

**** Bill No. ****

Introduced By *****

By Request of the *****

A Bill for an Act entitled: "An Act revising the definition of small employer for health insurance purposes; amending sections 33-22-140 and 33-22-1803, MCA; and providing an effective date."

Be it enacted by the Legislature of the State of Montana:

Section 1. 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

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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 25 years of age:
 - (i) who is not an employee eligible for coverage under a group health plan offered by the child's employer for which the

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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.

(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.

(7) "Enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for enrollment.

(8) "Excepted benefits" means:

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

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

(c) liability insurance, including general liability

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insurance and automobile liability insurance;

(d) workers' compensation or similar insurance;

(e) automobile medical payment insurance;

(f) credit-only insurance;

(g) coverage for onsite medical clinics;

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

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

(i) limited-scope dental or vision benefits;

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

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

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

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

(ii) hospital indemnity or other fixed indemnity insurance;

(k) if offered as a separate insurance policy:

(i) medicare supplement coverage;

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

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

(9) "Federally defined eligible individual" means an individual:

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

(b) whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with any of those plans;

(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) who does not have other health insurance coverage;

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

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

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

(10) "Group health insurance coverage" means health

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insurance coverage offered in connection with a group health plan or health insurance coverage offered to an eligible group as described in 33-22-501.

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

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

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

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

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

(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~~ 101 employees on business days during the preceding calendar year and who employs

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at least two employees on the first day of the plan year.

(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.

(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 under a covered employee's health benefit plan and a request for enrollment is made within 30 days after issuance of the court order.

(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 (19)(a); or

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

(20) "Network plan" means health insurance coverage offered by a health insurance issuer under which the financing and

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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.

(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).

(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.

(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.

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

{Internal References to 33-22-140:

2-18-701 x	33-15-403 x	33-22-101 x	33-22-143 * x
33-22-152 x	33-22-152 x	33-22-508 x	33-22-1501 x
33-22-1803 a	33-22-1811 x	33-22-1811 x	33-28-102 x
33-28-207 x	33-28-207 x	33-31-102 x	33-31-307 x
33-31-307 x	33-38-102 x	50-4-902x}	

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

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

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

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

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

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

(5) "Basic health benefit plan" means a health benefit plan, except a uniform health benefit plan, developed by a small

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employer carrier, that has a lower benefit value than the small employer carrier's standard benefit plan.

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

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

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

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

(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.

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(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;

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(b) an unmarried child under 25 years of age:

(i) who is not an employee 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 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.

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

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term also includes those persons eligible for coverage under 2-18-704.

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

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

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

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

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

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

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

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

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

(20) "Small employer" means a person, firm, corporation, partnership, or bona fide association that is actively engaged in business and that, with respect to a calendar year and a plan year, employed at least two but not more than ~~50~~ 100 eligible employees during the preceding calendar year and employed at least two employees on the first day of the plan year. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer must be based on the average number of employees reasonably expected to be employed by the employer in the current calendar year. In determining the number of eligible employees, companies are considered one employer if they:

(a) are affiliated companies;

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

(c) are members of a bona fide association.

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

(22) "Standard health benefit plan" means a health benefit plan that is developed by a small employer carrier."

{ Internal References to 33-22-1803:

33-22-133 x	33-22-140a	33-22-247 x	33-22-508x
33-22-2002 x	33-22-2002 x	33-22-2002 x	33-22-2005 x
33-30-1007 x	33-31-322x }		

NEW SECTION. **Section 3. {standard} Effective date.** [This act] is effective July 1, 2013.

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