

21 ~~(t) outpatient rehabilitation therapy; and~~

22 ~~(u) foot care for diabetics.~~

23 ~~(2) Subject to 33-22-1821, covered expenses must be charges determined by the small employer~~  
 24 ~~carrier as necessary and reasonable for the covered services and articles when prescribed by a physician~~  
 25 ~~or other licensed health care professional recognized by the small employer carrier as acting within the~~  
 26 ~~scope of the professional's license.~~

27  
 28 ~~NEW SECTION. Section 6. Commissioner to set terms of standard health benefit plan~~  
 29 ~~rulemaking. The commissioner may by rule establish minimum levels for annual deductible charges,~~  
 30 ~~coinsurance or copayments, annual maximum out of pocket charges, and lifetime maximum benefits for~~



1 ~~the standard health benefit plan. The minimum levels for annual deductible charges, coinsurance or~~  
 2 ~~copayments, annual maximum out-of-pocket charges and lifetime maximum benefits for the standard health~~  
 3 ~~benefit plan established by the commissioner may be different for a health benefit plan that includes a~~  
 4 ~~restricted network provision than for a health benefit plan that does not include a restricted network~~  
 5 ~~provision. The commissioner may not require coverage in a standard health benefit plan for any benefit~~  
 6 ~~unless other provisions of Title 33, chapter 22, 30, or 31, specifically require coverage for the benefit.~~

7  
 8 **NEW SECTION. SECTION 5. BENEFITS REQUIRED IN BASIC HEALTH BENEFIT PLAN. (1) THE**  
 9 **BASIC HEALTH BENEFIT PLAN MUST PROVIDE AT LEAST THE FOLLOWING BENEFITS:**

10 **(A) COVERAGE FOR THE SERVICES AND ARTICLES REQUIRED BY 33-22-1521(2);**

11 **(B) COVERAGE FOR MENTAL HEALTH AND CHEMICAL DEPENDENCY REQUIRED BY TITLE 33,**  
 12 **CHAPTER 22, PART 7; AND**

13 **(C) COVERAGE FOR CONVERSION OF BENEFITS REQUIRED BY 33-22-508 AND 33-22-510 OR**  
 14 **BY 33-30-1007.**

15 **(2) THE SMALL EMPLOYER CARRIER MAY DETERMINE VARYING LEVELS OF DEDUCTIBLES,**  
 16 **COPAYMENTS, MAXIMUM ANNUAL OUT-OF-POCKET EXPENSES, MAXIMUM LIFETIME BENEFITS, AND**  
 17 **OTHER FINANCIAL COST-SHARING ARRANGEMENTS WITH THE INSURED THAT GIVE THE BASIC**  
 18 **HEALTH BENEFIT PLAN A LOWER BENEFIT VALUE THAN THE STANDARD HEALTH BENEFIT PLAN.**

19 **(3) A BASIC HEALTH BENEFIT PLAN PROVIDED BY A HEALTH MAINTENANCE ORGANIZATION**  
 20 **OR A BASIC HEALTH BENEFIT PLAN WITH A RESTRICTED NETWORK PROVISION MUST PROVIDE A**  
 21 **COMPARABLE LEVEL OF BENEFITS TO THOSE REQUIRED BY SUBSECTIONS (1) AND (2), AS**  
 22 **DETERMINED BY THE BENEFIT EQUIVALENCY AND BENEFIT VALUE.**

23  
 24 **NEW SECTION. SECTION 6. BENEFITS REQUIRED IN STANDARD BENEFIT PLAN. (1) THE**  
 25 **MINIMUM BENEFITS MUST BE EQUAL TO AT LEAST 75% OF THE COVERED EXPENSES IN EXCESS OF**  
 26 **AN ANNUAL DEDUCTIBLE THAT DOES NOT EXCEED \$500 PER PERSON OR \$1,000 PER FAMILY. THE**  
 27 **COVERAGE MUST INCLUDE A LIMITATION OF \$2,000 PER PERSON OR \$4,000 PER FAMILY ON THE**  
 28 **TOTAL ANNUAL OUT-OF-POCKET EXPENSES FOR SERVICES COVERED. THE COVERAGE MAY BE**  
 29 **SUBJECT TO A MAXIMUM LIFETIME BENEFIT, BUT A MAXIMUM, IF ANY, MAY NOT BE LESS THAN \$1**  
 30 **MILLION.**

1           (2) THE COMMISSIONER MAY NOT REQUIRE COVERAGE IN A STANDARD HEALTH BENEFIT  
2 PLAN FOR ANY BENEFIT UNLESS OTHER PROVISIONS OF TITLE 33, CHAPTER 22, 30, OR 31,  
3 SPECIFICALLY REQUIRE COVERAGE FOR THE BENEFIT. A SMALL EMPLOYER CARRIER MAY OFFER  
4 COVERAGE FOR ADDITIONAL SERVICES AND ARTICLES.

5           (3) A STANDARD HEALTH BENEFIT PLAN PROVIDED BY A HEALTH MAINTENANCE  
6 ORGANIZATION OR A BASIC HEALTH BENEFIT PLAN WITH A RESTRICTED NETWORK PROVISION MUST  
7 PROVIDE A COMPARABLE LEVEL OF BENEFITS TO THOSE REQUIRED BY SUBSECTION (1), AS  
8 DETERMINED BY THE BENEFIT EQUIVALENCY AND BENEFIT VALUE.

9  
10           SECTION 7. SECTION 33-22-1818, MCA, IS AMENDED TO READ:

11           **"33-22-1818. Small employer carrier reinsurance program -- board membership.** (1) There is a  
12 nonprofit entity to be known as the Montana small employer health reinsurance program.

13           (2) (a) The program must operate subject to the supervision and control of the board. The board  
14 consists of nine members appointed by the commissioner plus the commissioner or the commissioner's  
15 designated representative, who shall serve as an ex officio member of the board.

16           (b) (i) In selecting the members of the board, the commissioner shall include representatives of  
17 small employers, small employer carriers, and other qualified individuals, as determined by the  
18 commissioner. At least six of the members of the board must be representatives of small employer carriers,  
19 one from each of the ~~five~~ four small employer carriers with the highest annual premium volume derived from  
20 health benefit plans issued to small employers in Montana in the previous calendar year, ~~and~~ one from the  
21 remaining small employer carriers, and one from a disability reinsurance carrier. One member of the board  
22 must be a ~~person licensed, certified, or otherwise authorized by the laws of Montana to provide health care~~  
23 ~~in the ordinary course of business or in the practice of a profession~~ a representative of a health benefit plan  
24 with a restricted network provision. One member of the board must be a small employer who is not active  
25 in the health care or insurance fields. One member of the board must be a representative of the general  
26 public who is employed by a small employer and is not employed in the health care or insurance fields.

27           (ii) The initial board members' terms are as follows: one-third of the members shall serve a term  
28 of 1 year; one-third of the members shall serve a term of 2 years; and one-third of the members shall serve  
29 a term of 3 years. Subsequent board members shall serve for a term of 3 years. A board member's term  
30 continues until that member's successor is appointed.

1 (iii) A vacancy on the board must be filled by the commissioner. The commissioner may remove  
2 a board member for cause.

3 (3) ~~Within 60 days of July 1, 1993, and on~~ On or before March 1 of each year ~~after that date~~, each  
4 assessable carrier shall file with the commissioner the carrier's net health insurance premium derived from  
5 health benefit plans issued in this state in the previous calendar year."

6  
7 **SECTION 8. SECTION 33-22-1819, MCA, IS AMENDED TO READ:**

8 **"33-22-1819. Program plan of operation -- treatment of losses -- exemption from taxation. (1)**

9 Within 180 days after the appointment of the initial board, the board shall submit to the commissioner a  
10 plan of operation and may at any time submit amendments to the plan necessary or suitable to ensure the  
11 fair, reasonable, and equitable administration of the program. The commissioner may, after notice and  
12 hearing, approve the plan of operation if the commissioner determines it to be suitable to ensure the fair,  
13 reasonable, and equitable administration of the program and if the plan of operation provides for the sharing  
14 of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this  
15 section. The plan of operation is effective upon written approval by the commissioner.

16 (2) If the board fails to submit a suitable plan of operation within 180 days after its appointment,  
17 the commissioner shall, after notice and hearing, promulgate and adopt a temporary plan of operation. The  
18 commissioner shall amend or rescind any temporary plan adopted under this subsection at the time a plan  
19 of operation is submitted by the board and approved by the commissioner.

20 (3) The plan of operation must:

21 (a) establish procedures for the handling and accounting of program assets and money and for an  
22 annual fiscal reporting to the commissioner;

23 (b) establish procedures for selecting an administering carrier and setting forth the powers and  
24 duties of the administering carrier;

25 (c) establish procedures for reinsuring risks in accordance with the provisions of this section;

26 (d) establish procedures for collecting assessments from assessable carriers to fund claims incurred  
27 by the program;

28 (e) establish procedures for allocating a portion of premiums collected from reinsuring carriers to  
29 fund administrative expenses incurred or to be incurred by the program; and

30 (f) provide for any additional matters necessary for the implementation and administration of the

1 program.

2 (4) The program has the general powers and authority granted under the laws of this state to  
3 insurance companies and health maintenance organizations licensed to transact business, except the power  
4 to issue health benefit plans directly to either groups or individuals. In addition, the program may:

5 (a) enter into contracts as are necessary or proper to carry out the provisions and purposes of this  
6 part, including the authority, with the approval of the commissioner, to enter into contracts with similar  
7 programs of other states for the joint performance of common functions or with persons or other  
8 organizations for the performance of administrative functions;

9 (b) sue or be sued, including taking any legal actions necessary or proper to recover any premiums  
10 and penalties for, on behalf of, or against the program or any reinsuring carriers;

11 (c) take any legal action necessary to avoid the payment of improper claims against the program;

12 (d) define the health benefit plans for which reinsurance will be provided and to issue reinsurance  
13 policies in accordance with the requirements of this part;

14 (e) establish conditions and procedures for reinsuring risks under the program;

15 (f) establish actuarial functions as appropriate for the operation of the program;

16 (g) appoint appropriate legal, actuarial, and other committees as necessary to provide technical  
17 assistance in operation of the program, policy and other contract design, and any other function within the  
18 authority of the program;

19 (h) to the extent permitted by federal law and in accordance with subsection (8)(c), make annual  
20 ~~fiscal year~~ assessments against assessable carriers and make interim assessments to fund claims  
21 incurred by the program; and

22 (i) borrow money to effect the purposes of the program. Any notes or other evidence of  
23 indebtedness of the program not in default are legal investments for carriers and may be carried as admitted  
24 assets.

25 (5) A reinsuring carrier may reinsure with the program as provided for in this subsection (5):

26 (a) With respect to a basic health benefit plan or a standard health benefit plan, the program shall  
27 reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to  
28 the level of coverage provided in a basic or standard health benefit plan.

29 (b) A small employer carrier may reinsure an entire employer group within 60 days of the  
30 commencement of the group's coverage under a health benefit plan.

1 (c) A reinsuring carrier may reinsure an eligible employee or dependent within a period of 60 days  
2 following the commencement of coverage with the small employer. A newly eligible employee or dependent  
3 of the reinsured small employer may be reinsured within 60 days of the commencement of coverage.

4 (d) (i) The program may not reimburse a reinsuring carrier with respect to the claims of a reinsured  
5 employee or dependent until the carrier has incurred an initial level of claims for the employee or dependent  
6 of \$5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier is  
7 responsible for 20% of the next \$100,000 of benefit payments during a calendar year and the program  
8 shall reinsure the remainder. A reinsuring carrier's liability under this subsection (d)(i) may not exceed a  
9 maximum limit of \$25,000 in any calendar year with respect to any reinsured individual.

10 (ii) The board annually shall adjust the initial level of claims and maximum limit to be retained by  
11 the carrier to reflect increases in costs and utilization within the standard market for health benefit plans  
12 within the state. The adjustment may not be less than the annual change in the medical component of the  
13 consumer price index for all urban consumers of the United States department of labor, bureau of labor  
14 statistics, unless the board proposes and the commissioner approves a lower adjustment factor.

15 (e) A small employer carrier may terminate reinsurance with the program for one or more of the  
16 reinsured employees or dependents of a small employer on any anniversary of the health benefit plan.

17 (f) A small employer group health benefit plan in effect before January 1, 1994, may not be  
18 reinsured by the program until January 1, 1997, and then only if the board determines that sufficient  
19 funding sources are available.

20 (g) A reinsuring carrier shall apply all managed care and claims-handling techniques, including  
21 utilization review, individual case management, preferred provider provisions, and other managed care  
22 provisions or methods of operation consistently with respect to reinsured and nonreinsured business.

23 (6) (a) As part of the plan of operation, the board shall establish a methodology for determining  
24 premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this  
25 section. The methodology must include a system for classification of small employers that reflects the types  
26 of case characteristics commonly used by small employer carriers in the state. The methodology must  
27 provide for the development of base reinsurance premium rates that must be multiplied by the factors set  
28 forth in subsection (6)(b) to determine the premium rates for the program. The base reinsurance premium  
29 rates must be established by the board, subject to the approval of the commissioner, and must be set at  
30 levels that reasonably approximate ~~gross premiums charged to small employers by small employer carriers~~

1 ~~for health benefit plans with benefits similar to the standard health benefit plan~~ THE PREMIUMS  
2 NECESSARY TO RECOVER ONE-HALF OF THE EXPENSES FOR THE CALENDAR YEAR. FOR PURPOSES  
3 OF THIS SECTION, EXPENSES INCLUDE ADMINISTRATIVE EXPENSES, ONE-HALF OF THE PROGRAM NET  
4 LOSS FOR THE PREVIOUS CALENDAR YEAR, AND THE ACTUARIALLY ANTICIPATED CLAIMS TO BE  
5 INCURRED, adjusted to reflect retention levels required under this part.

6 (b) Premiums for the program are as follows:

7 (i) An entire small employer group may be reinsured for a rate that is one and one-half times the  
8 base reinsurance premium rate for the group established pursuant to this subsection (6).

9 (ii) An eligible employee or dependent may be reinsured for a rate that is five times the base  
10 reinsurance premium rate for the individual established pursuant to this subsection (6).

11 (c) The board ~~periodically~~ shall annually review the methodology established under subsection  
12 (6)(a), including the system of classification and any rating factors, to ensure that it is actuarially sound and  
13 that it reasonably reflects the claims experience of the program. The board may propose changes to the  
14 methodology that are subject to the approval of the commissioner.

15 (d) The board may consider adjustments to the premium rates charged by the program to reflect  
16 the use of effective cost containment and managed care arrangements.

17 (7) If a health benefit plan for a small employer is entirely or partially reinsured with the program,  
18 the premium charged to the small employer for any rating period for the coverage issued must meet the  
19 requirements relating to premium rates set forth in 33-22-1809.

20 (8) (a) Prior to March 1 of each year, the board shall determine and report to the commissioner the  
21 program net loss for the previous calendar year, including administrative expenses and incurred losses for  
22 the year, taking into account investment income and other appropriate gains and losses, AND THE  
23 ACTUARIALLY ANTICIPATED LOSSES FOR THE CALENDAR YEAR. THE SUM OF ONE-HALF OF THE  
24 PROGRAM NET LOSS FOR THE PREVIOUS CALENDAR YEAR PLUS THE ANTICIPATED NET LOSS FOR THE  
25 CALENDAR YEAR MUST EQUAL THE TOTAL ASSESSMENT AMOUNT. IF THE PROGRAM NET LOSS FOR  
26 THE PREVIOUS CALENDAR YEAR IS ZERO OR LESS, THE TOTAL ASSESSMENT AMOUNT MUST EQUAL  
27 THE ACTUARIALLY ANTICIPATED LOSSES FOR THE CALENDAR YEAR.

28 ~~(b) To the extent permitted by federal law, each assessable carrier shall share in any net loss of~~  
29 ~~the program for the year in an amount equal to the ratio of the total premiums earned in the previous~~  
30 ~~calendar year from health benefit plans delivered or issued for delivery by each assessable carrier divided~~

1 ~~by the total premiums earned in the previous calendar year from health benefit plans delivered or issued~~  
2 ~~for delivery by all assessable carriers in the state.~~

3 (B) (I) EACH ASSESSABLE CARRIER SHALL SHARE IN THE PROGRAM IN AN AMOUNT  
4 DETERMINED BY MULTIPLYING THE TOTAL ASSESSMENT AMOUNT BY A FRACTION, THE NUMERATOR  
5 OF WHICH IS THE NUMBER OF INDIVIDUALS IN THIS STATE COVERED UNDER DISABILITY INSURANCE  
6 BY THE ASSESSABLE CARRIER AND THE DENOMINATOR OF WHICH IS THE NUMBER OF ALL  
7 INDIVIDUALS IN THIS STATE COVERED UNDER DISABILITY INSURANCE BY ALL ASSESSABLE CARRIERS.

8 (II) THE BOARD SHALL MAKE A REASONABLE EFFORT TO ENSURE THAT EACH INSURED  
9 INDIVIDUAL IS COUNTED ONLY ONCE FOR THE PURPOSE OF ASSESSMENT. THE BOARD SHALL  
10 REQUIRE EACH ASSESSABLE CARRIER THAT PROVIDES EXCESS OF LOSS OR STOP LOSS INSURANCE  
11 TO INCLUDE IN ITS COUNT OF INSURED INDIVIDUALS ALL INDIVIDUALS WHOSE COVERAGE IS  
12 REINSURED IN WHOLE OR IN PART, INCLUDING COVERAGE UNDER EXCESS OF LOSS OR STOP LOSS  
13 INSURANCE. THE BOARD SHALL ALLOW AN ASSESSABLE CARRIER WHO IS AN EXCESS OF LOSS OR  
14 STOP LOSS INSURER TO EXCLUDE FROM ITS COUNT OF INSURED INDIVIDUALS THOSE WHO HAVE  
15 BEEN COUNTED BY A PRIMARY DISABILITY INSURER OR BY A PRIMARY REINSURER.

16 (III) THE BOARD SHALL BASE EACH ASSESSABLE CARRIER'S ASSESSMENT ON REPORTS FILED  
17 WITH THE COMMISSIONER AS REQUIRED BY 33-22-1820. THE BOARD MAY USE ANY REASONABLE  
18 METHOD OF ESTIMATING THE NUMBER OF INDIVIDUALS INSURED BY AN ASSESSABLE CARRIER IF THE  
19 SPECIFIC NUMBER IS UNKNOWN.

20 (c) The board shall make an annual determination in accordance with this section of each  
21 assessable carrier's liability for its share of the ~~net loss of~~ CONTRIBUTION TO the program and, except as  
22 otherwise provided by this section, make an annual ~~fiscal year end~~ assessment against each assessable  
23 carrier to the extent of that liability. ~~If approved by the commissioner, the board may also make interim~~  
24 ~~assessments against assessable carriers to fund claims incurred by the program. Any interim assessment~~  
25 ~~must be credited against the amount of any fiscal year end assessment due or to be due from an assessable~~  
26 ~~carrier. Payment of a fiscal year end or interim~~ AN assessment is due within 30 days of receipt by the  
27 assessable carrier of written notice of the assessment. An assessable carrier that ceases doing business  
28 within the state is liable for assessments until the end of the calendar year in which the assessable carrier  
29 ceased doing business. The board may determine not to assess an assessable carrier if the assessable  
30 carrier's liability determined in accordance with this section does not exceed \$10.

1 ~~(d) An assessable carrier who is not a small employer carrier is not subject to an assessment of~~  
 2 ~~more than 5% of its underwriting profit on a line of insurance offered by the carrier.~~

3 (D) THE BOARD MAY ESTABLISH AND MAINTAIN PROGRAM RESERVES NOT TO EXCEED FIVE  
 4 TIMES THE ACTUARIALLY ANTICIPATED LOSSES FOR THE CALENDAR YEAR.

5 (E) IF THE SUM OF THE REINSURANCE PREMIUMS AND ASSESSMENTS IN ANY CALENDAR  
 6 YEAR EXCEEDS THE SUM OF THE ADMINISTRATIVE EXPENSES AND INCURRED CLAIMS FOR THAT  
 7 YEAR, THE BOARD MAY PROPORTIONATELY CREDIT THE EXCESS TO ASSESSABLE CARRIERS OR IT  
 8 MAY PLACE THE EXCESS IN PROGRAM RESERVES, SUBJECT TO THE LIMITS IN SUBSECTION (8)(D).

9 (9) The participation in the program as reinsuring carriers; the establishment of rates, forms, or  
 10 procedures; or any other joint collective action required by this part may not be the basis of any legal  
 11 action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers, either jointly  
 12 or separately.

13 (10) The board, as part of the plan of operation, shall develop standards setting forth the minimum  
 14 levels of compensation to be paid to producers for the sale of basic and standard health benefit plans. In  
 15 establishing the standards, the board shall take into consideration the need to ensure the broad availability  
 16 of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need  
 17 to provide ongoing service to small employers, the levels of compensation currently used in the industry,  
 18 and the overall costs of coverage to small employers selecting these plans.

19 (11) The program is exempt from taxation.

20 (12) On or before March 1 of each year, the commissioner shall evaluate the operation of the  
 21 program and report to the governor and the legislature in writing the results of the evaluation. The report  
 22 must include an estimate of future costs of the program, assessments necessary to pay those costs, the  
 23 appropriateness of premiums charged by the program, the level of insurance retention under the program,  
 24 the cost of coverage of small employers, and any recommendations for change to the plan of operation."  
 25

26 **Section 9.** Section 33-22-1820, MCA, is amended to read:

27 **"33-22-1820. Periodic market evaluation -- report.** The board~~, in consultation with members of~~  
 28 ~~the committee,],],~~ IN CONSULTATION WITH MEMBERS OF THE COMMITTEE, shall study and report at  
 29 least every 3 years to the commissioner on the effectiveness of this part. The report must analyze the  
 30 effectiveness of this part in promoting rate stability, product availability, and coverage affordability. The



1 report may contain recommendations for actions to improve the overall effectiveness, efficiency, and  
 2 fairness of the small employer health insurance markets. The report must address whether carriers and  
 3 producers are fairly and actively marketing or issuing health benefit plans to small employers in fulfillment  
 4 of the purposes of this part. The report may contain recommendations for market conduct or other  
 5 regulatory standards or action."

6  
 7 **Section 10.** Section 33-22-1821, MCA, is amended to read:

8 **"33-22-1821. Waiver of certain laws.** ~~A law or rule that requires the inclusion of a specific~~  
 9 ~~category of licensed health care practitioners practitioner and a law or rule that requires the coverage of~~  
 10 ~~a health care service or benefit do not apply to a basic health benefit plan delivered or issued for delivery~~  
 11 ~~to small employers in this state pursuant to this part [but do apply to a standard health benefit plan~~  
 12 ~~delivered or issued for delivery to small employers in this state pursuant to this part.] [BUT DO APPLY TO~~  
 13 ~~A STANDARD HEALTH BENEFIT PLAN DELIVERED OR ISSUED FOR DELIVERY TO SMALL EMPLOYERS~~  
 14 ~~IN THIS STATE PURSUANT TO THIS PART.] EXCEPT AS PROVIDED IN [SECTION 5], A SMALL EMPLOYER~~  
 15 ~~CARRIER MAY EXCLUDE ANY CATEGORY OF LICENSED HEALTH CARE PRACTITIONER AND ANY~~  
 16 ~~BENEFIT OR COVERAGE FOR HEALTH CARE SERVICES OTHERWISE REQUIRED BY LAW OR RULE FROM~~  
 17 ~~A BASIC HEALTH BENEFIT PLAN DELIVERED OR ISSUED FOR DELIVERY IN THIS STATE."~~

18  
 19 **NEW SECTION. SECTION 11. INSURED LIVES REPORTING REQUIREMENT. ON OR BEFORE**  
 20 **FEBRUARY 15 OF EACH YEAR, EACH INSURER PROVIDING DISABILITY INSURANCE SHALL, ON A FORM**  
 21 **PRESCRIBED BY THE COMMISSIONER, REPORT THE NUMBER OF MONTANA RESIDENTS INSURED ON**  
 22 **FEBRUARY 1 UNDER ANY POLICY OF INDIVIDUAL OR GROUP DISABILITY INSURANCE, INCLUDING**  
 23 **EXCESS OF LOSS OR STOP LOSS INSURANCE POLICIES COVERING DISABILITY INSURANCE.**

24  
 25 **NEW SECTION. SECTION 12. REENTRY BY A CARRIER. A CARRIER THAT ELECTED TO NOT**  
 26 **RENEW ALL OF ITS HEALTH BENEFIT PLANS PURSUANT TO 33-22-1810(1)(F) MAY NOTIFY THE**  
 27 **COMMISSIONER WITHIN 180 DAYS OF [THE EFFECTIVE DATE OF THIS ACT] OF ITS INTENT TO COMPLY**  
 28 **WITH TITLE 33, CHAPTER 22, PART 18.**

29  
 30 **NEW SECTION. Section 13. Repealer. CONTINGENT REPEALER.** Section 33-22-1812, MCA, is

1 repealed CONTINGENT UPON THE PASSAGE AND APPROVAL OF HOUSE BILL NO. 531.

2  
3 NEW SECTION. SECTION 9. COORDINATION INSTRUCTION. IF HOUSE BILL NO. 531 IS PASSED  
4 AND APPROVED, THEN THE MATERIAL IN THE FIRST SET OF BRACKETS REFERRING TO THE UNIFORM  
5 HEALTH BENEFIT PLAN (SECTION 3) AS PROVIDED IN HOUSE BILL NO. 531 OR TO THE HEALTH BENEFIT  
6 PLAN COMMITTEE IS TO BE CODIFIED. IF HOUSE BILL NO. 531 FAILS, THEN THE MATERIAL IN THE  
7 SECOND SET OF BRACKETS REFERRING TO BASIC AND STANDARD HEALTH BENEFIT PLANS AND  
8 DELETING REFERENCES TO THE HEALTH BENEFIT PLAN COMMITTEE MUST BE CODIFIED.

9  
10 NEW SECTION. Section 10. Codification instruction. [Sections 5 and 6] are intended to be  
11 codified as an integral part of Title 33, chapter 22, part 18, and the provisions of Title 33, chapter 22, part  
12 18, apply to [sections 5 and 6].

13  
14 NEW SECTION. SECTION 14. CODIFICATION INSTRUCTION. [SECTION 11] IS INTENDED TO  
15 BE CODIFIED AS AN INTEGRAL PART OF TITLE 33, CHAPTER 2, PART 7, AND THE PROVISIONS OF TITLE  
16 33, CHAPTER 2, PART 7, APPLY TO [SECTION 11].

17  
18 NEW SECTION. SECTION 15. COORDINATION INSTRUCTION. IF HOUSE BILL NO. 533 IS  
19 PASSED AND APPROVED AND CONTAINS A SECTION IMPLEMENTING A UNIFORM HEALTH BENEFIT  
20 PLAN, THEN THE BRACKETED PHRASES IN 33-22-1803 MUST BE INCLUDED.

21  
22 NEW SECTION. Section 16. Saving clause. [This act] does not affect rights and duties that  
23 matured, penalties that were incurred, or proceedings that were begun before [the effective date of this  
24 act].

25 -END-