SENATE BILL NO. 552

INTRODUCED BY G. HERTZ

A BILL FOR AN ACT ENTITLED: “AN ACT GENERALLY REVISING INSURANCE LAWS; REQUIRING CERTAIN DISABILITY INSURERS TO POOL RISK AMONG ALL OF THEIR CERTAIN GROUPS; REVISING THE DEFINITION OF "SMALL EMPLOYER"; REVISING CERTAIN FEES; PROVIDING RULEMAKING AUTHORITY; AMENDING SECTIONS 33-1-605 AND 33-22-1803, MCA; AND PROVIDING A CONTINGENT EFFECTIVE DATE AND AN APPLICABILITY DATE.”

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

NEW SECTION. **Section 1. Disability insurer -- pooled risk -- applicability.** (1) For the purposes of underwriting, an insurer that issues or delivers group disability insurance in this state must pool all members that are insured across all groups that are fully insured that consist of 101 to 300 eligible employees. Nothing in this section prohibits an insurer from pooling members from groups that consist of 101 to 300 eligible employees.

(2) A violation of this section by a group disability insurer is an unfair trade practice under 33-18-102.

(3) The commissioner may adopt rules necessary to implement the provisions of this section.

Section 2. Section 33-1-605, MCA, is amended to read:

"**33-1-605. Service of process -- foreign or alien insurer -- appointment of registered agent.** (1) A foreign or alien insurer that transacts any business in this state must have a registered agent upon whom any legal process, notice, or demand required or permitted by law to be served upon a company must be served. The agent must be a person who either resides or maintains a business address in this state.

(2) The written appointment of an agent must be provided to the commissioner in a form prescribed by the commissioner, and must, at minimum, include a consent to service of process and the official name and address of the agent and the insurer represented.

(3) The commissioner shall keep a record of the foreign and alien insurers transacting business in Montana and the name and address of their registered agents. This record must be made public in a readily accessible form prescribed by the commissioner.

(4) Service by certified mail to a registered agent listed for an insurer constitutes service of legal process upon that insurer.

(5) An insurer may revoke the appointment of an agent by filing with the commissioner a written appointment of another agent and a statement that the appointment of the former agent is revoked. The authority of the agent whose appointment has been revoked terminates 30 days after the notice is received by the commissioner.

(6) When a foreign or alien insurer ceases to do business in this state, the agent last designated by or acting for the insurer is deemed to continue as agent for it unless a new agent is appointed. Service by certified mail upon any such agent constitutes service of legal process upon the insurer.

~~(7) Each insurer shall include a fee of $10 with any initial appointment, change of agent appointment, or change of address. The fee is waived for an insurer filing an agent appointment with an original application for a certificate of authority or an annual renewal.~~

~~(8)~~(7) This section does not limit or affect the right to serve any process, notice, or demand upon an insurer in any other manner permitted by law.

~~(9)~~(8) When legal process is served pursuant to this section, the insurer must appear, answer, or plead within 30 days, exclusive of the date of mailing, after the date of the certified mailing or be subject to the laws of this state regarding default judgment.

~~(10)~~(9) For the purposes of this section:

(a) "certified mail" means a method of sending by common carrier with tracking capability; and

(b) "legal process" means a summons and complaint."

Section 3. 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 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.

(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;

(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 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.

(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;

(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."

NEW SECTION. **Section 4. Codification instruction.** [Section 1] is intended to be codified as an integral part of Title 33, chapter 22, part 5, and the provisions of Title 33, chapter 22, part 5, apply to [section 1].

NEW SECTION. **Section 5. Contingent effective date.** [Section 2] is effective on the date that the commissioner of insurance certifies to the code commissioner that the federal government has waived applicable federal insurance requirements relating to [section 2]. The commissioner of insurance shall submit certification within 30 days of the occurrence of the contingency.

NEW SECTION. **Section 6. Applicability.** [This act] applies to disability insurance policies issued or renewed on or after January 1, 2024.

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