

SENATE BILL NO. 419

INTRODUCED BY G. LIND

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR INSURANCE COVERAGE UNDER A PARENT'S POLICY FOR UNMARRIED CHILDREN UNDER ~~26~~ 25 YEARS OF AGE; DEFINING "DEPENDENT"; AMENDING SECTIONS 2-18-701, 2-18-704, 33-22-101, 33-22-140, ~~33-22-201~~, 33-22-1803, 33-31-102, 33-31-111, AND 33-35-306, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE."

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

NEW SECTION. Section 1. Continuation of dependent coverage. ~~(1) Any insurer, health service corporation, health maintenance organization, bona fide association of small employers, state employee group insurance program, university system group insurance program, employee group insurance program of a city, town, county, school district, or other political subdivision of the state, and any self-funded multiple employer welfare arrangement not regulated by the Employee Retirement Income Security Act of 1974 that provides coverage for an employee and the employee's dependents may not terminate coverage on the basis of the age of an unmarried dependent prior to the dependent reaching 26 years of age. Except as provided in subsection (4), the continuation of the coverage is at the option of the covered employee.~~

~~———— (2) Renewals of coverage under this section must provide for the same level of benefits that are available to other members of the group.~~

~~———— (3) Premiums charged to cover a dependent under this section must be the same as premiums charged to other similarly situated members of the group. The policyholder may determine by whom the premium for dependent coverage is paid.~~

~~———— (4) A disability insurance issuer subject to the provisions of subsection (1) may discontinue or not renew the coverage of a dependent under this section only if:~~

~~———— (a) the person who is responsible for paying premiums has failed to pay premiums or contributions in accordance with the terms of the disability insurance coverage;~~

~~———— (b) the disability insurance issuer has not received timely premium payments; or~~

~~———— (c) the disability insurance issuer is ceasing to offer coverage in the group disability market in accordance with applicable state law.~~ A HEALTH INSURANCE ISSUER THAT ISSUES OR RENEWS AN INDIVIDUAL OR A

1 GROUP HEALTH INSURANCE POLICY, CERTIFICATE, OR MEMBERSHIP CONTRACT UNDER WHICH AN INDIVIDUAL'S OR
2 EMPLOYEE'S DEPENDENTS ARE ELIGIBLE FOR COVERAGE MAY NOT TERMINATE COVERAGE ON THE BASIS OF THE AGE OF
3 AN UNMARRIED DEPENDENT, AS DEFINED IN 33-22-140(5)(B), PRIOR TO THE DEPENDENT REACHING ~~26~~ 25 YEARS OF AGE.
4 EXCEPT AS OTHERWISE PROVIDED BY LAW, THE CONTINUATION OF THE COVERAGE OF THE DEPENDENT, AS DEFINED IN
5 33-22-140(5)(B), IS AT THE OPTION OF THE COVERED EMPLOYEE.

6
7 **Section 2.** Section 2-18-701, MCA, is amended to read:

8 **"2-18-701. Definition.** ~~In~~ As used in this part, the following definitions apply:

9 (1) "Dependent" has the meaning provided in 33-22-140.

10 (2) (a) "Employee", as it the term applies to a person employed in the executive, judicial, or legislative
11 branches of state government:

12 ~~————~~ (1) "employee" means:

13 ~~(a)~~ (i) a permanent full-time employee, as provided in 2-18-601;

14 ~~(b)~~ (ii) a permanent part-time employee, as provided in 2-18-601, who is regularly scheduled to work 20
15 hours or more a week;

16 ~~(c)~~ (iii) a seasonal full-time employee, as provided in 2-18-601, who is regularly scheduled to work 6
17 months or more a year or who works for a continuous period of more than 6 months a year although not regularly
18 scheduled to do so;

19 ~~(d)~~ (iv) a seasonal part-time employee, as provided in 2-18-601, who is regularly scheduled to work 20
20 hours or more a week for 6 months or more a year or who works 20 hours or more a week for a continuous period
21 of more than 6 months a year although not regularly scheduled to do so;

22 ~~(e)~~ (v) elected officials;

23 ~~(f)~~ (vi) officers and permanent employees of the legislative branch;

24 ~~(g)~~ (vii) judges and permanent employees of the judicial branch;

25 ~~(h)~~ (viii) academic, professional, and administrative personnel having individual contracts under the
26 authority of the board of regents of higher education or the state board of public education;

27 ~~(i)~~ (ix) a temporary full-time employee, as provided in 2-18-601:

28 ~~(i)~~ (A) who is regularly scheduled to work more than 6 months a year;

29 ~~(ii)~~ (B) who works for a continuous period of more than 6 months a year although not regularly scheduled
30 to do so; or

1 ~~(iii)(C)~~ whose temporary status is defined through collective bargaining;

2 ~~(j)(x)~~ a temporary part-time employee, as provided in 2-18-601:

3 ~~(i)(A)~~ who is regularly scheduled to work 20 hours or more a week for 6 months or more a year;

4 ~~(ii)(B)~~ who works 20 hours or more a week for a continuous period of more than 6 months a year although
5 not regularly scheduled to do so; or

6 ~~(iii)(C)~~ whose temporary status is defined through collective bargaining; and

7 ~~(k)(xi)~~ a part-time or full-time employee of the state compensation insurance fund. As used in this
8 subsection, "part-time or full-time employee of the state compensation insurance fund" means an employee
9 eligible for inclusion in the state employee group benefit plans under the rules of the department of administration.

10 ~~(2)(b)~~ "employee" The term does not include a student intern, as defined in 2-18-101."

11
12 **Section 3.** Section 2-18-704, MCA, is amended to read:

13 **"2-18-704. Mandatory provisions.** (1) An insurance contract or plan issued under this part must contain
14 provisions that permit:

15 (a) the member of a group who retires from active service under the appropriate retirement provisions
16 of a defined benefit plan provided by law or, in the case of the defined contribution plan provided in Title 19,
17 chapter 3, part 21, a member with at least 5 years of service and who is at least age 50 while in covered
18 employment to remain a member of the group until the member becomes eligible for medicare under the federal
19 Health Insurance for the Aged Act, 42 U.S.C. 1395, as amended, unless the member is a participant in another
20 group plan with substantially the same or greater benefits at an equivalent cost or unless the member is employed
21 and, by virtue of that employment, is eligible to participate in another group plan with substantially the same or
22 greater benefits at an equivalent cost;

23 (b) the surviving spouse of a member to remain a member of the group as long as the spouse is eligible
24 for retirement benefits accrued by the deceased member as provided by law unless the spouse is eligible for
25 medicare under the federal Health Insurance for the Aged Act or unless the spouse has or is eligible for
26 equivalent insurance coverage as provided in subsection (1)(a);

27 (c) the surviving children of a member to remain members of the group as long as they are eligible for
28 retirement benefits accrued by the deceased member as provided by law unless they have equivalent coverage
29 as provided in subsection (1)(a) or are eligible for insurance coverage by virtue of the employment of a surviving
30 parent or legal guardian.

(2) An insurance contract or plan issued under this part must contain the provisions of subsection (1) for remaining a member of the group and also must permit:

- (a) the spouse of a retired member the same rights as a surviving spouse under subsection (1)(b);
- (b) the spouse of a retiring member to convert a group policy as provided in 33-22-508; and
- (c) continued membership in the group by anyone eligible under the provisions of this section, notwithstanding the person's eligibility for medicare under the federal Health Insurance for the Aged Act.

(3) (a) A state insurance contract or plan must contain provisions that permit a legislator to remain a member of the state's group plan until the legislator becomes eligible for medicare under the federal Health Insurance for the Aged Act, 42 U.S.C. 1395, as amended, if the legislator:

- (i) terminates service in the legislature and is a vested member of a state retirement system provided by law; and
- (ii) notifies the department of administration in writing within 90 days of the end of the legislator's legislative term.

(b) A former legislator may not remain a member of the group plan under the provisions of subsection (3)(a) if the person:

- (i) is a member of a plan with substantially the same or greater benefits at an equivalent cost; or
- (ii) is employed and, by virtue of that employment, is eligible to participate in another group plan with substantially the same or greater benefits at an equivalent cost.

(c) A legislator who remains a member of the group under the provisions of subsection (3)(a) and subsequently terminates membership may not rejoin the group plan unless the person again serves as a legislator.

(4) (a) A state insurance contract or plan must contain provisions that permit continued membership in the state's group plan by a member of the judges' retirement system who leaves judicial office but continues to be an inactive vested member of the judges' retirement system as provided by 19-5-301. The judge shall notify the department of administration in writing within 90 days of the end of the judge's judicial service of the judge's choice to continue membership in the group plan.

(b) A former judge may not remain a member of the group plan under the provisions of this subsection (4) if the person:

- (i) is a member of a plan with substantially the same or greater benefits at an equivalent cost;
- (ii) is employed and, by virtue of that employment, is eligible to participate in another group plan with

1 substantially the same or greater benefits at an equivalent cost; or

2 (iii) becomes eligible for medicare under the federal Health Insurance for the Aged Act, 42 U.S.C. 1395,
3 as amended.

4 (c) A judge who remains a member of the group under the provisions of this subsection (4) and
5 subsequently terminates membership may not rejoin the group plan unless the person again serves in a position
6 covered by the state's group plan.

7 (5) A person electing to remain a member of the group under subsection (1), (2), (3), or (4) shall pay the
8 full premium for coverage and for that of the person's covered dependents.

9 (6) An insurance contract or plan issued under this part that provides for the dispensing of prescription
10 drugs by an out-of-state mail service pharmacy, as defined in 37-7-702:

11 (a) must permit any member of a group to obtain prescription drugs from a pharmacy located in Montana
12 that is willing to match the price charged to the group or plan and to meet all terms and conditions, including the
13 same professional requirements that are met by the mail service pharmacy for a drug, without financial penalty
14 to the member; and

15 (b) may only be with an out-of-state mail service pharmacy that is registered with the board under Title
16 37, chapter 7, part 7, and that is registered in this state as a foreign corporation.

17 (7) An insurance contract or plan issued under this part must include coverage for treatment of inborn
18 errors of metabolism, as provided for in 33-22-131.

19 (8) An insurance contract or plan issued under this part must include substantially equivalent or greater
20 coverage for outpatient self-management training and education for the treatment of diabetes and certain diabetic
21 equipment and supplies as provided in 33-22-129.

22 (9) (A) UPON EXCEPT AS PROVIDED IN SUBSECTION (9)(B), UPON renewal, an insurance contract or plan
23 issued under this part under which coverage of a dependent terminates at a specified age must provide an option,
24 as provided in [section 1], for the insured to continue to provide coverage for any unmarried dependent, AS
25 DEFINED IN 33-22-140(5)(B), until the dependent reaches 26 25 years of age or marries, whichever occurs first.
26 FOR INSURANCE CONTRACTS OR PLANS ISSUED UNDER THIS PART, THE PREMIUM CHARGED FOR THE ADDITIONAL
27 COVERAGE OF A DEPENDENT, AS DEFINED IN 33-22-140(5)(B), MAY BE REQUIRED TO BE PAID BY THE INSURED AND NOT
28 BY THE EMPLOYER.

29 (B) AN INSURANCE CONTRACT OR PLAN ISSUED UNDER THIS PART FOR THE STATE EMPLOYEE GROUP INSURANCE
30 PROGRAM AND THE UNIVERSITY SYSTEM GROUP INSURANCE PROGRAM IS NOT SUBJECT TO SUBSECTION (9)(A)."

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

"33-22-101. Exceptions to scope. (1) Subject to subsection (2), parts 1 through 4 of this chapter, except 33-22-107, 33-22-110, 33-22-111, 33-22-114, 33-22-125, 33-22-129, 33-22-130 through 33-22-136, 33-22-140, 33-22-141, 33-22-142, 33-22-243, and 33-22-304, and part 19 of this chapter do not apply to or affect:

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

(b) any group or blanket policy;

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

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

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

(d) reinsurance.

(2) Sections 33-22-150, 33-22-151, section 11, and 33-22-301 apply to group or blanket policies."

Section 5. Section 33-22-140, MCA, is amended to read:

"33-22-140. Definitions. As used in this chapter, unless the context requires otherwise, the following definitions apply:

(1) "Beneficiary" has the meaning given the term by 29 U.S.C. 1002(33).

(2) "Church plan" has the meaning given the term by 29 U.S.C. 1002(33).

(3) "COBRA continuation provision" means:

(a) section 4980B of the Internal Revenue Code, 26 U.S.C. 4980B, other than subsection (f)(1) of that section as that subsection relates to pediatric vaccines;

(b) Title I, subtitle B, part 6, excluding section 609, of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001, et seq.; or

(c) Title XXII of the Public Health Service Act, 42 U.S.C. 300dd, et seq.

(4) (a) "Creditable coverage" means coverage of the individual under any of the following:

- (i) a group health plan;
- (ii) health insurance coverage;
- (iii) Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1395c through 1395i-4 or 42 U.S.C. 1395j through 1395w-4;
- (iv) Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, other than coverage consisting solely of a benefit under section 1928, 42 U.S.C. 1396s;
- (v) Title 10, chapter 55, United States Code;
- (vi) a medical care program of the Indian health service or of a tribal organization;
- (vii) the Montana comprehensive health association provided for in 33-22-1503;
- (viii) a health plan offered under Title 5, chapter 89, of the United States Code;
- (ix) a public health plan;
- (x) a health benefit plan under section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e);
- (xi) a high-risk pool in any state.
- (b) Creditable coverage does not include coverage consisting solely of coverage of excepted benefits.
- (5) "Dependent" means:
- (a) a spouse;
- (b) an unmarried child under 26 25 years of age:
- (i) who is not an employee covered by ELIGIBLE FOR COVERAGE UNDER a group health plan offered by the child's employer FOR WHICH THE CHILD'S PREMIUM CONTRIBUTION AMOUNT IS NO GREATER THAN THE PREMIUM AMOUNT FOR COVERAGE AS A DEPENDENT UNDER A PARENT'S INDIVIDUAL OR GROUP HEALTH PLAN;
- (ii) who is not a named subscriber, insured, enrollee, or covered individual under any other individual health insurance coverage, group health plan, government plan, church plan, or group health insurance;
- (iii) who is not entitled to benefits under 42 U.S.C. 1395, et seq.; and
- (iv) for whom the insured parent has requested coverage;
- (c) a child of any age who is disabled and dependent upon the parent as provided in 33-22-506 and 33-30-1003; or
- (d) any other individual defined as a dependent in the health benefit plan covering the employee.
- ~~(5)(6)~~ "Elimination rider" means a provision attached to a policy that excludes coverage for a specific condition that would otherwise be covered under the policy.
- ~~(6)(7)~~ "Enrollment date" means, with respect to an individual covered under a group health plan or health

1 insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of
2 the waiting period for enrollment.

3 ~~(7)~~(8) "Excepted benefits" means:

4 (a) coverage only for accident or disability income insurance, or both;

5 (b) coverage issued as a supplement to liability insurance;

6 (c) liability insurance, including general liability insurance and automobile liability insurance;

7 (d) workers' compensation or similar insurance;

8 (e) automobile medical payment insurance;

9 (f) credit-only insurance;

10 (g) coverage for onsite medical clinics;

11 (h) other similar insurance coverage under which benefits for medical care are secondary or incidental
12 to other insurance benefits, as approved by the commissioner;

13 (i) if offered separately, any of the following:

14 (i) limited-scope dental or vision benefits;

15 (ii) benefits for long-term care, nursing home care, home health care, community-based care, or any
16 combination of these types of care; or

17 (iii) other similar, limited benefits as approved by the commissioner;

18 (j) if offered as independent, noncoordinated benefits, any of the following:

19 (i) coverage only for a specified disease or illness; or

20 (ii) hospital indemnity or other fixed indemnity insurance;

21 (k) if offered as a separate insurance policy:

22 (i) medicare supplement coverage;

23 (ii) coverage supplemental to the coverage provided under Title 10, chapter 55, of the United States
24 Code; and

25 (iii) similar supplemental coverage provided under a group health plan.

26 ~~(8)~~(9) "Federally defined eligible individual" means an individual:

27 (a) for whom, as of the date on which the individual seeks coverage in the group market or individual
28 market or under an association portability plan, as defined in 33-22-1501, the aggregate of the periods of
29 creditable coverage is 18 months or more;

30 (b) whose most recent prior creditable coverage was under a group health plan, governmental plan,

1 church plan, or health insurance coverage offered in connection with any of those plans;

2 (c) who is not eligible for coverage under:

3 (i) a group health plan;

4 (ii) Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1395c through 1395i-4 or 42 U.S.C. 1395j
5 through 1395w-4; or

6 (iii) a state plan under Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, or a successor
7 program;

8 (d) who does not have other health insurance coverage;

9 (e) for whom the most recent coverage within the period of aggregate creditable coverage was not
10 terminated for factors relating to nonpayment of premiums or fraud;

11 (f) who, if offered the option of continuation coverage under a COBRA continuation provision or under
12 a similar state program, elected that coverage; and

13 (g) who has exhausted continuation coverage under the COBRA continuation provision or program
14 described in subsection ~~(8)(f)~~ (9)(f) if the individual elected the continuation coverage described in subsection
15 ~~(8)(f)~~ (9)(f).

16 ~~(9)(10)~~ "Group health insurance coverage" means health insurance coverage offered in connection with
17 a group health plan or health insurance coverage offered to an eligible group as described in 33-22-501.

18 ~~(10)(11)~~ "Group health plan" means an employee welfare benefit plan, as defined in 29 U.S.C. 1002(1),
19 to the extent that the plan provides medical care and items and services paid for as medical care to employees
20 or their dependents, directly or through insurance, reimbursement, or otherwise.

21 ~~(11)(12)~~ "Health insurance coverage" means benefits consisting of medical care, including items and
22 services paid for as medical care, that are provided directly, through insurance, reimbursement, or otherwise,
23 under a policy, certificate, membership contract, or health care services agreement offered by a health insurance
24 issuer.

25 ~~(12)(13)~~ "Health insurance issuer" means an insurer, a health service corporation, or a health
26 maintenance organization.

27 ~~(13)(14)~~ "Individual health insurance coverage" means health insurance coverage offered to individuals
28 in the individual market, but does not include short-term limited duration insurance.

29 ~~(14)(15)~~ "Individual market" means the market for health insurance coverage offered to individuals other
30 than in connection with group health insurance coverage.

~~(15)~~(16) "Large employer" means, in connection with a group health plan, with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

~~(16)~~(17) "Large group market" means the health insurance market under which individuals obtain health insurance coverage directly or through any arrangement on behalf of themselves and their dependents through a group health plan or group health insurance coverage issued to a large employer.

~~(17)~~(18) "Late enrollee" means an eligible employee or dependent, other than a special enrollee under 33-22-523, who requests enrollment in a group health plan following the initial enrollment period during which the individual was entitled to enroll under the terms of the group health plan if the initial enrollment period was a period of at least 30 days. However, an eligible employee or dependent is not considered a late enrollee if a court has ordered that coverage be provided for a spouse, minor, or dependent ~~child~~ under a covered employee's health benefit plan and a request for enrollment is made within 30 days after issuance of the court order.

~~(18)~~(19) "Medical care" means:

(a) the diagnosis, cure, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body;

(b) transportation primarily for and essential to medical care referred to in subsection ~~(18)(a)~~ (19)(a); or

(c) insurance covering medical care referred to in subsections ~~(18)(a)~~ (19)(a) and ~~(18)(b)~~ (19)(b).

~~(19)~~(20) "Network plan" means health insurance coverage offered by a health insurance issuer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the issuer.

~~(20)~~(21) "Plan sponsor" has the meaning provided under section 3(16)(B) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1002(16)(B).

~~(21)~~(22) "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on presence of a condition before the enrollment date coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the enrollment date.

~~(22)~~(23) "Small group market" means the health insurance market under which individuals obtain health insurance coverage directly or through an arrangement, on behalf of themselves and their dependents, through a group health plan or group health insurance coverage maintained by a small employer as defined in 33-22-1803.

1 ~~(23)~~(24) "Waiting period" means, with respect to a group health plan and an individual who is a potential
2 participant or beneficiary in the group health plan, the period that must pass with respect to the individual before
3 the individual is eligible to be covered for benefits under the terms of the group health plan."
4

5 ~~Section 6.~~ Section 33-22-201, MCA, is amended to read:

6 ~~"33-22-201. Format and content.~~ An individual policy of disability insurance may not be delivered or
7 issued for delivery to any person in this state unless it otherwise complies with this code and complies with the
8 following:

9 ~~(1) The entire money and other considerations for the policy must be expressed in the policy.~~

10 ~~(2) The time when the insurance takes effect and terminates must be expressed in the policy.~~

11 ~~(3) The policy may insure only one person, except that a policy may insure, originally or by subsequent~~
12 ~~amendment, upon the application of an adult member of a family who is the policyholder, any two or more eligible~~
13 ~~members of that family, including husband, wife, dependent children or any children under a specified age that~~
14 ~~may not exceed 25 26 years, and any other person dependent upon the policyholder.~~

15 ~~(4) The style, arrangement, and overall appearance of the policy may not give undue prominence to any~~
16 ~~portion of the text, and every printed portion of the text of the policy and of any endorsements or attached papers~~
17 ~~must be plainly printed in lightfaced type of a style in general use, the size of which must be uniform and not less~~
18 ~~than 10 point with a lowercase, unspaced alphabet length not less than 120 point.~~

19 ~~(5) The "text" must include all printed matter except the name and address of the insurer, name or title~~
20 ~~of the policy, the brief description, if any, and captions and subcaptions.~~

21 ~~(6) The exceptions and reductions of indemnity must be set forth in the policy and, other than those~~
22 ~~contained in 33-22-204 through 33-22-215 and 33-22-221 through 33-22-231, must be printed, at the insurer's~~
23 ~~option, either included with the benefit provision to which they apply or under an appropriate caption such as~~
24 ~~"Exceptions" or "Exceptions and Reductions", except that if an exception or reduction specifically applies only~~
25 ~~to a particular benefit of the policy, a statement of the exception or reduction must be included with the benefit~~
26 ~~provision to which it applies.~~

27 ~~(7) The policy may not contain a provision purporting to make any portion of the charter, rules,~~
28 ~~constitution, or bylaws of the insurer a part of the policy unless the portion is set forth in full in the policy, except~~
29 ~~in the case of the incorporation of or reference to a statement of rates or classification of risks or short-rate table~~
30 ~~filed with the commissioner."~~

1

2 **Section 6.** Section 33-22-1803, MCA, is amended to read:

3 **"33-22-1803. Definitions.** As used in this part, the following definitions apply:

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

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

11 (3) "Assessable carrier" means all carriers of disability insurance, including excess of loss and stop loss
12 disability insurance.

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

17 (5) "Basic health benefit plan" means a health benefit plan, except a uniform health benefit plan,
18 developed by a small employer carrier, that has a lower benefit value than the small employer carrier's standard
19 benefit plan and that provides the benefits required by 33-22-1827.

20 (6) "Benefit value" means a numerical value based on the expected dollar value of benefits payable to
21 an insured under a health benefit plan. The benefit value must be calculated by the small employer carrier using
22 an actuarially based method and must take into account all health care expenses covered by the health benefit
23 plan and all cost-sharing features of the health benefit plan, including deductibles, coinsurance, copayments, and
24 the insured individual's maximum out-of-pocket expenses. The benefit value must apply equally to indemnity-type
25 health benefit plans and to managed care health benefit plans, including health maintenance organization-type
26 plans.

27 (7) "Bona fide association" means an association that:

28 (a) has been actively in existence for at least 5 years;

29 (b) was formed and has been maintained in good faith for purposes other than obtaining insurance;

30 (c) does not condition membership in the association on a health status-related factor relating to an

individual, including an employee of an employer or a dependent of an employee;

(d) makes health insurance coverage offered through the association available to a member regardless of a health status-related factor relating to the member or an individual eligible for coverage through a member; and

(e) does not make health insurance coverage offered through the association available other than in connection with a member of the association.

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

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

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

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

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

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

(11) "Dependent" means:

(a) a spouse or;

~~(b) an unmarried child under 19 years of age;~~

~~—— (b) an unmarried child, under 23 years of age, who is a full-time student and who is financially dependent on the insured; under 26 25 years of age;~~

~~(i) who is not an employee covered by~~ ELIGIBLE FOR COVERAGE UNDER a group health plan offered by the child's employer FOR WHICH THE CHILD'S PREMIUM CONTRIBUTION AMOUNT IS NO GREATER THAN THE PREMIUM AMOUNT

1 FOR COVERAGE AS A DEPENDENT UNDER A PARENT'S INDIVIDUAL OR GROUP HEALTH PLAN;

2 (ii) who is not a named subscriber, insured, enrollee, or covered individual under any other individual
3 health insurance coverage, group health plan, government plan, church plan, or group health insurance;

4 (iii) who is not entitled to benefits under 42 U.S.C. 1395, et seq.; and

5 (iv) for whom the parent has requested coverage;

6 (c) a child of any age who is disabled and dependent upon the parent as provided in 33-22-506 and
7 33-30-1003; or

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

9 (12) (a) "Eligible employee" means an employee who works on a full-time basis with a normal workweek
10 of 30 hours or more, except that at the sole discretion of the employer, the term may include an employee who
11 works on a full-time basis with a normal workweek of between 20 and 40 hours as long as this eligibility criteria
12 is applied uniformly among all of the employer's employees. The term includes a sole proprietor, a partner of a
13 partnership, and an independent contractor if the sole proprietor, partner, or independent contractor is included
14 as an employee under a health benefit plan of a small employer. The term also includes those persons eligible
15 for coverage under 2-18-704.

16 (b) The term does not include an employee who works on a part-time, temporary, or substitute basis.

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

20 (14) (a) "Health benefit plan" means any hospital or medical policy or certificate providing for physical and
21 mental health care issued by an insurance company, a fraternal benefit society, or a health service corporation
22 or issued under a health maintenance organization subscriber contract.

23 ~~(b) Health benefit plan~~ The term does not include coverage of excepted benefits, as defined in 33-22-140,
24 if coverage is provided under a separate policy, certificate, or contract of insurance.

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

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

1 coverage.

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

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

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

11 (20) "Small employer" means a person, firm, corporation, partnership, or bona fide association that is
12 actively engaged in business and that, with respect to a calendar year and a plan year, employed at least two
13 but not more than 50 eligible employees during the preceding calendar year and employed at least two
14 employees on the first day of the plan year. In the case of an employer that was not in existence throughout the
15 preceding calendar year, the determination of whether the employer is a small or large employer must be based
16 on the average number of employees reasonably expected to be employed by the employer in the current
17 calendar year. In determining the number of eligible employees, companies are considered one employer if they:

18 (a) are affiliated companies;

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

20 (c) are members of a bona fide association.

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

23 (22) "Standard health benefit plan" means a health benefit plan that is developed by a small employer
24 carrier and that contains the provisions required pursuant to 33-22-1828."

25

26 **Section 7.** Section 33-31-102, MCA, is amended to read:

27 **"33-31-102. Definitions.** As used in this chapter, unless the context requires otherwise, the following
28 definitions apply:

29 (1) "Affiliation period" means a period that, under the terms of the health insurance coverage offered by
30 a health maintenance organization, must expire before the health insurance coverage becomes effective.

- 1 (2) "Basic health care services" means:
- 2 (a) consultative, diagnostic, therapeutic, and referral services by a provider;
- 3 (b) inpatient hospital and provider care;
- 4 (c) outpatient medical services;
- 5 (d) medical treatment and referral services;
- 6 (e) accident and sickness services by a provider to each newborn infant of an enrollee pursuant to
- 7 33-31-301(3)(e);
- 8 (f) care and treatment of mental illness, alcoholism, and drug addiction;
- 9 (g) diagnostic laboratory and diagnostic and therapeutic radiologic services;
- 10 (h) preventive health services, including:
- 11 (i) immunizations;
- 12 (ii) well-child care from birth;
- 13 (iii) periodic health evaluations for adults;
- 14 (iv) voluntary family planning services;
- 15 (v) infertility services; and
- 16 (vi) children's eye and ear examinations conducted to determine the need for vision and hearing
- 17 correction;
- 18 (i) minimum mammography examination, as defined in 33-22-132;
- 19 (j) outpatient self-management training and education for the treatment of diabetes along with certain
- 20 diabetic equipment and supplies as provided in 33-22-129; and
- 21 (k) treatment and medical foods for inborn errors of metabolism. "Medical foods" and "treatment" have
- 22 the meanings provided for in 33-22-131.
- 23 (3) "Commissioner" means the commissioner of insurance of the state of Montana.
- 24 (4) "Dependent" has the meaning provided in 33-22-140.
- 25 ~~(4)~~(5) "Enrollee" means a person:
- 26 (a) who enrolls in or contracts with a health maintenance organization;
- 27 (b) on whose behalf a contract is made with a health maintenance organization to receive health care
- 28 services; or
- 29 (c) on whose behalf the health maintenance organization contracts to receive health care services.
- 30 ~~(5)~~(6) "Evidence of coverage" means a certificate, agreement, policy, or contract issued to an enrollee

1 setting forth the coverage to which the enrollee is entitled.

2 ~~(6)~~(7) "Health care services" means:

3 (a) the services included in furnishing medical or dental care to a person;

4 (b) the services included in hospitalizing a person;

5 (c) the services incident to furnishing medical or dental care or hospitalization; or

6 (d) the services included in furnishing to a person other services for the purpose of preventing,
7 alleviating, curing, or healing illness, injury, or physical disability.

8 ~~(7)~~(8) "Health care services agreement" means an agreement for health care services between a health
9 maintenance organization and an enrollee.

10 ~~(8)~~(9) "Health maintenance organization" means a person who provides or arranges for basic health care
11 services to enrollees on a prepaid basis, either directly through provider employees or through contractual or
12 other arrangements with a provider or a group of providers. This subsection does not limit methods of provider
13 payments made by health maintenance organizations.

14 ~~(9)~~(10) "Insurance producer" means an individual, partnership, or corporation appointed or authorized
15 by a health maintenance organization to solicit applications for health care services agreements on its behalf.

16 ~~(10)~~(11) "Person" means:

17 (a) an individual;

18 (b) a group of individuals;

19 (c) an insurer, as defined in 33-1-201;

20 (d) a health service corporation, as defined in 33-30-101;

21 (e) a corporation, partnership, facility, association, or trust; or

22 (f) an institution of a governmental unit of any state licensed by that state to provide health care, including
23 but not limited to a physician, hospital, hospital-related facility, or long-term care facility.

24 ~~(11)~~(12) "Plan" means a health maintenance organization operated by an insurer or health service
25 corporation as an integral part of the corporation and not as a subsidiary.

26 ~~(12)~~(13) "Point-of-service option" means a delivery system that permits an enrollee of a health
27 maintenance organization to receive health care services from a provider who is, under the terms of the enrollee's
28 contract for health care services with the health maintenance organization, not on the provider panel of the health
29 maintenance organization.

30 ~~(13)~~(14) "Provider" means a physician, hospital, hospital-related facility, long-term care facility, dentist,

osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, registered pharmacist, or advanced practice registered nurse, as specifically listed in 37-8-202, who treats any illness or injury within the scope and limitations of the provider's practice or any other person who is licensed or otherwise authorized in this state to furnish health care services.

~~(14)~~(15) "Provider panel" means those providers with whom a health maintenance organization contracts to provide health care services to the health maintenance organization's enrollees.

~~(15)~~(16) "Purchaser" means the individual, employer, or other entity, but not the individual certificate holder in the case of group insurance, that enters into a health care services agreement.

~~(16)~~(17) "Uncovered expenditures" mean the costs of health care services that are covered by a health maintenance organization and for which an enrollee is liable if the health maintenance organization becomes insolvent."

Section 8. Section 33-31-111, MCA, is amended to read:

"33-31-111. (Temporary) Statutory construction and relationship to other laws. (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to a health maintenance organization authorized to transact business under this chapter. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives is not a violation of any law relating to solicitation or advertising by health professionals.

(3) A health maintenance organization authorized under this chapter is not practicing medicine and is exempt from Title 37, chapter 3, relating to the practice of medicine.

(4) This chapter does not exempt a health maintenance organization from the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

(5) This section does not exempt a health maintenance organization from the prohibition of pecuniary interest under 33-3-308 or the material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance organization must be considered an insurer for the purposes of 33-3-308 and 33-3-701 through 33-3-704.

(6) This section does not exempt a health maintenance organization from:

- (a) prohibitions against interference with certain communications as provided under chapter 1, part 8;
- (b) the provisions of Title 33, chapter 22, part 19;
- (c) the requirements of 33-22-134 and 33-22-135;
- (d) network adequacy and quality assurance requirements provided under chapter 36, except as provided in 33-22-262; or
- (e) the requirements of Title 33, chapter 18, part 9.

(7) Except as provided in 33-22-262, the provisions of Title 33, chapter 1, parts 12 and 13, Title 33, chapter 2, part 19, 33-2-1114, 33-2-1211, 33-2-1212, 33-3-422, 33-3-431, 33-15-308, Title 33, chapter 19, 33-22-107, 33-22-129, 33-22-131, 33-22-136, [section 1], 33-22-141, 33-22-142, 33-22-244, 33-22-246, 33-22-247, 33-22-514, 33-22-521, 33-22-523, 33-22-524, 33-22-526, and 33-22-706 apply to health maintenance organizations. (Terminates June 30, 2009--sec. 14, Ch. 325, L. 2003.)

33-31-111. (Effective July 1, 2009) Statutory construction and relationship to other laws. (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to a health maintenance organization authorized to transact business under this chapter. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives is not a violation of any law relating to solicitation or advertising by health professionals.

(3) A health maintenance organization authorized under this chapter is not practicing medicine and is exempt from Title 37, chapter 3, relating to the practice of medicine.

(4) This chapter does not exempt a health maintenance organization from the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

(5) This section does not exempt a health maintenance organization from the prohibition of pecuniary interest under 33-3-308 or the material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance organization must be considered an insurer for the purposes of 33-3-308 and 33-3-701 through 33-3-704.

(6) This section does not exempt a health maintenance organization from:

- (a) prohibitions against interference with certain communications as provided under chapter 1, part 8;
- (b) the provisions of Title 33, chapter 22, part 19;

1 (c) the requirements of 33-22-134 and 33-22-135;

2 (d) network adequacy and quality assurance requirements provided under chapter 36; or

3 (e) the requirements of Title 33, chapter 18, part 9.

4 (7) Title 33, chapter 1, parts 12 and 13, Title 33, chapter 2, part 19, 33-2-1114, 33-2-1211, 33-2-1212,
5 33-3-422, 33-3-431, 33-15-308, Title 33, chapter 19, 33-22-107, 33-22-129, 33-22-131, 33-22-136, [section 1],
6 33-22-141, 33-22-142, 33-22-244, 33-22-246, 33-22-247, 33-22-514, 33-22-521, 33-22-523, 33-22-524,
7 33-22-526, and 33-22-706 apply to health maintenance organizations."

8
9 **Section 9.** Section 33-35-306, MCA, is amended to read:

10 **"33-35-306. Application of insurance code to arrangements.** (1) In addition to this chapter,
11 self-funded multiple employer welfare arrangements are subject to the following provisions:

12 (a) Title 33, chapter 1, part 4, but the examination of a self-funded multiple employer welfare
13 arrangement is limited to those matters to which the arrangement is subject to regulation under this chapter;

14 (b) Title 33, chapter 1, part 7;

15 (c) 33-3-308;

16 (d) Title 33, chapter 18, except 33-18-242;

17 (e) Title 33, chapter 19;

18 (f) 33-22-107, 33-22-131, 33-22-134, ~~and~~ 33-22-135, and [section 1]; and

19 (g) 33-22-525 and 33-22-526.

20 (2) Except as provided in this chapter, other provisions of Title 33 do not apply to a self-funded multiple
21 employer welfare arrangement that has been issued a certificate of authority that has not been revoked."

22
23 **NEW SECTION. Section 10. Codification instruction.** [Section 1] is intended to be codified as an
24 integral part of Title 33, chapter 22, part 1, and the provisions of Title 33, chapter 22, part 1, apply to [section 1].

25
26 **NEW SECTION. Section 11. Effective date.** [This act] is effective January 1, 2008.

27 - END -