AN ACT AMENDING THE DEFINITION OF "ELIGIBLE PERSON" AS IT RELATES TO THE COMPREHENSIVE HEALTH ASSOCIATION AND PLAN; AUTHORIZING THE INSURANCE COMMISSIONER TO LIMIT CERTAIN ELIGIBILITY CRITERIA BY ADOPTING RULES ON WHICH TO BASE THE ELIGIBILITY ON INCOME LEVEL; DEFINING ELIGIBILITY IN TERMS OF FEDERAL TRADE ADJUSTMENT ASSISTANCE; AMENDING SECTIONS 33-22-1501, 33-22-1502, 33-22-1513, 33-22-1516, AND 33-22-1524, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE.

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

Section 1. Section 33-22-1501, MCA, is amended to read:

"33-22-1501. Definitions. As used in this part, the following definitions apply:

(1) "Association" means the comprehensive health association created by 33-22-1503.

(2) "Association plan" means a policy of insurance coverage that is offered by the association and that is certified by the association as required by 33-22-1521.

(3) "Association plan premium" means the charge determined pursuant to 33-22-1512 for membership in the association plan based on the benefits provided in 33-22-1521.

(4) "Association portability plan" means a policy of insurance coverage that is offered by the association to a federally defined eligible individual.

(5) "Association portability plan premium" means the charge determined by the association and approved by the commissioner for an association portability plan.

(6) "Block of business" means a separate risk pool grouping of covered individuals, enrollees, and dependents as defined by rules of the commissioner.

(7) (a) "Eligible person" means an individual who:

~~(a)~~(i) is a resident of this state and applies for coverage under the association plan;

(ii) is not eligible for any other form of health insurance coverage or health service benefits, except:

(A) for coverage consisting solely of excepted benefits, as defined in 33-22-140; or

(B) subject to eligibility limitations adopted pursuant to 33-22-1502(1)(b), if the individual has coverage comparable to the association plan but is paying a premium or has received a renewal notice to pay a premium

that is more than 150% of the average premium rate used to calculate the association plan premium rate pursuant to 33-22-1512(1); and

(iii) meets one or more of the following criteria:

~~(b) unless the individual's eligibility is waived by the association,~~(A) has, within 6 months prior to the date of application, been rejected for disability insurance or health service benefits by at least two insurers, societies, or health service corporations, unless the association waives this requirement; or

(B) has had a restrictive rider or preexisting conditions limitation, which limitation is required by at least two insurers, societies, or health service corporations, that has the effect of substantially reducing coverage from that received by a person considered a standard risk~~; and~~

~~(c) is not eligible for any other form of disability insurance or health service benefits~~.

(b) The term does not apply to an individual who is certified as eligible for federal trade adjustment assistance or for pension benefit guarantee corporation assistance, as provided by the federal Trade Adjustment Assistance Reform Act of 2002, and is eligible for the association portability plan.

(8) "Federally defined eligible individual" means a person who is an individual enrolling in the association portability plan:

(a) for whom, as of the date on which the individual seeks coverage under the association portability plan, the aggregate of the periods of creditable coverage is 18 months or more and whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan;

(b) who does not have other health insurance coverage;

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

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

(f) who has exhausted continuation coverage under the COBRA continuation provision or program

described in subsection (8)(e) if the individual elected the continuation coverage described in subsection (8)(e).

(9) "Health service corporation" means a corporation operating pursuant to Title 33, chapter 30, and offering or selling contracts of disability insurance.

(10) "Insurance arrangement" means any plan, program, contract, or other arrangement to the extent not exempt from inclusion by virtue of the provisions of the federal Employee Retirement Income Security Act of 1974 under which one or more employers, unions, or other organizations provide to their employees or members, either directly or indirectly through a trust of a third-party administrator, health care services or benefits other than through an insurer.

(11) "Insurer" means a company operating pursuant to Title 33, chapter 2 or 3, and offering or selling policies or contracts of disability insurance, as provided in Title 33, chapter 22.

(12) "Lead carrier" means the licensed administrator or insurer selected by the association to administer the association plan.

(13) "Medicare" means coverage under both parts A and B of Title XVIII of the Social Security Act, 42 U.S.C. 1395, et seq., as amended.

(14) "Preexisting condition" means any condition for which an applicant for coverage under the association plan has received medical attention during the 3 years immediately preceding the filing of an application.

(15) "Qualified TAA-eligible individual" means an individual and any dependent of that individual, in addition to meeting the requirements specified in subsection (17):

(a) who has 3 months of prior creditable coverage;

(b) whose application for association portability plan coverage is made within 63 days following termination of the applicant's most recent prior creditable coverage; and

(c) who, if eligible for COBRA, is not required to elect or exhaust continuation coverage under the COBRA continuation provision or under a similar state program.

~~(15)~~(16) "Society" means a fraternal benefit society operating pursuant to Title 33, chapter 7, and offering or selling certificates of disability insurance.

(17) "TAA-eligible individual" means an individual and any dependent of that individual enrolling in the association portability plan:

(a) who is a resident of this state on the date of application to the pool;

(b) who has been certified as eligible for federal trade adjustment assistance and a health insurance tax

credit or for pension benefit guarantee corporation assistance, as provided by the federal Trade Adjustment Assistance Reform Act of 2002;

(c) who does not have other health insurance coverage; and

(d) who is not covered under a group health plan maintained by an employer, including a group health plan available through a spouse, if the employer contributes 50% or more to the total cost of coverage."

Section 2. Section 33-22-1502, MCA, is amended to read:

"33-22-1502. Duties of commissioner -- rules. The commissioner shall:

(1) adopt rules to carry out the provisions and purposes of this part, including rules:

(a) regarding late payment penalties or rates of interest charged on unpaid assessments; and

(b) that limit association plan eligibility under 33-22-1501(7)(a)(ii)(B) according to income level;

(2) supervise the creation of the association within the limits described in 33-22-1503;

(3) approve the selection of the lead carrier by the association and approve the association's contract with the lead carrier, including the association plan coverage and premiums to be charged;

(4) conduct periodic audits to ensure the general accuracy of the financial data submitted by the lead carrier and the association; and

(5) undertake, directly or through contracts with other persons, studies or demonstration projects to develop awareness of the benefits of this part so that the residents of this state may best avail themselves of the health care benefits provided by this part."

Section 3. Section 33-22-1513, MCA, is amended to read:

"33-22-1513. Operation of association plan and association portability plans. (1) Upon acceptance by the lead carrier under 33-22-1516, an eligible person may enroll in the association plan by payment of the association plan premium to the lead carrier.

(2) Upon application by a federally defined eligible individual or a TAA-eligible individual to the lead carrier for an association portability plan, the association may not:

(a) decline to offer an association portability plan; or

(b) except as provided in subsection (3), impose a preexisting condition exclusion with respect to an individual's association portability plan coverage if application for association portability plan coverage is made within 63 days following termination of the applicant's most recent prior creditable coverage.

(3) The association may impose a preexisting condition exclusion as provided in 33-22-1516 with respect to a TAA-eligible individual's association portability plan coverage if that individual does not meet the requirements defining a qualified TAA-eligible individual.

~~(3)~~(4) Not less than 88% of the association plan premiums paid to the lead carrier may be used to pay claims and not more than 12% may be used for payment of the lead carrier's direct and indirect expenses as specified in 33-22-1514.

~~(4)~~(5) Any income in excess of the costs incurred by the association in providing reinsurance or administrative services must be held at interest and used by the association to offset past and future losses because of claims expenses of the association plan and the association portability plan or be allocated to reduce association plan premiums.

~~(5)~~(6) (a) Each participating member of the association shall share the losses because of claims expenses of the association plan and the association portability plan for plans issued or approved for issuance by the association and shall share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs in the following manner:

(i) Each participating member of the association must be assessed by the association on an annual basis an amount not to exceed 1% of the association member's total disability insurance premium received from or on behalf of Montana residents as determined by the commissioner. Assessments made under this subsection ~~(5)(a)~~ (6)(a) or funds from any other source must be allocated to the association plan and the association portability plan in proportion to the needs of the two plans. If the needs of the association plan and the association portability plan exceed the funds generated by the 1% assessment, the association is then authorized to spend any funds appropriated by the legislature for the support of the plans. Any appropriation to the association may be expended for the operation of the association plan or the association portability plan.

(ii) (A) Payment of an assessment is due within 30 days of receipt by a member of a written notice of the annual assessment. After 30 days, the association shall charge a member:

(I) a late payment penalty of 1.5% a month or fraction of a month on the unpaid assessment, not to exceed 18% of the assessment due;

(II) interest at the rate of 12% a year on the unpaid assessment, to be accrued at 1% a month or fraction of a month; or

(III) both of the charges in subsections ~~(5)(a)(ii)(A)(I)~~ (6)(a)(ii)(A)(I) and ~~(5)(a)(ii)(A)(II)~~ (6)(a)(ii)(A)(II).

(B) Failure by a contributing member to tender the association assessment within the 30-day period is

grounds for termination of membership. A member terminated for failure to tender the association assessment is ineligible to write health care benefit policies or contracts in this state under 33-22-1503(2).

(iii) An associate member that ceases to do disability insurance business within the state remains liable for assessments through the calendar year in which the member ceased doing disability insurance business. The association may decline to levy an assessment against an association member if the assessment, as determined pursuant to this section, would not exceed $50.

(b) For purposes of this subsection ~~(5)~~ (6), "total disability insurance premium" does not include premiums received from disability income insurance, credit disability insurance, disability waiver insurance, life insurance, medicare risk or other similar medicare health maintenance organization payments, or medicaid health maintenance organization payments.

(c) Any income in excess of the incurred or estimated claims expenses of the association plan and the association portability plan and the operating and administrative expenses of the association must be held at interest and used by the association to offset past and future losses because of claims expenses of the association plan and the association portability plan or be allocated to reduce association plan premiums.

~~(6)~~(7) The proportion of the annual assessment allocated to the operation and expenses of the association plan, not to include any amount of late payment penalty or interest charged, may be offset by an association member against the premium tax payable by that association member pursuant to 33-2-705 for the year in which the annual assessment is levied. The commissioner shall report to the office of budget and program planning, as a part of the information required by 17-7-111, the total amount of premium tax offset claimed by association members during the preceding biennium. The proportion of the annual assessment allocated to the operation and expenses of the association portability plan and levied against an association member may not be offset against the premium tax payable by that association member."

Section 4. Section 33-22-1516, MCA, is amended to read:

"33-22-1516. Enrollment by eligible person. (1) The association plan must be open for enrollment by eligible persons. An eligible person may enroll in the plan by submission of a certificate of eligibility to the lead carrier. The certificate must provide:

(a) the name, address, and age of the applicant and length of the applicant's residence in this state;

(b) the name, address, and age of spouse and children, if any, if they are to be insured;

(c) written evidence that the person fulfills all of the elements of an eligible person, as defined in

33-22-1501; and

(d) a designation of coverage desired.

(2) Within 30 days of receipt of the certificate, the lead carrier shall either reject the application for failing to comply with the requirements of subsection (1) or forward the eligible person a notice of acceptance and billing information. Insurance is effective on the first of the month following acceptance.

(3) An eligible person may not purchase more than one policy from the association plan.

(4) A person who obtains coverage under the association plan may not be covered for any preexisting condition during the first 12 months of coverage under the association plan if the person was diagnosed or treated for that condition during the 3 years immediately preceding the filing of an application. The association may not apply a preexisting condition exclusion to coverage under the association portability plan if application for association portability plan coverage is made by a federally defined eligible individual or a qualified TAA-eligible individual within 63 days following termination of the applicant's most recent prior creditable coverage. The association shall waive any time period applicable to a preexisting condition exclusion for the period of time that any other eligible individual, including an individual who is eligible pursuant to 33-22-1501(7)(a)(ii)(B), was covered under the following types of coverage if the coverage was continuous to a date not more than 30 days prior to submission of an application for coverage under the association plan:

(a) an individual health insurance policy that includes coverage by an insurance company, a fraternal benefit society, a health service corporation, or a health maintenance organization that provides benefits similar to or exceeding the benefits provided by the association plan; or

(b) an employer-based health insurance benefit arrangement that provides benefits similar to or exceeding the benefits provided by the association plan."

Section 5. Section 33-22-1524, MCA, is amended to read:

"33-22-1524. Association authority for borrowing. (1) If the amount of the annual assessment collected under 33-22-1513~~(5)~~(6) and other available funds is insufficient to meet incurred or estimated claims expenses of the association plan and the association portability plan and the operating and administrative expenses of the association, the association may borrow from the board of investments for a period not to exceed 2 years any funds necessary for the continued operation of the association plan and the association portability plan. The loaned funds may be used only to pay incurred or estimated claims expenses of the association plan and the association portability plan and the operating and administrative expenses of the association.

(2) Whenever the association accepts a loan from the board of investments pursuant to this section, it shall repay the loan and any interest required under the terms of the loan through assessments and premium income. In accordance with the constitutions of the United States and the state of Montana, the state pledges that it may not in any way impair the obligations of any loan agreement between the association and the board of investments by repealing the assessment imposed by 33-22-1513~~(5)~~(6) or by reducing it below the amount necessary to make annual loan payments."

Section 6. Effective date. [This act] is effective on passage and approval.

- END -

I hereby certify that the within bill,
SB 0111, originated in the Senate.

Secretary of the Senate

President of the Senate

Signed this _____ day
of _____, 2019.

Speaker of the House

Signed this _____ day
of _____, 2019.

SENATE BILL NO. 111

INTRODUCED BY NELSON

BY REQUEST OF THE STATE AUDITOR

AN ACT AMENDING THE DEFINITION OF "ELIGIBLE PERSON" AS IT RELATES TO THE COMPREHENSIVE HEALTH ASSOCIATION AND PLAN; AUTHORIZING THE INSURANCE COMMISSIONER TO LIMIT CERTAIN ELIGIBILITY CRITERIA BY ADOPTING RULES ON WHICH TO BASE THE ELIGIBILITY ON INCOME LEVEL; DEFINING ELIGIBILITY IN TERMS OF FEDERAL TRADE ADJUSTMENT ASSISTANCE; AMENDING SECTIONS 33-22-1501, 33-22-1502, 33-22-1513, 33-22-1516, AND 33-22-1524, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE.