HOUSE BILL NO. 533

INTRODUCED BY

A BILL FOR AN ACT ENTITLED: "AN ACT RELATING TO HEALTH BENEFIT PLANS; PROVIDING FOR THE PORTABILITY OF HEALTH BENEFIT PLANS BY REQUIRING INSURERS TO WAIVE CERTAIN TIME PERIODS APPLICABLE TO PREEXISTING CONDITIONS; REQUIRING CERTAIN INCREASES IN PLAN CHARGES TO BE DISTRIBUTED PROPORTIONATELY AMONG ALL PLANS OF AN INSURER; AND AMENDING SECTION 33-22-101, MCA."

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

NEW SECTION. **Section 1. Definitions.** As used in [section 2], unless the context indicates otherwise, the following definitions apply:

(1) "Health care insurer" means a health care insurer as defined in 33-22-125.

(2) (a) "Individual health benefit plan" means any hospital or medical expense policy or certificate, subscriber contract, or contract of insurance provided by a prepaid hospital or medical service plan or health maintenance organization subscriber contract and issued or delivered for issue to an individual or provided by any discretionary group trust policy providing hospital or medical expense coverage to individuals.

(b) Individual health benefit plan does not include a self-insured group health plan; a self-insured multiemployer group health plan; a group conversion plan; an insured group health plan; accident only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, medicare supplement, long-term care, or disability income insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical payment insurance.

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

(a) medicare or medicaid;

(b) group health insurance or a health benefit plan that provides benefits similar to or exceeding benefits provided under the standard health benefit plan referred to in 33-22-1811 and 33-22-1812 if the insurance or plan has been in effect for a period of at least 1 year; or

(c) an individual health benefit plan, including coverage issued by a health maintenance organization, a prepaid hospital or medical care plan, or a fraternal benefit society if the plan has been in

effect for a period of at least 1 year.

NEW SECTION. **Section 2. Portability of insurance required.** A health care insurer shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services in an individual health benefit plan for the period of time that 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 more than 30 days prior to the effective date of new coverage.

NEW SECTION. **Section 3. Premium increases to be distributed proportionately.** (1) A health care insurer may increase the health benefit plan charges for a group or individual policy, certificate, or contract previously issued by that insurer because of a change in the attained age of the insured. Increases in premium, certificate, or contract charges for policies, certificates, or contracts previously issued by that insurer, based on factors other than attained age, must be distributed proportionately by premium amount to all the policy, certificate, and contract holders of that insurer in the state.

(2) As used in this section, the following definitions apply:

(a) (i) "Health benefit plan" means a 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.

(ii) 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.

(b) "Health care insurer" or "insurer" means a health care insurer as defined in 33-22-125.

Section 4. Section 33-22-101, MCA, is amended to read:

"**33-22-101. Exceptions to scope.** Parts 1 through 4 of this chapter, except 33-22-107, 33-22-110, 33-22-111, 33-22-114, [section 3], 33-22-125, 33-22-130 through 33-22-132, and

33-22-304, do not apply to or affect:

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

(2) any group or blanket policy;

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

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

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

(4) reinsurance."

NEW SECTION. **Section 5. Codification instruction.** (1) [Sections 1 and 2] are intended to be codified as an integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [sections 1 and 2].

(2) [Section 3] is intended to be codified as an integral part of Title 33, chapter 22, part 1, and the provisions of Title 33, chapter 22, part 1, apply to [section 3].

-END-

APPROVED BY SELECT
COMMITTEE ON HEALTH CARE

HOUSE BILL NO. 533

INTRODUCED BY ARNOTT, BARNETT, MILLS, MCKEE, GRINDE, WELLS, BRAINARD, KEENAN, DEVANEY, WISEMAN, KNOX, GREEN, CURTISS, DENNY, T. NELSON, HIBBARD, FORBES, OHS, SLITER, ORR, MURDOCK, STOVALL, ZOOK, HAYNE, L. SMITH, DEBRUYCKER, GRADY, TASH, SOMERVILLE, AHNER, SOFT, HERRON, SIMON, ROSE, FELAND, CLARK, TAYLOR, MERCER, SIMPKINS, BOHLINGER, MCGEE

A BILL FOR AN ACT ENTITLED: "AN ACT RELATING TO HEALTH BENEFIT PLANS; PROVIDING FOR THE PORTABILITY OF HEALTH BENEFIT PLANS BY REQUIRING INSURERS TO WAIVE CERTAIN TIME PERIODS APPLICABLE TO PREEXISTING CONDITIONS; REQUIRING CERTAIN INCREASES IN PLAN CHARGES TO BE DISTRIBUTED PROPORTIONATELY AMONG ALL PLANS OF AN INSURER; ~~AND~~ AMENDING SECTION 33-22-101, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE AND AN APPLICABILITY DATE."

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

NEW SECTION. **Section 1. Definitions.** As used in [section 2], unless the context indicates otherwise, the following definitions apply:

(1) "BLOCK OF BUSINESS" MEANS AN INDIVIDUAL DISABILITY INSURANCE POLICY CERTIFICATE OR CONTRACT PRODUCT TYPE WRITTEN AND SOLD BY A HEALTH CARE INSURER TO A DEFINED SET OF INDIVIDUALS. ALL INDIVIDUALS COVERED BY THE TYPE OF POLICY OR CONTRACT ARE CONSIDERED TO BE WITHIN THE BLOCK OF BUSINESS.

~~(1)~~ (2) "Health care insurer" means a ~~health care insurer as defined in 33-22-125~~ DISABILITY INSURER, A HEALTH SERVICE CORPORATION, OR A HEALTH MAINTENANCE ORGANIZATION.

~~(2)~~ (3) (a) "Individual health benefit plan" means any hospital or medical expense policy or certificate, subscriber contract, or contract of insurance provided by a prepaid hospital or medical service plan or health maintenance organization subscriber contract and issued or delivered for issue to an individual or provided by any discretionary group trust policy providing hospital or medical expense coverage to individuals.

(b) Individual health benefit plan does not include a self-insured group health plan; a self-insured multiemployer group health plan; a group conversion plan; an insured group health plan; accident only,

specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, medicare supplement, long-term care, or disability income insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical payment insurance.

~~(3)~~ (4) "Qualifying previous coverage" means benefits or coverage provided under:

(a) medicare or medicaid;

(b) group health insurance or a health benefit plan that provides benefits similar to or exceeding benefits provided under the ~~standard health benefit plan referred to in 33-22-1811 and 33-22-1812~~ PLAN BEING APPLIED FOR if the insurance or plan has been in effect for a period of at least 1 year; or

(c) an individual health benefit plan, including coverage issued by a health maintenance organization, a prepaid hospital or medical care plan, or a fraternal benefit society, THAT PROVIDES BENEFITS SIMILAR TO OR EXCEEDING THE PLAN BEING APPLIED FOR if the plan has been in effect for a period of at least 1 year.

NEW SECTION. **Section 2. ~~Portability of insurance required~~ WAIVER OF PREEXISTING CONDITION EXCLUSION.** A health care insurer shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services in an individual health benefit plan for the period of time that 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 more than 30 days prior to the ~~effective~~ date of APPLICATION FOR new coverage.

NEW SECTION. **Section 3. Premium increases to be distributed proportionately.** (1) A health care insurer may increase the health benefit plan charges for a group or individual policy, certificate, or contract previously issued by that insurer because of a change in the attained age of the insured. Increases in premium, certificate, or contract charges for policies, certificates, or contracts previously issued by that insurer, based on factors other than attained age, must be distributed proportionately ~~by premium amount to all the policy, certificate, and contract holders of that insurer in the state~~ ACROSS THE BLOCK OF BUSINESS.

(2) As used in this section, the following definitions apply:

(a) (i) "Health benefit plan" means a 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.

(ii) Health benefit plan does not include:

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

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

(2) any group or blanket policy;

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

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

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

(4) reinsurance."

NEW SECTION. **Section 5. Codification instruction.** (1) [Sections 1 and 2] are intended to be codified as an integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [sections 1 and 2].

(2) [Section 3] is intended to be codified as an integral part of Title 33, chapter 22, part 1, and the provisions of Title 33, chapter 22, part 1, apply to [section 3].

NEW SECTION. **SECTION 6. APPLICABILITY.** [THIS ACT] APPLIES TO A POLICY, CERTIFICATE, OR CONTRACT OF DISABILITY INSURANCE AND A HEALTH SERVICE MEMBERSHIP CONTRACT ENTERED INTO OR RENEWED ON OR AFTER [THE EFFECTIVE DATE OF THIS ACT].

NEW SECTION. **SECTION 7. EFFECTIVE DATE.** [THIS ACT] IS EFFECTIVE JANUARY 1, 1996.

-END-

HOUSE BILL NO. 533

INTRODUCED BY ARNOTT, BARNETT, MILLS, MCKEE, GRINDE, WELLS, BRAINARD, KEENAN, DEVANEY, WISEMAN, KNOX, GREEN, CURTISS, DENNY, T. NELSON, HIBBARD, FORBES, OHS, SLITER, ORR, MURDOCK, STOVALL, ZOOK, HAYNE, L. SMITH, DEBRUYCKER, GRADY, TASH, SOMERVILLE, AHNER, SOFT, HERRON, SIMON, ROSE, FELAND, CLARK, TAYLOR, MERCER, SIMPKINS, BOHLINGER, MCGEE

A BILL FOR AN ACT ENTITLED: "AN ACT RELATING TO HEALTH BENEFIT PLANS; PROVIDING FOR THE PORTABILITY OF HEALTH BENEFIT PLANS BY REQUIRING INSURERS TO WAIVE CERTAIN TIME PERIODS APPLICABLE TO PREEXISTING CONDITIONS; REQUIRING CERTAIN INCREASES IN PLAN CHARGES TO BE DISTRIBUTED PROPORTIONATELY AMONG ALL PLANS OF AN INSURER; ~~AND~~ AMENDING SECTION 33-22-101, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE AND AN APPLICABILITY DATE."

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~~(1)~~ (2) "Health care insurer" means a ~~health care insurer as defined in 33-22-125~~ DISABILITY INSURER, A HEALTH SERVICE CORPORATION, OR A HEALTH MAINTENANCE ORGANIZATION.

~~(2)~~ (3) (a) "Individual health benefit plan" means any hospital or medical expense policy or certificate, subscriber contract, or contract of insurance provided by a prepaid hospital or medical service plan or health maintenance organization subscriber contract and issued or delivered for issue to an individual or provided by any discretionary group trust policy providing hospital or medical expense coverage to individuals.

(b) Individual health benefit plan does not include a self-insured group health plan; a self-insured multiemployer group health plan; a group conversion plan; an insured group health plan; accident only,

specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, medicare supplement, long-term care, or disability income insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical payment insurance.

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(a) medicare or medicaid;

(b) group health insurance or a health benefit plan that provides benefits similar to or exceeding benefits provided under the ~~standard health benefit plan referred to in 33-22-1811 and 33-22-1812~~ PLAN BEING APPLIED FOR if the insurance or plan has been in effect for a period of at least 1 year; or

(c) an individual health benefit plan, including coverage issued by a health maintenance organization, a prepaid hospital or medical care plan, or a fraternal benefit society, THAT PROVIDES BENEFITS SIMILAR TO OR EXCEEDING THE PLAN BEING APPLIED FOR if the plan has been in effect for a period of at least 1 year.

NEW SECTION. **Section 2.** ~~**Portability of insurance required**~~ **WAIVER OF PREEXISTING CONDITION EXCLUSION.** A health care insurer shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services in an individual health benefit plan for the period of time that 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 more than 30 days prior to the ~~effective~~ date of APPLICATION FOR new coverage.

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(2) As used in this section, the following definitions apply:

(a) (i) "Health benefit plan" means a 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.

(ii) 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.

(b) "Health care insurer" or "insurer" means a health care insurer as defined in 33-22-125.

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"**33-22-101. Exceptions to scope.** Parts 1 through 4 of this chapter, except 33-22-107, 33-22-110, 33-22-111, 33-22-114, [section 3], 33-22-125, 33-22-130 through 33-22-132, and 33-22-304, do not apply to or affect:

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

(2) any group or blanket policy;

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

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

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

(4) reinsurance."

NEW SECTION. **Section 5. Codification instruction.** (1) [Sections 1 and 2] are intended to be codified as an integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [sections 1 and 2].

(2) [Section 3] is intended to be codified as an integral part of Title 33, chapter 22, part 1, and the provisions of Title 33, chapter 22, part 1, apply to [section 3].

NEW SECTION. **SECTION 6. APPLICABILITY.** [THIS ACT] APPLIES TO A POLICY, CERTIFICATE, OR CONTRACT OF DISABILITY INSURANCE AND A HEALTH SERVICE MEMBERSHIP CONTRACT ENTERED INTO OR RENEWED ON OR AFTER [THE EFFECTIVE DATE OF THIS ACT].

NEW SECTION. **SECTION 7. EFFECTIVE DATE.** [THIS ACT] IS EFFECTIVE JANUARY 1, 1996.

-END-

JOINT SELECT COMMITTEE REPORT

March 17, 1995

MR. PRESIDENT:
We, your Joint Select committee on Health Care, having had under consideration HB 533 (third reading copy -- blue), respectfully report that HB 533 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 11.
Following: "INSURER;"
Insert: "REQUIRING DISCLOSURE OF CERTAIN POLICY FEATURES AT OR BEFORE THE TIME OF APPLICATION; CREATING A LOW-COST UNIFORM HEALTH BENEFIT PLAN; CAPPING PREMIUM RATES ON CERTAIN CONVERSION POLICIES;"

2. Title, line 11.
Strike: "SECTION"
Insert: "SECTIONS"

3. Title, line 12.
Following: "33-22-101,"
Insert: "33-22-508, AND 33-30-1007,"

4. Page 1, line 19.
Following: "CONTRACT"
Strike: "PRODUCT TYPE"
Insert: "filed and approved by the commissioner pursuant to 33-1-501 and"

5. Page 1, line 20.
Strike: "TYPE OF"

6. Page 1, line 23.
Strike: "OR"
Following: "ORGANIZATION"
Insert: ", or a fraternal benefit society"

7. Page 1, line 26.
Following: "issued"
Strike: "or delivered for issue"
Insert: "for delivery"

8. Page 1, lines 27 and 28
Strike: "or" on line 27 through "individuals" on line 28

Amd. Coord.
Sec. of Senate

Senator Carrying Bill

HB 533
JOINT H & S

9. Page 1, line 29.
Strike: "self-insured" in two places
Insert: "self-funded" in two places

10. Page 2, line 8.
Following: "FOR"
Strike: the remainder of line 8 through "year"

11. Page 2, lines 11 and 12.
Following: "FOR"
Strike: the remainder of line 11 through "year" on line 12

12. Page 2, line 22.
Strike: "a group or"
Insert: "an"

13. Page 2, line 24.
Following: "charges for"
Insert: "individual"

14. Page 2, line 27.
Following: "BUSINESS"
Insert: "as defined in [section 1]"

15. Page 3, line 8.
Following: "means a"
Strike: the remainder of line 8
Insert: "disability insurer, a health service corporation, a health maintenance organization, or a fraternal benefit society."

16. Page 3, line 9.
Insert: "(3) The provisions of Title 33, chapter 1, parts 3 and 7, apply to this section."

17. Page 3, line 25.
Insert: "

NEW SECTION. **Section 5. Disclosure standards -- individual policy.** (1) In order to provide for full and fair disclosure in the sale of disability insurance, an individual disability insurance policy may not be delivered or issued for delivery in this state unless an outline of coverage is delivered to the applicant at the time the application is made.

(2) The outline of coverage must include:

(a) a general description of the principal benefits and coverages provided by the policy;

(b) a general description of the insured's financial responsibility under the policy, including, if applicable, the

amount of the deductible, the amount or percentage of copayment, and the maximum annual out-of-pocket expenses to be paid by the insured;

(c) a statement of the maximum lifetime benefit available under the policy;

(d) a statement of the estimated periodic premium to be paid by the insured;

(e) a general description of the factors or case characteristics that the insurer may consider in establishing or changing the premiums and, if applicable, in determining the insurability of the applicant; and

(f) a general description of the trend of premium increases or decreases for comparable policies issued by the insurer during the preceding 5 years, if the trend data is available.

(3) The outline of coverage may include any other information that the insurer considers relevant to the applicant's selection of an appropriate individual disability policy.

(4) An insurer or producer shall provide to an individual, upon request, an outline of coverage for any health benefit product marketed to the general public. The outline of coverage provided under this subsection may exclude the statement of the estimated periodic premium to be paid by the insured.

NEW SECTION. **Section 6. Disclosure standards -- group policy.** (1) In order to provide for full and fair disclosure in the sale of disability insurance, a group disability insurance policy may not be delivered or issued for delivery in this state unless an outline of coverage is delivered to the applicant at the time the application is made.

(2) The outline of coverage must include:

(a) a general description of the principal benefits and coverages provided by the policy;

(b) a general description of the insured's financial responsibility under the policy, including, if applicable, the amount of the deductible, the amount or percentage of copayment, and the maximum annual out-of-pocket expenses to be paid by the insured;

(c) a statement of the maximum lifetime benefit available under the policy;

(d) a statement of the estimated periodic premium to be paid by the insured;

(e) a general description of the factors or case characteristics that the insurer may consider in establishing or changing the premiums and, if applicable, in determining the insurability of the applicant; and

(f) a general description of the trend of premium increases or decreases for comparable policies issued by the insurer during

the preceding 5 years, if the trend data is available.

(3) If applicable, the outline of coverage must disclose that the policy does not contain coverage for mental illness or chemical dependency.

(4) The outline of coverage may include any other information that the insurer considers relevant to the applicant's selection of an appropriate group disability policy.

(5) An insurer or producer shall provide to an individual, upon request, an outline of coverage for any health benefit product marketed to the general public. The outline of coverage provided under this subsection may exclude the statement of the estimated periodic premium to be paid by the insured.

NEW SECTION. **Section 7. Disclosure standards -- health maintenance organizations.** (1) In order to provide for full and fair disclosure in the sale of disability insurance, an enrollment form or evidence of coverage may not be delivered or issued for delivery in this state by a health maintenance organization unless an outline of coverage is delivered to the applicant at the time the application is made. The outline of coverage must be filed with the commissioner as required by 33-1-501.

(2) The outline of coverage must include:

(a) a general description of the principal benefits and coverages provided by the policy;

(b) a general description of the insured's financial responsibility under the policy, including, if applicable, the amount of the deductible, the amount or percentage of copayment, and the maximum annual out-of-pocket expenses to be paid by the insured;

(c) a statement of the maximum lifetime benefit available under the policy;

(d) a statement of the estimated periodic premium to be paid by the insured;

(e) a general description of the factors or case characteristics that the insurer may consider in establishing or changing the premiums and, if applicable, in determining the insurability of the applicant; and

(f) a general description of the trend of premium increases or decreases for comparable policies issued by the insurer during the preceding 5 years, if the trend data is available.

(3) The outline of coverage may include any other information that the insurer considers relevant to the applicant's selection of an appropriate health benefit plan.

(4) An insurer or producer shall provide to an individual, upon request, an outline of coverage for any health benefit product marketed to the general public. The outline of coverage

provided under this subsection may exclude the statement of the estimated periodic premium to be paid by the insured.

NEW SECTION. **Section 8. Uniform health benefit plan -- individual.** (1) Each insurer or health service corporation delivering or issuing for a delivery in this state an individual disability insurance policy, certificate, or contract shall make available a uniform health benefit plan providing the benefits and services required in subsection (2).

(2) The uniform health benefit plan must:

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

(b) pay 50% of the covered expenses in excess of an annual deductible that may not exceed $1,000 per person or $2,000 per family;

(c) include a limitation of $5,000 per person or $7,500 per family on the total annual out-of-pocket expenses for services covered; and

(d) be subject to a maximum lifetime benefit of $1 million.

NEW SECTION. **Section 9. Uniform health benefit plan -- group.** (1) Each insurer or health service corporation delivering or issuing for a delivery in this state a group disability insurance policy, certificate, or contract shall make available a uniform health benefit plan providing the benefits and services required in subsection (2).

(2) The uniform health benefit plan must:

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

(b) pay 50% of the covered expenses in excess of an annual deductible that may not exceed $1,000 per person or $2,000 per family;

(c) include a limitation of $5,000 per person or $7,500 per family on the total annual out-of-pocket expenses for services covered; and

(d) be subject to a maximum lifetime benefit of $1 million.

NEW SECTION. **Section 10. Uniform health benefit plan -- health maintenance organization.** Each health maintenance organization delivering or issuing for a delivery in this state an enrollment form or evidence of coverage shall make available a uniform health benefit plan [providing benefit equivalency and benefit value, as defined in section 1 of House Bill No. 466] comparable to the uniform health benefit plan required in [section 8(2)].

Section 11. Section 33-22-508, MCA, is amended to read:

"**33-22-508. Conversion on termination of eligibility.** (1) A

group disability insurance policy issued or renewed after October 1, 1981, must contain a provision that if the insurance or any portion of it on a person, ~~his~~ a person's dependents, or family members covered under the policy ceases because of termination of ~~his~~ the person's employment or of ~~his~~ the person's membership in the class or classes eligible for coverage under the policy or as a result of ~~his~~ a person's employer discontinuing ~~his~~ the employer's business or as a result of ~~his~~ a person's employer discontinuing the group disability insurance policy and not providing for any other group disability insurance or plan and if the person had been insured for a period of 3 months and ~~he~~ the person is not insured under another major medical disability insurance policy or plan, ~~he~~ the person is entitled to have issued to ~~him~~ the person by the insurer, without evidence of insurability, group coverage or an individual policy issued by the insurer or, in the absence of an individual policy issued by the insurer, a group policy issued by the insurer, of hospital or medical service insurance on ~~himself~~ the person~~, his~~ or the person's dependents~~,~~ or family members if application for the individual policy is made and the first premium tendered to the insurer within 31 days after the termination of group coverage.

(2) The individual policy or group policy, at the option of the insured, may be on any form then customarily issued by the insurer to individual or group policyholders, with the exception of a policy the eligibility for which is determined by affiliation other than by employment with a common entity. In addition, the insurer shall make available a conversion policy as required by subsection (4).

(3) The premium on the individual policy or group policy must be at the insurer's then customary conversion rate applicable to the coverage of the individual or group policy.

(4) The insurer shall make available an individual conversion policy that provides the level of benefits provided by the insurer's lowest cost basic health benefit plan, as defined in 33-22-1803. If the insurer is not a small employer carrier under part 18, the insurer shall make available an individual conversion policy that provides equivalent benefits to a basic health benefit plan. The conversion rate may not exceed 150% of the highest rate charged for that plan."

Section 12. Section 33-30-1007, MCA, is amended to read:

"**33-30-1007. Conversion on termination of eligibility.** (1) The group hospital or medical service plan contract issued or renewed by a health service corporation after October 1, 1981, shall contain a provision that if the insurance or any portion of it on a person, ~~his~~ or a person's dependents~~,~~ or family members covered under the policy ceases because of termination of ~~his~~ the person's employment or of ~~his~~ a person's membership in the class

or classes eligible for coverage under the policy, as a result of an employer discontinuing ~~his~~ the employer's business, or as a result of an employer discontinuing the policy issued by the health service corporation and not providing for any other group disability insurance or plan, ~~such~~ a person shall, provided ~~he~~ that the person has been insured for a period of 3 months and that ~~he~~ the person is not insured under another major medical disability insurance policy or plan, be entitled to have issued to ~~him~~ the person by the insurer, without evidence of insurability, an individual policy of hospital or medical service insurance on ~~himself~~ the person~~, his~~ or the person's dependents~~,~~ or family members~~, provided application~~. Application for the individual policy ~~shall~~ must be made and the first premium tendered to the insurer within 31 days after the termination of group coverage.

(2) The individual policy shall, at the option of the insured, be on any of the forms then customarily issued by the insurer to individual policyholders with the exception of those whose eligibility is determined by their affiliation other than by employment with a particular entity. In addition, the health services corporation shall make available a conversion policy as required by subsection (4).

(3) The premium on the individual policy ~~shall~~ must be at the insurer's then customary rate applicable to the coverage of the individual policy but may not be greater than 150% of the insurer's highest group rate for a policy with the same benefits as the conversion policy.

(4) The health service corporation shall make available an individual conversion policy that provides the level of benefits provided by its lowest cost basic health benefit plan, as defined in 33-22-1803. If the insurer is not a small employer carrier under chapter 22, part 18, the insurer shall make available an individual conversion policy that provides equivalent benefits to a basic health benefit plan. The conversion rate may not exceed 150% of the highest rate charged for that plan."

NEW SECTION. **Section 13. Coordination instruction.** If House Bill No. 466 is passed and approved, then the bracketed language in [section 10], referring to benefit equivalency and benefit value, must be codified."

Renumber: subsequent sections

18. Page 3, lines 29 and 30.
Strike: "1"
Insert: "2"

19. Page 4, line 1.
Insert: "(3) [Sections 5 and 8] are intended to be codified as an integral part of Title 33, chapter 22, part 2, and the provisions of Title 33, chapter 22, part 2, apply to [sections 5 and 8].

(4) [Sections 6 and 9] are intended to be codified as an integral part of Title 33, chapter 22, part 5, and the provisions of Title 33, chapter 22, part 5, apply to [sections 6 and 9].

(5) [Sections 7 and 10] are intended to be codified as an integral part of Title 33, chapter 31, part 3, and the provisions of Title 33, chapter 31, part 3, apply to [sections 7 and 10]."

-END-

HOUSE BILL NO. 533

INTRODUCED BY ARNOTT, BARNETT, MILLS, MCKEE, GRINDE, WELLS, BRAINARD, KEENAN, DEVANEY, WISEMAN, KNOX, GREEN, CURTISS, DENNY, T. NELSON, HIBBARD, FORBES, OHS, SLITER, ORR, MURDOCK, STOVALL, ZOOK, HAYNE, L. SMITH, DEBRUYCKER, GRADY, TASH, SOMERVILLE, AHNER, SOFT, HERRON, SIMON, ROSE, FELAND, CLARK, TAYLOR, MERCER, SIMPKINS, BOHLINGER, MCGEE

A BILL FOR AN ACT ENTITLED: "AN ACT RELATING TO HEALTH BENEFIT PLANS; PROVIDING FOR THE PORTABILITY OF HEALTH BENEFIT PLANS BY REQUIRING INSURERS TO WAIVE CERTAIN TIME PERIODS APPLICABLE TO PREEXISTING CONDITIONS; REQUIRING CERTAIN INCREASES IN PLAN CHARGES TO BE DISTRIBUTED PROPORTIONATELY AMONG ALL PLANS OF AN INSURER; REQUIRING DISCLOSURE OF CERTAIN POLICY FEATURES AT OR BEFORE THE TIME OF APPLICATION; CREATING A LOW-COST UNIFORM HEALTH BENEFIT PLAN; CAPPING PREMIUM RATES ON CERTAIN CONVERSION POLICIES; ~~AND~~ AMENDING ~~SECTION~~ SECTIONS 33-22-101, 33-22-508, AND 33-30-1007, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE AND AN APPLICABILITY DATE."

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

NEW SECTION. **Section 1. Definitions.** As used in [section 2], unless the context indicates otherwise, the following definitions apply:

(1) "BLOCK OF BUSINESS" MEANS AN INDIVIDUAL DISABILITY INSURANCE POLICY CERTIFICATE OR CONTRACT ~~PRODUCT TYPE~~ FILED AND APPROVED BY THE COMMISSIONER PURSUANT TO 33-1-501 AND WRITTEN AND SOLD BY A HEALTH CARE INSURER TO A DEFINED SET OF INDIVIDUALS. ALL INDIVIDUALS COVERED BY THE ~~TYPE OF~~ POLICY OR CONTRACT ARE CONSIDERED TO BE WITHIN THE BLOCK OF BUSINESS.

~~(1)~~(2) "Health care insurer" means a ~~health care insurer as defined in 33-22-125~~ DISABILITY INSURER, A HEALTH SERVICE CORPORATION, ~~OR~~ A HEALTH MAINTENANCE ORGANIZATION, OR A FRATERNAL BENEFIT SOCIETY.

~~(2)~~(3) (a) "Individual health benefit plan" means any hospital or medical expense policy or certificate, subscriber contract, or contract of insurance provided by a prepaid hospital or medical service

plan or health maintenance organization subscriber contract and issued ~~or delivered for issue~~ FOR DELIVERY to an individual ~~or provided by any discretionary group trust policy providing hospital or medical expense coverage to individuals~~.

(b) Individual health benefit plan does not include a ~~self-insured~~ SELF-FUNDED group health plan; a ~~self-insured~~ SELF-FUNDED multiemployer group health plan; a group conversion plan; an insured group health plan; accident only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, medicare supplement, long-term care, or disability income insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical payment insurance.

~~(3)~~(4) "Qualifying previous coverage" means benefits or coverage provided under:

(a) medicare or medicaid;

(b) group health insurance or a health benefit plan that provides benefits similar to or exceeding benefits provided under the ~~standard health benefit plan referred to in 33-22-1811 and 33-22-1812~~ PLAN BEING APPLIED FOR ~~if the insurance or plan has been in effect for a period of at least 1 year~~; or

(c) an individual health benefit plan, including coverage issued by a health maintenance organization, a prepaid hospital or medical care plan, or a fraternal benefit society, THAT PROVIDES BENEFITS SIMILAR TO OR EXCEEDING THE PLAN BEING APPLIED FOR ~~if the plan has been in effect for a period of at least 1 year~~.

NEW SECTION. **Section 2. ~~Portability of insurance required~~ WAIVER OF PREEXISTING CONDITION EXCLUSION.** A health care insurer shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services in an individual health benefit plan for the period of time that 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 more than 30 days prior to the ~~effective~~ date of APPLICATION FOR new coverage.

NEW SECTION. **Section 3. Premium increases to be distributed proportionately.** (1) A health care insurer may increase the health benefit plan charges for ~~a group or~~ AN individual policy, certificate, or contract previously issued by that insurer because of a change in the attained age of the insured. Increases in premium, certificate, or contract charges for INDIVIDUAL policies, certificates, or contracts previously

issued by that insurer, based on factors other than attained age, must be distributed proportionately ~~by premium amount to all the policy, certificate, and contract holders of that insurer in the state~~ ACROSS THE BLOCK OF BUSINESS AS DEFINED IN [SECTION 1].

(2) As used in this section, the following definitions apply:

(a) (i) "Health benefit plan" means a 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.

(ii) 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.

(b) "Health care insurer" or "insurer" means a ~~health care insurer as defined in 33-22-125.~~ DISABILITY INSURER, A HEALTH SERVICE CORPORATION, A HEALTH MAINTENANCE ORGANIZATION, OR A FRATERNAL BENEFIT SOCIETY.

(3) THE PROVISIONS OF TITLE 33, CHAPTER 1, PARTS 3 AND 7, APPLY TO THIS SECTION.

Section 4. Section 33-22-101, MCA, is amended to read:

"**33-22-101. Exceptions to scope.** Parts 1 through 4 of this chapter, except 33-22-107, 33-22-110, 33-22-111, 33-22-114, [section 3], 33-22-125, 33-22-130 through 33-22-132, and 33-22-304, do not apply to or affect:

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

(2) any group or blanket policy;

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

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

(b) operate to safeguard contracts against lapse or to give a special surrender value or special

benefit or an annuity in the event that the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract;

(4) reinsurance."

NEW SECTION. **SECTION 5. DISCLOSURE STANDARDS -- INDIVIDUAL POLICY.** (1) IN ORDER TO PROVIDE FOR FULL AND FAIR DISCLOSURE IN THE SALE OF DISABILITY INSURANCE, AN INDIVIDUAL DISABILITY INSURANCE POLICY MAY NOT BE DELIVERED OR ISSUED FOR DELIVERY IN THIS STATE UNLESS AN OUTLINE OF COVERAGE IS DELIVERED TO THE APPLICANT AT THE TIME THE APPLICATION IS MADE.

(2) THE OUTLINE OF COVERAGE MUST INCLUDE:

(A) A GENERAL DESCRIPTION OF THE PRINCIPAL BENEFITS AND COVERAGES PROVIDED BY THE POLICY;

(B) A GENERAL DESCRIPTION OF THE INSURED'S FINANCIAL RESPONSIBILITY UNDER THE POLICY, INCLUDING, IF APPLICABLE, THE AMOUNT OF THE DEDUCTIBLE, THE AMOUNT OR PERCENTAGE OF COPAYMENT, AND THE MAXIMUM ANNUAL OUT-OF-POCKET EXPENSES TO BE PAID BY THE INSURED;

(C) A STATEMENT OF THE MAXIMUM LIFETIME BENEFIT AVAILABLE UNDER THE POLICY;

(D) A STATEMENT OF THE ESTIMATED PERIODIC PREMIUM TO BE PAID BY THE INSURED;

(E) A GENERAL DESCRIPTION OF THE FACTORS OR CASE CHARACTERISTICS THAT THE INSURER MAY CONSIDER IN ESTABLISHING OR CHANGING THE PREMIUMS AND, IF APPLICABLE, IN DETERMINING THE INSURABILITY OF THE APPLICANT; AND

(F) A GENERAL DESCRIPTION OF THE TREND OF PREMIUM INCREASES OR DECREASES FOR COMPARABLE POLICIES ISSUED BY THE INSURER DURING THE PRECEDING 5 YEARS, IF THE TREND DATA IS AVAILABLE.

(3) THE OUTLINE OF COVERAGE MAY INCLUDE ANY OTHER INFORMATION THAT THE INSURER CONSIDERS RELEVANT TO THE APPLICANT'S SELECTION OF AN APPROPRIATE INDIVIDUAL DISABILITY POLICY.

(4) AN INSURER OR PRODUCER SHALL PROVIDE TO AN INDIVIDUAL, UPON REQUEST, AN OUTLINE OF COVERAGE FOR ANY HEALTH BENEFIT PRODUCT MARKETED TO THE GENERAL PUBLIC. THE OUTLINE OF COVERAGE PROVIDED UNDER THIS SUBSECTION MAY EXCLUDE THE STATEMENT

OF THE ESTIMATED PERIODIC PREMIUM TO BE PAID BY THE INSURED.

NEW SECTION. **SECTION 6. DISCLOSURE STANDARDS -- GROUP POLICY.** (1) IN ORDER TO PROVIDE FOR FULL AND FAIR DISCLOSURE IN THE SALE OF DISABILITY INSURANCE, A GROUP DISABILITY INSURANCE POLICY MAY NOT BE DELIVERED OR ISSUED FOR DELIVERY IN THIS STATE UNLESS AN OUTLINE OF COVERAGE IS DELIVERED TO THE APPLICANT AT THE TIME THE APPLICATION IS MADE.

(2) THE OUTLINE OF COVERAGE MUST INCLUDE:

(A) A GENERAL DESCRIPTION OF THE PRINCIPAL BENEFITS AND COVERAGES PROVIDED BY THE POLICY;

(B) A GENERAL DESCRIPTION OF THE INSURED'S FINANCIAL RESPONSIBILITY UNDER THE POLICY, INCLUDING, IF APPLICABLE, THE AMOUNT OF THE DEDUCTIBLE, THE AMOUNT OR PERCENTAGE OF COPAYMENT, AND THE MAXIMUM ANNUAL OUT-OF-POCKET EXPENSES TO BE PAID BY THE INSURED;

(C) A STATEMENT OF THE MAXIMUM LIFETIME BENEFIT AVAILABLE UNDER THE POLICY;

(D) A STATEMENT OF THE ESTIMATED PERIODIC PREMIUM TO BE PAID BY THE INSURED;

(E) A GENERAL DESCRIPTION OF THE FACTORS OR CASE CHARACTERISTICS THAT THE INSURER MAY CONSIDER IN ESTABLISHING OR CHANGING THE PREMIUMS AND, IF APPLICABLE, IN DETERMINING THE INSURABILITY OF THE APPLICANT; AND

(F) A GENERAL DESCRIPTION OF THE TREND OF PREMIUM INCREASES OR DECREASES FOR COMPARABLE POLICIES ISSUED BY THE INSURER DURING THE PRECEDING 5 YEARS, IF THE TREND DATA IS AVAILABLE.

(3) IF APPLICABLE, THE OUTLINE OF COVERAGE MUST DISCLOSE THAT THE POLICY DOES NOT CONTAIN COVERAGE FOR MENTAL ILLNESS OR CHEMICAL DEPENDENCY.

(4) THE OUTLINE OF COVERAGE MAY INCLUDE ANY OTHER INFORMATION THAT THE INSURER CONSIDERS RELEVANT TO THE APPLICANT'S SELECTION OF AN APPROPRIATE GROUP DISABILITY POLICY.

(5) AN INSURER OR PRODUCER SHALL PROVIDE TO AN INDIVIDUAL, UPON REQUEST, AN OUTLINE OF COVERAGE FOR ANY HEALTH BENEFIT PRODUCT MARKETED TO THE GENERAL PUBLIC. THE OUTLINE OF COVERAGE PROVIDED UNDER THIS SUBSECTION MAY EXCLUDE THE STATEMENT

OF THE ESTIMATED PERIODIC PREMIUM TO BE PAID BY THE INSURED.

NEW SECTION. **SECTION 7. DISCLOSURE STANDARDS -- HEALTH MAINTENANCE ORGANIZATIONS.** (1) IN ORDER TO PROVIDE FOR FULL AND FAIR DISCLOSURE IN THE SALE OF DISABILITY INSURANCE, AN ENROLLMENT FORM OR EVIDENCE OF COVERAGE MAY NOT BE DELIVERED OR ISSUED FOR DELIVERY IN THIS STATE BY A HEALTH MAINTENANCE ORGANIZATION UNLESS AN OUTLINE OF COVERAGE IS DELIVERED TO THE APPLICANT AT THE TIME THE APPLICATION IS MADE. THE OUTLINE OF COVERAGE MUST BE FILED WITH THE COMMISSIONER AS REQUIRED BY 33-1-501.

(2) THE OUTLINE OF COVERAGE MUST INCLUDE:

(A) A GENERAL DESCRIPTION OF THE PRINCIPAL BENEFITS AND COVERAGES PROVIDED BY THE POLICY;

(B) A GENERAL DESCRIPTION OF THE INSURED'S FINANCIAL RESPONSIBILITY UNDER THE POLICY, INCLUDING, IF APPLICABLE, THE AMOUNT OF THE DEDUCTIBLE, THE AMOUNT OR PERCENTAGE OF COPAYMENT, AND THE MAXIMUM ANNUAL OUT-OF-POCKET EXPENSES TO BE PAID BY THE INSURED;

(C) A STATEMENT OF THE MAXIMUM LIFETIME BENEFIT AVAILABLE UNDER THE POLICY;

(D) A STATEMENT OF THE ESTIMATED PERIODIC PREMIUM TO BE PAID BY THE INSURED;

(E) A GENERAL DESCRIPTION OF THE FACTORS OR CASE CHARACTERISTICS THAT THE INSURER MAY CONSIDER IN ESTABLISHING OR CHANGING THE PREMIUMS AND, IF APPLICABLE, IN DETERMINING THE INSURABILITY OF THE APPLICANT; AND

(F) A GENERAL DESCRIPTION OF THE TREND OF PREMIUM INCREASES OR DECREASES FOR COMPARABLE POLICIES ISSUED BY THE INSURER DURING THE PRECEDING 5 YEARS, IF THE TREND DATA IS AVAILABLE.

(3) THE OUTLINE OF COVERAGE MAY INCLUDE ANY OTHER INFORMATION THAT THE INSURER CONSIDERS RELEVANT TO THE APPLICANT'S SELECTION OF AN APPROPRIATE HEALTH BENEFIT PLAN.

(4) AN INSURER OR PRODUCER SHALL PROVIDE TO AN INDIVIDUAL, UPON REQUEST, AN OUTLINE OF COVERAGE FOR ANY HEALTH BENEFIT PRODUCT MARKETED TO THE GENERAL PUBLIC. THE OUTLINE OF COVERAGE PROVIDED UNDER THIS SUBSECTION MAY EXCLUDE THE STATEMENT OF THE ESTIMATED PERIODIC PREMIUM TO BE PAID BY THE INSURED.

NEW SECTION. **SECTION 8. UNIFORM HEALTH BENEFIT PLAN -- INDIVIDUAL.** (1) EACH INSURER OR HEALTH SERVICE CORPORATION DELIVERING OR ISSUING FOR A DELIVERY IN THIS STATE ~~AN INDIVIDUAL DISABILITY INSURANCE POLICY, CERTIFICATE, OR CONTRACT~~ A HEALTH BENEFIT PLAN, AS DEFINED IN [SECTION 3], TO AN INDIVIDUAL SHALL MAKE AVAILABLE A UNIFORM HEALTH BENEFIT PLAN PROVIDING THE BENEFITS AND SERVICES REQUIRED IN SUBSECTION (2).

(2) THE UNIFORM HEALTH BENEFIT PLAN MUST:

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

(B) PAY 50% OF THE COVERED EXPENSES IN EXCESS OF AN ANNUAL DEDUCTIBLE THAT MAY NOT EXCEED $1,000 PER PERSON OR $2,000 PER FAMILY;

(C) INCLUDE A LIMITATION OF $5,000 PER PERSON OR $7,500 PER FAMILY ON THE TOTAL ANNUAL OUT-OF-POCKET EXPENSES FOR SERVICES COVERED; AND

(D) BE SUBJECT TO A MAXIMUM LIFETIME BENEFIT OF $1 MILLION.

NEW SECTION. **SECTION 9. UNIFORM HEALTH BENEFIT PLAN -- GROUP.** (1) EACH INSURER OR HEALTH SERVICE CORPORATION DELIVERING OR ISSUING FOR A DELIVERY IN THIS STATE A ~~GROUP DISABILITY INSURANCE POLICY, CERTIFICATE, OR CONTRACT~~ HEALTH BENEFIT PLAN, AS DEFINED IN [SECTION 3], TO A GROUP SHALL MAKE AVAILABLE A UNIFORM HEALTH BENEFIT PLAN PROVIDING THE BENEFITS AND SERVICES REQUIRED IN SUBSECTION (2).

(2) THE UNIFORM HEALTH BENEFIT PLAN MUST:

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

(B) PAY 50% OF THE COVERED EXPENSES IN EXCESS OF AN ANNUAL DEDUCTIBLE THAT MAY NOT EXCEED $1,000 PER PERSON OR $2,000 PER FAMILY;

(C) INCLUDE A LIMITATION OF $5,000 PER PERSON OR $7,500 PER FAMILY ON THE TOTAL ANNUAL OUT-OF-POCKET EXPENSES FOR SERVICES COVERED; AND

(D) BE SUBJECT TO A MAXIMUM LIFETIME BENEFIT OF $1 MILLION.

NEW SECTION. **SECTION 10. UNIFORM HEALTH BENEFIT PLAN -- HEALTH MAINTENANCE ORGANIZATION.** EACH HEALTH MAINTENANCE ORGANIZATION DELIVERING OR ISSUING FOR A DELIVERY IN THIS STATE AN ENROLLMENT FORM OR EVIDENCE OF COVERAGE SHALL MAKE AVAILABLE A UNIFORM HEALTH BENEFIT PLAN [PROVIDING BENEFIT EQUIVALENCY AND BENEFIT

VALUE, AS DEFINED IN SECTION 1 OF HOUSE BILL NO. 466] COMPARABLE TO THE UNIFORM HEALTH BENEFIT PLAN REQUIRED IN [SECTION 8(2)].

SECTION 11. SECTION 33-22-508, MCA, IS AMENDED TO READ:

"**33-22-508. Conversion on termination of eligibility.** (1) A group disability insurance policy issued or renewed after October 1, 1981, must contain a provision that if the insurance or any portion of it on a person, ~~his~~ a person's dependents, or family members covered under the policy ceases because of termination of ~~his~~ the person's employment or of ~~his~~ the person's membership in the class or classes eligible for coverage under the policy or as a result of ~~his~~ a person's employer discontinuing ~~his~~ the employer's business or as a result of ~~his~~ a person's employer discontinuing the group disability insurance policy and not providing for any other group disability insurance or plan and if the person had been insured for a period of 3 months and ~~he~~ the person is not insured under another major medical disability insurance policy or plan, ~~he~~ the person is entitled to have issued to ~~him~~ the person by the insurer, without evidence of insurability, group coverage or an individual policy issued by the insurer or, in the absence of an individual policy issued by the insurer, a group policy issued by the insurer, of hospital or medical service insurance on ~~himself~~ the person~~, his~~ or the person's dependents~~,~~ or family members if application for the individual policy is made and the first premium tendered to the insurer within 31 days after the termination of group coverage.

(2) The individual policy or group policy, at the option of the insured, may be on any form then customarily issued by the insurer to individual or group policyholders, with the exception of a policy the eligibility for which is determined by affiliation other than by employment with a common entity. In addition, the insurer shall make available a conversion policy as required by subsection (4).

(3) The premium on the individual policy or group policy must be at the insurer's then customary conversion rate applicable to the coverage of the individual or group policy.

(4) The insurer shall make available an individual conversion policy that provides the level of benefits provided by the insurer's lowest cost basic health benefit plan, as defined in 33-22-1803. If the insurer is not a small employer carrier under part 18, the insurer shall make available an individual conversion policy that provides equivalent benefits to a basic health benefit plan. The conversion rate may not exceed 150% of the highest rate charged for that plan."

SECTION 12. SECTION 33-30-1007, MCA, IS AMENDED TO READ:

"**33-30-1007. Conversion on termination of eligibility.** (1) The group hospital or medical service plan contract issued or renewed by a health service corporation after October 1, 1981, shall contain a provision that if the insurance or any portion of it on a person, ~~his~~ or a person's dependents~~,~~ or family members covered under the policy ceases because of termination of ~~his~~ the person's employment or of ~~his~~ a person's membership in the class or classes eligible for coverage under the policy, as a result of an employer discontinuing ~~his~~ the employer's business, or as a result of an employer discontinuing the policy issued by the health service corporation and not providing for any other group disability insurance or plan, ~~such~~ a person shall, provided ~~he~~ that the person has been insured for a period of 3 months and that ~~he~~ the person is not insured under another major medical disability insurance policy or plan, be entitled to have issued to ~~him~~ the person by the insurer, without evidence of insurability, an individual policy of hospital or medical service insurance on ~~himself~~ the person~~,~~ ~~his~~ or the person's dependents~~,~~ or family members~~,~~ ~~provided application~~. Application for the individual policy ~~shall~~ must be made and the first premium tendered to the insurer within 31 days after the termination of group coverage.

(2) The individual policy shall, at the option of the insured, be on any of the forms then customarily issued by the insurer to individual policyholders with the exception of those whose eligibility is determined by their affiliation other than by employment with a particular entity. In addition, the health services corporation shall make available a conversion policy as required by subsection (4).

(3) The premium on the individual policy ~~shall~~ must be at the insurer's then customary conversion rate applicable to the coverage of the individual policy but may not be greater than 150% of the insurer's highest group rate for a policy with the same benefits as the conversion policy.

(4) The health service corporation shall make available an individual conversion policy that provides the level of benefits provided by its lowest cost basic health benefit plan, as defined in 33-22-1803. If the insurer is not a small employer carrier under chapter 22, part 18, the insurer shall make available an individual conversion policy that provides equivalent benefits to a basic health benefit plan. The conversion rate may not exceed 150% of the highest rate charged for that plan."

NEW SECTION. **SECTION 13. COORDINATION INSTRUCTION.** IF HOUSE BILL NO. 466 IS PASSED AND APPROVED, THEN THE BRACKETED LANGUAGE IN [SECTION 10], REFERRING TO BENEFIT EQUIVALENCY AND BENEFIT VALUE, MUST BE CODIFIED.

NEW SECTION. **Section 14. Codification instruction.** (1) [Sections 1 and 2] are intended to be codified as an integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [sections 1 and 2].

(2) [Section 3] is intended to be codified as an integral part of Title 33, chapter 22, part ~~1~~ 2, and the provisions of Title 33, chapter 22, part ~~1~~ 2, apply to [section 3].

(3) [SECTIONS 5 AND 8] ARE INTENDED TO BE CODIFIED AS AN INTEGRAL PART OF TITLE 33, CHAPTER 22, PART 2, AND THE PROVISIONS OF TITLE 33, CHAPTER 22, PART 2, APPLY TO [SECTIONS 5 AND 8].

(4) [SECTIONS 6 AND 9] ARE INTENDED TO BE CODIFIED AS AN INTEGRAL PART OF TITLE 33, CHAPTER 22, PART 5, AND THE PROVISIONS OF TITLE 33, CHAPTER 22, PART 5, APPLY TO [SECTIONS 6 AND 9].

(5) [SECTIONS 7 AND 10] ARE INTENDED TO BE CODIFIED AS AN INTEGRAL PART OF TITLE 33, CHAPTER 31, PART 3, AND THE PROVISIONS OF TITLE 33, CHAPTER 31, PART 3, APPLY TO [SECTIONS 7 AND 10].

NEW SECTION. **SECTION 15. APPLICABILITY.** [THIS ACT] APPLIES TO A POLICY, CERTIFICATE, OR CONTRACT OF DISABILITY INSURANCE AND A HEALTH SERVICE MEMBERSHIP CONTRACT ENTERED INTO OR RENEWED ON OR AFTER [THE EFFECTIVE DATE OF THIS ACT].

NEW SECTION. **SECTION 16. EFFECTIVE DATE.** [THIS ACT] IS EFFECTIVE JANUARY 1, 1996.

-END-

SENATE COMMITTEE OF THE WHOLE AMENDMENT

March 20, 1995 10:48 am

Mr. Chairman: I move to amend HB 533 (third reading copy -- blue).

ADOPT V.V.

REJECT

Signed: Ken D. Miller
Senator Miller

That such amendments read:

Amend the Joint Select Committee on Health Care committee report dated March 17, 1995, as follows:

1. Amendment #17, Section 8(1).
Strike: "an individual disability insurance policy, certificate, or contract"
Insert: "a health benefit plan, as defined in [section 3], to an individual"

2. Amendment #17, Section 9(1).
Strike: "group disability insurance policy, certificate, or contract"
Insert: "health benefit plan, as defined in [section 3], to a group"

-END-

Amd. Coord.

HB 533

SENATE

GOVERNOR'S AMENDMENTS TO
HOUSE BILL NO. 533
(REFERENCE COPY)
April 12, 1995

1. Page 8, line 23.
Following: "at"
Insert: "no more than 200% of"

2. Page 8, line 24.
Strike: "conversion"
Following: "policy."
Insert: "The customary rate is that rate that is normally issued for medically underwritten policies without discount for healthy lifestyles."

3. Page 9, line 19.
Following: "at"
Insert: "no more than 200% of"
Strike: "conversion"

4. Page lines 20 and 21.
Following: "policy"
Strike: the remainder of line 20 through "conversion policy" on line 21
Following: "."
Insert: "The customary rate is that rate that is normally issued for medically underwritten policies without discount for healthy lifestyles."

HB 533

HOUSE BILL NO. 533

INTRODUCED BY ARNOTT, BARNETT, MILLS, MCKEE, GRINDE, WELLS, BRAINARD, KEENAN, DEVANEY, WISEMAN, KNOX, GREEN, CURTISS, DENNY, T. NELSON, HIBBARD, FORBES, OHS, SLITER, ORR, MURDOCK, STOVALL, ZOOK, HAYNE, L. SMITH, DEBRUYCKER, GRADY, TASH, SOMERVILLE, AHNER, SOFT, HERRON, SIMON, ROSE, FELAND, CLARK, TAYLOR, MERCER, SIMPKINS, BOHLINGER, MCGEE

A BILL FOR AN ACT ENTITLED: "AN ACT RELATING TO HEALTH BENEFIT PLANS; PROVIDING FOR THE PORTABILITY OF HEALTH BENEFIT PLANS BY REQUIRING INSURERS TO WAIVE CERTAIN TIME PERIODS APPLICABLE TO PREEXISTING CONDITIONS; REQUIRING CERTAIN INCREASES IN PLAN CHARGES TO BE DISTRIBUTED PROPORTIONATELY AMONG ALL PLANS OF AN INSURER; REQUIRING DISCLOSURE OF CERTAIN POLICY FEATURES AT OR BEFORE THE TIME OF APPLICATION; CREATING A LOW-COST UNIFORM HEALTH BENEFIT PLAN; CAPPING PREMIUM RATES ON CERTAIN CONVERSION POLICIES; ~~AND~~ AMENDING ~~SECTION~~ SECTIONS 33-22-101, 33-22-508, AND 33-30-1007, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE AND AN APPLICABILITY DATE."

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

NEW SECTION. **Section 1. Definitions.** As used in [section 2], unless the context indicates otherwise, the following definitions apply:

(1) "BLOCK OF BUSINESS" MEANS AN INDIVIDUAL DISABILITY INSURANCE POLICY CERTIFICATE OR CONTRACT ~~PRODUCT TYPE~~ FILED AND APPROVED BY THE COMMISSIONER PURSUANT TO 33-1-501 AND WRITTEN AND SOLD BY A HEALTH CARE INSURER TO A DEFINED SET OF INDIVIDUALS. ALL INDIVIDUALS COVERED BY THE ~~TYPE OF~~ POLICY OR CONTRACT ARE CONSIDERED TO BE WITHIN THE BLOCK OF BUSINESS.

~~(1)~~(2) "Health care insurer" means a ~~health care insurer as defined in 33-22-125~~ DISABILITY INSURER, A HEALTH SERVICE CORPORATION, ~~OR~~ A HEALTH MAINTENANCE ORGANIZATION, OR A FRATERNAL BENEFIT SOCIETY.

~~(2)~~(3) (a) "Individual health benefit plan" means any hospital or medical expense policy or certificate, subscriber contract, or contract of insurance provided by a prepaid hospital or medical service

REFERENCE BILL: INCLUDES GOVERNOR'S AMENDMENTS DATED 4-12-95

plan or health maintenance organization subscriber contract and issued ~~or delivered for issue~~ FOR DELIVERY to an individual ~~or provided by any discretionary group trust policy providing hospital or medical expense coverage to individuals~~.

(b) Individual health benefit plan does not include a ~~self-insured~~ SELF-FUNDED group health plan; a ~~self-insured~~ SELF-FUNDED multiemployer group health plan; a group conversion plan; an insured group health plan; accident only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, medicare supplement, long-term care, or disability income insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical payment insurance.

~~(3)~~(4) "Qualifying previous coverage" means benefits or coverage provided under:

(a) medicare or medicaid;

(b) group health insurance or a health benefit plan that provides benefits similar to or exceeding benefits provided under the ~~standard health benefit plan referred to in 33-22-1811 and 33-22-1812~~ PLAN BEING APPLIED FOR ~~if the insurance or plan has been in effect for a period of at least 1 year~~; or

(c) an individual health benefit plan, including coverage issued by a health maintenance organization, a prepaid hospital or medical care plan, or a fraternal benefit society, THAT PROVIDES BENEFITS SIMILAR TO OR EXCEEDING THE PLAN BEING APPLIED FOR ~~if the plan has been in effect for a period of at least 1 year~~.

NEW SECTION. **Section 2. ~~Portability of insurance required~~ WAIVER OF PREEXISTING CONDITION EXCLUSION.** A health care insurer shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services in an individual health benefit plan for the period of time that 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 more than 30 days prior to the ~~effective~~ date of APPLICATION FOR new coverage.

NEW SECTION. **Section 3. Premium increases to be distributed proportionately.** (1) A health care insurer may increase the health benefit plan charges for ~~a group or~~ AN individual policy, certificate, or contract previously issued by that insurer because of a change in the attained age of the insured. Increases in premium, certificate, or contract charges for INDIVIDUAL policies, certificates, or contracts previously

issued by that insurer, based on factors other than attained age, must be distributed proportionately ~~by premium amount to all the policy, certificate, and contract holders of that insurer in the state~~ ACROSS THE BLOCK OF BUSINESS AS DEFINED IN [SECTION 1].

(2) As used in this section, the following definitions apply:

(a) (i) "Health benefit plan" means a 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.

(ii) 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.

(b) "Health care insurer" or "insurer" means a ~~health care insurer as defined in 33-22-125.~~ DISABILITY INSURER, A HEALTH SERVICE CORPORATION, A HEALTH MAINTENANCE ORGANIZATION, OR A FRATERNAL BENEFIT SOCIETY.

(3) THE PROVISIONS OF TITLE 33, CHAPTER 1, PARTS 3 AND 7, APPLY TO THIS SECTION.

Section 4. Section 33-22-101, MCA, is amended to read:

"**33-22-101. Exceptions to scope.** Parts 1 through 4 of this chapter, except 33-22-107, 33-22-110, 33-22-111, 33-22-114, [section 3], 33-22-125, 33-22-130 through 33-22-132, and 33-22-304, do not apply to or affect:

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

(2) any group or blanket policy;

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

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

(b) operate to safeguard contracts against lapse or to give a special surrender value or special

benefit or an annuity in the event that the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract;

(4) reinsurance."

NEW SECTION. **SECTION 5. DISCLOSURE STANDARDS -- INDIVIDUAL POLICY.** (1) IN ORDER TO PROVIDE FOR FULL AND FAIR DISCLOSURE IN THE SALE OF DISABILITY INSURANCE, AN INDIVIDUAL DISABILITY INSURANCE POLICY MAY NOT BE DELIVERED OR ISSUED FOR DELIVERY IN THIS STATE UNLESS AN OUTLINE OF COVERAGE IS DELIVERED TO THE APPLICANT AT THE TIME THE APPLICATION IS MADE.

(2) THE OUTLINE OF COVERAGE MUST INCLUDE:

(A) A GENERAL DESCRIPTION OF THE PRINCIPAL BENEFITS AND COVERAGES PROVIDED BY THE POLICY;

(B) A GENERAL DESCRIPTION OF THE INSURED'S FINANCIAL RESPONSIBILITY UNDER THE POLICY, INCLUDING, IF APPLICABLE, THE AMOUNT OF THE DEDUCTIBLE, THE AMOUNT OR PERCENTAGE OF COPAYMENT, AND THE MAXIMUM ANNUAL OUT-OF-POCKET EXPENSES TO BE PAID BY THE INSURED;

(C) A STATEMENT OF THE MAXIMUM LIFETIME BENEFIT AVAILABLE UNDER THE POLICY;

(D) A STATEMENT OF THE ESTIMATED PERIODIC PREMIUM TO BE PAID BY THE INSURED;

(E) A GENERAL DESCRIPTION OF THE FACTORS OR CASE CHARACTERISTICS THAT THE INSURER MAY CONSIDER IN ESTABLISHING OR CHANGING THE PREMIUMS AND, IF APPLICABLE, IN DETERMINING THE INSURABILITY OF THE APPLICANT; AND

(F) A GENERAL DESCRIPTION OF THE TREND OF PREMIUM INCREASES OR DECREASES FOR COMPARABLE POLICIES ISSUED BY THE INSURER DURING THE PRECEDING 5 YEARS, IF THE TREND DATA IS AVAILABLE.

(3) THE OUTLINE OF COVERAGE MAY INCLUDE ANY OTHER INFORMATION THAT THE INSURER CONSIDERS RELEVANT TO THE APPLICANT'S SELECTION OF AN APPROPRIATE INDIVIDUAL DISABILITY POLICY.

(4) AN INSURER OR PRODUCER SHALL PROVIDE TO AN INDIVIDUAL, UPON REQUEST, AN OUTLINE OF COVERAGE FOR ANY HEALTH BENEFIT PRODUCT MARKETED TO THE GENERAL PUBLIC. THE OUTLINE OF COVERAGE PROVIDED UNDER THIS SUBSECTION MAY EXCLUDE THE STATEMENT

OF THE ESTIMATED PERIODIC PREMIUM TO BE PAID BY THE INSURED.

NEW SECTION. **SECTION 6. DISCLOSURE STANDARDS -- GROUP POLICY.** (1) IN ORDER TO PROVIDE FOR FULL AND FAIR DISCLOSURE IN THE SALE OF DISABILITY INSURANCE, A GROUP DISABILITY INSURANCE POLICY MAY NOT BE DELIVERED OR ISSUED FOR DELIVERY IN THIS STATE UNLESS AN OUTLINE OF COVERAGE IS DELIVERED TO THE APPLICANT AT THE TIME THE APPLICATION IS MADE.

(2) THE OUTLINE OF COVERAGE MUST INCLUDE:

(A) A GENERAL DESCRIPTION OF THE PRINCIPAL BENEFITS AND COVERAGES PROVIDED BY THE POLICY;

(B) A GENERAL DESCRIPTION OF THE INSURED'S FINANCIAL RESPONSIBILITY UNDER THE POLICY, INCLUDING, IF APPLICABLE, THE AMOUNT OF THE DEDUCTIBLE, THE AMOUNT OR PERCENTAGE OF COPAYMENT, AND THE MAXIMUM ANNUAL OUT-OF-POCKET EXPENSES TO BE PAID BY THE INSURED;

(C) A STATEMENT OF THE MAXIMUM LIFETIME BENEFIT AVAILABLE UNDER THE POLICY;

(D) A STATEMENT OF THE ESTIMATED PERIODIC PREMIUM TO BE PAID BY THE INSURED;

(E) A GENERAL DESCRIPTION OF THE FACTORS OR CASE CHARACTERISTICS THAT THE INSURER MAY CONSIDER IN ESTABLISHING OR CHANGING THE PREMIUMS AND, IF APPLICABLE, IN DETERMINING THE INSURABILITY OF THE APPLICANT; AND

(F) A GENERAL DESCRIPTION OF THE TREND OF PREMIUM INCREASES OR DECREASES FOR COMPARABLE POLICIES ISSUED BY THE INSURER DURING THE PRECEDING 5 YEARS, IF THE TREND DATA IS AVAILABLE.

(3) IF APPLICABLE, THE OUTLINE OF COVERAGE MUST DISCLOSE THAT THE POLICY DOES NOT CONTAIN COVERAGE FOR MENTAL ILLNESS OR CHEMICAL DEPENDENCY.

(4) THE OUTLINE OF COVERAGE MAY INCLUDE ANY OTHER INFORMATION THAT THE INSURER CONSIDERS RELEVANT TO THE APPLICANT'S SELECTION OF AN APPROPRIATE GROUP DISABILITY POLICY.

(5) AN INSURER OR PRODUCER SHALL PROVIDE TO AN INDIVIDUAL, UPON REQUEST, AN OUTLINE OF COVERAGE FOR ANY HEALTH BENEFIT PRODUCT MARKETED TO THE GENERAL PUBLIC. THE OUTLINE OF COVERAGE PROVIDED UNDER THIS SUBSECTION MAY EXCLUDE THE STATEMENT

OF THE ESTIMATED PERIODIC PREMIUM TO BE PAID BY THE INSURED.

NEW SECTION. **SECTION 7. DISCLOSURE STANDARDS -- HEALTH MAINTENANCE ORGANIZATIONS.** (1) IN ORDER TO PROVIDE FOR FULL AND FAIR DISCLOSURE IN THE SALE OF DISABILITY INSURANCE, AN ENROLLMENT FORM OR EVIDENCE OF COVERAGE MAY NOT BE DELIVERED OR ISSUED FOR DELIVERY IN THIS STATE BY A HEALTH MAINTENANCE ORGANIZATION UNLESS AN OUTLINE OF COVERAGE IS DELIVERED TO THE APPLICANT AT THE TIME THE APPLICATION IS MADE. THE OUTLINE OF COVERAGE MUST BE FILED WITH THE COMMISSIONER AS REQUIRED BY 33-1-501.

(2) THE OUTLINE OF COVERAGE MUST INCLUDE:

(A) A GENERAL DESCRIPTION OF THE PRINCIPAL BENEFITS AND COVERAGES PROVIDED BY THE POLICY;

(B) A GENERAL DESCRIPTION OF THE INSURED'S FINANCIAL RESPONSIBILITY UNDER THE POLICY, INCLUDING, IF APPLICABLE, THE AMOUNT OF THE DEDUCTIBLE, THE AMOUNT OR PERCENTAGE OF COPAYMENT, AND THE MAXIMUM ANNUAL OUT-OF-POCKET EXPENSES TO BE PAID BY THE INSURED;

(C) A STATEMENT OF THE MAXIMUM LIFETIME BENEFIT AVAILABLE UNDER THE POLICY;

(D) A STATEMENT OF THE ESTIMATED PERIODIC PREMIUM TO BE PAID BY THE INSURED;

(E) A GENERAL DESCRIPTION OF THE FACTORS OR CASE CHARACTERISTICS THAT THE INSURER MAY CONSIDER IN ESTABLISHING OR CHANGING THE PREMIUMS AND, IF APPLICABLE, IN DETERMINING THE INSURABILITY OF THE APPLICANT; AND

(F) A GENERAL DESCRIPTION OF THE TREND OF PREMIUM INCREASES OR DECREASES FOR COMPARABLE POLICIES ISSUED BY THE INSURER DURING THE PRECEDING 5 YEARS, IF THE TREND DATA IS AVAILABLE.

(3) THE OUTLINE OF COVERAGE MAY INCLUDE ANY OTHER INFORMATION THAT THE INSURER CONSIDERS RELEVANT TO THE APPLICANT'S SELECTION OF AN APPROPRIATE HEALTH BENEFIT PLAN.

(4) AN INSURER OR PRODUCER SHALL PROVIDE TO AN INDIVIDUAL, UPON REQUEST, AN OUTLINE OF COVERAGE FOR ANY HEALTH BENEFIT PRODUCT MARKETED TO THE GENERAL PUBLIC. THE OUTLINE OF COVERAGE PROVIDED UNDER THIS SUBSECTION MAY EXCLUDE THE STATEMENT OF THE ESTIMATED PERIODIC PREMIUM TO BE PAID BY THE INSURED.

NEW SECTION. **SECTION 8. UNIFORM HEALTH BENEFIT PLAN -- INDIVIDUAL.** (1) EACH INSURER OR HEALTH SERVICE CORPORATION DELIVERING OR ISSUING FOR A DELIVERY IN THIS STATE ~~AN INDIVIDUAL DISABILITY INSURANCE POLICY, CERTIFICATE, OR CONTRACT~~ A HEALTH BENEFIT PLAN, AS DEFINED IN [SECTION 3], TO AN INDIVIDUAL SHALL MAKE AVAILABLE A UNIFORM HEALTH BENEFIT PLAN PROVIDING THE BENEFITS AND SERVICES REQUIRED IN SUBSECTION (2).

(2) THE UNIFORM HEALTH BENEFIT PLAN MUST:

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

(B) PAY 50% OF THE COVERED EXPENSES IN EXCESS OF AN ANNUAL DEDUCTIBLE THAT MAY NOT EXCEED $1,000 PER PERSON OR $2,000 PER FAMILY;

(C) INCLUDE A LIMITATION OF $5,000 PER PERSON OR $7,500 PER FAMILY ON THE TOTAL ANNUAL OUT-OF-POCKET EXPENSES FOR SERVICES COVERED; AND

(D) BE SUBJECT TO A MAXIMUM LIFETIME BENEFIT OF $1 MILLION.

NEW SECTION. **SECTION 9. UNIFORM HEALTH BENEFIT PLAN -- GROUP.** (1) EACH INSURER OR HEALTH SERVICE CORPORATION DELIVERING OR ISSUING FOR A DELIVERY IN THIS STATE A ~~GROUP DISABILITY INSURANCE POLICY, CERTIFICATE, OR CONTRACT~~ HEALTH BENEFIT PLAN, AS DEFINED IN [SECTION 3], TO A GROUP SHALL MAKE AVAILABLE A UNIFORM HEALTH BENEFIT PLAN PROVIDING THE BENEFITS AND SERVICES REQUIRED IN SUBSECTION (2).

(2) THE UNIFORM HEALTH BENEFIT PLAN MUST:

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

(B) PAY 50% OF THE COVERED EXPENSES IN EXCESS OF AN ANNUAL DEDUCTIBLE THAT MAY NOT EXCEED $1,000 PER PERSON OR $2,000 PER FAMILY;

(C) INCLUDE A LIMITATION OF $5,000 PER PERSON OR $7,500 PER FAMILY ON THE TOTAL ANNUAL OUT-OF-POCKET EXPENSES FOR SERVICES COVERED; AND

(D) BE SUBJECT TO A MAXIMUM LIFETIME BENEFIT OF $1 MILLION.

NEW SECTION. **SECTION 10. UNIFORM HEALTH BENEFIT PLAN -- HEALTH MAINTENANCE ORGANIZATION.** EACH HEALTH MAINTENANCE ORGANIZATION DELIVERING OR ISSUING FOR A DELIVERY IN THIS STATE AN ENROLLMENT FORM OR EVIDENCE OF COVERAGE SHALL MAKE AVAILABLE A UNIFORM HEALTH BENEFIT PLAN [PROVIDING BENEFIT EQUIVALENCY AND BENEFIT

VALUE, AS DEFINED IN SECTION 1 OF HOUSE BILL NO. 466] COMPARABLE TO THE UNIFORM HEALTH BENEFIT PLAN REQUIRED IN [SECTION 8(2)].

SECTION 11. SECTION 33-22-508, MCA, IS AMENDED TO READ:

"**33-22-508. Conversion on termination of eligibility.** (1) A group disability insurance policy issued or renewed after October 1, 1981, must contain a provision that if the insurance or any portion of it on a person, ~~his~~ a person's dependents, or family members covered under the policy ceases because of termination of ~~his~~ the person's employment or of ~~his~~ the person's membership in the class or classes eligible for coverage under the policy or as a result of ~~his~~ a person's employer discontinuing ~~his~~ the employer's business or as a result of ~~his~~ a person's employer discontinuing the group disability insurance policy and not providing for any other group disability insurance or plan and if the person had been insured for a period of 3 months and ~~he~~ the person is not insured under another major medical disability insurance policy or plan, ~~he~~ the person is entitled to have issued to ~~him~~ the person by the insurer, without evidence of insurability, group coverage or an individual policy issued by the insurer or, in the absence of an individual policy issued by the insurer, a group policy issued by the insurer, of hospital or medical service insurance on ~~himself~~ the person~~, his~~ or the person's dependents~~,~~ or family members if application for the individual policy is made and the first premium tendered to the insurer within 31 days after the termination of group coverage.

(2) The individual policy or group policy, at the option of the insured, may be on any form then customarily issued by the insurer to individual or group policyholders, with the exception of a policy the eligibility for which is determined by affiliation other than by employment with a common entity. In addition, the insurer shall make available a conversion policy as required by subsection (4).

(3) The premium on the individual policy or group policy must be at NO MORE THAN 200% OF the insurer's then customary ~~conversion~~ rate applicable to the coverage of the individual or group policy. THE CUSTOMARY RATE IS THAT RATE THAT IS NORMALLY ISSUED FOR MEDICALLY UNDERWRITTEN POLICIES WITHOUT DISCOUNT FOR HEALTHY LIFESTYLES.

(4) The insurer shall make available an individual conversion policy that provides the level of benefits provided by the insurer's lowest cost basic health benefit plan, as defined in 33-22-1803. If the insurer is not a small employer carrier under part 18, the insurer shall make available an individual conversion policy that provides equivalent benefits to a basic health benefit plan. The conversion rate may

not exceed 150% of the highest rate charged for that plan."

SECTION 12. SECTION 33-30-1007, MCA, IS AMENDED TO READ:

"**33-30-1007. Conversion on termination of eligibility.** (1) The group hospital or medical service plan contract issued or renewed by a health service corporation after October 1, 1981, shall contain a provision that if the insurance or any portion of it on a person, ~~his~~ or a person's dependents~~,~~ or family members covered under the policy ceases because of termination of ~~his~~ the person's employment or of ~~his~~ a person's membership in the class or classes eligible for coverage under the policy, as a result of an employer discontinuing ~~his~~ the employer's business, or as a result of an employer discontinuing the policy issued by the health service corporation and not providing for any other group disability insurance or plan, ~~such~~ a person shall, provided ~~he~~ that the person has been insured for a period of 3 months and that ~~he~~ the person is not insured under another major medical disability insurance policy or plan, be entitled to have issued to ~~him~~ the person by the insurer, without evidence of insurability, an individual policy of hospital or medical service insurance on ~~himself~~ the person~~, his~~ or the person's dependents~~,~~ or family members~~,~~ ~~provided application~~. Application for the individual policy ~~shall~~ must be made and the first premium tendered to the insurer within 31 days after the termination of group coverage.

(2) The individual policy shall, at the option of the insured, be on any of the forms then customarily issued by the insurer to individual policyholders with the exception of those whose eligibility is determined by their affiliation other than by employment with a particular entity. In addition, the health services corporation shall make available a conversion policy as required by subsection (4).

(3) The premium on the individual policy ~~shall~~ must be at NO MORE THAN 200% OF the insurer's then customary ~~conversion~~ rate applicable to the coverage of the individual policy ~~but may not be greater than 150% of the insurer's highest group rate for a policy with the same benefits as the conversion policy~~. THE CUSTOMARY RATE IS THAT RATE THAT IS NORMALLY ISSUED FOR MEDICALLY UNDERWRITTEN POLICIES WITHOUT DISCOUNT FOR HEALTHY LIFESTYLES.

(4) The health service corporation shall make available an individual conversion policy that provides the level of benefits provided by its lowest cost basic health benefit plan, as defined in 33-22-1803. If the insurer is not a small employer carrier under chapter 22, part 18, the insurer shall make available an individual conversion policy that provides equivalent benefits to a basic health benefit plan. The conversion rate may not exceed 150% of the highest rate charged for that plan."

NEW SECTION. **SECTION 13. COORDINATION INSTRUCTION.** IF HOUSE BILL NO. 466 IS PASSED AND APPROVED, THEN THE BRACKETED LANGUAGE IN [SECTION 10], REFERRING TO BENEFIT EQUIVALENCY AND BENEFIT VALUE, MUST BE CODIFIED.

NEW SECTION. **Section 14. Codification instruction.** (1) [Sections 1 and 2] are intended to be codified as an integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [sections 1 and 2].

(2) [Section 3] is intended to be codified as an integral part of Title 33, chapter 22, part ~~1~~ 2, and the provisions of Title 33, chapter 22, part ~~1~~ 2, apply to [section 3].

(3) [SECTIONS 5 AND 8] ARE INTENDED TO BE CODIFIED AS AN INTEGRAL PART OF TITLE 33, CHAPTER 22, PART 2, AND THE PROVISIONS OF TITLE 33, CHAPTER 22, PART 2, APPLY TO [SECTIONS 5 AND 8].

(4) [SECTIONS 6 AND 9] ARE INTENDED TO BE CODIFIED AS AN INTEGRAL PART OF TITLE 33, CHAPTER 22, PART 5, AND THE PROVISIONS OF TITLE 33, CHAPTER 22, PART 5, APPLY TO [SECTIONS 6 AND 9].

(5) [SECTIONS 7 AND 10] ARE INTENDED TO BE CODIFIED AS AN INTEGRAL PART OF TITLE 33, CHAPTER 31, PART 3, AND THE PROVISIONS OF TITLE 33, CHAPTER 31, PART 3, APPLY TO [SECTIONS 7 AND 10].

NEW SECTION. **SECTION 15. APPLICABILITY.** [THIS ACT] APPLIES TO A POLICY, CERTIFICATE, OR CONTRACT OF DISABILITY INSURANCE AND A HEALTH SERVICE MEMBERSHIP CONTRACT ENTERED INTO OR RENEWED ON OR AFTER [THE EFFECTIVE DATE OF THIS ACT].

NEW SECTION. **SECTION 16. EFFECTIVE DATE.** [THIS ACT] IS EFFECTIVE JANUARY 1, 1996.

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