

HOUSE BILL NO. 250

INTRODUCED BY MACLAREN, STEINBEISSER

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A BILL FOR AN ACT ENTITLED: "AN ACT REVISING THE MONTANA COMPREHENSIVE HEALTH ASSOCIATION AND PLAN; INCREASING THE PUBLIC MEMBERS OF THE ASSOCIATION BOARD; CHANGING PREMIUM LIMITS; INCREASING ELIGIBILITY FOR PREMIUM ASSISTANCE; INCREASING LIFETIME BENEFITS; ~~APPROPRIATING FUNDS~~; AMENDING SECTIONS 33-22-1504, 33-22-1512, AND 33-22-1521, MCA; AND PROVIDING AN EFFECTIVE DATE."

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

Section 1. 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~~ nine members as follows:

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

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

(c) ~~a member~~ two members at large, appointed by the commissioner to represent the public interest.

(2) The public interest board ~~member is~~ members are entitled to one board vote each. 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 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~~ reimbursing the board of directors must be borne by participating members of the association in accordance with 33-22-1513.

(4) The commissioner may replace a board member if the commissioner determines that the board

1 member is not actively participating in the affairs of the board or if the participating member does not appoint a
 2 board representative within a reasonable time period. A board member appointed under subsection (1)(a) must
 3 be replaced by a participating member of the association with the next highest annual Montana premium volume
 4 of disability insurance contracts, health maintenance organization health care service agreements, or health
 5 service corporation contracts, derived from or on behalf of residents in the previous calendar year, as determined
 6 by the commissioner.

7 (5) The commissioner shall include the applicable premium volume of all affiliates, as defined in
 8 33-2-1101, in making the determination required by subsection (1)(a) or (4)."

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10 **Section 2.** Section 33-22-1512, MCA, is amended to read:

11 **"33-22-1512. Association plan and association portability plan premium.** (1) The association shall
 12 establish the schedule of premiums to be charged eligible persons for membership in the association plan. The
 13 schedule of association plan premiums for eligible persons may not exceed ~~200%~~ 150% of the average premium
 14 rates charged by the five insurers or health service corporations with the largest premium amount of individual
 15 plans of major medical insurance in force in this state. The schedule of association portability plan premiums for
 16 federally defined eligible individuals may not at any time exceed 150% of the average premium rates charged by
 17 the five insurers or health service corporations with the largest premium amount of individual plans of major
 18 medical insurance in force in this state. The premium rates of the five insurers or health service corporations used
 19 to establish the premium rates for each type of coverage offered by the association must be determined by the
 20 commissioner from information provided annually at the request of the commissioner. The association shall use
 21 generally acceptable actuarial principles and structurally compatible rates.

22 (2) (a) The association, with the approval of the commissioner, may adopt a reduced premium rate
 23 schedule that is equitably proportional to the income level for eligible persons who have an income less than or
 24 equal to ~~450%~~ 200% of the federal poverty level. The association may not adopt a reduced premium rate
 25 schedule unless it has secured federal, state, or private funding specifically for that purpose and the use of the
 26 reduced premium rate schedule is limited to the available federal, state, or private funding.

27 (b) The association, with the approval of the commissioner, may adopt as many income categories as
 28 it finds necessary.

29 (c) Any person who qualifies for coverage under this section may apply to the association for a reduced
 30 premium. However, eligible persons with coverage in the traditional association plan must receive first priority

1 for reduced premiums. By agreement of the association and the commissioner, reduced premiums may be made
2 available to persons eligible for the portability plan.

3 (d) The association may grant as many reduced premiums as funding sources allow but may not
4 increase overall premium rates to subsidize the reduced premium rate schedule. The association may limit the
5 number of people receiving reduced premiums when funds are not available and may establish a waiting list for
6 reduced premiums, if necessary."

7

8 **Section 3.** Section 33-22-1521, MCA, is amended to read:

9 **"33-22-1521. Association plan -- minimum benefits.** A plan of health coverage must be certified as
10 an association plan if it otherwise meets the requirements of Title 33, chapters 15, 22 (excepting 33-22-701
11 through 33-22-705), and 30, and other laws of this state, whether or not the policy is issued in this state, and
12 meets or exceeds the following minimum standards:

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

18 (b) One association plan must be offered with coverage for 80% of the covered expenses provided in
19 this section in excess of an annual deductible that does not exceed \$1,000 per person. This association plan must
20 provide a maximum lifetime benefit of at least ~~\$500,000~~ \$2 million.

21 (c) Covered expenses for plans under subsection (1)(a) and (1)(b) must be paid as specified in provider
22 contracts or, in the absence of a provider contract, at the prevailing charge in the state where the service is
23 provided.

24 (d) The board may authorize other association plans, including managed care plans as defined in
25 33-36-103.

26 (2) Covered expenses for plans offered under subsections (1)(a) and (1)(b) must be for the following
27 medically necessary services and articles when prescribed by a physician or other licensed health care
28 professional and when designated in the contract:

29 (a) hospital services;

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

- 1 dental;
- 2 (c) use of radium or other radioactive materials;
- 3 (d) oxygen;
- 4 (e) anesthetics;
- 5 (f) diagnostic x-rays and laboratory tests, except as specifically provided in subsection (3);
- 6 (g) services of a physical therapist;
- 7 (h) transportation provided by licensed ambulance service to the nearest facility qualified to treat the
- 8 condition;
- 9 (i) oral surgery for the gums and tissues of the mouth when not performed in connection with the
- 10 extraction or repair of teeth or in connection with TMJ;
- 11 (j) rental or purchase of durable medical equipment, which must be reimbursed after the deductible has
- 12 been met at the rate of 50%, up to a maximum of \$1,000;
- 13 (k) prosthetics, other than dental;
- 14 (l) services of a licensed home health agency, up to a maximum of 180 visits per year;
- 15 (m) drugs requiring a physician's prescription that are approved for use in human beings in the manner
- 16 prescribed by the United States food and drug administration, covered at 50% of the expense, up to an annual
- 17 maximum of \$2,000;
- 18 (n) medically necessary, nonexperimental transplants of the kidney, pancreas, heart, heart/lung, lungs,
- 19 liver, cornea, and high-dose chemotherapy bone marrow transplantation, limited to a lifetime maximum of
- 20 \$150,000, with an additional benefit not to exceed \$10,000 for expenses associated with the donor;
- 21 (o) pregnancy, including complications of pregnancy;
- 22 (p) newborn infant coverage, as required by 33-22-301;
- 23 (q) sterilization;
- 24 (r) immunizations;
- 25 (s) outpatient rehabilitation therapy;
- 26 (t) foot care for diabetics;
- 27 (u) services of a convalescent home, as an alternative to hospital services, limited to a maximum of 60
- 28 days per year;
- 29 (v) travel, other than transportation by a licensed ambulance service, to the nearest facility qualified to
- 30 treat the patients medical condition when approved in advance by the insurer; and

- 1 (w) coverage for severe mental illness as required in 33-22-706.
- 2 (3) (a) Covered expenses for the services or articles specified in this section do not include:
- 3 (i) home and office calls, except as specifically provided in subsection (2);
- 4 (ii) rental or purchase of durable medical equipment, except as specifically provided in subsection (2);
- 5 (iii) the first \$20 of diagnostic x-ray and laboratory charges in each 14-day period;
- 6 (iv) oral surgery, except as specifically provided in subsection (2);
- 7 (v) that part of a charge for services or articles that exceeds the prevailing charge in the state where the
- 8 service is provided; or
- 9 (vi) care that is primarily for custodial or domiciliary purposes that would not qualify as eligible services
- 10 under medicare.
- 11 (b) Covered expenses for the services or articles specified in this section do not include charges for:
- 12 (i) care or for any injury or disease arising out of an injury in the course of employment and subject to
- 13 a workers' compensation or similar law, for which benefits are payable under another policy of disability insurance
- 14 or medicare;
- 15 (ii) treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or
- 16 congenital bodily defect to restore normal bodily functions;
- 17 (iii) travel other than transportation provided by a licensed ambulance service to the nearest facility
- 18 qualified to treat the condition, except as provided by subsection (2);
- 19 (iv) confinement in a private room to the extent that ~~it is in excess of the institution's~~ the charge exceeds
- 20 the facility's charge for its most common semiprivate room, unless the private room is prescribed as medically
- 21 necessary by a physician;
- 22 (v) services or articles ~~the provision of which is~~ that are not within the scope of authorized practice of the
- 23 ~~institution~~ facility or individual rendering the services or articles;
- 24 (vi) room and board for a nonemergency admission on Friday or Saturday;
- 25 (vii) routine well baby care;
- 26 (viii) complications to a newborn, unless no other source of coverage is available;
- 27 (ix) reversal of sterilization;
- 28 (x) abortion, unless the life of the mother would be endangered if the fetus were carried to term;
- 29 (xi) weight modification or modification of the body to improve the mental or emotional well-being of an
- 30 insured;

1 (xii) artificial insemination or treatment for infertility; or

2 (xiii) breast augmentation or reduction."

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4 ~~NEW SECTION. **Section 4. Appropriation.** (1) There is appropriated \$8 million from the general fund~~
5 ~~to the office of the state auditor for the biennium beginning July 1, 2009, for the Montana comprehensive health~~
6 ~~association plan provided for in Title 33, chapter 22, part 15.~~

7 ~~(2) Any portion of the appropriation that is not used for the plan shall revert to the general fund.~~

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9 NEW SECTION. **Section 4. Effective date.** [This act] is effective July 1, 2009.

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