HOUSE BILL NO. 609

INTRODUCED BY T. WINTER

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING INSURANCE REGULATIONS RELATING TO HEALTH INSURANCE POLICY PROVISIONS; ELIMINATING A LIFETIME OR ANNUAL LIMIT PERTAINING TO BENEFITS PAID UNDER AN INSURANCE POLICY; PROHIBITING EXCLUSIONS OF COVERAGE ON THE BASIS OF A PREEXISTING CONDITION; ELIMINATING A TIME REQUIREMENT FOR APPLICATION OF A PREEXISTING CONDITION; AMENDING SECTIONS 7-21-3710, 33-22-110, 33-22-241, 33-22-246, 33-22-308, 33-22-514, 33-22-1802, 33-22-1809, 33-22-1811, 33-22-1815, AND 33-31-307, MCA; REPEALING SECTIONS 33-22-109 AND 33-22-242; AND PROVIDING AN APPLICABILITY DATE."

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

NEW SECTION. **Section 1. Lifetime cap prohibited.** (1) A disability insurance policy, whether a group policy or an individual policy, may not establish a lifetime or annual limit on the dollar amount of benefits provided, whether provided in-network or out-of-network, in compliance with 42 U.S.C. 300gg-11.

(2) This section does not apply to excepted benefits plans, including limited-scope dental or vision policies, or to medicare supplement policies.

Section 2. Section 7-21-3710, MCA, is amended to read:

"7-21-3710. Tax credits for employers in empowerment zone. (1) There is allowed to an employer a credit against taxes imposed under 15-30-2103, 15-31-121, 15-31-122, or 33-2-705 for an increase in net employees as provided in this section.

(2) To be eligible for a credit under this section, the owner of a business located in an empowerment zone:

(a) shall conduct a business in a facility within the empowerment zone in which retail sales of tangible personal property, other than that manufactured in the business facility, are not in excess of 10% of the business conducted in the facility, whether measured by number of employees doing retail sales, by square footage, or by dollar volume; and

(b) shall increase employment in the empowerment zone with employees:

(i) who are employed for at least 1,750 hours a year in permanent employment intended to last at least 3 years;

(ii) who were not employed by the business in the preceding 12 months;

(iii) at least 35% of whom were residents of the county in which the empowerment zone is located at the time they were hired by the business;

(iv) who are provided a health benefit plan for employees in accordance with 33-22-1811~~(3)(d)~~(3)(b) of which at least 50% of the premium is paid by the business; and

(v) who are paid for job duties performed at the empowerment zone location of the business.

(3) (a) For the purposes of subsection (2)(b)(i), an employee hired in the last 90 days of a year is considered to be an employee beginning employment in the following year. If an employee terminates employment, a replacement employee may be hired and the credit for the combined length of time may be claimed.

(b) For the purposes of subsection (2)(b)(iii), if an employee for whom a credit was claimed and who counted as an empowerment zone county resident for credit eligibility in either of the immediate 2 preceding years terminates employment, the replacement employee must have been a resident of the county in which the empowerment zone is located at the time the replacement employee is hired.

(4) An employer shall apply for certification to claim a credit under the provisions of this section. The department shall require a report that contains detailed information to determine whether an employer qualifies under subsections (2) and (3). The information must be detailed enough for auditing purposes. The department is authorized to inspect employers applying for certification or who have obtained certification.

(5) The department shall certify to the department of revenue or the state auditor's office, as applicable, whether a business may claim a credit under the provisions of this section as well as how many additional employees qualify and the year of initial employment of qualifying employees."

Section 3. Section 33-22-110, MCA, is amended to read:

"33-22-110. Preexisting ~~conditions~~ condition exclusion prohibited. (1) ~~Except as provided in 33-22-246 and 33-22-514, a~~ A policy or certificate of disability insurance may not exclude coverage for a condition for which medical advice or treatment was recommended by or received from a provider of health care services ~~unless the condition occurred within 5 years preceding the effective date of coverage of an insured person. The condition may only be excluded for a maximum of 12 months~~.

(2) An insurer may use an application form designed to elicit the complete health history of an applicant ~~and, on the basis of the answers on that application, perform underwriting in accordance with the insurer's established underwriting standards~~.

(3) A policy of disability income insurance may not exclude coverage for a condition for which medical advice or treatment was recommended by or received from a provider of health care services ~~unless the condition occurred within 5 years preceding the effective date of coverage of an insured person. An exclusion may not apply to a disability commencing more than 12 months from the effective date of coverage of an insured person~~."

Section 4. Section 33-22-241, MCA, is amended to read:

"33-22-241. Definitions. As used in ~~33-22-242 and~~ 33-22-243, unless the context indicates otherwise, the following definitions apply:

(1) "Block of business" means an individual disability insurance policy certificate or contract filed and approved by the commissioner pursuant to 33-1-501 and written and sold by a health care insurer to a defined set of individuals. All individuals covered by the policy or contract are considered to be within the block of business.

(2) "Health care insurer" means a disability insurer, a health service corporation, a health maintenance organization, or a fraternal benefit society.

(3) (a) "Individual health benefit plan" means any hospital or medical expense policy or certificate, subscriber contract, or contract of insurance provided by a prepaid hospital or medical service plan or health maintenance organization subscriber contract and issued for delivery to an individual.

(b) Individual health benefit plan does not include a self-funded group health plan; a self-funded multiemployer group health plan; a group conversion plan; an insured group health plan; accident-only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, medicare supplement, long-term care, or disability income insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical payment insurance.

~~(4) "Qualifying previous coverage" means benefits or coverage provided under:~~

~~(a) medicare or medicaid;~~

~~(b) group health insurance or a health benefit plan that provides benefits similar to or exceeding benefits provided under the plan being applied for; or~~

~~(c) an individual health benefit plan, including coverage issued by a health maintenance organization,~~

~~a prepaid hospital or medical care plan, or a fraternal benefit society, that provides benefits similar to or exceeding the plan being applied for.~~"

Section 5. Section 33-22-246, MCA, is amended to read:

"33-22-246. Preexisting ~~conditions~~ condition exclusion relating to individual market prohibited. (1) ~~Except as provided in subsection (2), a~~ A health insurance issuer offering individual health insurance coverage may not exclude coverage for a preexisting condition ~~unless:~~

~~(a) medical advice, diagnosis, care, or treatment was recommended to or received by the participant or beneficiary within the 3 years preceding the effective date of coverage; and~~

~~(b) coverage for the condition is excluded for not more than 12 months~~.

(2) A health insurance issuer offering health insurance coverage may not impose a preexisting condition exclusion on a federally defined eligible individual because of a preexisting condition."

Section 6. Section 33-22-308, MCA, is amended to read:

"33-22-308. Form of coverage -- requirements -- evidence of insurability -- preexisting ~~conditions~~ condition limitations prohibited. (1) Coverage continued through the issuance of a converted policy shall consist of the form of coverage then being offered by the carrier as a conversion policy in the jurisdiction where the person exercising the conversion right resides that most nearly approximates the coverage of the policy from which conversion is exercised. Continued and converted coverages, other than those provided through the exercise of continuation or conversion rights contained in optionally renewable or limited right of renewal contracts, must contain:

(a) provisions allowing the person exercising the continuation or conversion the right to renew the coverage until the attainment of the age of eligibility for medicare or any other similar federal or state disability insurance program, subject to the right of the carrier to nonrenew all such policies in this state as a class; or

(b) other renewal provisions that are not less favorable to the insured than those contained in the policy from which conversion is exercised.

(2) Coverage provided through continuation or conversion may not require additional evidence of insurability except as to overinsurance and may not impose any preexisting condition limitations or other contractual time limitations ~~other than those remaining unexpired under the policy or contract from which continuation or conversion is exercised~~."

Section 7. Section 33-22-514, MCA, is amended to read:

"33-22-514. Preexisting ~~conditions~~ condition exclusions relating to group market prohibited. (1) A group health plan or a health insurance issuer offering group health insurance coverage may not exclude coverage for a preexisting condition ~~unless:~~

~~(a) medical advice, diagnosis, care, or treatment was recommended or received by the participant or beneficiary within the 6-month period ending on the enrollment date;~~

~~(b) exclusion of coverage extends for a period of not more than 12 months or 18 months in the case of a late enrollee; and~~

~~(c) the period of the preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date~~.

~~(2) Genetic information may not be excluded as a preexisting condition in the absence of a diagnosis of the condition related to the genetic information.~~

~~(3)~~(2) Pregnancy may not be excluded as a preexisting condition."

Section 8. Section 33-22-1802, MCA, is amended to read:

"33-22-1802. Purpose. (1) This part must be interpreted and construed to effectuate the following express legislative purposes:

(a) to promote the availability of health insurance coverage to small employers regardless of health status or claims experience;

(b) to prevent abusive rating practices;

(c) to require disclosure of rating practices to purchasers;

(d) to establish rules regarding renewability of coverage;

(e) to ~~establish limitations on~~ prohibit the use of preexisting condition exclusions;

(f) to provide for the development of basic and standard health benefit plans to be offered to all small employers;

(g) to provide for the establishment of a reinsurance program; and

(h) to improve the overall fairness and efficiency of the small employer health insurance market.

(2) This part is not intended to provide a comprehensive solution to the problem of affordability of health care or health insurance."

Section 9. Section 33-22-1809, MCA, is amended to read:

"33-22-1809. Restrictions relating to premium rates. (1) Premium rates for health benefit plans under this part are subject to the following provisions:

(a) The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than 20%.

(b) For each class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage or the rates that could be charged to the employer under the rating system for that class of business may not vary from the index rate by more than 25% of the index rate.

(c) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period; in the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;

(ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less than 1 year, because of the claims experience, health status, or duration of coverage of the employees or dependents of the small employer, as determined from the small employer carrier's rate manual for the class of business; and

(iii) any adjustment because of a change in coverage or a change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual for the class of business.

(d) Adjustments in rates for claims experience, health status, and duration of coverage may not be charged to individual employees or dependents. Any adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer.

(e) If a small employer carrier uses industry as a case characteristic in establishing premium rates, the rate factor associated with any industry classification may not vary from the average of the rate factors associated with all industry classifications by more than 15%.

(f) A small employer carrier shall:

(i) apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors must produce premiums for identical groups that differ only by the amounts attributable to plan design and that do not reflect differences because of the nature of the groups. Differences among base premium rates may not be based in any way on the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan.

(ii) treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(g) For the purposes of this subsection (1), a health benefit plan that includes a restricted network provision may not be considered similar coverage to a health benefit plan that does not include a restricted network provision.

(2) A small employer carrier may not transfer a small employer involuntarily into or out of a class of business. A small employer carrier may not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all small employers in the class of business without regard to case characteristics, claims experience, health status, or duration of coverage since the insurance was issued.

(3) The commissioner may suspend for a specified period the application of subsection (1)(a) for the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner either that the suspension is reasonable in light of the financial condition of the small employer carrier or that the suspension would enhance the fairness and efficiency of the small employer health insurance market.

(4) In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of each of the following:

(a) the extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or upon the actual or expected variation in health status of the employees of small employers and the employees' dependents;

(b) the provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and the factors, other than claims experience, that affect changes in premium rates;

(c) the provisions relating to renewability of policies and contracts; and

(d) the provisions ~~relating to any~~ prohibiting any preexisting condition exclusion.

(5) (a) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(b) Each small employer carrier shall file with the commissioner annually, on or before March 15, an actuarial certification certifying that the carrier is in compliance with this part and that the rating methods of the small employer carrier are actuarially sound. The actuarial certification must be in a form and manner and must contain information as specified by the commissioner. A copy of the actuarial certification must be retained by the small employer carrier at its principal place of business.

(c) A small employer carrier shall make the information and documentation described in subsection (5)(a) available to the commissioner upon request. Except in cases of violations of the provisions of this part and except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction, the information must be considered proprietary and trade secret information and is not subject to disclosure by the commissioner to persons outside of the department.

(6) The commissioner may not require prior approval of the rating methods used by small employer carriers or the premium rates of the health benefit plans offered to small employers."

Section 10. Section 33-22-1811, MCA, is amended to read:

"33-22-1811. Availability of coverage -- required plans. (1) (a) As a condition of transacting business in this state with small employers, each small employer carrier must have approved for issuance to small employer groups at least two health benefit plans.

(b) (i) A small employer carrier shall issue all plans marketed under this part to any eligible small employer that applies for a plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this part.

(ii) In the case of a small employer carrier that establishes more than one class of business pursuant to 33-22-1808, the small employer carrier shall maintain and offer to eligible small employers all plans marketed under this part in each established class of business. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business, provided that:

(A) the criteria are not intended to discourage or prevent acceptance of small employers applying for a health benefit plan;

(B) the criteria are not related to the health status or claims experience of the small employers' employees;

(C) the criteria are applied consistently to all small employers that apply for coverage in that class of business; and

(D) the small employer carrier provides for the acceptance of all eligible small employers into one or more classes of business.

(iii) The provisions of subsection (1)(b)(ii) may not be applied to a class of business into which the small employer carrier is no longer enrolling new small businesses.

(2) (a) A small employer carrier shall, pursuant to 33-1-501, file the basic health benefit plans and the standard health benefit plans to be used by the small employer carrier.

(b) The commissioner may at any time, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a basic or standard health benefit plan on the grounds that the plan does not meet the requirements of this part.

(3) Health benefit plans covering small employers must comply with the following provisions:

(a) A health benefit plan may not~~:~~

~~(i) because of a preexisting condition,~~ deny, exclude, or limit benefits for a covered individual because of a preexisting condition ~~for losses incurred more than 12 months following the individual's enrollment date. A health benefit plan may not define a preexisting condition exclusion more restrictively than 33-22-140.~~

~~(ii) use a preexisting condition exclusion more restrictive than exclusions allowed under 33-22-514.~~

~~(b) A health benefit plan must waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period of time that an individual was previously covered by creditable coverage that provided benefits with respect to those services if the creditable coverage was continuous to a date not more than 63 days prior to the submission of an application for new coverage. A health benefit plan may determine waivers of time periods applicable to preexisting condition exclusions or limitations on the basis of prior coverage of benefits within each of several classes or categories as specified in regulations implementing Public Law 104-191, rather than as provided in this subsection (3)(b). This subsection (3)(b) does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.~~

~~(c) A health benefit plan may exclude coverage for late enrollees for 18 months or for an 18-month preexisting condition exclusion, provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period may not exceed 18 months from the~~

~~date on which the individual enrolls for coverage under the health benefit plan~~.

~~(d)~~(b) (i) Requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, must be applied uniformly among all small employers that have the same number of eligible employees and that apply for coverage or receive coverage from the small employer carrier. For the purpose of meeting minimum participation requirements of groups of four or more, a small employer carrier may not consider employees who, because they are covered under another health plan, waive coverage under the small employer's plan as part of the group of eligible employees. However, a small employer carrier may require at least two eligible employees to participate in a plan.

(ii) A small employer carrier may vary the application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

~~(e)~~(c) (i) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier may not offer coverage only to certain individuals in a small employer group or only to part of the group~~, except in the case of late enrollees as provided in subsection (3)(c)~~.

(ii) A small employer carrier may not modify a plan marketed under this part with respect to a small employer or any eligible employee or dependent, through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

(iii) A small employer carrier shall secure a waiver of coverage from each eligible employee who declines, at the sole discretion of the eligible employee, an offer of coverage under a health benefit plan provided by the small employer. The waiver must be signed by the eligible employee and must certify that the employee was informed of the availability of coverage under the health benefit plan and of the penalties for late enrollment. The waiver may not require the eligible employee to disclose the reasons for declining coverage.

(iv) A small employer carrier may not issue coverage to a small employer if the carrier or a producer for the carrier has evidence that the small employer induced or pressured an eligible employee to decline coverage due to the health status or risk characteristics of the eligible employee or of the dependents of the eligible employee.

(4) (a) A small employer carrier may not be required to offer coverage or accept applications pursuant to subsection (1) in the case of the following:

(i) to an employer whose employees do not work or reside within the small employer carrier's established

geographic service area for a network plan, as defined in 33-22-140; or

(ii) within an area where the small employer carrier reasonably anticipates and demonstrates to the satisfaction of the commissioner that it will not have the capacity within its established geographic service area to deliver service adequately to the members of a group because of its obligations to existing group policyholders and enrollees. The small employer carrier may not deny coverage under this subsection unless the small employer carrier acts uniformly without regard to claims experience or health status-related factors of employers, employees, or dependents.

(b) A small employer carrier may not be required to provide coverage to small employers pursuant to subsection (1) for which the commissioner determines that the small employer carrier does not have the financial reserves necessary to underwrite additional coverage and that the small employer carrier has denied coverage of small employers uniformly throughout the state and without regard to the claims experience and health status-related factors of the applicant small employer groups. The small employer carrier exempted from providing coverage under this subsection may not offer coverage to small employer groups in this state for 180 days after the date on which coverage is denied or until the small employer carrier has demonstrated to the commissioner that the small employer carrier has sufficient financial reserves to underwrite additional coverage, whichever is later."

Section 11. Section 33-22-1815, MCA, is amended to read:

"33-22-1815. Qualifications for voluntary purchasing pool. A voluntary purchasing pool of disability insurance purchasers may be formed solely for the purpose of obtaining disability insurance upon compliance with the following provisions:

(1) It contains at least 51 eligible employees.

(2) It establishes requirements for membership. The voluntary purchasing pool shall accept for membership any small employers and may accept for membership any employers with at least 51 eligible employees that otherwise meet the requirements for membership. However, the voluntary purchasing pool may not exclude any small employers that otherwise meet the requirements for membership on the basis of claim experience, occupation, or health status.

(3) It holds an open enrollment period at least once a year during which new members can join the voluntary purchasing pool.

(4) It offers coverage to eligible employees of member employers and to the employees' dependents.

Coverage may not be limited to certain employees of member small employers ~~except as provided in 33-22-1811(3)(c)~~.

(5) It does not assume any risk or form self-insurance plans among its members.

(6) (a) Disability insurance policies, certificates, or contracts offered through the voluntary purchasing pool must rate the entire purchasing pool group as a whole and charge each insured person based on a community rate within the common group, adjusted for case characteristics as permitted by the laws governing group disability insurance.

(b) Rates for voluntary purchasing pool groups must be set pursuant to the provisions of 33-22-1809.

(c) At its discretion, premiums may be paid to the disability insurance policies, certificates, or contracts by the voluntary purchasing pool or by member employers.

(7) A person marketing disability insurance policies, certificates, or contracts for a voluntary purchasing pool must be licensed as an insurance producer."

Section 12. Section 33-31-307, MCA, is amended to read:

"33-31-307. ~~Affiliation periods~~ Preexisting condition exclusion prohibited. ~~(1)~~ A health maintenance organization that offers health insurance coverage in connection with a group health plan ~~and that does~~ may not impose a preexisting condition exclusion ~~allowed by 33-22-246 or 33-22-514 with respect to any particular coverage option may impose an affiliation period for that coverage option if:~~

~~(a) the affiliation period is applied uniformly without regard to any health status-related factors; and~~

~~(b) the affiliation period does not exceed 2 months, or 3 months in the case of a late enrollee, as defined in 33-22-140.~~

~~(2) A health maintenance organization is not required to provide health care services or benefits during the affiliation period, and a premium may not be charged to the participant or beneficiary for any coverage during the affiliation period. An affiliation period begins on the enrollment date and runs concurrently with any waiting period under the plan.~~

~~(3) A health maintenance organization may use a method other than an affiliation period to address adverse selection if the method is approved by the commissioner.~~

~~(4) The definitions in 33-22-140 apply to this section~~."

NEW SECTION. **Section 13. Repealer.** The following sections of the Montana Code Annotated are

repealed:

33-22-109. Riders.

33-22-242. Waiver of preexisting condition exclusion -- exclusion prohibited.

NEW SECTION. **Section 14. Codification instruction.** [Section 1] is intended to be codified as an integral part of Title 33, chapter 22, part 1, and the provisions of Title 33, chapter 22, part 1, apply to [section 1].

NEW SECTION. **Section 15. Applicability.** [This act] applies to disability insurance contracts issued or renewed on or after October 1, 2019.

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