HOUSE BILL NO. 503

INTRODUCED BY T. WINTER

A BILL FOR AN ACT ENTITLED: "AN ACT REGULATING SHORT-TERM, LIMITED-DURATION INSURANCE; ESTABLISHING LIMITATIONS ON PERIODS OF COVERAGE; REQUIRING GUARANTEED ISSUE; PROHIBITING PREEXISTING CONDITION EXCLUSIONS; ESTABLISHING DISCLOSURE REQUIREMENTS; PROVIDING RULEMAKING AUTHORITY; AMENDING SECTIONS 33-22-140 AND 33-31-111, MCA; AND PROVIDING AN EFFECTIVE DATE AND AN APPLICABILITY DATE."

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

NEW SECTION. **Section 1. Short title.** [Sections 1 through 6] may be cited as the "Short-Term, Limited-Duration Health Insurance Coverage Act".

NEW SECTION. **Section 2. Application -- scope -- duration of coverage.** (1) [Sections 1 through 6] apply to health insurance issuers that offer short-term, limited-duration insurance to individuals in this state and to short-term, limited-duration insurance that is delivered or issued for delivery in this state, including coverage issued outside of this state that covers individuals in this state.

(2) A short-term, limited-duration insurance policy, membership contract, or certificate of insurance may not be issued or delivered to any person residing in this state unless the policy, contract, or certificate complies with the provisions of [sections 1 through 6].

(3) A short-term, limited-duration insurance policy, contract, or certificate:

(a) must contain an expiration date that is less than 91 days after the effective date of the coverage; and

(b) may not be renewed or extended for 365 days after coverage ends, either at the option of the health insurance issuer or the policyholder.

(4) Renewal of short-term, limited-duration insurance includes the issuance of a new short-term, limited-duration insurance policy, contract, or certificate to an individual within 275 days after the expiration of a policy, contract, or certificate previously issued by the health insurance issuer to the individual.

(5) Short-term, limited-duration insurance may not be rescinded or terminated before the expiration date in the policy, contract, or certificate except in cases of nonpayment of premiums, fraud, or as provided in

subsection (6).

(6) A policy, contract, or certificate must contain an option for an individual to cancel coverage after any 30-day interval during the term of the coverage.

NEW SECTION. **Section 3. Guaranteed issue -- coverage of preexisting conditions.** An issuer of short-term, limited-duration insurance:

(1) shall accept every individual who applies for the coverage;

(2) may not deny coverage to an individual because the individual has a preexisting medical condition; and

(3) may not limit or exclude from coverage a medical condition based on the fact the condition was present before the date of enrollment in coverage.

NEW SECTION. **Section 4. Disclosure requirements.** (1) A health insurance issuer that offers short-term, limited-duration insurance shall deliver an outline of coverage to an applicant for or an enrollee in the coverage.

(2) (a) A short-term, limited-duration insurance policy, membership contract, or certificate of insurance shall display prominently in all materials related to the policy, contract, or certificate a notice in at least 14-point bold type containing the following: "NOTICE: THE SHORT-TERM, LIMITED-DURATION INSURANCE BENEFITS UNDER THIS COVERAGE DO NOT MEET ALL FEDERAL REQUIREMENTS TO QUALIFY AS "MINIMUM ESSENTIAL COVERAGE" FOR HEALTH INSURANCE UNDER THE AFFORDABLE CARE ACT. BE SURE TO CHECK YOUR POLICY CAREFULLY TO MAKE SURE YOU UNDERSTAND WHAT THE POLICY DOES AND DOES NOT COVER. IF THIS COVERAGE EXPIRES OR YOU LOSE ELIGIBILITY FOR THIS COVERAGE, YOU MIGHT HAVE TO WAIT UNTIL THE NEXT OPEN ENROLLMENT PERIOD TO OBTAIN OTHER HEALTH INSURANCE COVERAGE. YOU MAY BE ABLE TO OBTAIN LONGER-TERM INSURANCE THAT QUALIFIES AS "MINIMUM ESSENTIAL COVERAGE" FOR HEALTH INSURANCE UNDER THE AFFORDABLE CARE ACT NOW AND HELP TO PAY FOR IT AT WWW.HEALTHCARE.GOV."

(b) The disclosure also must be displayed prominently:

(i) in any application, sales, and marketing materials provided in connection with enrollment in short-term, limited-duration insurance; and

(ii) on any website page where a prospective purchaser would purchase the insurance.

(3) An individual selling short-term, limited-duration insurance in face-to-face or telephonic sales interactions shall read out loud the disclosure in subsection (2) to a prospective purchaser.

(4) Nothing in this section prevents a health insurance issuer from providing additional disclosures if approved by the commissioner.

NEW SECTION. **Section 5. Filing and approval.** (1) Coverage subject to the provisions of [sections 1 through 6] may not be delivered or issued for delivery in this state unless the application and policy forms have been filed with and been approved by the commissioner.

(2) A health insurance issuer who intends to offer short-term, limited-duration insurance shall also file with the commissioner all sales and marketing materials provided in connection with enrollment for informational purposes.

NEW SECTION. **Section 6. Rulemaking.** The commissioner shall adopt rules to carry out the provisions of [sections 1 through 6], including but not limited to the manner and form for filing the information required under [sections 1 through 6].

Section 7. 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) a health plan offered under Title 5, chapter 89, of the United States Code;

(viii) a public health plan;

(ix) a health benefit plan under section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e); or

(x) a high-risk pool in any state.

(b) Creditable coverage does not include coverage consisting solely of coverage of excepted benefits or short-term, limited-duration insurance.

(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 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 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:

(a) for whom, as of the date on which the individual seeks coverage in the group market or individual market, 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 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~~ 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 employees on business days during the preceding calendar year and who employs 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 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) "Short-term, limited-duration health insurance" means health insurance coverage that has an expiration date that is less than 12 months after the original effective date of the coverage.

~~(23)~~(24) "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)~~(25) "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."

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

"33-31-111. 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 Title 33, chapter 1, part 8;

(b) the provisions of Title 33, chapter 22, parts 7 and 19;

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

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

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

(7) Title 33, chapter 1, parts 12 and 13, 33-2-1114, 33-2-1211, 33-2-1212, Title 33, chapter 2, parts 13, 19, and 23, 33-3-401, 33-3-422, 33-3-431, Title 33, chapter 3, part 6, 33-15-308, Title 33, chapter 17, Title 33, chapter 19, 33-22-107, 33-22-129, 33-22-131, 33-22-136, 33-22-137, 33-22-138, 33-22-139, 33-22-141, 33-22-142, 33-22-152, 33-22-153, 33-22-156 through 33-22-159, 33-22-244, 33-22-246, 33-22-247, 33-22-514, 33-22-515, 33-22-521, 33-22-523, 33-22-524, 33-22-526, [sections 1 through 6], and Title 33, chapter 32, apply

to health maintenance organizations."

NEW SECTION. **Section 9. Codification instruction.** [Sections 1 through 6] are intended to be codified as an integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [sections 1 through 6].

NEW SECTION. **Section 10. Effective date.** [This act] is effective July 1, 2019, and applies to short-term, limited-duration insurance issued on or after July 1, 2019.

- END -