SENATE BILL NO. 341

INTRODUCED BY Holden

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING THE MONTANA COMPREHENSIVE HEALTH ASSOCIATION PLAN; ESTABLISHING LIMITS ON ELIGIBILITY; PROHIBITING REFERRAL OF INDIVIDUALS TO THE PLAN FOR CERTAIN PURPOSES AND MAKING THOSE REFERRALS AN UNFAIR TRADE PRACTICE; MAKING OFFICERS AND DIRECTORS OF THE ASSOCIATION NOT INDIVIDUALLY LIABLE FOR CERTAIN ACTIONS; EXCEPTING THE ASSOCIATION PLAN FROM THE PROHIBITION AGAINST AN INSURER DENYING OR REDUCING BENEFITS FOR PERSONS ELIGIBLE TO RECEIVE PUBLIC MEDICAL ASSISTANCE; PROVIDING DEFINITIONS; DELETING PREGNANCY AS AN ASSOCIATION PLAN EXCLUSION; ALLOWING THE ASSOCIATION BOARD AND THE COMMISSIONER OF INSURANCE TO ESTABLISH REFERRAL FEES; REQUIRING WAIVER OF PREEXISTING CONDITION EXCLUSIONS UNDER CERTAIN CIRCUMSTANCES; MODIFYING THE COMPOSITION OF THE ASSOCIATION BOARD; ADDING HEALTH SERVICE CORPORATIONS TO THE MANNER IN WHICH PREMIUMS ARE CALCULATED; AND AMENDING SECTIONS 27-1-732, 33-22-113, 33-22-1501, 33-22-1503, 33-22-1504, 33-22-1512, 33-22-1515, 33-22-1516, AND 33-22-1521, MCA."

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

NEW SECTION. **Section 1. Limitations on eligibility.** An individual who purchases a policy of insurance pursuant to 33-22-1516 is no longer eligible for insurance under an association plan and is subject to cancellation of enrollment if the individual:

(1) receives benefits under the Montana medicaid program as established in Title 53, chapter 6;

(2) fails to pay the premium for the policy of insurance purchased pursuant to 33-22-1516;

(3) changes residence from Montana to another state;

(4) exceeds the lifetime maximum benefit provided in the association plan; or

(5) enrolls under another disability insurance policy or plan for health service benefits. However, the individual may maintain enrollment in the association plan during a waiting period applicable to preexisting conditions under the other policy or plan. If the individual maintains the association plan during the waiting period, the association plan may coordinate the benefits with the individual's new policy or plan

and the benefits of the association plan are considered secondary to the benefits available under the individual's new policy or plan.

NEW SECTION. **Section 2. Unfair referral to plan.** An insurer, insurance producer, insurance broker, or third-party administrator may not refer an individual or an individual's dependant to the association plan or arrange for the individual or the individual's employee to apply to the association for enrollment under an association plan in order to separate the individual or the individual's dependant from coverage under a group health insurance contract, policy, or certificate obtained in connection with the individual's employment.

NEW SECTION. **Section 3. Unfair referral as unfair trade practice.** A referral made in violation of [section 2] is an unfair trade practice under this chapter.

Section 4. Section 27-1-732, MCA, is amended to read:

"**27-1-732. Immunity of nonprofit corporation officers, directors, and volunteers.** (1) ~~No~~ An officer, director, or volunteer of a nonprofit corporation is not individually liable for any action or omission made in the course and scope of ~~his~~ the officer's, director's, or volunteer's official capacity on behalf of the nonprofit corporation. This section does not apply to liability for willful or wanton misconduct. The immunity granted by this section does not apply to the liability of a nonprofit corporation.

(2) For purposes of this section, "nonprofit corporation" means:

(a) an organization exempt from taxation under section 501(c) of the Internal Revenue Code of 1954; ~~or~~

(b) a corporation or organization ~~which~~ that is eligible for or has been granted by the department of revenue ~~tax exempt~~ tax-exempt status under the provisions of 15-31-102; or

(c) the comprehensive health association created by 33-22-1503."

Section 5. Section 33-22-113, MCA, is amended to read:

"**33-22-113. Disability insurance coverage of persons eligible for public medical assistance.** ~~No~~ (1) Except as provided in subsection (2), a disability insurance policy providing hospital, medical, or surgical expense benefits delivered or issued for delivery in this state on or after July 1, 1979, may not contain any

provision denying or reducing ~~such~~ those benefits for the reason that the person insured is eligible for or receiving public medical assistance provided under Title 53, chapter 2.

(2) This section does not apply to the comprehensive health association plan issued pursuant to Title 33, chapter 22, part 15."

Section 6. Section 33-22-1501, MCA, is amended to read:

"**33-22-1501. Definitions.** As used in this part, the following definitions apply:

(1) "Association" means the comprehensive health association created by 33-22-1503.

(2) "Association plan" means a policy of insurance coverage that is offered by the association and that is certified by the association as required by 33-22-1521.

(3) "Association plan premium" means the charge determined pursuant to 33-22-1512 for membership in the association plan based on the benefits provided in 33-22-1521.

(4) "Eligible person" means an individual who:

(a) is a resident of this state and applies for coverage under the association plan; ~~and~~

(b) unless the individual's eligibility is waived by the association, has, within 6 months prior to the date of application, been rejected for disability insurance or health service benefits by at least two insurers, societies, or health service corporations~~,~~ or has had a restrictive rider or preexisting conditions limitation, which limitation is required by at least two insurers, societies, or health service corporations, which has the effect of substantially reducing coverage from that received by a person considered a standard risk; and

(c) is not eligible for any other form of disability insurance, health service benefits, or the Montana medicaid program.

(5) "Health service corporation" means a corporation operating pursuant to Title 33, chapter 30, and offering or selling contracts of disability insurance.

(6) "Insurance arrangement" means any plan, program, contract, or other arrangement to the extent not exempt from inclusion by virtue of the provisions of the federal Employee Retirement Income Security Act of 1974 under which one or more employers, unions, or other organizations provide to their employees or members, either directly or indirectly through a trust of a third-party administrator, health care services or benefits other than through an insurer.

(7) "Insurer" means a company operating pursuant to Title 33, chapter 2 or 3, and offering or selling policies or contracts of disability insurance, as provided in Title 33, chapter 22.

(8) "Lead carrier" means the licensed administrator or insurer selected by the association to administer the association plan.

(9) "Medicare" means coverage under both parts A and B of Title XVIII of the Social Security Act, 42 U.S.C. 1395, et seq., as amended.

~~(9)~~(10) "Preexisting condition" means any condition for which an applicant for coverage under the association plan has received medical attention during the 5 years immediately preceding the filing of an application.

~~(10)~~(11) "Society" means a fraternal benefit society operating pursuant to Title 33, chapter 7, and offering or selling certificates of disability insurance."

Section 7. Section 33-22-1503, MCA, is amended to read:

"**33-22-1503. Comprehensive health association -- mandatory membership.** (1) There is established a nonprofit legal entity, to be known as the Montana comprehensive health association, with participating membership consisting of all insurers, insurance arrangements, societies, and health service corporations licensed or authorized to do business in this state. The association is exempt from taxation under the laws of this state, and all property owned by the association is exempt from taxation.

(2) All participating members shall maintain their membership in the association as a condition for writing health care benefits policies or contracts in this state. The association shall submit its articles, bylaws, and operating rules to the commissioner for approval.

(3) The association may:

(a) exercise the powers granted to insurers under the laws of this state;

(b) sue or be sued;

(c) enter into contracts with insurers, administrators, similar associations in other states, or other persons for the performance of administrative functions;

(d) establish administrative and accounting procedures for the operation of the association;

(e) provide for the reinsuring of risks incurred as a result of issuing the coverages required by members of the association; ~~and~~

(f) provide for the administration by the association of policies that are reinsured pursuant to subsection (3)(e); and

(g) issue additional types of health insurance policies to provide optional coverage, including

medicare supplemental health insurance."

Section 8. Section 33-22-1504, MCA, is amended to read:

"**33-22-1504. Association board of directors -- organization.** (1) There is a board of directors of the association, consisting of eight individuals:

(a) one from each of the ~~seven~~ five participating members of the association with the highest annual premium volume of disability insurance contracts or health service corporation contracts, derived from or on behalf of residents in the previous calendar year, as determined by the commissioner; ~~and~~

(b) two members at large who must be participating members of the association, appointed by the commissioner; and

~~(b)~~(c) a member at large, appointed by the commissioner to represent the public interest, who shall serve in an advisory capacity only.

(2) Each of the seven board members representing the association members is entitled to a weighted average vote, in person or by proxy, based on the association member's annual Montana premium volume. However, a board member may not have more than 50% of the vote.

(3) Members of the board may be reimbursed from the money of the association for expenses incurred by them ~~due to~~ because of their service as board members but may not otherwise be compensated by the association for their services. The costs of conducting the meetings of the association and its board of directors must be borne by participating members of the association in accordance with 33-22-1513."

Section 9. Section 33-22-1512, MCA, is amended to read:

"**33-22-1512. Association plan premium.** The association shall establish the schedule of premiums to be charged eligible persons for membership in the association plan. The schedule of premiums may not be less than 150% or more than 400% of the average premium rates charged by the five insurers or health service corporations with the largest premium amount of individual plans of major medical insurance in force in this state. The premium rates of the five insurers or health service corporations used to establish the premium rates for each type of coverage offered by the association must be determined by the commissioner from information provided annually ~~by all insurers~~ at the request of the commissioner. The association shall ~~utilize~~ use generally acceptable actuarial principles and structurally compatible rates."

Section 10. Section 33-22-1515, MCA, is amended to read:

"**33-22-1515. Solicitation of eligible persons.** (1) The association, pursuant to a plan approved by the commissioner, shall disseminate appropriate information to the residents of this state regarding the existence of the association plan and the means of enrollment. Means of communication may include use of the press, radio, and television, as well as publication in appropriate state offices and publications.

(2) The association shall devise and implement means of maintaining public awareness of this part and shall administer this part in a manner ~~which~~ that facilitates public participation in the association plan.

(3) All licensed disability insurance producers may engage in the selling or marketing of the association plan. The lead carrier shall pay an insurance producer's referral fee of at least $25 to each licensed disability insurance producer who refers an applicant to the association plan, if the applicant is accepted. The amount of the referral fee must be set by the board of directors of the association and is subject to the approval of the commissioner. The referral fees must be paid by the lead carrier from money received as premiums for the association plan.

(4) An insurer, society, or health service corporation that rejects or applies underwriting restrictions to an applicant for disability insurance ~~must~~ shall notify the applicant of the existence of the association plan, requirements for being accepted in it, and the procedure for applying to it."

Section 11. Section 33-22-1516, MCA, is amended to read:

"**33-22-1516. Enrollment by eligible person.** (1) The association plan must be open for enrollment by eligible persons. An eligible person may enroll in the plan by submission of a certificate of eligibility to the lead carrier. The certificate must provide:

(a) the name, address, and age of the applicant and length of the applicant's residence in this state;

(b) the name, address, and age of spouse and children, if any, if they are to be insured;

(c) written evidence that ~~he~~ the person fulfills all of the elements of an eligible person, as defined in 33-22-1501; and

(d) a designation of coverage desired.

(2) Within 30 days of receipt of the certificate, the lead carrier shall either reject the application for failing to comply with the requirements of subsection (1) or forward the eligible person a notice of acceptance and billing information. Insurance is effective on the first of the month following acceptance.

(3) An eligible person may not purchase more than one policy from the association plan.

(4) A person who obtains coverage pursuant to this section may not be covered for any preexisting condition during the first 12 months of coverage under the association plan if the person was diagnosed or treated for that condition during the 5 years immediately preceding the filing of an application. ~~This subsection does not apply to a person who has had continuous coverage under an individual, family, or group policy during the year immediately preceding the filing of an application and whose cancellation date was within 30 days prior to the date of submission of a certificate of eligibility to the lead carrier for nonelective procedures.~~ The association shall waive any time period applicable to a preexisting condition exclusion for the period of time that an individual was covered under the following types of coverage if the coverage was continuous to a date not more than 30 days prior to submission of an application for coverage under the association plan:

(a) an individual health insurance policy that includes coverage 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 by the association plan; or

(b) an employer-based health insurance benefit arrangement that provides benefits similar to or exceeding the benefits provided by the association plan.

~~(5) A change of residence from Montana to another state immediately terminates eligibility for renewal of coverage under the association plan.~~"

Section 12. Section 33-22-1521, MCA, is amended to read:

"**33-22-1521. Association plan -- minimum benefits.** A plan of health coverage must be certified as an association plan if it otherwise meets the requirements of Title 33, chapters 15, 22 (excepting part 7 and 33-22-113), and 30, and other laws of this state, whether or not the policy is issued in this state, and meets or exceeds the following minimum standards:

(1) The minimum benefits for an insured must, subject to the other provisions of this section, be equal to at least 80% of the covered expenses required by this section in excess of an annual deductible that does not exceed $1,000 per person. The coverage must include a limitation of $5,000 per person on the total annual out-of-pocket expenses for services covered under this section. Coverage must be subject to a maximum lifetime benefit, but ~~such~~ the maximums may not be less than $100,000.

(2) Covered expenses must be the usual and customary charges for the following services and articles when prescribed by a physician or other licensed health care professional provided for in 33-22-111:

(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, except as specifically provided in subsection (3);

(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 ~~shall~~ 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; and

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

(3) (a) Covered expenses for the services or articles specified in this section do not include:

(i) drugs requiring a physician's prescription;

(ii) services of a nursing home;

(iii) home and office calls, except as specifically provided in subsection (2);

(iv) rental or purchase of durable medical equipment, except as specifically provided in subsection (2);

(v) the first $20 of diagnostic x-ray and laboratory charges in each 14-day period;

(vi) oral surgery, except as specifically provided in subsection (2);

(vii) that part of a charge for services or articles ~~which~~ that exceeds the prevailing charge in the locality where the service is provided; or

(viii) care that is primarily for custodial or domiciliary purposes ~~which~~ that would not qualify as eligible services under medicare.

(b) Covered expenses for the services or articles specified in this section do not include charges for:

(i) care or for any injury or disease either arising out of an injury in the course of employment and subject to a workers' compensation or similar law, for which benefits are payable under another policy of disability insurance or medicare;

(ii) treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or congenital bodily defect to restore normal bodily functions;

(iii) travel other than transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition;

(iv) confinement in a private room to the extent that it is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as medically necessary by a physician;

(v) services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles;

(vi) organ transplants, including bone marrow transplants;

(vii) room and board for a nonemergency admission on Friday or Saturday;

~~(viii) pregnancy, except complications of pregnancy;~~

~~(ix)~~(viii) routine well baby care;

~~(x)~~(ix) complications to a newborn, unless no other source of coverage is available;

~~(xi)~~(x) sterilization or reversal of sterilization;

~~(xii)~~(xi) abortion, unless the life of the mother would be endangered if the fetus were carried to term;

~~(xiii)~~(xii) weight modification or modification of the body to improve the mental or emotional well-being of an insured;

~~(xiv)~~(xiii) artificial insemination or treatment for infertility; or

~~(xv)~~(xiv) breast augmentation or reduction."

NEW SECTION. **Section 13. Codification instruction.** (1) [Sections 1 and 2] are intended to be codified as an integral part of Title 33, chapter 22, part 15, and the provisions of Title 33, chapter 22, part 15, apply to [sections 1 and 2].

(2) [Section 3] is intended to be codified as an integral part of Title 30, chapter 14, and the provisions of Title 30, chapter 14, apply to [section 3].

-END-

STATE OF MONTANA - FISCAL NOTE

Fiscal Note for SB0341, reference bill, as amended

DESCRIPTION OF PROPOSED LEGISLATION:
An act revising the Montana comprehensive health association (MCHA) plan; establishing limits on eligibility; prohibiting referral of individuals to the plan for certain purposes;

ASSUMPTIONS:
1. The current association plan premium is 200% of the average premium of the five insurers with the largest premium amount of individual major medical insurance in Montana. It is assumed that this premium will remain the same.
2. The total 1994 association plan premiums were $1,508,508. The association plan had an average of 278 participants throughout the year resulting in an average annual premium of $5,426 per participant. The increase in benefits will encourage more participation in the MCHA. It is estimated that total enrollment will grow from 278 to 407 in FY96 and that total plan premiums will increase to $2,208,382 ($5,426 x 407).
4. The annual assessment against members, based on comparable experience in other states with programs similar to the MCHA under the new statute and the increase in benefits, is expected to be about 50% of the total premiums received in that year. For FY96, this is estimated to be $1,104,191 ($2,208,382 x 50%).
5. It is assumed that 52% of the annual assessment against members will be deducted dollar-for-dollar from the premium tax. This is estimated to amount to $574,179 based upon estimated FY96 premiums. It is assumed that 43% of the premium is collected by Blue Cross and Blue Shield of Montana, which is exempt from premium tax, and 5% is attributable to other companies that owe no premium tax in any given year.
6. Assessments are offset against premium tax due in the year following the assessment. It is estimated that the FY97 general fund revenue will be reduced by the offset of FY96 assessments by $474,179. This is based upon the estimated FY97 assessment offset of $574,179 ($5,426 x 407 x 50% x 52%) less the $100,000 estimated assessment offset under present law ($574,179 - $100,000 = $474,179).

FISCAL IMPACT:

Revenues:

	FY96 Difference	FY97 Difference
General Fund (premium tax) (01)	0	(474,179)

Dave Lewis 3-30-95
DAVE LEWIS, BUDGET DIRECTOR DATE
Office of Budget and Program Planning

Ric Holden 3-30-
RIC HOLDEN, PRIMARY SPONSOR DATE

Fiscal Note for SB0341, reference bill, as amended

SB 341

APPROVED BY COM ON PUBLIC HEALTH, WELFARE & SAFETY

SENATE BILL NO. 341

INTRODUCED BY HOLDEN

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING THE MONTANA COMPREHENSIVE HEALTH ASSOCIATION PLAN; ESTABLISHING LIMITS ON ELIGIBILITY; PROHIBITING REFERRAL OF INDIVIDUALS TO THE PLAN FOR CERTAIN PURPOSES AND MAKING THOSE REFERRALS AN UNFAIR TRADE PRACTICE; MAKING OFFICERS AND DIRECTORS OF THE ASSOCIATION NOT INDIVIDUALLY LIABLE FOR CERTAIN ACTIONS; ~~EXCEPTING THE ASSOCIATION PLAN FROM THE PROHIBITION AGAINST AN INSURER DENYING OR REDUCING BENEFITS FOR PERSONS ELIGIBLE TO RECEIVE PUBLIC MEDICAL ASSISTANCE;~~ PROVIDING DEFINITIONS; DELETING PREGNANCY AS AN ASSOCIATION PLAN EXCLUSION; ALLOWING THE ASSOCIATION BOARD AND THE COMMISSIONER OF INSURANCE TO ESTABLISH REFERRAL FEES; REQUIRING WAIVER OF PREEXISTING CONDITION EXCLUSIONS UNDER CERTAIN CIRCUMSTANCES; MODIFYING THE COMPOSITION OF THE ASSOCIATION BOARD; ADDING HEALTH SERVICE CORPORATIONS TO THE MANNER IN WHICH PREMIUMS ARE CALCULATED; AND AMENDING SECTIONS 27-1-732, ~~33-22-113,~~ 33-22-1501, 33-22-1503, 33-22-1504, 33-22-1512, 33-22-1515, 33-22-1516, AND 33-22-1521, MCA."

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~~(1) receives benefits under the Montana medicaid program as established in Title 53, chapter 6;~~

~~(2)~~(1) fails to pay the premium for the policy of insurance purchased pursuant to 33-22-1516;

~~(3)~~(2) changes residence from Montana to another state;

~~(4)~~(3) exceeds the lifetime maximum benefit provided in the association plan; or

~~(5)~~(4) enrolls under another disability insurance policy or plan for health service benefits. However, the individual may maintain enrollment in the association plan during a waiting period applicable to preexisting conditions under the other policy or plan. If the individual maintains the association plan during the waiting period, the association plan may coordinate the benefits with the individual's new policy or plan

and the benefits of the association plan are considered secondary to the benefits available under the individual's new policy or plan.

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NEW SECTION. **Section 3. Unfair referral as unfair trade practice.** A referral made in violation of [section 2] is an unfair trade practice under this chapter.

Section 4. Section 27-1-732, MCA, is amended to read:

"**27-1-732. Immunity of nonprofit corporation officers, directors, and volunteers.** (1) ~~No~~ An officer, director, or volunteer of a nonprofit corporation is not individually liable for any action or omission made in the course and scope of ~~his~~ the officer's, director's, or volunteer's official capacity on behalf of the nonprofit corporation. This section does not apply to liability for willful or wanton misconduct. The immunity granted by this section does not apply to the liability of a nonprofit corporation.

(2) For purposes of this section, "nonprofit corporation" means:

(a) an organization exempt from taxation under section 501(c) of the Internal Revenue Code of 1954; ~~or~~

(b) a corporation or organization ~~which~~ that is eligible for or has been granted by the department of revenue ~~tax-exempt~~ tax-exempt status under the provisions of 15-31-102; or

(c) the comprehensive health association created by 33-22-1503."

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~~provision denying or reducing such those benefits for the reason that the person insured is eligible for or receiving public medical assistance provided under Title 53, chapter 2.~~

~~(2) This section does not apply to the comprehensive health association plan issued pursuant to Title 33, chapter 22, part 15.~~"

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"**33-22-1501. Definitions.** As used in this part, the following definitions apply:

(1) "Association" means the comprehensive health association created by 33-22-1503.

(2) "Association plan" means a policy of insurance coverage that is offered by the association and that is certified by the association as required by 33-22-1521.

(3) "Association plan premium" means the charge determined pursuant to 33-22-1512 for membership in the association plan based on the benefits provided in 33-22-1521.

(4) "Eligible person" means an individual who:

(a) is a resident of this state and applies for coverage under the association plan; ~~and~~

(b) unless the individual's eligibility is waived by the association, has, within 6 months prior to the date of application, been rejected for disability insurance or health service benefits by at least two insurers, societies, or health service corporations~~,~~ or has had a restrictive rider or preexisting conditions limitation, which limitation is required by at least two insurers, societies, or health service corporations, which has the effect of substantially reducing coverage from that received by a person considered a standard risk; and

(c) is not eligible for any other form of disability insurance~~,~~ OR health service benefits~~, or the Montana medicaid program~~.

(5) "Health service corporation" means a corporation operating pursuant to Title 33, chapter 30, and offering or selling contracts of disability insurance.

(6) "Insurance arrangement" means any plan, program, contract, or other arrangement to the extent not exempt from inclusion by virtue of the provisions of the federal Employee Retirement Income Security Act of 1974 under which one or more employers, unions, or other organizations provide to their employees or members, either directly or indirectly through a trust of a third-party administrator, health care services or benefits other than through an insurer.

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(f) provide for the administration by the association of policies that are reinsured pursuant to subsection (3)(e); and

(g) issue additional types of health insurance policies to provide optional coverage, including

medicare supplemental health insurance."

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"**33-22-1504. Association board of directors -- organization.** (1) There is a board of directors of the association, consisting of eight individuals:

(a) one from each of the ~~seven~~ five participating members of the association with the highest annual premium volume of disability insurance contracts or health service corporation contracts, derived from or on behalf of residents in the previous calendar year, as determined by the commissioner; ~~and~~

(b) two members at large who must be participating members of the association, appointed by the commissioner; and

~~(b)~~(c) a member at large, appointed by the commissioner to represent the public interest, who shall serve in an advisory capacity only.

(2) Each of the seven board members representing the association members is entitled to a weighted average vote, in person or by proxy, based on the association member's annual Montana premium volume. However, a board member may not have more than 50% of the vote.

(3) Members of the board may be reimbursed from the money of the association for expenses incurred by them ~~due to~~ because of their service as board members but may not otherwise be compensated by the association for their services. The costs of conducting the meetings of the association and its board of directors must be borne by participating members of the association in accordance with 33-22-1513."

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(2) The association shall devise and implement means of maintaining public awareness of this part and shall administer this part in a manner ~~which~~ that facilitates public participation in the association plan.

(3) All licensed disability insurance producers may engage in the selling or marketing of the association plan. The lead carrier shall pay an insurance producer's referral fee of at least $25 to each licensed disability insurance producer who refers an applicant to the association plan, if the applicant is accepted. The amount of the referral fee must be set by the board of directors of the association and is subject to the approval of the commissioner. The referral fees must be paid by the lead carrier from money received as premiums for the association plan.

(4) An insurer, society, or health service corporation that rejects or applies underwriting restrictions to an applicant for disability insurance ~~must~~ shall notify the applicant of the existence of the association plan, requirements for being accepted in it, and the procedure for applying to it."

Section 10. Section 33-22-1516, MCA, is amended to read:

"**33-22-1516. Enrollment by eligible person.** (1) The association plan must be open for enrollment by eligible persons. An eligible person may enroll in the plan by submission of a certificate of eligibility to the lead carrier. The certificate must provide:

(a) the name, address, and age of the applicant and length of the applicant's residence in this state;

(b) the name, address, and age of spouse and children, if any, if they are to be insured;

(c) written evidence that ~~he~~ the person fulfills all of the elements of an eligible person, as defined in 33-22-1501; and

(d) a designation of coverage desired.

(2) Within 30 days of receipt of the certificate, the lead carrier shall either reject the application for failing to comply with the requirements of subsection (1) or forward the eligible person a notice of acceptance and billing information. Insurance is effective on the first of the month following acceptance.

(3) An eligible person may not purchase more than one policy from the association plan.

(4) A person who obtains coverage pursuant to this section may not be covered for any preexisting condition during the first 12 months of coverage under the association plan if the person was diagnosed or treated for that condition during the 5 years immediately preceding the filing of an application. ~~This subsection does not apply to a person who has had continuous coverage under an individual, family, or group policy during the year immediately preceding the filing of an application and whose cancellation date was within 30 days prior to the date of submission of a certificate of eligibility to the lead carrier for nonelective procedures.~~ The association shall waive any time period applicable to a preexisting condition exclusion for the period of time that an individual was covered under the following types of coverage if the coverage was continuous to a date not more than 30 days prior to submission of an application for coverage under the association plan:

(a) an individual health insurance policy that includes coverage 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 by the association plan; or

(b) an employer-based health insurance benefit arrangement that provides benefits similar to or exceeding the benefits provided by the association plan.

~~(5) A change of residence from Montana to another state immediately terminates eligibility for renewal of coverage under the association plan.~~"

Section 11. Section 33-22-1521, MCA, is amended to read:

"**33-22-1521. Association plan -- minimum benefits.** A plan of health coverage must be certified as an association plan if it otherwise meets the requirements of Title 33, chapters 15, 22 (excepting part 7 ~~and 33-22-113~~), and 30, and other laws of this state, whether or not the policy is issued in this state, and meets or exceeds the following minimum standards:

(1) The minimum benefits for an insured must, subject to the other provisions of this section, be equal to at least 80% of the covered expenses required by this section in excess of an annual deductible that does not exceed $1,000 per person. The coverage must include a limitation of $5,000 per person on the total annual out-of-pocket expenses for services covered under this section. Coverage must be subject to a maximum lifetime benefit, but ~~such~~ the maximums may not be less than $100,000.

(2) Covered expenses must be the usual and customary charges for the following services and articles when prescribed by a physician or other licensed health care professional provided for in 33-22-111:

(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, except as specifically provided in subsection (3);

(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 ~~shall~~ 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; and

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

(3) (a) Covered expenses for the services or articles specified in this section do not include:

(i) drugs requiring a physician's prescription;

(ii) services of a nursing home;

(iii) home and office calls, except as specifically provided in subsection (2);

(iv) rental or purchase of durable medical equipment, except as specifically provided in subsection (2);

(v) the first $20 of diagnostic x-ray and laboratory charges in each 14-day period;

(vi) oral surgery, except as specifically provided in subsection (2);

(vii) that part of a charge for services or articles ~~which~~ that exceeds the prevailing charge in the locality where the service is provided; or

(viii) care that is primarily for custodial or domiciliary purposes ~~which~~ that would not qualify as eligible services under medicare.

(b) Covered expenses for the services or articles specified in this section do not include charges for:

(i) care or for any injury or disease either arising out of an injury in the course of employment and subject to a workers' compensation or similar law, for which benefits are payable under another policy of disability insurance or medicare;

(ii) treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or congenital bodily defect to restore normal bodily functions;

(iii) travel other than transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition;

(iv) confinement in a private room to the extent that it is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as medically necessary by a physician;

(v) services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles;

(vi) organ transplants, including bone marrow transplants;

(vii) room and board for a nonemergency admission on Friday or Saturday;

~~(viii) pregnancy, except complications of pregnancy;~~

~~(ix)~~(viii) routine well baby care;

~~(x)~~(ix) complications to a newborn, unless no other source of coverage is available;

~~(xi)~~(x) sterilization or reversal of sterilization;

~~(xii)~~(xi) abortion, unless the life of the mother would be endangered if the fetus were carried to term;

~~(xiii)~~(xii) weight modification or modification of the body to improve the mental or emotional well-being of an insured;

~~(xiv)~~(xiii) artificial insemination or treatment for infertility; or

~~(xv)~~(xiv) breast augmentation or reduction."

NEW SECTION. **Section 12. Codification instruction.** (1) [Sections 1 and 2] are intended to be codified as an integral part of Title 33, chapter 22, part 15, and the provisions of Title 33, chapter 22, part 15, apply to [sections 1 and 2].

(2) [Section 3] is intended to be codified as an integral part of Title ~~30~~ 33, chapter ~~14~~ 18, and the provisions of Title ~~30~~ 33, chapter ~~14~~ 18, apply to [section 3].

-END-

SENATE BILL NO. 341

INTRODUCED BY HOLDEN

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING THE MONTANA COMPREHENSIVE HEALTH ASSOCIATION PLAN; ESTABLISHING LIMITS ON ELIGIBILITY; PROHIBITING REFERRAL OF INDIVIDUALS TO THE PLAN FOR CERTAIN PURPOSES AND MAKING THOSE REFERRALS AN UNFAIR TRADE PRACTICE; MAKING OFFICERS AND DIRECTORS OF THE ASSOCIATION NOT INDIVIDUALLY LIABLE FOR CERTAIN ACTIONS; ~~EXCEPTING THE ASSOCIATION PLAN FROM THE PROHIBITION AGAINST AN INSURER DENYING OR REDUCING BENEFITS FOR PERSONS ELIGIBLE TO RECEIVE PUBLIC MEDICAL ASSISTANCE;~~ PROVIDING DEFINITIONS; DELETING PREGNANCY AS AN ASSOCIATION PLAN EXCLUSION; ALLOWING THE ASSOCIATION BOARD AND THE COMMISSIONER OF INSURANCE TO ESTABLISH REFERRAL FEES; REQUIRING WAIVER OF PREEXISTING CONDITION EXCLUSIONS UNDER CERTAIN CIRCUMSTANCES; MODIFYING THE COMPOSITION OF THE ASSOCIATION BOARD; ADDING HEALTH SERVICE CORPORATIONS TO THE MANNER IN WHICH PREMIUMS ARE CALCULATED; AND AMENDING SECTIONS 27-1-732, ~~33-22-113,~~ 33-22-1501, 33-22-1503, 33-22-1504, 33-22-1512, 33-22-1515, 33-22-1516, AND 33-22-1521, MCA."

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

HOUSE STANDING COMMITTEE REPORT

March 17, 1995

Mr. Speaker: We, the committee on **Joint Select Committee on Health Care** report that **Senate Bill 341** (third reading copy -- blue) **be concurred in as amended**.

Signed: _____

Steve Benedict, Chair

Carried by: Rep. Tuss

And, that such amendments read:

1. Title, line 11.
Following: "EXCLUSION;"
Insert: "REVISING ASSOCIATION PLAN MINIMUM BENEFITS;"

2. Page 5, line 24.
Strike: "be less than 150% or more than 400%"
Insert: "exceed 200%"

3. Page 7, line 24.
Following: "(1)"
Insert: "(a)"

4. Page 7, line 25.
Strike: "80%"
Insert: "50%"

5. Page 7.
Following: line 28
Insert: "(b) One association plan must be offered with coverage for 80% of the covered expenses provided in this section in excess of an annual deductible that does not exceed $1,000 per person. This association plan must provide a maximum lifetime benefit of $500,000."

SB341

Committee Vote:
Yes 10, No 0.

HOUSE

6. Page 7, line 29.
Following: "following"
Insert: "medically necessary"

7. Page 7, line 30.
Strike: "provided for in for 33-22-111"
Insert: "and when designated in the contract"

8. Page 8, line 13.
Following: "purchase of"
Insert: "durable"

9. Page 8, line 15.
Strike: "and"

10. Page 8, line 16.
Strike: "."
Insert: ";
(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, covered at 50% of the expense, up to an annual maximum of $1,000;
(n) medically necessary, nonexperimental transplants of the kidney, pancreas, heart, heart/lung, lungs, liver, cornea, and high-dose chemotherapy bone marrow transplantation, limited to a lifetime maximum of $150,000, with an additional benefit not to exceed $10,000 for expenses associated with the donor;
(o) pregnancy, including complications of pregnancy;
(p) newborn infant coverage, as required by 33-22-301;
(q) sterilization;
(r) immunizations;
(s) outpatient rehabilitation therapy;
(t) foot care for diabetics;
(u) services of a convalescent home, as an alternative to hospital services, limited to a maximum of 60 days per year; and
(v) travel, other than transportation by a licensed ambulance service, to the nearest facility qualified to treat the patient's medical condition when approved in advance by the insurer."

11. Page 8, lines 18 and 19.
Strike: subsection (i) and (ii) in their entirety

Renumber: subsequent sections

12. Page 9, line 7.

Following: "condition"
Insert: ", except as provided by subsection (2)"

13. Page 9, line 13.
Strike: subsection (vi) in its entirely

Renumber: subsequent subsections

14. Page 9, line 18.
Strike: "sterilization or"

-END-

SENATE BILL NO. 341

INTRODUCED BY HOLDEN

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING THE MONTANA COMPREHENSIVE HEALTH ASSOCIATION PLAN; ESTABLISHING LIMITS ON ELIGIBILITY; PROHIBITING REFERRAL OF INDIVIDUALS TO THE PLAN FOR CERTAIN PURPOSES AND MAKING THOSE REFERRALS AN UNFAIR TRADE PRACTICE; MAKING OFFICERS AND DIRECTORS OF THE ASSOCIATION NOT INDIVIDUALLY LIABLE FOR CERTAIN ACTIONS; ~~EXCEPTING THE ASSOCIATION PLAN FROM THE PROHIBITION AGAINST AN INSURER DENYING OR REDUCING BENEFITS FOR PERSONS ELIGIBLE TO RECEIVE PUBLIC MEDICAL ASSISTANCE;~~ PROVIDING DEFINITIONS; DELETING PREGNANCY AS AN ASSOCIATION PLAN EXCLUSION; REVISING ASSOCIATION PLAN MINIMUM BENEFITS; ALLOWING THE ASSOCIATION BOARD AND THE COMMISSIONER OF INSURANCE TO ESTABLISH REFERRAL FEES; REQUIRING WAIVER OF PREEXISTING CONDITION EXCLUSIONS UNDER CERTAIN CIRCUMSTANCES; MODIFYING THE COMPOSITION OF THE ASSOCIATION BOARD; ADDING HEALTH SERVICE CORPORATIONS TO THE MANNER IN WHICH PREMIUMS ARE CALCULATED; AND AMENDING SECTIONS 27-1-732, ~~33-22-113,~~ 33-22-1501, 33-22-1503, 33-22-1504, 33-22-1512, 33-22-1515, 33-22-1516, AND 33-22-1521, MCA."

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

NEW SECTION. **Section 1. Limitations on eligibility.** An individual who purchases a policy of insurance pursuant to 33-22-1516 is no longer eligible for insurance under an association plan and is subject to cancellation of enrollment if the individual:

~~(1) receives benefits under the Montana medicaid program as established in Title 53, chapter 6;~~

~~(2)~~(1) fails to pay the premium for the policy of insurance purchased pursuant to 33-22-1516;

~~(3)~~(2) changes residence from Montana to another state;

~~(4)~~(3) exceeds the lifetime maximum benefit provided in the association plan; or

~~(5)~~(4) enrolls under another disability insurance policy or plan for health service benefits. However, the individual may maintain enrollment in the association plan during a waiting period applicable to preexisting conditions under the other policy or plan. If the individual maintains the association plan during the waiting period, the association plan may coordinate the benefits with the individual's new policy or plan

and the benefits of the association plan are considered secondary to the benefits available under the individual's new policy or plan.

NEW SECTION. **Section 2. Unfair referral to plan.** An insurer, insurance producer, insurance broker, or third-party administrator may not refer an individual or an individual's dependant to the association plan or arrange for the individual or the individual's employee to apply to the association for enrollment under an association plan in order to separate the individual or the individual's dependant from coverage under a group health insurance contract, policy, or certificate obtained in connection with the individual's employment.

NEW SECTION. **Section 3. Unfair referral as unfair trade practice.** A referral made in violation of [section 2] is an unfair trade practice under this chapter.

Section 4. Section 27-1-732, MCA, is amended to read:

"27-1-732. Immunity of nonprofit corporation officers, directors, and volunteers. (1) ~~No~~ An officer, director, or volunteer of a nonprofit corporation is not individually liable for any action or omission made in the course and scope of ~~his~~ the officer's, director's, or volunteer's official capacity on behalf of the nonprofit corporation. This section does not apply to liability for willful or wanton misconduct. The immunity granted by this section does not apply to the liability of a nonprofit corporation.

(2) For purposes of this section, "nonprofit corporation" means:

(a) an organization exempt from taxation under section 501(c) of the Internal Revenue Code of 1954; ~~or~~

(b) a corporation or organization ~~which~~ that is eligible for or has been granted by the department of revenue ~~tax-exempt~~ tax-exempt status under the provisions of 15-31-102; or

(c) the comprehensive health association created by 33-22-1503."

~~**Section 5.** Section 33-22-113, MCA, is amended to read:~~

~~**"33-22-113. Disability insurance coverage of persons eligible for public medical assistance.** No (1) Except as provided in subsection (2), a disability insurance policy providing hospital, medical, or surgical expense benefits delivered or issued for delivery in this state on or after July 1, 1979, may not~~

~~contain any provision denying or reducing such those benefits for the reason that the person insured is eligible for or receiving public medical assistance provided under Title 53, chapter 2.~~

~~(2) This section does not apply to the comprehensive health association plan issued pursuant to Title 33, chapter 22, part 15."~~

Section 5. Section 33-22-1501, MCA, is amended to read:

"**33-22-1501. Definitions.** As used in this part, the following definitions apply:

(1) "Association" means the comprehensive health association created by 33-22-1503.

(2) "Association plan" means a policy of insurance coverage that is offered by the association and that is certified by the association as required by 33-22-1521.

(3) "Association plan premium" means the charge determined pursuant to 33-22-1512 for membership in the association plan based on the benefits provided in 33-22-1521.

(4) "Eligible person" means an individual who:

(a) is a resident of this state and applies for coverage under the association plan; ~~and~~

(b) unless the individual's eligibility is waived by the association, has, within 6 months prior to the date of application, been rejected for disability insurance or health service benefits by at least two insurers, societies, or health service corporations~~,~~ or has had a restrictive rider or preexisting conditions limitation, which limitation is required by at least two insurers, societies, or health service corporations, which has the effect of substantially reducing coverage from that received by a person considered a standard risk; and

(c) is not eligible for any other form of disability insurance~~,~~ OR health service benefits~~, or the Montana medicaid program~~.

(5) "Health service corporation" means a corporation operating pursuant to Title 33, chapter 30, and offering or selling contracts of disability insurance.

(6) "Insurance arrangement" means any plan, program, contract, or other arrangement to the extent not exempt from inclusion by virtue of the provisions of the federal Employee Retirement Income Security Act of 1974 under which one or more employers, unions, or other organizations provide to their employees or members, either directly or indirectly through a trust of a third-party administrator, health care services or benefits other than through an insurer.

(7) "Insurer" means a company operating pursuant to Title 33, chapter 2 or 3, and offering or selling policies or contracts of disability insurance, as provided in Title 33, chapter 22.

(8) "Lead carrier" means the licensed administrator or insurer selected by the association to administer the association plan.

(9) "Medicare" means coverage under both parts A and B of Title XVIII of the Social Security Act, 42 U.S.C. 1395, et seq., as amended.

~~(9)~~(10) "Preexisting condition" means any condition for which an applicant for coverage under the association plan has received medical attention during the 5 years immediately preceding the filing of an application.

~~(10)~~(11) "Society" means a fraternal benefit society operating pursuant to Title 33, chapter 7, and offering or selling certificates of disability insurance."

Section 6. Section 33-22-1503, MCA, is amended to read:

"**33-22-1503. Comprehensive health association -- mandatory membership.** (1) There is established a nonprofit legal entity, to be known as the Montana comprehensive health association, with participating membership consisting of all insurers, insurance arrangements, societies, and health service corporations licensed or authorized to do business in this state. The association is exempt from taxation under the laws of this state, and all property owned by the association is exempt from taxation.

(2) All participating members shall maintain their membership in the association as a condition for writing health care benefits policies or contracts in this state. The association shall submit its articles, bylaws, and operating rules to the commissioner for approval.

(3) The association may:

(a) exercise the powers granted to insurers under the laws of this state;

(b) sue or be sued;

(c) enter into contracts with insurers, administrators, similar associations in other states, or other persons for the performance of administrative functions;

(d) establish administrative and accounting procedures for the operation of the association;

(e) provide for the reinsuring of risks incurred as a result of issuing the coverages required by members of the association; ~~and~~

(f) provide for the administration by the association of policies that are reinsured pursuant to subsection (3)(e); and

(g) issue additional types of health insurance policies to provide optional coverage, including

medicare supplemental health insurance."

Section 7. Section 33-22-1504, MCA, is amended to read:

"33-22-1504. Association board of directors -- organization. (1) There is a board of directors of the association, consisting of eight individuals:

(a) one from each of the ~~seven~~ five participating members of the association with the highest annual premium volume of disability insurance contracts or health service corporation contracts, derived from or on behalf of residents in the previous calendar year, as determined by the commissioner; ~~and~~

(b) two members at large who must be participating members of the association, appointed by the commissioner; and

~~(b)~~(c) a member at large, appointed by the commissioner to represent the public interest, who shall serve in an advisory capacity only.

(2) Each of the seven board members representing the association members is entitled to a weighted average vote, in person or by proxy, based on the association member's annual Montana premium volume. However, a board member may not have more than 50% of the vote.

(3) Members of the board may be reimbursed from the money of the association for expenses incurred by them ~~due to~~ because of their service as board members but may not otherwise be compensated by the association for their services. The costs of conducting the meetings of the association and its board of directors must be borne by participating members of the association in accordance with 33-22-1513."

Section 8. Section 33-22-1512, MCA, is amended to read:

"33-22-1512. Association plan premium. The association shall establish the schedule of premiums to be charged eligible persons for membership in the association plan. The schedule of premiums may not ~~be less than 150% or more than 400%~~ EXCEED 200% of the average premium rates charged by the five insurers or health service corporations with the largest premium amount of individual plans of major medical insurance in force in this state. The premium rates of the five insurers or health service corporations used to establish the premium rates for each type of coverage offered by the association must be determined by the commissioner from information provided annually ~~by all insurers~~ at the request of the commissioner. The association shall ~~utilize~~ use generally acceptable actuarial principles and structurally compatible rates."

Section 9. Section 33-22-1515, MCA, is amended to read:

"**33-22-1515. Solicitation of eligible persons.** (1) The association, pursuant to a plan approved by the commissioner, shall disseminate appropriate information to the residents of this state regarding the existence of the association plan and the means of enrollment. Means of communication may include use of the press, radio, and television, as well as publication in appropriate state offices and publications.

(2) The association shall devise and implement means of maintaining public awareness of this part and shall administer this part in a manner ~~which~~ that facilitates public participation in the association plan.

(3) All licensed disability insurance producers may engage in the selling or marketing of the association plan. The lead carrier shall pay an insurance producer's referral fee of at least $25 to each licensed disability insurance producer who refers an applicant to the association plan, if the applicant is accepted. The amount of the referral fee must be set by the board of directors of the association and is subject to the approval of the commissioner. The referral fees must be paid by the lead carrier from money received as premiums for the association plan.

(4) An insurer, society, or health service corporation that rejects or applies underwriting restrictions to an applicant for disability insurance ~~must~~ shall notify the applicant of the existence of the association plan, requirements for being accepted in it, and the procedure for applying to it."

Section 10. Section 33-22-1516, MCA, is amended to read:

"**33-22-1516. Enrollment by eligible person.** (1) The association plan must be open for enrollment by eligible persons. An eligible person may enroll in the plan by submission of a certificate of eligibility to the lead carrier. The certificate must provide:

(a) the name, address, and age of the applicant and length of the applicant's residence in this state;

(b) the name, address, and age of spouse and children, if any, if they are to be insured;

(c) written evidence that ~~he~~ the person fulfills all of the elements of an eligible person, as defined in 33-22-1501; and

(d) a designation of coverage desired.

(2) Within 30 days of receipt of the certificate, the lead carrier shall either reject the application for failing to comply with the requirements of subsection (1) or forward the eligible person a notice of acceptance and billing information. Insurance is effective on the first of the month following acceptance.

(3) An eligible person may not purchase more than one policy from the association plan.

(4) A person who obtains coverage pursuant to this section may not be covered for any preexisting condition during the first 12 months of coverage under the association plan if the person was diagnosed or treated for that condition during the 5 years immediately preceding the filing of an application. ~~This subsection does not apply to a person who has had continuous coverage under an individual, family, or group policy during the year immediately preceding the filing of an application and whose cancellation date was within 30 days prior to the date of submission of a certificate of eligibility to the lead carrier for nonelective procedures.~~ The association shall waive any time period applicable to a preexisting condition exclusion for the period of time that an individual was covered under the following types of coverage if the coverage was continuous to a date not more than 30 days prior to submission of an application for coverage under the association plan:

(a) an individual health insurance policy that includes coverage 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 by the association plan; or

(b) an employer-based health insurance benefit arrangement that provides benefits similar to or exceeding the benefits provided by the association plan.

~~(5) A change of residence from Montana to another state immediately terminates eligibility for renewal of coverage under the association plan.~~"

Section 11. Section 33-22-1521, MCA, is amended to read:

"**33-22-1521. Association plan -- minimum benefits.** A plan of health coverage must be certified as an association plan if it otherwise meets the requirements of Title 33, chapters 15, 22 (excepting part 7 ~~and 33-22-113~~), and 30, and other laws of this state, whether or not the policy is issued in this state, and meets or exceeds the following minimum standards:

(1) (A) The minimum benefits for an insured must, subject to the other provisions of this section, be equal to at least ~~80%~~ 50% of the covered expenses required by this section in excess of an annual deductible that does not exceed $1,000 per person. The coverage must include a limitation of $5,000 per person on the total annual out-of-pocket expenses for services covered under this section. Coverage must be subject to a maximum lifetime benefit, but ~~such~~ the maximums may not be less than $100,000.

(B) ONE ASSOCIATION PLAN MUST BE OFFERED WITH COVERAGE FOR 80% OF THE COVERED EXPENSES PROVIDED IN THIS SECTION IN EXCESS OF AN ANNUAL DEDUCTIBLE THAT DOES NOT

EXCEED $1,000 PER PERSON. THIS ASSOCIATION PLAN MUST PROVIDE A MAXIMUM LIFETIME BENEFIT OF $500,000.

(2) Covered expenses must be the usual and customary charges for the following MEDICALLY NECESSARY services and articles when prescribed by a physician or other licensed health care professional ~~provided for in 33-22-111~~ AND WHEN DESIGNATED IN THE CONTRACT:

(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, except as specifically provided in subsection (3);

(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 DURABLE medical equipment, which ~~shall~~ 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; ~~and~~

(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, COVERED AT 50% OF THE EXPENSE, UP TO AN ANNUAL MAXIMUM OF $1,000;

(N) MEDICALLY NECESSARY, NONEXPERIMENTAL TRANSPLANTS OF THE KIDNEY, PANCREAS, HEART, HEART/LUNG, LUNGS, LIVER, CORNEA, AND HIGH-DOSE CHEMOTHERAPY BONE MARROW TRANSPLANTATION, LIMITED TO A LIFETIME MAXIMUM OF $150,000, WITH AN ADDITIONAL BENEFIT NOT TO EXCEED $10,000 FOR EXPENSES ASSOCIATED WITH THE DONOR;

(O) PREGNANCY, INCLUDING COMPLICATIONS OF PREGNANCY;

(P) NEWBORN INFANT COVERAGE, AS REQUIRED BY 33-22-301;

(Q) STERILIZATION;

(R) IMMUNIZATIONS;

(S) OUTPATIENT REHABILITATION THERAPY;

(T) FOOT CARE FOR DIABETICS;

(U) SERVICES OF A CONVALESCENT HOME, AS AN ALTERNATIVE TO HOSPITAL SERVICES, LIMITED TO A MAXIMUM OF 60 DAYS PER YEAR; AND

(V) TRAVEL, OTHER THAN TRANSPORTATION BY A LICENSED AMBULANCE SERVICE, TO THE NEAREST FACILITY QUALIFIED TO TREAT THE PATIENT'S MEDICAL CONDITION WHEN APPROVED IN ADVANCE BY THE INSURER.

(3) (a) Covered expenses for the services or articles specified in this section do not include:

~~(i) drugs requiring a physician's prescription;~~

~~(ii) services of a nursing home;~~

~~(iii)~~(I) home and office calls, except as specifically provided in subsection (2);

~~(iv)~~(II) rental or purchase of durable medical equipment, except as specifically provided in subsection (2);

~~(v)~~(III) the first $20 of diagnostic x-ray and laboratory charges in each 14-day period;

~~(vi)~~(IV) oral surgery, except as specifically provided in subsection (2);

~~(vii)~~(V) that part of a charge for services or articles ~~which~~ that exceeds the prevailing charge in the locality where the service is provided; or

~~(viii)~~(VI) care that is primarily for custodial or domiciliary purposes ~~which~~ that would not qualify as eligible services under medicare.

(b) Covered expenses for the services or articles specified in this section do not include charges for:

(i) care or for any injury or disease either arising out of an injury in the course of employment and subject to a workers' compensation or similar law, for which benefits are payable under another policy of disability insurance or medicare;

(ii) treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or congenital bodily defect to restore normal bodily functions;

(iii) travel other than transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition, EXCEPT AS PROVIDED BY SUBSECTION (2);

(iv) confinement in a private room to the extent that it is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as medically necessary by a physician;

(v) services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles;

~~(vi) organ transplants, including bone marrow transplants;~~

~~(vii)~~(VI) room and board for a nonemergency admission on Friday or Saturday;

~~(viii) pregnancy, except complications of pregnancy;~~

~~(ix)(viii)~~(VII) routine well baby care;

~~(x)(ix)~~(VIII) complications to a newborn, unless no other source of coverage is available;

~~(xi)(x)~~(IX) ~~sterilization or~~ reversal of sterilization;

~~(xii)(xi)~~(X) abortion, unless the life of the mother would be endangered if the fetus were carried to term;

~~(xiii)(xii)~~(XI) weight modification or modification of the body to improve the mental or emotional well-being of an insured;

~~(xiv)(xiii)~~(XII) artificial insemination or treatment for infertility; or

~~(xv)(xiv)~~(XIII) breast augmentation or reduction."

NEW SECTION. **Section 12. Codification instruction.** (1) [Sections 1 and 2] are intended to be codified as an integral part of Title 33, chapter 22, part 15, and the provisions of Title 33, chapter 22, part 15, apply to [sections 1 and 2].

(2) [Section 3] is intended to be codified as an integral part of Title ~~30~~ 33, chapter ~~14~~ 18, and the provisions of Title ~~30~~ 33, chapter ~~14~~ 18, apply to [section 3].

-END-

SENATE BILL NO. 341

INTRODUCED BY HOLDEN

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING THE MONTANA COMPREHENSIVE HEALTH ASSOCIATION PLAN; ESTABLISHING LIMITS ON ELIGIBILITY; PROHIBITING REFERRAL OF INDIVIDUALS TO THE PLAN FOR CERTAIN PURPOSES AND MAKING THOSE REFERRALS AN UNFAIR TRADE PRACTICE; MAKING OFFICERS AND DIRECTORS OF THE ASSOCIATION NOT INDIVIDUALLY LIABLE FOR CERTAIN ACTIONS; ~~EXCEPTING THE ASSOCIATION PLAN FROM THE PROHIBITION AGAINST AN INSURER DENYING OR REDUCING BENEFITS FOR PERSONS ELIGIBLE TO RECEIVE PUBLIC MEDICAL ASSISTANCE;~~ PROVIDING DEFINITIONS; DELETING PREGNANCY AS AN ASSOCIATION PLAN EXCLUSION; REVISING ASSOCIATION PLAN MINIMUM BENEFITS; ALLOWING THE ASSOCIATION BOARD AND THE COMMISSIONER OF INSURANCE TO ESTABLISH REFERRAL FEES; REQUIRING WAIVER OF PREEXISTING CONDITION EXCLUSIONS UNDER CERTAIN CIRCUMSTANCES; MODIFYING THE COMPOSITION OF THE ASSOCIATION BOARD; ADDING HEALTH SERVICE CORPORATIONS TO THE MANNER IN WHICH PREMIUMS ARE CALCULATED; AND AMENDING SECTIONS 27-1-732, ~~33-22-113,~~ 33-22-1501, 33-22-1503, 33-22-1504, 33-22-1512, 33-22-1515, 33-22-1516, AND 33-22-1521, MCA."

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

NEW SECTION. **Section 1. Limitations on eligibility.** An individual who purchases a policy of insurance pursuant to 33-22-1516 is no longer eligible for insurance under an association plan and is subject to cancellation of enrollment if the individual:

~~(1) receives benefits under the Montana medicaid program as established in Title 53, chapter 6;~~

~~(2)~~(1) fails to pay the premium for the policy of insurance purchased pursuant to 33-22-1516;

~~(3)~~(2) changes residence from Montana to another state;

~~(4)~~(3) exceeds the lifetime maximum benefit provided in the association plan; or

~~(5)~~(4) enrolls under another disability insurance policy or plan for health service benefits. However, the individual may maintain enrollment in the association plan during a waiting period applicable to preexisting conditions under the other policy or plan. If the individual maintains the association plan during the waiting period, the association plan may coordinate the benefits with the individual's new policy or plan

and the benefits of the association plan are considered secondary to the benefits available under the individual's new policy or plan.

NEW SECTION. **Section 2. Unfair referral to plan.** An insurer, insurance producer, insurance broker, or third-party administrator may not refer an individual or an individual's dependent to the association plan or arrange for the individual or the individual's employee to apply to the association for enrollment under an association plan in order to separate the individual or the individual's dependent from coverage under a group health insurance contract, policy, or certificate obtained in connection with the individual's employment.

NEW SECTION. **Section 3. Unfair referral as unfair trade practice.** A referral made in violation of [section 2] is an unfair trade practice under this chapter.

Section 4. Section 27-1-732, MCA, is amended to read:

"**27-1-732. Immunity of nonprofit corporation officers, directors, and volunteers.** (1) ~~No~~ An officer, director, or volunteer of a nonprofit corporation is not individually liable for any action or omission made in the course and scope of ~~his~~ the officer's, director's, or volunteer's official capacity on behalf of the nonprofit corporation. This section does not apply to liability for willful or wanton misconduct. The immunity granted by this section does not apply to the liability of a nonprofit corporation.

(2) For purposes of this section, "nonprofit corporation" means:

(a) an organization exempt from taxation under section 501(c) of the Internal Revenue Code of 1954; ~~or~~

(b) a corporation or organization ~~which~~ that is eligible for or has been granted by the department of revenue ~~tax-exempt~~ tax-exempt status under the provisions of 15-31-102; or

(c) the comprehensive health association created by 33-22-1503."

~~**Section 5.** Section 33-22-113, MCA, is amended to read:~~

~~"**33-22-113. Disability insurance coverage of persons eligible for public medical assistance.** No (1) Except as provided in subsection (2), a disability insurance policy providing hospital, medical, or surgical expense benefits delivered or issued for delivery in this state on or after July 1, 1979, may not~~

~~contain any provision denying or reducing such~~ those ~~benefits for the reason that the person insured is eligible for or receiving public medical assistance provided under Title 53, chapter 2.~~

~~(2) This section does not apply to the comprehensive health association plan issued pursuant to Title 33, chapter 22, part 15.~~"

Section 5. Section 33-22-1501, MCA, is amended to read:

"**33-22-1501. Definitions.** As used in this part, the following definitions apply:

(1) "Association" means the comprehensive health association created by 33-22-1503.

(2) "Association plan" means a policy of insurance coverage that is offered by the association and that is certified by the association as required by 33-22-1521.

(3) "Association plan premium" means the charge determined pursuant to 33-22-1512 for membership in the association plan based on the benefits provided in 33-22-1521.

(4) "Eligible person" means an individual who:

(a) is a resident of this state and applies for coverage under the association plan; ~~and~~

(b) unless the individual's eligibility is waived by the association, has, within 6 months prior to the date of application, been rejected for disability insurance or health service benefits by at least two insurers, societies, or health service corporations~~,~~ or has had a restrictive rider or preexisting conditions limitation, which limitation is required by at least two insurers, societies, or health service corporations, which has the effect of substantially reducing coverage from that received by a person considered a standard risk; and

(c) is not eligible for any other form of disability insurance~~,~~ OR health service benefits~~, or the Montana medicaid program~~.

(5) "Health service corporation" means a corporation operating pursuant to Title 33, chapter 30, and offering or selling contracts of disability insurance.

(6) "Insurance arrangement" means any plan, program, contract, or other arrangement to the extent not exempt from inclusion by virtue of the provisions of the federal Employee Retirement Income Security Act of 1974 under which one or more employers, unions, or other organizations provide to their employees or members, either directly or indirectly through a trust of a third-party administrator, health care services or benefits other than through an insurer.

(7) "Insurer" means a company operating pursuant to Title 33, chapter 2 or 3, and offering or selling policies or contracts of disability insurance, as provided in Title 33, chapter 22.

(8) "Lead carrier" means the licensed administrator or insurer selected by the association to administer the association plan.

(9) "Medicare" means coverage under both parts A and B of Title XVIII of the Social Security Act, 42 U.S.C. 1395, et seq., as amended.

~~(9)~~(10) "Preexisting condition" means any condition for which an applicant for coverage under the association plan has received medical attention during the 5 years immediately preceding the filing of an application.

~~(10)~~(11) "Society" means a fraternal benefit society operating pursuant to Title 33, chapter 7, and offering or selling certificates of disability insurance."

Section 6. Section 33-22-1503, MCA, is amended to read:

"**33-22-1503. Comprehensive health association -- mandatory membership.** (1) There is established a nonprofit legal entity, to be known as the Montana comprehensive health association, with participating membership consisting of all insurers, insurance arrangements, societies, and health service corporations licensed or authorized to do business in this state. The association is exempt from taxation under the laws of this state, and all property owned by the association is exempt from taxation.

(2) All participating members shall maintain their membership in the association as a condition for writing health care benefits policies or contracts in this state. The association shall submit its articles, bylaws, and operating rules to the commissioner for approval.

(3) The association may:

(a) exercise the powers granted to insurers under the laws of this state;

(b) sue or be sued;

(c) enter into contracts with insurers, administrators, similar associations in other states, or other persons for the performance of administrative functions;

(d) establish administrative and accounting procedures for the operation of the association;

(e) provide for the reinsuring of risks incurred as a result of issuing the coverages required by members of the association; ~~and~~

(f) provide for the administration by the association of policies that are reinsured pursuant to subsection (3)(e); and

(g) issue additional types of health insurance policies to provide optional coverage, including

medicare supplemental health insurance."

Section 7. Section 33-22-1504, MCA, is amended to read:

"**33-22-1504. Association board of directors -- organization.** (1) There is a board of directors of the association, consisting of eight individuals:

(a) one from each of the ~~seven~~ five participating members of the association with the highest annual premium volume of disability insurance contracts or health service corporation contracts, derived from or on behalf of residents in the previous calendar year, as determined by the commissioner; ~~and~~

(b) two members at large who must be participating members of the association, appointed by the commissioner; and

~~(b)~~(c) a member at large, appointed by the commissioner to represent the public interest, who shall serve in an advisory capacity only.

(2) Each of the seven board members representing the association members is entitled to a weighted average vote, in person or by proxy, based on the association member's annual Montana premium volume. However, a board member may not have more than 50% of the vote.

(3) Members of the board may be reimbursed from the money of the association for expenses incurred by them ~~due to~~ because of their service as board members but may not otherwise be compensated by the association for their services. The costs of conducting the meetings of the association and its board of directors must be borne by participating members of the association in accordance with 33-22-1513."

Section 8. Section 33-22-1512, MCA, is amended to read:

"**33-22-1512. Association plan premium.** The association shall establish the schedule of premiums to be charged eligible persons for membership in the association plan. The schedule of premiums may not ~~be less than 150% or more than 400%~~ EXCEED 200% of the average premium rates charged by the five insurers or health service corporations with the largest premium amount of individual plans of major medical insurance in force in this state. The premium rates of the five insurers or health service corporations used to establish the premium rates for each type of coverage offered by the association must be determined by the commissioner from information provided annually ~~by all insurers~~ at the request of the commissioner. The association shall ~~utilize~~ use generally acceptable actuarial principles and structurally compatible rates."

Section 9. Section 33-22-1515, MCA, is amended to read:

"**33-22-1515. Solicitation of eligible persons.** (1) The association, pursuant to a plan approved by the commissioner, shall disseminate appropriate information to the residents of this state regarding the existence of the association plan and the means of enrollment. Means of communication may include use of the press, radio, and television, as well as publication in appropriate state offices and publications.

(2) The association shall devise and implement means of maintaining public awareness of this part and shall administer this part in a manner ~~which~~ that facilitates public participation in the association plan.

(3) All licensed disability insurance producers may engage in the selling or marketing of the association plan. The lead carrier shall pay an insurance producer's referral fee of at least $25 to each licensed disability insurance producer who refers an applicant to the association plan, if the applicant is accepted. The amount of the referral fee must be set by the board of directors of the association and is subject to the approval of the commissioner. The referral fees must be paid by the lead carrier from money received as premiums for the association plan.

(4) An insurer, society, or health service corporation that rejects or applies underwriting restrictions to an applicant for disability insurance ~~must~~ shall notify the applicant of the existence of the association plan, requirements for being accepted in it, and the procedure for applying to it."

Section 10. Section 33-22-1516, MCA, is amended to read:

"**33-22-1516. Enrollment by eligible person.** (1) The association plan must be open for enrollment by eligible persons. An eligible person may enroll in the plan by submission of a certificate of eligibility to the lead carrier. The certificate must provide:

(a) the name, address, and age of the applicant and length of the applicant's residence in this state;

(b) the name, address, and age of spouse and children, if any, if they are to be insured;

(c) written evidence that ~~he~~ the person fulfills all of the elements of an eligible person, as defined in 33-22-1501; and

(d) a designation of coverage desired.

(2) Within 30 days of receipt of the certificate, the lead carrier shall either reject the application for failing to comply with the requirements of subsection (1) or forward the eligible person a notice of acceptance and billing information. Insurance is effective on the first of the month following acceptance.

(3) An eligible person may not purchase more than one policy from the association plan.

(4) A person who obtains coverage pursuant to this section may not be covered for any preexisting condition during the first 12 months of coverage under the association plan if the person was diagnosed or treated for that condition during the 5 years immediately preceding the filing of an application. ~~This subsection does not apply to a person who has had continuous coverage under an individual, family, or group policy during the year immediately preceding the filing of an application and whose cancellation date was within 30 days prior to the date of submission of a certificate of eligibility to the lead carrier for nonelective procedures.~~ The association shall waive any time period applicable to a preexisting condition exclusion for the period of time that an individual was covered under the following types of coverage if the coverage was continuous to a date not more than 30 days prior to submission of an application for coverage under the association plan:

(a) an individual health insurance policy that includes coverage 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 by the association plan; or

(b) an employer-based health insurance benefit arrangement that provides benefits similar to or exceeding the benefits provided by the association plan.

~~(5) A change of residence from Montana to another state immediately terminates eligibility for renewal of coverage under the association plan.~~"

Section 11. Section 33-22-1521, MCA, is amended to read:

"**33-22-1521. Association plan -- minimum benefits.** A plan of health coverage must be certified as an association plan if it otherwise meets the requirements of Title 33, chapters 15, 22 (excepting part 7 ~~and 33-22-113~~), and 30, and other laws of this state, whether or not the policy is issued in this state, and meets or exceeds the following minimum standards:

(1) (A) The minimum benefits for an insured must, subject to the other provisions of this section, be equal to at least ~~80%~~ 50% of the covered expenses required by this section in excess of an annual deductible that does not exceed $1,000 per person. The coverage must include a limitation of $5,000 per person on the total annual out-of-pocket expenses for services covered under this section. Coverage must be subject to a maximum lifetime benefit, but ~~such~~ the maximums may not be less than $100,000.

(B) ONE ASSOCIATION PLAN MUST BE OFFERED WITH COVERAGE FOR 80% OF THE COVERED EXPENSES PROVIDED IN THIS SECTION IN EXCESS OF AN ANNUAL DEDUCTIBLE THAT DOES NOT

EXCEED $1,000 PER PERSON. THIS ASSOCIATION PLAN MUST PROVIDE A MAXIMUM LIFETIME BENEFIT OF $500,000.

(2) Covered expenses must be the usual and customary charges for the following MEDICALLY NECESSARY services and articles when prescribed by a physician or other licensed health care professional ~~provided for in 33-22-111~~ AND WHEN DESIGNATED IN THE CONTRACT:

(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, except as specifically provided in subsection (3);

(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 DURABLE medical equipment, which ~~shall~~ 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; ~~and~~

(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, COVERED AT 50% OF THE EXPENSE, UP TO AN ANNUAL MAXIMUM OF $1,000;

(N) MEDICALLY NECESSARY, NONEXPERIMENTAL TRANSPLANTS OF THE KIDNEY, PANCREAS, HEART, HEART/LUNG, LUNGS, LIVER, CORNEA, AND HIGH-DOSE CHEMOTHERAPY BONE MARROW TRANSPLANTATION, LIMITED TO A LIFETIME MAXIMUM OF $150,000, WITH AN ADDITIONAL BENEFIT NOT TO EXCEED $10,000 FOR EXPENSES ASSOCIATED WITH THE DONOR;

(O) PREGNANCY, INCLUDING COMPLICATIONS OF PREGNANCY;

(P) NEWBORN INFANT COVERAGE, AS REQUIRED BY 33-22-301;

(Q) STERILIZATION;

(R) IMMUNIZATIONS;

(S) OUTPATIENT REHABILITATION THERAPY;

(T) FOOT CARE FOR DIABETICS;

(U) SERVICES OF A CONVALESCENT HOME, AS AN ALTERNATIVE TO HOSPITAL SERVICES, LIMITED TO A MAXIMUM OF 60 DAYS PER YEAR; AND

(V) TRAVEL, OTHER THAN TRANSPORTATION BY A LICENSED AMBULANCE SERVICE, TO THE NEAREST FACILITY QUALIFIED TO TREAT THE PATIENT'S MEDICAL CONDITION WHEN APPROVED IN ADVANCE BY THE INSURER.

(3) (a) Covered expenses for the services or articles specified in this section do not include:

~~(i) drugs requiring a physician's prescription;~~

~~(ii) services of a nursing home;~~

~~(iii)~~(I) home and office calls, except as specifically provided in subsection (2);

~~(iv)~~(II) rental or purchase of durable medical equipment, except as specifically provided in subsection (2);

~~(v)~~(III) the first $20 of diagnostic x-ray and laboratory charges in each 14-day period;

~~(vi)~~(IV) oral surgery, except as specifically provided in subsection (2);

~~(vii)~~(V) that part of a charge for services or articles ~~which~~ that exceeds the prevailing charge in the locality where the service is provided; or

~~(viii)~~(VI) care that is primarily for custodial or domiciliary purposes ~~which~~ that would not qualify as eligible services under medicare.

(b) Covered expenses for the services or articles specified in this section do not include charges for:

(i) care or for any injury or disease either arising out of an injury in the course of employment and subject to a workers' compensation or similar law, for which benefits are payable under another policy of disability insurance or medicare;

(ii) treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or congenital bodily defect to restore normal bodily functions;

(iii) travel other than transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition, EXCEPT AS PROVIDED BY SUBSECTION (2);

(iv) confinement in a private room to the extent that it is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as medically necessary by a physician;

(v) services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles;

~~(vi) organ transplants, including bone marrow transplants;~~

~~(vii)~~(VI) room and board for a nonemergency admission on Friday or Saturday;

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~~(ix)~~~~(viii)~~(VII) routine well baby care;

~~(x)~~~~(ix)~~(VIII) complications to a newborn, unless no other source of coverage is available;

~~(xi)~~~~(x)~~(IX) ~~sterilization or~~ reversal of sterilization;

~~(xii)~~~~(xi)~~(X) abortion, unless the life of the mother would be endangered if the fetus were carried to term;

~~(xiii)~~~~(xii)~~(XI) weight modification or modification of the body to improve the mental or emotional well-being of an insured;

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~~(xv)~~~~(xiv)~~(XIII) breast augmentation or reduction."

NEW SECTION. **Section 12. Codification instruction.** (1) [Sections 1 and 2] are intended to be codified as an integral part of Title 33, chapter 22, part 15, and the provisions of Title 33, chapter 22, part 15, apply to [sections 1 and 2].

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-END-