HOUSE BILL NO. 183

INTRODUCED BY STEINBEISSER

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING 45-DAY OR 60-DAY NOTICES FOR HEALTH INSURANCE POLICY RATE CHANGES OR BENEFIT MODIFICATIONS AND PROVIDING FOR DELIVERY OF THE NOTICES; REQUIRING NOTICE FOR CANCELLATION FOR NONPAYMENT OF GROUP HEALTH INSURANCE PREMIUMS; REVISING REQUIREMENTS REGARDING CERTIFICATES OF CREDITABLE COVERAGE; AMENDING SECTIONS 33-1-501, 33-22-107, 33-22-122, 33-22-141, 33-22-142, 33-30-1007, 33-31-111, AND 33-35-306, MCA; AND REPEALING SECTION 33-30-307, MCA."

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

Section 1. Section 33-1-501, MCA, is amended to read:

"33-1-501. Filing and approval of forms. (1) (a) An insurance policy or annuity contract form, certificate, enrollment form, application form, viatical disclosure form, printed rider or endorsement form, <u>certificate of creditable coverage form,</u> or form of renewal certificate may not be delivered or issued for delivery in Montana unless the form and, for the purposes of disability insurance, an outline of coverage as required by 33-22-244 and 33-22-521 have been filed with and approved by the commissioner and, if required, the regulatory official of the state of domicile of the insurer. This provision does not apply to surety bonds or policies, riders, endorsements, or forms of unique character designed for and used with relation to insurance upon a particular subject or that relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or disability insurance policies and are used at the request of the individual policyholder, contract holder, or certificate holder. Forms for use in property, marine, other than ocean marine and foreign trade coverages, casualty, and surety insurance coverages may be filed by a rating organization on behalf of its members and subscribers or by a member or subscriber on its own behalf.

(b) The approval of an insurance policy or annuity contract form, certificate, enrollment form, application form, or other related insurance form by the state of domicile may be waived by the commissioner if the commissioner considers the requirements of subsection (1)(a) unnecessary for the protection of Montana insurance consumers. If the requirement is waived, an insurer shall notify the commissioner in writing within 10 days of disapproval, denial, or withdrawal of approval of a form by the state of domicile.

(2) The filing must be made not less than 60 days in advance of delivery. Approval of a form by the commissioner constitutes a waiver of any unexpired portion of the waiting period. The commissioner may extend by not more than an additional 60 days the period within which the commissioner may approve or disapprove a form by giving notice of the extension before expiration of the initial 60-day period. The commissioner may at any time, after notice and for cause shown, withdraw any approval.

(3) Notice by the commissioner disapproving a form or withdrawing a previous approval must state the grounds for disapproval or withdrawal in sufficient detail to inform the insurer.

(4) The commissioner may exempt from the requirements of this section, for so long as the commissioner considers proper, an insurance document, form, or type of document or form to which, in the commissioner's opinion, this section may not practicably be applied or the filing and approval of which are not desirable or necessary for the protection of the public.

(5) This section applies to a form used by a domestic insurer for delivery in a jurisdiction outside Montana if the insurance supervisory official of the jurisdiction informs the commissioner that the form is not subject to approval or disapproval by the official and upon the commissioner's order requiring the form to be submitted to the commissioner for the purpose. The same standards apply to these forms as apply to forms for domestic use.

(6) This section and 33-1-502 do not apply to:

(a) reinsurance;

(b) policies or contracts not issued for delivery in Montana or delivered in Montana, except as provided in subsection (5); or

(c) ocean marine and foreign trade insurances.

(7) Except as provided in chapter 21, group certificates that are delivered or issued for delivery in Montana for group insurance policies effectuated and delivered outside Montana but covering persons resident in Montana must be filed with the commissioner upon request. The certificates must meet the minimum provisions mandated by Montana if Montana law prevails over conflicting provisions of other state law."

Section 2. Section 33-22-107, MCA, is amended to read:

"33-22-107. Premium increase restriction -- exception -- notice of rate increase and policy changes. (1) An insurer or a health service corporation that issues a policy, certificate, or membership contract covering a resident of this state may not increase a premium in an individual's or an individual's group disability insurance policy more frequently than once during a 12-month period, including the initial 12-month period after a policy is issued, unless failure to increase the premium more frequently than once during the 12-month period

would:

(a) place the insurer in violation of the laws of this state; or

(b) cause the financial impairment of the insurer to the extent that further transaction of insurance by the insurer injures or is hazardous to its policyholders or to the public.

(2) Subsection (1) does not apply to a premium increase necessitated by a state or federal law, court decision, or rule adopted by an agency of competent jurisdiction of the state or federal government.

(3) (a) Every health insurance issuer delivering or issuing for delivery group or individual health insurance coverage shall give a group policyholder at least 60 days' advance notice and an individual policyholder at least 45 days' advance notice of a change in rates or a change in terms or benefits.

(b) A notice given under this subsection (3) must be delivered in the following manner:

(i) it must be mailed to the policyholder's last-known address as shown by the records of the insurer; and

(ii) if a health insurance issuer bills any certificate holder directly at the certificate holder's home address for premiums, the notice must be mailed by the health insurer directly to each certificate holder's last-known home address.

(c) If the health insurance issuer fails to provide the notice required by this subsection (3), the coverage must remain in effect at the existing rate with the existing benefits until the full notice period has expired or until the effective date of the replacement coverage obtained by the insured, whichever occurs first."

NEW SECTION. **Section 3. Notice required for cancellation for nonpayment of group health insurance.** (1) A health insurance issuer shall provide at least 15 days prior notification of cancellation for nonpayment of premium for group health insurance coverage.

(2) The notice must be sent to the policyholder at the policyholder's last-known address and must specify the date of cancellation of coverage. The insurer shall attach a properly executed proof of mailing to this notice and maintain a copy of the proof of mailing in its records.

(3) The policy continues in full force and effect until the proper 15-day notice has been given, unless the coverage has already been replaced.

(4) The 15-day period begins to run from the date of the proof of mailing.

(5) The issuer may collect premiums for any time period that the coverage remains in effect.

(6) When coverage is actually canceled, notice must also be mailed to all certificate holders at:

(a) their last-known home addresses if available; or

(b) the business address of the group policyholder.

(7) The notice of cancellation to certificate holders must be separate from the certificate of creditable coverage required in 33-22-142, although it may be mailed simultaneously with the certificate.

Section 4. Section 33-22-122, MCA, is amended to read:

"33-22-122. Contents of notice -- proof -- limitation on recovery -- exemptions. (1) (a) The notice of cancellation ~~shall~~ must state:

(i) the amount of the premium, installment, or interest due on ~~such~~ the policy;

(ii) the place where it must be paid; and

(iii) the name and address of the person or company to which the premium is payable.

(b) The notice must also state that unless the premium or other sums are paid to the company or its insurance producer, the policy will lapse or be forfeited.

(2) "Policyowner", as used in this section, means the owner of the policy or any other person designated as the person to receive premium notices, as shown by the records of the insurance company.

(3) The affidavit of any responsible officer, clerk, or insurance producer of the insurance company authorized to mail the notice that it is the standard practice of the company to mail to policyowners the notice required by this section is prima facie evidence that the notice has been duly given.

(4) ~~No~~ An action may not be maintained to recover under a lapsed or forfeited policy on the ground that the insurance company failed to comply with this section unless the action is instituted within 2 years from the due date upon which default was made in paying the premium, installment, or interest for which lapse or forfeiture is claimed.

(5) Section 33-22-121 does not apply to:

(a) group or group-type policies; or

(b) industrial life or industrial disability policies~~; or~~

~~(c) policies upon which premiums are payable monthly or at more frequent intervals~~."

Section 5. Section 33-22-141, MCA, is amended to read:

"33-22-141. Crediting previous coverage. (1) (a) A period of creditable coverage may not be counted, with respect to enrollment of an individual under a group health plan, if there was a 63-day break in coverage~~, during which the individual was not covered under any creditable coverage~~.

(b) The 63-day period provided for in subsection (1)(a) must be counted from the date that the certificate of creditable coverage was ~~actually mailed~~ ISSUED to the individual.

(2) The time that an individual is in a waiting period for coverage under a group health plan or for group health insurance coverage or is in an affiliation period, as defined in 33-31-102, may not be considered in determining the continuous period under subsection (1).

(3) Except as provided in subsection (4), for the purposes of applying 33-22-514, a group health plan or a health insurance issuer offering group health insurance coverage shall count a period of creditable coverage without regard to the specific benefits coverage during the period.

(4) (a) A group health plan or a health insurance issuer offering group health insurance may elect to apply the provisions of 33-22-514 based on coverage of benefits within each of several classes or categories of benefits specified in regulations implementing Public Law 104-191, rather than as provided under subsection (3). If electing to apply the provisions of 33-22-514 pursuant to this subsection (4), a group health plan or a health insurance issuer shall:

(i) make the election on a uniform basis for all participants and beneficiaries; and

(ii) count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.

(b) In the case of an election under this subsection (4), a group health plan shall:

(i) prominently state in a disclosure statement concerning the group health plan to each enrollee at the time of enrollment that the group health plan has made an election; and

(ii) include a description of the effect of the election in the statement.

(c) In the case of an election under this subsection (4), a health insurance issuer shall:

(i) prominently state in a disclosure statement concerning the health insurance coverage to each employer at the time of the offer or sale of the health insurance coverage that the health insurance issuer has made an election; and

(ii) include a description of the effect of the election in the statement.

(5) Periods of creditable coverage with respect to an individual must be established through presentation of certifications described in 33-22-142 or in such other manner as may be specified in regulations implementing Public Law 104-191."

Section 6. Section 33-22-142, MCA, is amended to read:

"33-22-142. Certification of creditable coverage. (1) A group health plan and a health insurance issuer offering group health insurance coverage shall ~~provide~~ ISSUE the certification described in subsection (3):

(a) ~~at the time that~~ within 10 days after an individual ceases to be covered under the group health plan

or otherwise becomes covered under a COBRA continuation provision;

(b) not later than 10 days after cancellation for nonpayment of premium is effective pursuant to the provisions of [section 3] or after termination of coverage for any other reason;

~~(b)~~(c) in the case of an individual becoming covered under a COBRA continuation provision, at the time that the individual ceases to be covered under a COBRA continuation provision; and

~~(c)~~(d) at the request on behalf of an individual made not later than 24 months after the date of termination of the coverage described in subsection (1)(a) or ~~(1)(b)~~ (1)(c), whichever is later.

(2) The certification pursuant to subsection (1)(a) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

(3) Certification is the written:

(a) certification of the period of creditable coverage of the individual under a group health plan and the coverage under the COBRA continuation provision;

(b) certification of the waiting period, if any, and affiliation period, as defined in 33-31-102, if applicable, imposed with respect to the individual for any coverage under a group health plan; ~~and~~

(C) CERTIFICATION OF THE DATE OF ISSUANCE OF THE CERTIFICATE SPECIFIED ON THE FORM; AND

~~(c)~~(D) notification to the individual of:

(i) the individual's option to apply to the Montana comprehensive health association, provided for in 33-22-1503, for an association portability plan, as defined in 33-22-1501, within 63 days of ~~termination of creditable coverage~~ ~~the mailing~~ ISSUANCE of a certificate of creditable coverage;

(ii) the individual's conversion rights;

(iii) the availability of COBRA continuation coverage;

(iv) the telephone number and address of the Montana comprehensive health association; and

(v) other notification as determined necessary and in the form prescribed by rule by the commissioner.

(4) To the extent that medical care under a group health plan consists of group health insurance coverage, a group health plan satisfies the certification requirement of this section if the health insurance issuer offering the coverage provides the certification in accordance with this section.

(5) In the case of an election described in 33-22-141 by a group health plan or health insurance issuer, if the group health plan or health insurance issuer enrolls an individual for coverage under the group health plan and the individual provides a certification of coverage of the individual, the entity that issued the certification shall upon request of the group health plan or health insurance issuer promptly disclose information on coverage of classes and categories of health benefits available under the certified coverage. The entity may charge the

requesting group health plan or health insurance issuer the reasonable cost of disclosing the information.

(6) This section applies to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as it applies to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the group market.

(7) The certifications of creditable coverage described in this section must be filed with and approved by the commissioner in accordance with the provisions of 33-1-501."

Section 7. Section 33-30-1007, MCA, is amended to read:

"33-30-1007. Conversion on termination of eligibility. (1) The group hospital or medical service plan contract issued or renewed by a health service corporation after October 1, 1981, must contain a provision that if the insurance or any portion of it on a person or a person's dependents or family members covered under the policy ceases because of termination of the person's employment or of a person's membership in the class or classes eligible for coverage under the policy as a result of an employer discontinuing the employer's business or as a result of an employer discontinuing the policy issued by the health service corporation and not providing for any other group disability insurance or plan, a person must, if the person has been insured for a period of 3 months and if the person is not insured under another major medical disability insurance policy or plan, be entitled to have issued to the person by the insurer, without evidence of insurability, an individual policy of hospital or medical service insurance on the person or the person's dependents or family members. Application for the individual policy must be made and the first premium tendered to the insurer within 31 days after the termination of group coverage.

(2) The individual policy must, at the option of the insured, be on any of the forms then customarily issued by the insurer to individual policyholders with the exception of those whose eligibility is determined by their affiliation other than by employment with a particular entity. In addition, the health service corporation shall make available a conversion policy as required by subsection (4).

(3) The premium on the individual policy ~~must~~ may not be ~~at no~~ more than 200% of the insurer's then customary rate applicable to the coverage of the individual policy. If the person entitled to conversion under this section has been insured for more than 3 years, the premium may not be more than 150% of the customary rate. The customary rate is that rate that is normally issued for medically underwritten policies without discount for healthy lifestyles.

(4) The health service corporation shall make available an individual conversion policy that provides the level of benefits provided by its lowest cost basic health benefit plan, as defined in 33-22-1803. If the insurer is

not a small employer carrier under chapter 22, part 18, the insurer shall make available an individual conversion policy that provides equivalent benefits to a basic health benefit plan. The conversion rate may not exceed 150% of the highest rate charged for that plan.

(5) The premium rate for an individual policy converted from a group plan in accordance with the provisions of subsection (3) may not be increased during the first 6 months of coverage of the individual policy."

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 chapter 1, part 8;

(b) the provisions of Title 33, chapter 22, part 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) Chapter 1, parts 12 and 13, of this title, 33-2-1114, 33-2-1211, 33-2-1212, 33-3-422, 33-3-431, 33-15-308, 33-22-107, 33-22-129, 33-22-131, 33-22-136, 33-22-141, 33-22-142, 33-22-244, 33-22-246,

33-22-247, 33-22-514, 33-22-521, 33-22-523, 33-22-524, 33-22-526, and 33-22-706 apply to health maintenance organizations."

Section 9. Section 33-35-306, MCA, is amended to read:

"33-35-306. Application of insurance code to arrangements. (1) In addition to this chapter, self-funded multiple employer welfare arrangements are subject to the following provisions of Title 33:

(a) Title 33, chapter 1, part 4, but the examination of a self-funded multiple employer welfare arrangement is limited to those matters to which the arrangement is subject to regulation under this chapter;

(b) Title 33, chapter 1, part 7;

(c) 33-3-308;

(d) Title 33, chapter 18, except 33-18-242;

(e) 33-22-107, 33-22-131, 33-22-134, and 33-22-135; and

(f) 33-22-525 and 33-22-526.

(2) Except as provided in this chapter, other provisions of Title 33 do not apply to a self-funded multiple employer welfare arrangement that has been issued a certificate of authority that has not been revoked."

NEW SECTION. **Section 10. Repealer.** Section 33-30-307, MCA, is repealed.

NEW SECTION. **Section 11. Codification instruction.** [Section 3] 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 3].

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