AN ACT REVISING THE MONTANA COMPREHENSIVE HEALTH ASSOCIATION AND PLAN; REDUCING THE NUMBER OF INSURANCE REJECTIONS OR RESTRICTIONS REQUIRED UNDER THE "ELIGIBLE PERSON" DEFINITION; INCREASING THE NUMBER OF PUBLIC MEMBERS OF THE ASSOCIATION BOARD; CHANGING PREMIUM LIMITS; INCREASING ELIGIBILITY FOR PREMIUM ASSISTANCE; INCREASING LIFETIME BENEFITS; AMENDING SECTIONS 33-22-1501, 33-22-1504, 33-22-1512, AND 33-22-1521, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE.

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

Section 1. 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) "Association portability plan" means a policy of insurance coverage that is offered by the association to a federally defined eligible individual.

(5) "Association portability plan premium" means the charge determined by the association and approved by the commissioner for an association portability plan.

(6) "Block of business" means a separate risk pool grouping of covered individuals, enrollees, and dependents as defined by rules of the commissioner.

(7) (a) "Eligible person" means an individual who:

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

(ii) is not eligible for any other form of health insurance coverage or health service benefits, except:

(A) for coverage consisting solely of excepted benefits, as defined in 33-22-140; or

(B) subject to eligibility limitations adopted pursuant to 33-22-1502(2), if the individual has coverage comparable to the association plan but is paying a premium or has received a renewal notice to pay a premium that is more than 150% of the average premium rate used to calculate the association plan premium rate pursuant to 33-22-1512(1); and

(iii) meets one or more of the following criteria:

(A) 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~~ one insurer, society, or health service corporation, unless the association waives this requirement; or

(B) has had a restrictive rider or preexisting conditions limitation~~, which limitation is~~ required by at least ~~two insurers, societies, or health service corporations,~~ one insurer, society, or health service corporation that has the effect of substantially reducing coverage from that received by a person considered a standard risk.

(b) The term does not apply to an individual who is certified as eligible for federal trade adjustment assistance or for pension benefit guaranty corporation assistance, as provided by the federal Trade Adjustment Assistance Reform Act of 2002, and is eligible for the association portability plan.

(8) "Federally defined eligible individual" means a person who is an individual enrolling in the association portability plan:

(a) for whom, as of the date on which the individual seeks coverage under the association portability plan, the aggregate of the periods of creditable coverage is 18 months or more and whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan;

(b) who does not have other health insurance coverage;

(c) who is not eligible for coverage under:

(i) a group health plan;

(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 through 1395w-4; or

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

(d) for whom the most recent coverage was not terminated for factors relating to nonpayment of premiums or fraud;

(e) who, if offered the option of continuation coverage under a COBRA continuation provision or under

a similar state program, elected that coverage; and

(f) who has exhausted continuation coverage under the COBRA continuation provision or program described in subsection (8)(e) if the individual elected the continuation coverage described in subsection (8)(e).

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

(10) "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.

(11) "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.

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

(13) "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.

(14) "Preexisting condition" means any condition for which an applicant for coverage under the association plan has received medical attention during the 3 years immediately preceding the filing of an application.

(15) "Qualified TAA-eligible individual" means an individual and any dependent of that individual, in addition to meeting the requirements specified in subsection (18):

(a) who has 3 months of prior creditable coverage;

(b) whose application for association portability plan coverage is made within 63 days following termination of the applicant's most recent prior creditable coverage; and

(c) who, if eligible for COBRA, is not required to elect or exhaust continuation coverage under the COBRA continuation provision or under a similar state program.

(16) "Resident" means an individual who has been legally domiciled in this state for a period of at least 30 days, except that for a federally defined eligible individual there is no 30-day requirement. The criteria for determining residency must be specified in the association's operating rules.

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

(18) "TAA-eligible individual" means an individual and any dependent of that individual enrolling in the association portability plan:

(a) who is a resident of this state on the date of application to the pool;

(b) who has been certified as eligible for federal trade adjustment assistance and a health insurance tax credit or for pension benefit guaranty corporation assistance, as provided by the federal Trade Adjustment Assistance Reform Act of 2002;

(c) who does not have other health insurance coverage; and

(d) who is not covered under a group health plan maintained by an employer, including a group health plan available through a spouse, if the employer contributes 50% or more to the total cost of coverage."

Section 2. 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 members provided for in subsection (1)(c) must be enrolled in a Montana comprehensive health association plan at the time of appointment.

~~(2)~~(3) 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)~~(4) 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 its board of directors must be borne by participating members of the association in accordance with 33-22-1513.

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

~~(5)~~(6) The commissioner shall include the applicable premium volume of all affiliates, as defined in 33-2-1101, in making the determination required by subsection (1)(a) or ~~(4)~~ (5)."

Section 3. Section 33-22-1512, MCA, is amended to read:

"33-22-1512. Association plan and association portability plan premium. (1) The association shall establish the schedule of premiums to be charged eligible persons for membership in the association plan. The schedule of association plan premiums for eligible persons may not exceed ~~200%~~ 150% 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 schedule of association portability plan premiums for federally defined eligible individuals may not at any time exceed 150% 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 at the request of the commissioner. The association shall use generally acceptable actuarial principles and structurally compatible rates.

(2) (a) The association, with the approval of the commissioner, may adopt a reduced premium rate schedule that is equitably proportional to the income level for eligible persons who have an income less than or equal to ~~150%~~ 200% of the federal poverty level. The association may not adopt a reduced premium rate schedule unless it has secured federal, state, or private funding specifically for that purpose and the use of the

reduced premium rate schedule is limited to the available federal, state, or private funding.

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

(c) Any person who qualifies for coverage under this section may apply to the association for a reduced premium. However, eligible persons with coverage in the traditional association plan must receive first priority for reduced premiums. By agreement of the association and the commissioner, reduced premiums may be made available to persons eligible for the portability plan.

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

Section 4. 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 33-22-701 through 33-22-705), 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 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 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 at least ~~$500,000~~ $2 million.

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

(d) The board may authorize other association plans, including managed care plans as defined in

33-36-103.

(2) Covered expenses for plans offered under subsections (1)(a) and (1)(b) must be for the following medically necessary services and articles when prescribed by a physician or other licensed health care professional 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 must be reimbursed after the deductible has been met at the rate of 50%, up to a maximum of $1,000;

(k) prosthetics, other than dental;

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

(m) drugs requiring a physician's prescription that are approved for use in human beings in the manner prescribed by the United States food and drug administration, covered at 50% of the expense, up to an annual maximum of $2,000;

(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;

(v) travel, other than transportation by a licensed ambulance service, to the nearest facility qualified to treat the patients medical condition when approved in advance by the insurer; and

(w) coverage for severe mental illness as required in 33-22-706.

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

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

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

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

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

(v) that part of a charge for services or articles that exceeds the prevailing charge in the state where the service is provided; or

(vi) care that is primarily for custodial or domiciliary purposes 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 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~~ the charge exceeds the facility'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~~ that are not within the scope of authorized practice of the

~~institution~~ facility or individual rendering the services or articles;

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

(vii) routine well baby care;

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

(ix) reversal of sterilization;

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

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

(xii) artificial insemination or treatment for infertility; or

(xiii) breast augmentation or reduction."

Section 5. Effective date. [This act] is effective on passage and approval.

- END -

I hereby certify that the within bill,

HB 0324, originated in the House.

Chief Clerk of the House

Speaker of the House

Signed this _____ day

of _____, 2011.

President of the Senate

Signed this _____ day

of _____, 2011.

HOUSE BILL NO. 324

INTRODUCED BY G. MACLAREN

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