House BILL NO. 466

INTRODUCED BY Tom Nelson Trudi Tuss 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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) automobile medical payment insurance.

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

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

enrollee if:

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

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

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

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

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

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

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

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

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

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

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

(a) medicare or medicaid;

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

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

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

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

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

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

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

(a) are affiliated companies;

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

(c) are members of an association that:

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

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

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

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

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

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

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

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

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

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

~~(3)~~(c) the health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of section 106, 125, or 162 of the Internal Revenue Code.

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

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

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

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

(b) For each class of business:

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

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

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

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

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

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

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

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

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

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

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

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

(g) A small employer carrier shall:

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

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

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

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

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

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

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

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

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

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

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

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

(d) the provisions relating to any preexisting condition.

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

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

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

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

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

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

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

part.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) hospital services;

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

(c) use of radium or other radioactive materials;

(d) oxygen;

(e) anesthetics;

(f) diagnostic x-rays and laboratory tests;

(g) services of a physical therapist;

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

the condition;

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

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

(k) prosthetics, other than dental;

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

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

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

(i) kidney;

(ii) pancreas;

(iii) heart;

(iv) heart/lung;

(v) single lung;

(vi) double lung;

(vii) liver;

(viii) bone marrow, including high dose chemotherapy and stem cell rescue;

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

(p) pregnancy, including complications of pregnancy;

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

(r) sterilization;

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

(i) inpatient treatment for mental illness, alcoholism, and drug addiction may be subject to a

maximum yearly benefit of 21 days;

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

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

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

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

(t) outpatient rehabilitation therapy; and

(u) foot care for diabetics.

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

NEW SECTION. **Section 6. Commissioner to set terms of standard health benefit plan -- rulemaking.** The commissioner may by rule establish minimum levels for annual deductible charges, coinsurance or copayments, annual maximum out-of-pocket charges, and lifetime maximum benefits for the standard health benefit plan. The minimum levels for annual deductible charges, coinsurance or copayments, annual maximum out-of-pocket charges and lifetime maximum benefits for the standard health benefit plan established by the commissioner may be different for a health benefit plan that includes a restricted network provision than for a health benefit plan that does not include a restricted network provision. 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.

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

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

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

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

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

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

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

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

-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 honoria.
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:

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

Dave Lewis 2.14.95

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

Thomas E. Nelson

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 honoria 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 intevention 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 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:

	FY96 Difference	FY97 Difference
FTE	2.00	2.00
Personal Services	103,775	104,052
Operating Expenses	67,039	64,789
Total	170,814	168,841
Funding:		
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

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; CONTINGENTLY ELIMINATING THE HEALTH BENEFIT PLAN COMMITTEE; PROVIDING FOR THE CONTENT OF BASIC AND STANDARD HEALTH BENEFIT PLANS; REQUIRING AN ANNUAL ACTUARIAL REVIEW OF THE SMALL EMPLOYER CARRIER REINSURANCE PROGRAM; LIMITING THE ASSESSMENT ON ASSESSABLE CARRIERS WHO ARE NOT SMALL EMPLOYER CARRIERS; AMENDING SECTIONS 33-22-1803, 33-22-1804, 33-22-1809, 33-22-1811, 33-22-1819, 33-22-1820, AND 33-22-1821, MCA; AND CONTINGENTLY 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~~ EXCLUDING the state group benefits plan provided for in Title 2,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) automobile medical payment insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) medicare or medicaid;

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

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

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

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

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

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

(a) are affiliated companies;

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

(c) are members of an association that:

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

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

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

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

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

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

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

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

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

~~(3)~~(c) the health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of section 106, 125, or 162 of the Internal Revenue Code.

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

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

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

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

(b) For each class of business:

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

index rate; or

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

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

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

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

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

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

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

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

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

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

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

(g) A small employer carrier shall:

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

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

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

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

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

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

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

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

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

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

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

(d) the provisions relating to any preexisting condition.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(a) hospital services;~~

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

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

~~(d) oxygen;~~

~~(e) anesthetics;~~

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

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

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

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

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

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

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

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

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

~~(i) kidney;~~

~~(ii) pancreas;~~

~~(iii) heart;~~

~~(iv) heart/lung;~~

~~(v) single lung;~~

~~(vi) double lung;~~

~~(vii) liver;~~

~~(viii) bone marrow, including high-dose chemotherapy and stem cell rescue;~~

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

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

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

~~(r) sterilization;~~

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

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

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

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

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

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

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

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

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

~~NEW SECTION. Section 6. Commissioner to set terms of standard health benefit plan -- rulemaking. The commissioner may by rule establish minimum levels for annual deductible charges, coinsurance or copayments, annual maximum out-of-pocket charges, and lifetime maximum benefits for the standard health benefit plan. The minimum levels for annual deductible charges, coinsurance or copayments, annual maximum out-of-pocket charges and lifetime maximum benefits for the standard health benefit plan established by the commissioner may be different for a health benefit plan that includes a restricted network provision than for a health benefit plan that does not include a restricted network provision. 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.~~

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

"**33-22-1819. Program plan of operation -- treatment of losses -- exemption from taxation.** (1) Within 180 days after the appointment of the initial board, the board shall submit to the commissioner a plan of operation and may at any time submit amendments to the plan necessary or suitable to ensure the fair, reasonable, and equitable administration of the program. The commissioner may, after notice and hearing, approve the plan of operation if the commissioner determines it to be suitable to ensure the fair, reasonable, and equitable administration of the program and if the plan of operation provides for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation is effective upon written approval by the commissioner.

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

(3) The plan of operation must:

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

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

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

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

by the program;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Premiums for the program are as follows:

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

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

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

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

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

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

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

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

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

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

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

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

(11) The program is exempt from taxation.

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

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

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

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

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

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

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

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

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

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

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

-END-

HOUSE BILL NO. 466

INTRODUCED BY T. NELSON, FRANKLIN, TUSS, 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; CONTINGENTLY ELIMINATING THE HEALTH BENEFIT PLAN COMMITTEE; PROVIDING FOR THE CONTENT OF BASIC AND STANDARD HEALTH BENEFIT PLANS; REQUIRING AN ANNUAL ACTUARIAL REVIEW OF THE SMALL EMPLOYER CARRIER REINSURANCE PROGRAM; LIMITING THE ASSESSMENT ON ASSESSABLE CARRIERS WHO ARE NOT SMALL EMPLOYER CARRIERS; AMENDING SECTIONS 33-22-1803, 33-22-1804, 33-22-1809, 33-22-1811, 33-22-1819, 33-22-1820, AND 33-22-1821, MCA; AND CONTINGENTLY REPEALING SECTION 33-22-1812, MCA."

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

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

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: Steve Benedict
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.]"

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-

HOUSE BILL NO. 466

INTRODUCED BY T. NELSON, FRANKLIN, TUSS, 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; ~~CONTINGENTLY~~ ELIMINATING THE HEALTH BENEFIT PLAN COMMITTEE; PROVIDING FOR THE CONTENT OF BASIC AND STANDARD HEALTH BENEFIT PLANS; REQUIRING AN ANNUAL ACTUARIAL REVIEW OF THE SMALL EMPLOYER CARRIER REINSURANCE PROGRAM; ~~LIMITING THE ASSESSMENT ON ASSESSABLE CARRIERS WHO ARE NOT SMALL EMPLOYER CARRIERS;~~ CHANGING THE COMPOSITION OF THE BOARD OF THE MONTANA SMALL EMPLOYER REINSURANCE PROGRAM; AMENDING SECTIONS 33-22-1803, 33-22-1804, 33-22-1809, 33-22-1811, 33-22-1818, 33-22-1819, 33-22-1820, AND 33-22-1821, MCA; AND ~~CONTINGENTLY~~ 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~~ EXCLUDING ~~the state group benefits plan provided for in Title 2, chapter 18, part 8, the Montana university system health plan, and any self-funded disability insurance plan provided by a political subdivision of the state~~, INCLUDING EXCESS OF LOSS AND STOP LOSS DISABILITY INSURANCE.

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

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

[(5) "BASIC HEALTH BENEFIT PLAN" MEANS A ~~LOWER COST~~ HEALTH BENEFIT PLAN[, EXCEPT A UNIFORM HEALTH BENEFIT PLAN,] DEVELOPED ~~PURSUANT TO 33-22-1812.]~~ 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) automobile medical payment insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) medicare or medicaid;

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

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

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

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

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

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

(a) are affiliated companies;

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

(c) are members of an association that:

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

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

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

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

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

(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]."

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

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

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

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

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

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

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

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

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

(b) For each class of business:

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

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

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

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

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

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

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

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

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

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

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

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

(g) A small employer carrier shall:

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

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

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

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

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

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

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

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

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

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

(d) the provisions relating to any preexisting condition.

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

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

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

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

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

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

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

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

part.

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

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

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

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

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

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

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

(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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(a) hospital services;~~

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

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

~~(d) oxygen;~~

~~(e) anesthetics;~~

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

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

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

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

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

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

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

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

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

~~(i) kidney;~~

~~(ii) pancreas;~~

~~(iii) heart;~~

~~(iv) heart/lung;~~

~~(v) single lung;~~

~~(vi) double lung;~~

~~(vii) liver;~~

~~(viii) bone marrow, including high dose chemotherapy and stem cell rescue;~~

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

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

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

~~(r) sterilization;~~

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

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

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

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

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

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

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

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

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

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

~~the standard health benefit plan. The minimum levels for annual deductible charges, coinsurance or copayments, annual maximum out-of-pocket charges and lifetime maximum benefits for the standard health benefit plan established by the commissioner may be different for a health benefit plan that includes a restricted network provision than for a health benefit plan that does not include a restricted network provision. 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.~~

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 MUST 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."

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

"**33-22-1819. Program plan of operation -- treatment of losses -- exemption from taxation.** (1) Within 180 days after the appointment of the initial board, the board shall submit to the commissioner a plan of operation and may at any time submit amendments to the plan necessary or suitable to ensure the fair, reasonable, and equitable administration of the program. The commissioner may, after notice and hearing, approve the plan of operation if the commissioner determines it to be suitable to ensure the fair, reasonable, and equitable administration of the program and if the plan of operation provides for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation is effective upon written approval by the commissioner.

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

(3) The plan of operation must:

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

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

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

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

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

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

program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~for health benefit plans with benefits similar to the standard health benefit plan~~ 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, adjusted to reflect retention levels required under this part.

(b) Premiums for the program are as follows:

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

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

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

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

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

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

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

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

(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 OF LOSS 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.

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

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

(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).

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

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

(11) The program is exempt from taxation.

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

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

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

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

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

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

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 EXCESS OF LOSS OR STOP 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 BENEFIT 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.

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

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

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

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

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.

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

-END-