HOUSE BILL NO. 128

INTRODUCED BY P. NOONAN

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING HEALTH INSURANCE LAWS; PROHIBITING PREEXISTING CONDITION EXCLUSIONS FOR CHILDREN UNDER 19 YEARS OF AGE AND PROVIDING OPEN ENROLLMENT PERIODS; REMOVING CERTAIN DOLLAR LIMITS AND LIFETIME LIMITS; PROVIDING ENROLLMENT OPTIONS FOR LOSS OF COVERAGE UNDER CERTAIN CIRCUMSTANCES; PROVIDING FOR COVERAGE OF PREVENTIVE SERVICES WITH NO COST SHARING; PROVIDING FOR A CHOICE OF PRIMARY CARE PROVIDERS; PROHIBITING RESCISSIONS AND PROVIDING EXCEPTIONS; EXPANDING COVERAGE FOR CHILDREN UNDER 26 YEARS OF AGE AS DEPENDENTS; DELINEATING CHANGES THAT APPLY TO GRANDFATHERED PLAN COVERAGE INCLUDING PLANS FOR GOVERNMENT ENTITIES; EXTENDING RULEMAKING AUTHORITY; INCREASING AMOUNTS TO BE PAID FOR MAMMOGRAMS; AMENDING SECTIONS 2-18-704, 7-21-3710, 33-1-102, 33-15-403, 33-18-215, 33-22-101, 33-22-109, 33-22-129, 33-22-131, 33-22-132, 33-22-140, 33-22-143, 33-22-152, 33-22-242, 33-22-246, 33-22-303, 33-22-508, 33-22-512, 33-22-514, 33-22-515, 33-22-703, 33-22-1516, 33-22-1521, 33-22-1704, 33-22-1706, 33-22-1802, 33-22-1803, 33-22-1810, 33-22-1811, 33-22-1813, 33-22-1815, 33-22-1901, 33-22-1902, 33-22-1903, 33-22-1904, 33-22-1905, 33-22-1906, 33-22-1907, 33-22-1908, 33-30-1007, 33-30-1014, 33-31-111, AND 33-35-306, MCA; REPEALING SECTIONS 33-22-245, 33-22-522, 33-22-1821, 33-22-1827, 33-22-1828, AND 33-31-322, MCA; AND PROVIDING EFFECTIVE DATES AND APPLICABILITY DATES."

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

NEW SECTION. **Section 1. Prohibition on preexisting condition exclusions for individuals under 19 years of age in individual health insurance coverage -- definition -- open enrollment.** (1) A health insurance issuer may not limit or exclude coverage under an individual health insurance plan, except for coverage consisting solely of excepted benefits, for an individual under 19 years of age by imposing a preexisting condition exclusion on that individual.

(2) For the purposes of this section, "preexisting condition exclusion" means a limitation or exclusion of

benefits under health insurance coverage or a denial of coverage to an individual:

(a) based on the condition's presence before the effective date of coverage or, if the coverage is denied, the date of denial, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the effective date of coverage or denial date; or

(b) as a result of information relating to an individual's health status learned by the health insurance issuer before the individual's effective date of coverage or, if the coverage is denied, the date of denial, such as a condition identified as a result of a preenrollment questionnaire or physical examination given to the individual or a review of medical records relating to the preenrollment period.

(3) (a) Except as provided in subsection (3)(d), each health insurance issuer offering an individual health insurance plan that covers individuals under 19 years of age, other than dependent coverage, shall provide for two or more open enrollment periods of at least 30 days each. The open enrollment periods must begin on a date chosen by the health insurance issuer that complies with the effective dates of applicable state and federal laws and must be repeated at least once every 6 months until January 1, 2014, to allow enrollment by any individual under 19 years of age who applies for coverage. For the purposes of this subsection, "open enrollment" means, with respect to an individual health plan, the period during which any individual under 19 years of age may apply for coverage under a health plan offered by a health insurance issuer and, if the individual applies, must be accepted for coverage under the plan without regard to a preexisting condition.

(b) During the open enrollment period, a health insurance issuer may not, on the basis of a preexisting condition, deny or unreasonably delay the issuance of coverage, refuse to issue coverage, or issue coverage with any preexisting condition exclusion or elimination rider or endorsement to an applicant or insured who is under 19 years of age.

(c) Coverage under this section becomes effective for those applying during the open enrollment period on the same basis as any applicant qualifying for coverage on an underwritten basis.

(d) As an alternative to open enrollment periods, health insurance issuers may accept individuals under 19 years of age on a year-round basis, with no preexisting condition exclusions or elimination riders or endorsements.

(4) If the health insurance issuer chooses to apply open enrollment periods to an applicant for individual health insurance coverage who is under 19 years of age, that health insurance issuer shall provide prior written notice annually to each of its policyholders of the open enrollment rights for individuals under 19 years of age and provide information regarding how an individual eligible for this open enrollment period may apply for coverage

with the health insurance issuer during the open enrollment period. The availability of these open enrollment periods must be prominently and publicly advertised by the health insurance issuer.

(5) Health insurance issuers may not directly or indirectly discourage applicants from exercising their open enrollment rights. Health insurance issuers may not penalize insurance producers for submitting applications for individuals that qualify for open enrollment.

(6) This section applies to all individual health insurance coverage for those under 19 years of age, except grandfathered plan coverage for individual health insurance.

NEW SECTION. **Section 2. Prohibition of preexisting condition exclusions in group health insurance coverage relating to individuals under 19 years of age.** (1) A health insurance issuer may not limit or exclude coverage under group health insurance coverage for an individual under 19 years of age by denying enrollment or imposing a preexisting condition exclusion, as defined in [section 1], on that individual.

(2) This section applies to all group health insurance coverage except for coverage consisting solely of excepted benefits, including grandfathered group health insurance plans. This section also applies to the state employee group insurance program, the university system employee group insurance program, any employee group insurance program of a city, town, school district, or other political subdivision of this state, and any self-funded multiple employer welfare arrangement that is subject to licensing requirements under Title 33, chapter 35.

NEW SECTION. **Section 3. Applicability of prohibition on lifetime and annual limits.** (1) Except as provided in subsection (2), [sections 4 through 6] apply to all individual health insurance coverage or group health insurance coverage but do not apply to coverage consisting solely of excepted benefits. These sections also apply to the state employee group insurance program, the university system employee group insurance program, any employee group insurance program of a city, town, school district, or other political subdivision of this state, and any self-funded multiple employer welfare arrangement that is subject to licensing requirements under Title 33, chapter 35.

(2) The prohibition on lifetime limits applies to all grandfathered plan coverage. The prohibition on annual limits provided for in [section 4(2)] and the annual limits provided for in [section 4(3) and (4)] do not apply to grandfathered individual health insurance plans.

NEW SECTION. **Section 4. Prohibition on lifetime and annual limits.** (1) Except as provided in subsection (4), a health insurance issuer offering group or individual health insurance plans may not establish a lifetime limit on the dollar amount of essential benefits for any individual.

(2) (a) Except as provided in subsections (2)(b), (3), and (4), a health insurance issuer offering group or individual health insurance plans may not establish an annual limit on the dollar amount of essential benefits for any individual.

(b) The following are not subject to the requirements of subsection (2)(a):

(i) a flexible spending arrangement, as provided in 26 U.S.C. 106(c)(2);

(ii) a medical savings account, as provided in 26 U.S.C. 220; and

(iii) a health savings account, as defined in 26 U.S.C. 223.

(3) The provisions of subsection (1) do not prohibit a health insurance issuer from placing annual or lifetime dollar limits for any individual on specific covered benefits that are not essential health benefits to the extent that those limits are otherwise permitted under applicable federal or state law.

(4) For plan or policy years beginning prior to January 1, 2014, a group health plan or a health insurance issuer offering group or individual health insurance coverage may establish for any individual an annual limit on the dollar amount of benefits that are essential benefits if the limit is no less than the following:

(a) $750,000 for a plan or policy year beginning after September 22, 2010, but before September 23, 2011;

(b) $1,250,000 for a plan or policy year beginning after September 22, 2011, but before September 23, 2012; and

(c) $2,000,000 for a plan or policy year beginning after September 22, 2012, but before January 1, 2014.

(5) In determining whether an individual has received benefits that meet or exceed the allowable limits, as provided in subsection (4), a health insurance issuer shall take into account only essential benefits.

(6) (a) For plan or policy years beginning prior to January 1, 2014, a health plan is exempt from the annual limit requirements listed in subsection (3) if the plan is approved for a waiver from such requirements by the U.S. department of health and human services. However, the exemption under this subsection (6) applies only for the specified period of time that the waiver from the U.S. department of health and human services applies.

(b) At the time the health plan receives a waiver from the U.S. department of health and human services, the health plan shall notify prospective applicants and affected policyholders and certificate holders and the

insurance commissioner in each state where prospective applicants and any affected insureds are known to reside.

(c) At the time the waiver expires or is otherwise no longer in effect, the health plan shall notify affected policyholders and certificate holders and the insurance commissioner in each state where any affected insured is known to reside.

NEW SECTION. **Section 5. Reinstatement of coverage if coverage lost due to previously imposed lifetime limit.** (1) This section applies to any individual:

(a) whose coverage or benefits under group or individual health insurance coverage ended by reason of reaching a lifetime limit on the dollar value of all benefits for the individual; and

(b) who, due to the provisions of this section, becomes eligible or is required to become eligible for benefits not subject to a lifetime limit on the dollar value of all benefits under a health plan beginning on or after September 23, 2010:

(i) on the first day of the first plan year for group health insurance coverage; or

(ii) on the first day of the first policy year for individual health insurance coverage.

(2) For individual health insurance coverage, an individual is not entitled to reinstatement under the health insurance coverage under this section if the individual reached the lifetime limit and the contract is not renewed or is otherwise no longer in effect. However, reinstatement of the health insurance coverage under this section applies to an individual family member who reached the individual's lifetime limit in a family plan but other family members remain covered under the plan.

(3) If an individual described in subsection (1) is eligible for benefits or is required to become eligible for benefits under the group or individual health insurance coverage, the health insurance issuer shall provide the individual with written notice that:

(a) the lifetime limit on the dollar value of all benefits no longer applies; and

(b) the individual, if still covered under the health insurance coverage, is again eligible to receive benefits under the health plan or health insurance coverage.

(4) If the individual is not enrolled in the health insurance coverage or if an individual is eligible for but not enrolled in any benefit package under the health insurance coverage, the health insurance issuer shall provide an opportunity for the individual to enroll in the plan for a period of at least 30 days.

(5) The notices and enrollment opportunity under this section must be provided beginning not later than:

(a) the first day of the first plan year beginning on or after September 23, 2010, for group health insurance coverage; or

(b) the first day of the first policy year beginning on or after September 23, 2010, for individual health insurance coverage.

(6) The notices required under this section must be provided:

(a) for individual health insurance coverage to the primary subscriber on behalf of the primary subscriber's dependent;

(b) for group health insurance coverage to an employee on behalf of the employee's dependent. The notices for group health insurance coverage may be included with other enrollment materials that a health plan distributes to employees, provided that the statement is prominent. If a notice for group health insurance coverage that satisfies the requirements of this subsection (6)(b) is provided to an individual, a health insurance issuer's requirement to provide the notice with respect to that individual is satisfied for both the group health plan and the issuer.

(7) For any individual who enrolls in health insurance coverage in accordance with this section, coverage under the plan becomes effective not later than:

(a) the first day of the first plan year beginning on or after September 23, 2010, for group health insurance coverage; or

(b) the first day of the first policy year beginning on or after September 23, 2010, for individual health insurance coverage.

NEW SECTION. **Section 6. Special enrollment requirement for reinstating coverage after coverage lost due to lifetime limit.** (1) An individual enrolling in group health insurance coverage in accordance with [section 5] must be treated as a special enrollee in the plan.

(2) The individual:

(a) must be offered all of the benefit packages available to similarly situated individuals who did not lose coverage under the plan by reason of reaching a lifetime limit on the dollar value of all benefits; and

(b) may not be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of reaching a lifetime limit on the dollar value of all benefits.

(3) For purposes of subsection (2)(a), any difference in benefits or cost sharing constitutes a different benefit package.

NEW SECTION. **Section 7. Coverage for preventive services.** (1) A health insurance issuer shall provide coverage for all of the following items and services and, except as provided in [section 8], may not impose any cost-sharing requirements with respect to the following items and services, updated annually as provided in subsection (2):

(a) evidence-based items or services that have a rating of "A" or "B" in the recommendations of the United States preventive services task force as of September 23, 2010;

(b) immunizations for routine use in children, adolescents, and adults that have an existing recommendation from the advisory committee on immunization practices of the centers for disease control and prevention with respect to the individual involved; and

(c) evidence-based preventive care and screenings provided for in comprehensive guidelines supported by the health resources and services administration with respect to infants, children, and adolescents, and to women, to the extent not described in subsection (1)(a).

(2) (a) A health insurance issuer shall, at least annually at the beginning of each new plan year or policy year, whichever is applicable, revise the preventive services covered under its health plans pursuant to this section to be consistent with the recommendations of the United States preventive services task force, the advisory committee on immunization practices of the centers for disease control and prevention, and the guidelines in effect at the time on evidence-based preventive care and screenings provided by the health resources and services administration with respect to infants, children, adolescents, and women.

(b) For the purposes of subsection (1)(b), a recommendation from the advisory committee on immunization practices of the centers for disease control and prevention is considered to be in effect after it has been adopted by the director of the centers for disease control and prevention. A recommendation is considered to be for routine use if it is listed on the immunization schedules of the centers for disease control and prevention.

(c) A health insurance issuer is not required to provide coverage for any items or service specified in any recommendation or guideline described in subsection (1) or updated as provided in subsection (2)(a) after the item or service is no longer described in those recommendations or guidelines.

(d) The United States preventive services task force recommendations regarding breast cancer screening, mammography, and prevention issued in November 2009 are not considered to be current and do not apply to the coverage required under this section.

(3) The notice provisions of 33-22-107, 33-22-247, and 33-22-524 apply to this section.

(4) A health insurance issuer is not prevented by this section from using a reasonable medical management technique to determine the frequency, method, treatment, or setting for an item or service described in this section if the management technique is not specified in the recommendation or guideline.

(5) This section does not prohibit a health insurance issuer from:

(a) providing coverage for items and services in addition to those recommended by the United States preventive services task force or the advisory committee on immunization practices of the centers for disease control and prevention or provided by guidelines supported by the health resources and services administration; or

(b) denying coverage for items and services that are not recommended or within guidelines as described in subsection (2).

(6) A health insurance issuer may impose cost-sharing requirements for a treatment not described in subsection (1) even if the treatment results from an item or service described in this section.

(7) (a) Except as provided in subsection (7)(b), the provisions of [sections 8 and 9] and this section apply to:

(i) all group and individual health insurance coverage;

(ii) the state employee group insurance program;

(iii) the university system employee group insurance program;

(iv) any employee group insurance program of a city, town, school district, or other political subdivision of this state; and

(v) any self-funded multiple employer welfare arrangement that is subject to licensing requirements under Title 33, chapter 35.

(b) The provisions of [sections 8 and 9] and this section do not apply to coverage consisting solely of excepted benefits or to grandfathered group or individual health insurance plans.

(8) For the purposes of this section, a cost-sharing requirement includes but is not limited to a copayment, coinsurance, or deductible.

NEW SECTION. **Section 8. Coverage for office visits in conjunction with preventive items and services.** (1) A health insurance issuer may impose cost-sharing requirements with respect to an office visit if an item or a service described in [section 7] is billed separately or is tracked as individual encounter data separately from the office visit.

(2) A health insurance issuer may not impose cost-sharing requirements with respect to an office visit if an item or service described in [section 7] is not billed separately or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is the delivery of the item or the service.

(3) A health insurance issuer may impose cost-sharing requirements with respect to an office visit regardless of whether the item or service described in [section 7] is billed separately or is tracked as individual encounter data separately from the office visit if the primary purpose of the office visit is not the delivery of the item or service.

NEW SECTION. **Section 9. Preventive items and services delivered by out-of-network providers.** (1) Nothing in [sections 7 and 8] requires a health insurance issuer that has a network of providers to provide benefits for items and services described in [section 7] that are delivered by an out-of-network provider.

(2) Nothing in [section 7] precludes a health insurance issuer that has a network of providers from imposing cost-sharing requirements for items or services described in [section 7] that are delivered by an out-of-network provider.

NEW SECTION. **Section 10. Choice of health care professional for primary care.** (1) If a health insurance issuer offering group or individual health insurance coverage requires or provides for the designation by a covered person of a participating primary health care professional, the health insurance issuer shall permit each covered person to designate any participating primary care health care professional who is available to accept the covered person.

(2) If a health insurance issuer requires or provides for the designation of a participating health care professional for a child by a covered person, the health insurance issuer shall permit the covered person to designate a participating pediatrician as the child's primary care health care professional if the health care professional is available to accept the designation.

(3) This section may not be construed to waive any exclusions of coverage under the terms and conditions of the health plan with respect to coverage of pediatric care.

NEW SECTION. **Section 11. Notice requirements.** (1) If a health insurance issuer requires the designation by a covered person of a primary care health care professional, the health insurance issuer shall provide notice informing each participant or, in the individual market, each primary subscriber of the terms of the

health plan regarding designation of a primary care health care professional and of a covered person's rights:

(a) to designate any participating health care professional as the covered person's primary care health care professional;

(b) to designate with respect to a child any participating physician who specializes in pediatrics as the child's primary care health care professional; and

(c) to obtain with respect to a covered person obstetrical or gynecological care from a participating health care professional who specializes in obstetrics or gynecology without prior authorization or referral from a health insurance issuer or any other person, including a primary care health care professional.

(2) (a) In the case of group health insurance coverage, the notice described in subsection (1) must be included whenever the health insurance issuer provides a participant with a summary plan description or other similar description of benefits under the health plan.

(b) In the case of individual health insurance coverage, the notice described in subsection (1) must be included whenever the health insurance issuer provides a primary subscriber with a policy, certificate, or contract of health insurance.

(3) A health insurance issuer may use the model notice language in 45 CFR 147.138 to satisfy the requirements of this section.

NEW SECTION. **Section 12. Applicability.** (1) The provisions of [sections 10 and 11] and Title 33, chapter 22, part 19, apply to all health insurance issuers issuing group or individual insurance coverage, except for coverage consisting solely of excepted benefits, and the state employee group insurance program, the university system employee group insurance program, any employee group insurance program of a city, town, school district, or other political subdivision of this state, and any self-funded multiple employer welfare arrangement that is subject to licensing requirements under Title 33, chapter 35.

(2) Title 33, chapter 22, part 19, does not apply to a grandfathered individual or group health insurance plan.

NEW SECTION. **Section 13. Prohibition on rescissions of coverage -- exceptions -- notice.** (1) A health insurance issuer may not rescind health insurance coverage with respect to an individual, including a group to which the individual belongs or family coverage in which the individual is included, after the individual has coverage under the plan unless the individual:

(a) makes a misrepresentation, omission, concealment of facts, or incorrect statement that was fraudulent; or

(b) makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan.

(2) Before coverage under the plan may be rescinded pursuant to subsection (1), a health insurance issuer shall provide at least 30 days in advance written notice to each group health plan enrollee, regardless of whether the rescission applies to the entire group or only to an individual within the group, or for individual health insurance coverage to the primary subscriber who would be affected by the proposed rescission of coverage.

(3) The provisions of this section apply regardless of any applicable contestability period.

(4) (a) For the purposes of this section, "rescission" means a cancellation or discontinuance of coverage under a health plan that has a retroactive effect.

(b) The term does not include cancellation or discontinuance of health insurance coverage if:

(i) the cancellation or discontinuance of coverage has only a prospective effect; or

(ii) the cancellation or discontinuance of coverage is effective retroactively to the extent that it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(5) The provisions of this section apply to all individual and group health insurance coverage, including grandfathered plan coverage, and to multiple employer welfare arrangements subject to licensing under Title 33, chapter 35.

Section 14. Section 2-18-704, MCA, is amended to read:

"2-18-704. Mandatory provisions. (1) An insurance contract or plan issued under this part must contain provisions that permit:

(a) the member of a group who retires from active service under the appropriate retirement provisions of a defined benefit plan provided by law or, in the case of the defined contribution plan provided in Title 19, chapter 3, part 21, a member with at least 5 years of service and who is at least age 50 while in covered employment to remain a member of the group until the member becomes eligible for medicare under the federal Health Insurance for the Aged Act, 42 U.S.C. 1395, as amended, unless the member is a participant in another group plan with substantially the same or greater benefits at an equivalent cost or unless the member is employed and, by virtue of that employment, is eligible to participate in another group plan with substantially the same or greater benefits at an equivalent cost;

(b) the surviving spouse of a member to remain a member of the group as long as the spouse is eligible

for retirement benefits accrued by the deceased member as provided by law unless the spouse is eligible for medicare under the federal Health Insurance for the Aged Act or unless the spouse has or is eligible for equivalent insurance coverage as provided in subsection (1)(a);

(c) the surviving children of a member to remain members of the group as long as they are eligible for retirement benefits accrued by the deceased member as provided by law unless they have equivalent coverage as provided in subsection (1)(a) or are eligible for insurance coverage by virtue of the employment of a surviving parent or legal guardian.

(2) An insurance contract or plan issued under this part must contain the provisions of subsection (1) for remaining a member of the group and also must permit:

(a) the spouse of a retired member the same rights as a surviving spouse under subsection (1)(b);

(b) the spouse of a retiring member to convert a group policy as provided in 33-22-508; and

(c) continued membership in the group by anyone eligible under the provisions of this section, notwithstanding the person's eligibility for medicare under the federal Health Insurance for the Aged Act.

(3) (a) A state insurance contract or plan must contain provisions that permit a legislator to remain a member of the state's group plan until the legislator becomes eligible for medicare under the federal Health Insurance for the Aged Act, 42 U.S.C. 1395, as amended, if the legislator:

(i) terminates service in the legislature and is a vested member of a state retirement system provided by law; and

(ii) notifies the department of administration in writing within 90 days of the end of the legislator's legislative term.

(b) A former legislator may not remain a member of the group plan under the provisions of subsection (3)(a) if the person:

(i) is a member of a plan with substantially the same or greater benefits at an equivalent cost; or

(ii) is employed and, by virtue of that employment, is eligible to participate in another group plan with substantially the same or greater benefits at an equivalent cost.

(c) A legislator who remains a member of the group under the provisions of subsection (3)(a) and subsequently terminates membership may not rejoin the group plan unless the person again serves as a legislator.

(4) (a) A state insurance contract or plan must contain provisions that permit continued membership in the state's group plan by a member of the judges' retirement system who leaves judicial office but continues to

be an inactive vested member of the judges' retirement system as provided by 19-5-301. The judge shall notify the department of administration in writing within 90 days of the end of the judge's judicial service of the judge's choice to continue membership in the group plan.

(b) A former judge may not remain a member of the group plan under the provisions of this subsection (4) if the person:

(i) is a member of a plan with substantially the same or greater benefits at an equivalent cost;

(ii) is employed and, by virtue of that employment, is eligible to participate in another group plan with substantially the same or greater benefits at an equivalent cost; or

(iii) becomes eligible for medicare under the federal Health Insurance for the Aged Act, 42 U.S.C. 1395, as amended.

(c) A judge who remains a member of the group under the provisions of this subsection (4) and subsequently terminates membership may not rejoin the group plan unless the person again serves in a position covered by the state's group plan.

(5) A person electing to remain a member of the group under subsection (1), (2), (3), or (4) shall pay the full premium for coverage and for that of the person's covered dependents.

(6) An insurance contract or plan issued under this part that provides for the dispensing of prescription drugs by an out-of-state mail service pharmacy, as defined in 37-7-702:

(a) must permit any member of a group to obtain prescription drugs from a pharmacy located in Montana that is willing to match the price charged to the group or plan and to meet all terms and conditions, including the same professional requirements that are met by the mail service pharmacy for a drug, without financial penalty to the member; and

(b) may only be with an out-of-state mail service pharmacy that is registered with the board under Title 37, chapter 7, part 7, and that is registered in this state as a foreign corporation.

(7) An insurance contract or plan issued under this part must include coverage for treatment of inborn errors of metabolism, as provided for in 33-22-131.

(8) An insurance contract or plan issued under this part must include substantially equivalent or greater coverage for outpatient self-management training and education for the treatment of diabetes and certain diabetic equipment and supplies as provided in 33-22-129.

(9) (a) An insurance contract or plan issued under this part that provides coverage for an individual in a member's family must provide coverage for well-child care for children from the moment of birth through 7 years

of age as provided in 33-22-512. Benefits provided under this coverage are exempt from any deductible provision that may be in force in the contract or plan.

(b) Coverage for well-child care under subsection (9)(a) must include:

(i) a history, physical examination, developmental assessment, anticipatory guidance, and laboratory tests, according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment services program provided for in 53-6-101; ~~and~~

(ii) routine immunizations according to the schedule for immunization recommended by the immunization practice advisory committee of the U.S. department of health and human services~~.~~; and

(iii) the items and services described in [sections 7 through 9] and, to the extent that federal law preempts state law, 45 CFR 147.130.

(c) Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit as provided for in this subsection (9), except as provided by [sections 7 through 9].

(d) For purposes of this subsection (9):

(i) "developmental assessment" and "anticipatory guidance" mean the services described in the Guidelines for Health Supervision II, published by the American academy of pediatrics; and

(ii) "well-child care" means the services described in [section 7] and subsection (9)(b) of this section and delivered by a physician or a health care professional supervised by a physician.

(10) ~~(a) Except as provided in subsection (10)(b), upon~~ Upon renewal, an insurance contract or plan issued under this part under which coverage of a dependent terminates at a specified age must, as provided in 33-22-152, continue to provide coverage for any ~~unmarried~~ dependent, as defined in ~~33-22-140(5)(b)~~ 33-22-140(6)(b), until the dependent reaches ~~25~~ 26 years of age ~~or marries, whichever occurs first~~. For insurance contracts or plans issued under this part, the premium charged for the additional coverage of a dependent, as defined in ~~33-22-140(5)(b)~~ 33-22-140(6)(b), may be required to be paid by the insured and not by the employer.

~~(b) An insurance contract or plan issued under this part for the state employee group insurance program and the university system group insurance program is not subject to subsection (10)(a).~~

(11) Prior to issuance of an insurance contract or plan under this part, written informational materials describing the contract's or plan's cancer screening coverages must be provided to a prospective group or plan member.

(12) The provisions of [sections 1 through 13] and Title 33, chapter 22, part 19, apply to insurance contracts or plans issued under this part."

Section 15. 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)~~ 33-22-1811(3) 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 16. Section 33-1-102, MCA, is amended to read:

"33-1-102. Compliance required -- exceptions -- health service corporations -- health maintenance organizations -- governmental insurance programs -- service contracts. (1) A person may not transact a business of insurance in Montana or a business relative to a subject resident, located, or to be performed in Montana without complying with the applicable provisions of this code.

(2) The provisions of this code do not apply with respect to:

(a) domestic farm mutual insurers as identified in chapter 4, except as stated in chapter 4;

(b) domestic benevolent associations as identified in chapter 6, except as stated in chapter 6; and

(c) fraternal benefit societies, except as stated in chapter 7.

(3) This code applies to health service corporations as prescribed in 33-30-102. The existence of the corporations is governed by Title 35, chapter 2, and related sections of the Montana Code Annotated.

(4) (a) ~~This~~ Except as provided in subsection (4)(b), this code does not apply to health maintenance organizations or to managed care community networks, as defined in 53-6-702, to the extent that the existence and operations of those organizations are governed by chapter 31 or to the extent that the existence and operations of those networks are governed by Title 53, chapter 6, part 7. The department of public health and human services is responsible to protect the interests of consumers by providing complaint, appeal, and grievance procedures relating to managed care community networks and health maintenance organizations under contract to provide services under Title 53, chapter 6.

(b) This code, [sections 1 through 13], and Title 33, chapter 22, part 19, apply to all health maintenance organizations.

(5) This code does not apply to workers' compensation insurance programs provided for in Title 39, chapter 71, parts 21 and 23, and related sections.

(6) The department of public health and human services may limit the amount, scope, and duration of services for programs established under Title 53 that are provided under contract by entities subject to this title.

The department of public health and human services may establish more restrictive eligibility requirements and fewer services than may be required by this title.

(7) Except as otherwise provided in Title 33, chapter 22, this code does not apply to the state employee group insurance program established in Title 2, chapter 18, part 8.

(8) This code does not apply to insurance funded through the state self-insurance reserve fund provided for in 2-9-202.

(9) (a) Except as otherwise provided in Title 33, chapter 22, this code does not apply to any arrangement, plan, or interlocal agreement between political subdivisions of this state in which the political subdivisions undertake to separately or jointly indemnify one another by way of a pooling, joint retention, deductible, or self-insurance plan.

(b) Except as otherwise provided in Title 33, chapter 22, this code does not apply to any arrangement, plan, or interlocal agreement between political subdivisions of this state or any arrangement, plan, or program of a single political subdivision of this state in which the political subdivision provides to its officers, elected officials, or employees disability insurance or life insurance through a self-funded program.

(10) (a) This code does not apply to the marketing of, sale of, offering for sale of, issuance of, making of, proposal to make, and administration of a service contract.

(b) A "service contract" means a contract or agreement for a separately stated consideration for a specific duration to perform the repair, replacement, or maintenance of property or to indemnify for the repair, replacement, or maintenance of property if an operational or structural failure is due to a defect in materials or manufacturing or to normal wear and tear, with or without an additional provision for incidental payment or indemnity under limited circumstances, including but not limited to towing, rental, and emergency road service. A service contract may provide for the repair, replacement, or maintenance of property for damage resulting from power surges or accidental damage from handling. A service contract does not include motor club service as defined in 61-12-301.

(11) (a) Subject to 33-18-201 and 33-18-242, this code does not apply to insurance for ambulance services sold by a county, city, or town or to insurance sold by a third party if the county, city, or town is liable for the financial risk under the contract with the third party as provided in 7-34-103.

(b) If the financial risk for ambulance service insurance is with an entity other than the county, city, or town, the entity is subject to the provisions of this code."

Section 17. Section 33-15-403, MCA, is amended to read:

"33-15-403. Representations in applications -- recovery precluded if fraudulent or material. (1) All statements and descriptions in any application for an insurance policy or annuity contract or in negotiations for an insurance policy or annuity contract by or on behalf of the insured or annuitant are considered representations and not warranties.

(2) (a) ~~Misrepresentations~~ Except as provided in subsection (2)(b), misrepresentations, omissions, concealment of facts, and incorrect statements do not prevent a recovery under the policy or contract unless:

~~(a)~~(i) fraudulent;

~~(b)~~(ii) material either to the acceptance of the risk or to the hazard assumed by the insurer; or

~~(c)~~(iii) the insurer in good faith would either not have issued the policy or contract or would not have issued a policy or contract in as large an amount or at the same premium or rate or would not have provided coverage with respect to the hazard resulting in the loss if the true facts had been made known to the insurer as required either by the application for the policy or contract or otherwise.

(b) For health insurance coverage, the provisions of subsection (2)(a) do not apply unless the misrepresentation, omission, concealment of facts, or incorrect statement was fraudulent or an intentional misrepresentation of material fact, as prohibited by the terms of the health insurance coverage.

~~(3)~~(c) Subsection ~~(2)(c)~~ (2)(a)(iii) does not apply to nonrenewal or discontinuation of group health insurance offered in connection with a group health plan in the small group market or large group market, as those terms are defined in 33-22-140."

Section 18. Section 33-18-215, MCA, is amended to read:

"33-18-215. Postclaim underwriting prohibited -- condition. An insurer, health service corporation, or health maintenance organization may not place an elimination rider on or rescind coverage provided by a disability policy, certificate, or subscriber contract after a policy, certificate, or contract has been issued unless the insured has made ~~a material~~ an intentional misrepresentation of material fact or a fraudulent misstatement on the application or has failed to pay the premium when due."

Section 19. Section 33-22-101, MCA, is amended to read:

"33-22-101. Exceptions to scope. (1) Subject to subsection (2), parts 1 through 4 of this chapter, except 33-22-107, 33-22-110, 33-22-111, 33-22-114, 33-22-125, 33-22-129, 33-22-130 through 33-22-136,

33-22-140, 33-22-141, 33-22-142, 33-22-243, and 33-22-304, and part 19 of this chapter do not apply to or affect:

(a) any policy of liability or workers' compensation insurance with or without supplementary expense coverage;

(b) any group or blanket policy;

(c) life insurance, endowment, or annuity contracts or supplemental contracts that contain only those provisions relating to disability insurance that:

(i) provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means; or

(ii) operate to safeguard contracts against lapse or to give a special surrender value or special benefit or an annuity if the insured or annuitant becomes totally and permanently disabled as defined by the contract or supplemental contract;

(d) reinsurance.

(2) Sections 33-22-137, 33-22-150 through 33-22-152, [sections 1 through 13], and 33-22-301 apply to group or blanket policies."

Section 20. Section 33-22-109, MCA, is amended to read:

"33-22-109. Riders. (1) Except as provided in subsection (4) and except for group health insurance coverage provided by a group health plan or a health insurance issuer, a policy of disability insurance may contain a provision that excludes coverage for specific conditions through the use of elimination riders for conditions for which medical advice, diagnosis, care, or treatment was recommended by or received from a provider of health care services within 3 years preceding the effective date of coverage of an insured person. The provisions of 33-22-110 do not apply to elimination riders.

(2) An insured person may apply to the insurer for removal or modification of a rider, and the insurer shall respond to the application within 60 days of receipt.

~~(2)~~(3) An insurer may not, except upon agreement by the insured, retroactively impose an elimination rider on an existing policy, certificate, or contract.

(4) A health insurance issuer offering individual health insurance coverage, except for grandfathered individual health insurance plans, may not impose an elimination rider on an individual under 19 years of age for conditions for which medical advice, diagnosis, care, or treatment was previously recommended by or received from a provider of health care services."

Section 21. Section 33-22-129, MCA, is amended to read:

"33-22-129. Coverage for outpatient self-management training and education for treatment of diabetes -- limited benefit for medically necessary equipment and supplies. (1) Each group disability policy, certificate of insurance, and membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide coverage for outpatient self-management training and education for the treatment of diabetes. Any education must be provided by a licensed health care professional with expertise in diabetes.

(2) (a) Coverage must include a $250 benefit for a person each year for medically necessary and prescribed outpatient self-management training and education for the treatment of diabetes.

(b) Nothing in subsection (2)(a) prohibits an insurer from providing a greater benefit.

(3) Each group disability policy, certificate of insurance, and membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide coverage for diabetic equipment and supplies that is limited to insulin, syringes, injection aids, devises for self-monitoring of glucose levels (including those for the visually impaired), test strips, visual reading and urine test strips, one insulin pump for each warranty period, accessories to insulin pumps, one prescriptive oral agent for controlling blood sugar levels for each class of drug approved by the United States food and drug administration, and glucagon emergency kits.

(4) Annual copayment and deductible provisions are subject to the same terms and conditions applicable to all other covered benefits within a given policy, except as provided in [sections 7 through 9].

(5) This section does not apply to disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, specific disease, or long-term care policies.

(6) (a) ~~This~~ Except as otherwise provided in [sections 7 through 9], this section does not apply to the state employee group insurance program, the university system employee group insurance program, or any employee group insurance program of a city, town, county, school district, or other political subdivision of this state that on January 1, 2002, provides substantially equivalent or greater coverage for outpatient self-management training and education for the treatment of diabetes and certain diabetic equipment and supplies provided for in subsection (3).

(b) The state employee group insurance program, the university system employee group insurance program, or any employee group insurance program of a city, town, county, school district, or other political subdivision of this state that reduces or discontinues substantially equivalent or greater coverage after January

1, 2002, is subject to the provisions of this section."

Section 22. Section 33-22-131, MCA, is amended to read:

"33-22-131. Coverage for treatment of inborn errors of metabolism. (1) Each group or individual medical expense disability policy, certificate of insurance, and membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide coverage for the treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism and for which medically standard methods of diagnosis, treatment, and monitoring exist.

(2) Coverage must include expenses of diagnosing, monitoring, and controlling the disorders by nutritional and medical assessment, including but not limited to clinical services, biochemical analysis, medical supplies, prescription drugs, corrective lenses for conditions related to the inborn error of metabolism, nutritional management, and medical foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

(3) For purposes of this section:

(a) "medical foods" means nutritional substances in any form that are:

(i) formulated to be consumed or administered enterally under supervision of a physician;

(ii) specifically processed or formulated to be distinct in one or more nutrients present in natural food;

(iii) intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and

(iv) essential to optimize growth, health, and metabolic homeostasis;

(b) "treatment" means licensed professional medical services under the supervision of a physician.

(4) These services are subject to the terms of the applicable group or individual disability policy, certificate, or membership contract that establishes durational limits, dollar limits except as provided in [section 4], and deductibles, ~~and copayment~~ copayments, or other cost-sharing provisions except as provided in [sections 7 through 9] as long as the terms are not less favorable than for physical illness generally.

(5) This section does not apply to disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, or specified disease policies."

Section 23. Section 33-22-132, MCA, is amended to read:

"33-22-132. Coverage for mammography examinations. (1) Each group or individual medical expense, cancer, and blanket disability policy, certificate of insurance, and membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide minimum mammography examination coverage.

(2) For the purpose of this section, "minimum mammography examination" means:

(a) one baseline mammogram for a woman who is 35 years of age or older and under 40 years of age;

(b) a mammogram every 2 years for any woman who is 40 years of age or older and under 50 years of age or more frequently if recommended by the woman's physician; ~~and~~

(c) a mammogram each year for a woman who is 50 years of age or older; and

(d) a mammogram, as provided in [section 7] and, to the extent that federal law preempts state law, 45 CFR 147.130.

(3) The restrictions on cost sharing as provided in [sections 7 through 9] apply to the types of health insurance coverage described in those sections.

~~(3)~~(4) ~~A~~ If restrictions on cost sharing as provided in [sections 7 through 9] do not apply, a minimum ~~$70~~ $180 payment or the actual charge if the charge is less than ~~$70~~ $180 must be made for each mammography examination performed before the application of the terms of the applicable group or individual disability policy, certificate of insurance, or membership contract that establish durational limits~~, deductibles,~~ and ~~copayment~~ cost-sharing provisions as long as the terms are not less favorable than for physical illness generally.

~~(4)~~(5) This section does not apply to disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, or specified disease policies."

Section 24. 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) "Covered person" means a policyholder, certificate holder, member, subscriber, enrollee, or other individual participating in a health plan.

~~(4)~~(5) (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) the Montana comprehensive health association provided for in 33-22-1503;

(viii) a health plan offered under Title 5, chapter 89, of the United States Code;

(ix) a public health plan;

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

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

(b) Creditable coverage does not include coverage consisting solely of coverage of excepted benefits.

~~(5)~~(6) "Dependent" means:

(a) a spouse;

(b) ~~an unmarried~~ a child ~~under 25~~ who has not attained 26 years of age:

(i) who otherwise meets the requirements of 33-22-152 and who, for the purposes of determining eligibility for dependent coverage under a grandfathered group health insurance plan until January 1, 2014, 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; and

~~(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)~~(ii) 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)~~(7) "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)~~(8) "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.

(9) "Essential benefits" means:

(a) ambulatory patient services;

(b) emergency services;

(c) hospitalization;

(d) laboratory services;

(e) maternity and newborn care;

(f) mental health and substance abuse disorder services, including behavioral health treatment;

(g) pediatric services, including oral and vision care;

(h) prescription drugs;

(i) preventative and wellness services and chronic disease management;

(j) rehabilitative and habilitative services and devices; and

(k) other benefits as described in federal regulations pertaining to the definition of essential benefits.

~~(8)~~(10) "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.

(11) "Facility" means an institution or other setting providing health care services, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic centers, imaging centers, laboratories, and rehabilitation or other therapeutic centers.

~~(9)~~(12) "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 or under an association portability plan, as defined in 33-22-1501, 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)~~ (12)(f) if the individual elected the continuation coverage described in subsection ~~(9)(f)~~ (12)(f).

(13) "Grandfathered plan coverage" or "grandfathered individual health insurance plan" or "grandfathered group health insurance plan" means coverage provided by a health insurance issuer in which an individual or single employer group health plan was enrolled on March 23, 2010, for as long as the individual or single employer group health plan maintains the coverage status in accordance with federal regulations under 26 CFR, part 54, 29 CFR, part 2590, and 45 CFR, part 147.

~~(10)~~(14) "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)~~(15) "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.

(16) "Health care professional" means a physician or other health care practitioner licensed, accredited, or certified under Title 37 to perform health care services specified by statute or rule.

(17) "Health care provider" or "provider" means a health care professional or facility.

(18) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

~~(12)~~(19) "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)~~(20) "Health insurance issuer" means an insurer, a health service corporation, ~~or~~ a consumer operated and oriented plan established under 42 U.S.C. 18042 and licensed in this state, a health maintenance organization, or any other entity providing health insurance coverage, health benefits, or health services that is

subject to the insurance laws and regulations of this state or subject to the jurisdiction of the commissioner.

(21) (a) "Health plan" means a policy, membership contract, subscriber contract, certificate, or agreement offered by a health insurance issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(b) The term does not include coverage consisting solely of excepted benefits.

~~(14)~~(22) (a) "Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market~~, but~~.

(b) The term does not include short-term limited duration insurance.

~~(15)~~(23) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with group health insurance coverage.

~~(16)~~(24) "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)~~(25) "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)~~(26) "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~~ 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)~~(27) "Medical care" means:

(a) the diagnosis, ~~cure~~ care, 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)~~ (27)(a); or

(c) insurance ~~covering~~ that pays benefits for medical care referred to in subsections ~~(19)(a)~~ (27)(a) and ~~(19)(b)~~ (27)(b).

~~(20)~~(28) "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)~~(29) "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)~~(30) "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, except as provided in [sections 1 and 2].

~~(23)~~(31) "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)~~(32) "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 25. Section 33-22-143, MCA, is amended to read:

"33-22-143. Rules. The commissioner may adopt rules to implement 33-22-140 through 33-22-142, [sections 1 through 13], 33-22-246, 33-22-247, 33-22-508, 33-22-514, 33-22-523 through 33-22-526, and 33-22-1523."

Section 26. Section 33-22-152, MCA, is amended to read:

"33-22-152. ~~Continuation of~~ Eligibility for dependent coverage for children up to 26 years of age. (1) A health insurance issuer that issues or renews an individual or a group health insurance policy, certificate, or membership contract under which an individual's or employee's dependents are eligible for coverage may not terminate or refuse to offer coverage on the basis of the age of ~~an unmarried~~ a dependent, as defined in ~~33-22-140(5)(b)~~ 33-22-140(6)(b), prior to the dependent reaching ~~25~~ 26 years of age. Except as otherwise provided by law, the ~~continuation of the~~ coverage of the dependent, as defined in ~~33-22-140(5)(b)~~ 33-22-140(6)(b), is at the option of the covered employee.

(2) A health insurance issuer may not deny or restrict coverage for a child who has not attained 26 years of age based on any of the following conditions or combination of conditions:

(a) the presence or absence of the child's financial dependency upon the participant or primary subscriber or other person;

(b) residency with the participant or primary subscriber or other person;

(c) student status; or

(d) employment.

(3) A health insurance issuer may not deny or restrict coverage of a child based on eligibility for other coverage, including eligibility for coverage in an employer group health plan, except as provided in subsection (7).

(4) A health insurance issuer is not required to provide dependent coverage for a grandchild unless the grandparent becomes the legal guardian of that grandchild.

(5) The terms of the health insurance coverage cannot vary based on age.

(6) A child who has not attained 26 years of age and whose coverage ended or who was denied coverage because of age or other reasons prohibited by this section must be offered an open enrollment period that complies with 45 CFR 147.120(f).

(7) (a) For plan years beginning before January 1, 2014, a group health plan that qualifies as grandfathered plan coverage and that makes available dependent coverage of children may exclude an adult child who has not attained 26 years of age from coverage only if the adult child is an employee eligible to enroll in an employer-sponsored group health plan other than a group health plan of a parent, as described in 33-22-140(6)(b)(i).

(b) For plan years beginning on or after January 1, 2014, a group health plan that qualifies as grandfathered plan coverage may not exclude a dependent described in subsection (7)(a)."

Section 27. Section 33-22-242, MCA, is amended to read:

"33-22-242. Waiver of preexisting condition exclusion -- exclusion prohibited. (1) A health care insurer shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services in an individual health ~~benefit~~ plan for the period of time that an individual was previously covered by qualifying previous coverage that provided benefits with respect to those services~~,~~ if the qualifying previous coverage was continuous to a date not more than 30 days prior to the date of application for new coverage.

(2) A health care insurer that offers individual health insurance coverage to a federally defined eligible

individual may not impose a preexisting condition exclusion with respect to that coverage.

(3) A health insurance issuer offering individual health insurance coverage, except for grandfathered individual health insurance plans, may not impose a preexisting condition exclusion, as defined in [section 1], on an individual under 19 years of age because of a preexisting condition."

Section 28. Section 33-22-246, MCA, is amended to read:

"33-22-246. Preexisting conditions relating to individual market. (1) Except as provided in ~~subsection~~ subsections (2) and (3), a health insurance issuer offering individual health insurance coverage may ~~not~~ exclude coverage for a preexisting condition ~~unless~~ if:

(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.

(3) A health insurance issuer offering individual health insurance coverage, except for grandfathered individual health insurance plans, may not impose a preexisting condition exclusion, as defined in [section 1], on an individual under 19 years of age because of a preexisting condition."

Section 29. Section 33-22-303, MCA, is amended to read:

"33-22-303. Coverage for well-child care. (1) Each medical expense policy of disability insurance or certificate issued under the policy that is delivered, issued for delivery, renewed, extended, or modified in this state by a disability insurer and that provides coverage for a family member of the insured or subscriber must provide coverage for well-child care for children from the moment of birth through 7 years of age. Benefits provided under this coverage are exempt from any deductible provision that may be in force in the policy or certificate issued under the policy.

(2) If the provisions of [sections 7 through 9] and 45 CFR 147.130 apply, cost sharing is prohibited, except as described in those sections.

~~(2)~~(3) Coverage for well-child care under subsection (1) must include:

(a) a history, physical examination, developmental assessment, anticipatory guidance, and laboratory tests, according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment

services program provided for in 53-6-101; ~~and~~

(b) routine immunizations according to the schedule for immunizations recommended by the immunization practices advisory committee of the U.S. department of health and human services; and

(c) the items and services described in [sections 7 through 9] and, to the extent that federal law preempts state law, 45 CFR 147.130.

~~(3)~~(4) Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit cited in this section unless the provisions of [sections 7 through 9] and, to the extent that federal law preempts state law, 45 CFR 147.130 provide greater benefits.

~~(4)~~(5) This section does not apply to disability income, specified disease, accident-only, medicare supplement, or hospital indemnity policies.

~~(5)~~(6) For the purposes of this section:

(a) "well-child care" means the services described in [section 7] and subsection ~~(2)~~ (3) of this section and delivered by a physician or a health care professional supervised by a physician; and

(b) "developmental assessment" and "anticipatory guidance" mean the services described in the Guidelines for Health Supervision II, published by the American academy of pediatrics.

~~(6)~~(7) When a policy of disability insurance or a certificate issued under the policy provides coverage or benefits to a resident of this state, it is considered to be delivered in this state within the meaning of this section, whether the insurer that issued or delivered the policy or certificate is located inside or outside of this state."

Section 30. Section 33-22-508, MCA, is amended to read:

"33-22-508. Conversion on termination of eligibility. (1) A group disability insurance policy or certificate of insurance ~~delivered or issued for delivery or renewed after October 1, 1981,~~ must contain a provision that if the insurance or any portion of the insurance on a person or the person's dependents or family members covered under the policy ceases because of termination of the person's membership in a group eligible for coverage under the policy, because of termination of the person's employment, as a result of a person's employer discontinuing the employer's business, or as a result of a person's employer discontinuing the group disability insurance policy and not providing for any other group disability insurance or plan and if the person had been insured for a period of 3 months and ~~the person~~ is not insured under another major medical disability insurance policy or plan, the person is entitled to have issued to the person by the insurer, without evidence of insurability, group disability coverage or an individual disability policy or, in the absence of an individual disability policy issued

by the insurer, a group disability policy issued by the insurer on the person or on the person's dependents or family members if application for the individual policy is made and the first premium tendered to the insurer within 31 days after the termination of the group coverage.

(2) A group insurer may meet the requirements of this section by contracting with another insurer to issue conversion policies as described in subsections (5) and (6). The conversion carrier must be authorized to act as an insurer in this state, and the commissioner shall approve the conversion policies pursuant to 33-1-501.

(3) The individual policy or group policy, at the option of the insured, may be on any form then customarily issued by the insurer to individual or group policyholders, with the exception of a policy the eligibility for which is determined by affiliation other than by employment with a common entity. In addition, the insurer or conversion carrier shall make available a conversion policy as required by subsection (6).

(4) The premium for the individual policy or group policy must be at no more than 200% of the insurer's customary rate applicable to the group policy being terminated at the time of the conversion. 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 of the policy being terminated at the time of the conversion. The customary rate is that rate that is normally issued for medically underwritten policies without discount for healthy lifestyles.

(5) A conversion carrier shall offer an individual or group conversion policy that provides the same schedule of benefits and covers the same eligible expenses as those being terminated. The premium for the policy must be calculated as described in subsection (4).

(6) The insurer or conversion carrier shall also make available a conversion policy, certificate, or membership contract that provides at least the level of benefits provided by ~~the insurer's lowest cost basic health benefit plan, as defined in 33-22-1803. If the insurer or conversion carrier is not a small employer carrier under part 18, the insurer shall make available a conversion policy, certificate, or membership contract that provides equivalent benefits to a basic health benefit plan as provided in 33-22-1827~~ 33-22-1521(1)(b) and (2), except that the deductible may not exceed $1,500 for a covered person. The conversion rate for that plan may not exceed 150% of the ~~highest~~ average market rate ~~charged for that plan~~ of the five insurers or health service corporations with the largest premium amount of individual plans of major medical insurance in force in this state. This subsection does not apply to disability plans that provide only excepted benefits as defined in 33-22-140.

(7) The effective date and time of the conversion policy must be established to ensure that there is no break in coverage between the termination of the group policy coverage and the inception of the conversion policy."

Section 31. Section 33-22-512, MCA, is amended to read:

"33-22-512. Coverage for well-child care. (1) Each group disability policy or certificate of insurance that is delivered, issued for delivery, renewed, extended, or modified in this state by a disability insurer and that provides coverage for a family member of the insured or subscriber must provide coverage for well-child care for children from the moment of birth through 7 years of age. Benefits provided under this coverage are exempt from any deductible provision that may be in force in the policy or certificate issued under the policy.

(2) If the provisions of [sections 7 through 9] and 45 CFR 147.130 apply, cost sharing is prohibited, except as described in those sections.

~~(2)~~(3) Coverage for well-child care under subsection (1) must include:

(a) a history, physical examination, developmental assessment, anticipatory guidance, and laboratory tests, according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment services program provided for in 53-6-101; ~~and~~

(b) routine immunizations according to the schedule for immunizations recommended by the immunization practices advisory committee of the U.S. department of health and human services; and

(c) the items and services described in [sections 7 through 9] and, to the extent that federal law preempts state law, 45 CFR 147.130.

~~(3)~~(4) Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit cited in this section unless the provisions of [sections 7 through 9] and, to the extent that federal law preempts state law, 45 CFR 147.130 provide greater benefits.

~~(4)~~(5) This section does not apply to disability income, specified disease, accident-only, medicare supplement, or hospital indemnity policies or certificates.

~~(5)~~(6) For purposes of this section:

(a) "well-child care" means the services described in [section 7] and subsection ~~(2)~~ (3) of this section and delivered by a physician or a health care professional supervised by a physician; and

(b) "developmental assessment" and "anticipatory guidance" mean the services described in the Guidelines for Health Supervision II, published by the American academy of pediatrics.

~~(6)~~(7) When a group disability policy or certificate of insurance issued under the policy provides coverage or benefits to a resident of this state, it is considered to be delivered in this state within the meaning of this section, whether the insurer that issued or delivered the policy or certificate is located inside or outside of this

state."

Section 32. Section 33-22-514, MCA, is amended to read:

"33-22-514. Preexisting conditions relating to group market. (1) ~~A~~ Except as provided in subsection (4), 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) Pregnancy may not be excluded as a preexisting condition.

(4) A group health plan or a health insurance issuer offering group health insurance coverage may not impose a preexisting condition exclusion, as defined in [section 1], on an individual under 19 years of age because of a preexisting condition."

Section 33. Section 33-22-515, MCA, is amended to read:

"33-22-515. Coverage of autism spectrum disorders. (1) Each group disability policy, certificate of insurance, or membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide coverage for diagnosis and treatment of autism spectrum disorders for a covered child 18 years of age or younger.

(2) Coverage under this section must be provided to a child who is diagnosed with one of the following disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders:

(a) autistic disorder;

(b) Asperger's disorder; or

(c) pervasive developmental disorder not otherwise specified.

(3) (a) Coverage under this section must include:

(i) habilitative or rehabilitative care that is prescribed, provided, or ordered by a licensed physician or licensed psychologist, including but not limited to professional, counseling, and guidance services and treatment programs that are medically necessary to develop and restore, to the maximum extent practicable, the functioning of the covered child;

(ii) medications prescribed by a physician licensed under Title 37, chapter 3;

(iii) psychiatric or psychological care; and

(iv) therapeutic care that is provided by a speech-language pathologist, audiologist, occupational therapist, or physical therapist licensed in this state.

(b) (i) Habilitative and rehabilitative care includes medically necessary interactive therapies derived from evidence-based research, including applied behavior analysis, which is also known as Lovaas therapy, discrete trial training, pivotal response training, intensive intervention programs, and early intensive behavioral intervention.

(ii) Applied behavior analysis covered under this section must be provided by an individual who is licensed by the behavior analyst certification board or is certified by the department of public health and human services as a family support specialist with an autism endorsement.

(4) (a) Coverage for treatment of autism spectrum disorders under this section may be limited to a maximum benefit of:

(i) $50,000 a year for a child 8 years of age or younger; and

(ii) $20,000 a year for a child 9 years of age through 18 years of age.

(b) Benefits provided under this section may not be construed as limiting physical health benefits that are otherwise available to the covered child.

(5) (a) Coverage under this section may be subject to deductibles, coinsurance, and copayment provisions.

(b) Special deductible, coinsurance, copayment, or other limitations that are not generally applicable to other medical care covered under the plan may not be imposed on the coverage for autism spectrum disorders provided for under this section.

(6) When treatment is expected to require continued services, the insurer may request that the treating physician provide a treatment plan consisting of diagnosis, proposed treatment by type and frequency, the anticipated duration of treatment, the anticipated outcomes stated as goals, and the reasons the treatment is medically necessary. The treatment plan must be based on evidence-based screening criteria. The insurer may

ask that the treatment plan be updated every 6 months.

(7) As used in this section, "medically necessary" means any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a physician or psychologist licensed in this state and that will or is reasonably expected to:

(a) prevent the onset of an illness, condition, injury, or disability;

(b) reduce or improve the physical, mental, or developmental effects of an illness, condition, injury, or disability; or

(c) assist in achieving maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and the functional capacities that are appropriate for a child of the same age.

(8) This section applies to the state employee group insurance program, the university system employee group insurance program, any employee group insurance program of a city, town, school district, or other political subdivision of this state, and any self-funded multiple employer welfare arrangement that is not regulated by the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001, et seq.

(9) This section does not apply to disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, specific disease, or long-term care policies.

(10) Except for grandfathered individual health insurance plan coverage, the annual dollar amounts described in subsection (4) do not apply to the extent that the benefits provided are considered to be essential benefits as described in 42 U.S.C. 18022 and applicable federal regulations."

Section 34. Section 33-22-703, MCA, is amended to read:

"33-22-703. Coverage for mental illness, alcoholism, and drug addiction. A group health plan or a health insurance issuer that provides group health insurance coverage shall provide for Montana residents covered by the plan at least the following level of benefits for the necessary care and treatment of mental illness, alcoholism, and drug addiction:

(1) under basic inpatient expense policies or contracts, inpatient hospital benefits and outpatient benefits consisting of durational limits, ~~dollar limits,~~ deductibles, and coinsurance factors that are not less favorable than for physical illness generally, except that:

(a) inpatient treatment for mental illness is subject to a maximum yearly benefit of 21 days;

(b) inpatient treatment for mental illness may be traded on a 2-for-1 basis for a benefit for partial

hospitalization through a program that complies with the standards for a partial hospitalization program that are published by the American association for partial hospitalization if the program is operated by a hospital;

~~(c) inpatient and outpatient treatment for alcoholism and drug addiction, excluding costs for medical detoxification, is subject to a maximum benefit of $6,000 for a 12-month period until a lifetime maximum inpatient benefit of $12,000 is met, after which the annual benefit may be reduced to $2,000; and~~

~~(d)~~(c) costs for medical detoxification treatment must be paid the same as any other illness under the terms of the contract ~~and are not subject to the annual and lifetime limits in subsection (1)(c)~~;

(2) under major medical policies or contracts, inpatient benefits and outpatient benefits consisting of durational limits, ~~dollar limits,~~ deductibles, and coinsurance factors that are not less favorable than for physical illness generally, except that:

(a) inpatient treatment for mental illness is subject to a maximum yearly benefit of 21 days;

(b) inpatient treatment for mental illness may be traded on a 2-for-1 basis for a benefit for partial hospitalization through a program that complies with the standards for a partial hospitalization program that are published by the American association for partial hospitalization if the program is operated by a hospital; and

~~(c) inpatient and outpatient treatment for alcoholism and drug addiction, excluding costs for medical detoxification, may be subject to a maximum benefit of $6,000 for a 12-month period until a lifetime maximum inpatient benefit of $12,000 is met, after which the annual benefit may be reduced to $2,000;~~

~~(d)~~(c) costs for medical detoxification treatment must be paid the same as any other illness under the terms of the contract ~~and are not subject to the annual and lifetime benefits in subsection (2)(c); and~~

~~(e) outpatient treatment for mental illness may be subject to a maximum yearly benefit of no less than $2,000, but this subsection (2)(e) does not apply to benefits for services furnished before September 30, 2001~~."

Section 35. 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, for those who 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 or the association portability plan.

(4) ~~A~~ Except as provided in subsection (5), 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 an 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 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.

(5) Except for grandfathered individual health insurance plans, the association may not impose a preexisting condition exclusion, as defined in [section 1], on an individual under 19 years of age because of a preexisting condition."

Section 36. Section 33-22-1521, MCA, is amended to read:

"33-22-1521. Association plan -- minimum benefits. A plan of health coverage must be certified as an association plan if it otherwise meets the requirements of Title 33, chapters 15, 22 (excepting 33-22-701 through 33-22-705), and 30, and other laws of this state, whether or not the policy is issued in this state, and meets or exceeds the following minimum standards:

(1) (a) The minimum benefits for an insured must, subject to the other provisions of this section, be equal to at least 50% of the covered expenses required by this section in excess of an annual deductible that does not exceed $1,000 ~~per~~ a person, except as provided in [sections 7 through 9]. The coverage must include a limitation of $5,000 ~~per~~ for each person on the total annual out-of-pocket expenses for services covered under this section. Coverage, except for coverage consisting of essential benefits, must be subject to a maximum lifetime benefit, but the maximums may not be less than $100,000.

(b) One association plan must be offered with coverage for 80% of the covered expenses provided in this section in excess of an annual deductible that does not exceed $1,000 ~~per~~ a person, except as provided in [sections 7 through 9]. This association plan must provide a maximum lifetime benefit of at least $500,000, except that the association may not impose a lifetime maximum on benefits consisting of essential benefits.

(c) Covered expenses for plans under subsection (1)(a) and (1)(b) must be paid as specified in provider contracts or, in the absence of a provider contract, at the prevailing charge in the state where the service is provided.

(d) The board may authorize other association plans, including managed care plans as defined in 33-36-103.

(2) Covered expenses for plans offered under subsections (1)(a) and (1)(b) must be for the following medically necessary services and articles when prescribed by a physician or other licensed health care professional and when designated in the contract:

(a) hospital services;

(b) professional services for the diagnosis or treatment of injuries, illness, or conditions, other than dental;

(c) use of radium or other radioactive materials;

(d) oxygen;

(e) anesthetics;

(f) diagnostic x-rays and laboratory tests, except as specifically provided in subsection (3);

(g) services of a physical therapist;

(h) transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition;

(i) oral surgery for the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth or in connection with TMJ;

(j) rental or purchase of durable medical equipment, which must be reimbursed after the deductible has been met at the rate of 50%, up to a maximum of $1,000, unless the benefits provided under this subsection (2)(j) are determined to be an essential benefit as provided in 42 U.S.C. 18022 and applicable federal regulations;

(k) prosthetics, other than dental;

(l) services of a licensed home health agency, up to a maximum of 180 visits per year;

(m) drugs requiring a physician's prescription that are approved for use in human beings in the manner prescribed by the United States food and drug administration, covered at 50% of the expense~~, up to an annual maximum of $2,000~~;

(n) medically necessary, nonexperimental transplants of the kidney, pancreas, heart, heart/lung, lungs, liver, cornea, and high-dose chemotherapy bone marrow transplantation, limited to a lifetime maximum of $150,000, with an additional benefit not to exceed $10,000 for expenses associated with the donor;

(o) pregnancy, including complications of pregnancy;

(p) newborn infant coverage, as required by 33-22-301;

(q) sterilization;

(r) immunizations;

(s) outpatient rehabilitation therapy;

(t) foot care for diabetics;

(u) services of a convalescent home, as an alternative to hospital services, limited to a maximum of 60 days per year;

(v) travel, other than transportation by a licensed ambulance service, to the nearest facility qualified to treat the ~~patients~~ patient's medical condition when approved in advance by the insurer; and

(w) coverage for severe mental illness as required in 33-22-706.

(3) (a) Covered expenses for the services or articles specified in this section do not include:

(i) home and office calls, except as specifically provided in subsection (2);

(ii) rental or purchase of durable medical equipment, except as specifically provided in subsection (2);

(iii) the first $20 of diagnostic x-ray and laboratory charges in each 14-day period, except as provided in [sections 3, 4, and 7 through 9];

(iv) oral surgery, except as specifically provided in subsection (2);

(v) that part of a charge for services or articles that exceeds the prevailing charge in the state where the service is provided; or

(vi) care that is primarily for custodial or domiciliary purposes that would not qualify as eligible services under medicare.

(b) Covered expenses for the services or articles specified in this section do not include charges for:

(i) care or for any injury or disease arising out of an injury in the course of employment and subject to a workers' compensation or similar law, for which benefits are payable under another policy of disability insurance or medicare;

(ii) treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or congenital bodily defect to restore normal bodily functions;

(iii) travel other than transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition, except as provided by subsection (2);

(iv) confinement in a private room to the extent that it is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as medically necessary by a physician;

(v) services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles;

(vi) room and board for a nonemergency admission on Friday or Saturday;

~~(vii) routine well baby care;~~

~~(viii) complications to a newborn, unless no other source of coverage is available;~~

~~(ix)~~(vii) reversal of sterilization;

~~(x)~~(viii) abortion, unless the life of the mother would be endangered if the fetus were carried to term;

~~(xi)~~(ix) weight modification or modification of the body to improve the mental or emotional well-being of an insured;

~~(xii)~~(x) artificial insemination or treatment for infertility; or

~~(xiii)~~(xi) breast augmentation or reduction."

Section 37. Section 33-22-1704, MCA, is amended to read:

"33-22-1704. Preferred provider agreements authorized. (1) Notwithstanding any other provision of law to the contrary, a health care insurer may:

(a) enter into agreements with providers relating to health care services that may be rendered to insureds or subscribers on whose behalf the health care insurer is providing health care coverage, including preferred provider agreements relating to:

(i) the amounts an insured may be charged for services rendered; and

(ii) the amount and manner of payment to the provider; and

(b) issue or administer policies or subscriber contracts in this state that include incentives for the insured to use the services of a provider that has entered into an agreement with the insurer pursuant to subsection (1)(a).

(2) A preferred provider agreement issued or delivered in this state may not unfairly deny health benefits for health care services covered.

~~(3) A preferred provider agreement entered into or renewed after March 26, 1993, must provide each health care provider with the opportunity to participate on the basis of a competitive bid or offer. For each health care service that an insurer proposes to obtain for its insureds from a preferred provider in the geographic area covered by the proposal, the insurer shall provide all known providers of the health care service in that area with an equal opportunity to submit a competitive bid or offer to become a preferred provider. Except as provided in subsection (5), the insurer shall issue a request for proposals and shall select the lowest cost bid or offer. If only one bid or offer is received, the insurer may enter into a preferred provider agreement with the health care provider.~~

~~(4) If a bid or an offer is not received in response to a request for proposals under subsection (3), the insurer may not establish a preferred provider agreement for that service in the geographic area except pursuant to a new request for proposals.~~

~~(5) An insurer may reserve the right in its request for proposals to reject bids or offers submitted in response to the request, including the lowest cost bid or offer. A bid or offer must be rejected in the manner established in the request for proposals. An insurer may not enter into a preferred provider agreement for a health care service except pursuant to a request for proposals.~~"

Section 38. Section 33-22-1706, MCA, is amended to read:

"33-22-1706. Permissible and mandatory provisions in provider agreements, insurance policies, and subscriber contracts. (1) A provider agreement, insurance policy, or subscriber contract issued or delivered in this state may contain certain other components designed to control the cost and improve the quality of health care for insureds and subscribers, including:

(a) a provision setting a payment difference for reimbursement of a nonpreferred provider as compared to a preferred provider. If the health benefit plan contains a payment difference provision, the payment difference

may not exceed 25% of the reimbursement level at which a preferred provider would be reimbursed, except as provided in [section 9]. The commissioner shall review differences between copayments, deductibles, and other cost-sharing arrangements.

(b) conditions, not inconsistent with other provisions of this part, designed to give policyholders or subscribers an incentive to choose a particular provider.

(2) All terms or conditions of an insurance policy or subscriber contract, except those already approved by the commissioner, are subject to the prior approval of the commissioner.

(3) A plan offering prepaid dental services under this part must offer its insureds the right to obtain dental care from any licensed dental care provider of their choice, subject to the same terms and conditions imposed under subsection (1)."

Section 39. Section 33-22-1802, MCA, is amended to read:

"33-22-1802. Purpose. (1) This part must be interpreted and construed to ~~effectuate~~ achieve 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 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)~~(f) to provide for the establishment of a reinsurance program; and

~~(h)~~(g) 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 40. 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 and that provides the benefits required by 33-22-1827.~~

~~(6)~~(5) "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)~~(6) "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)~~(7) "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)~~(8) "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)~~(9) "Class of business" means all or a separate grouping of small employers established pursuant to 33-22-1808.

~~(11)~~(10) "Dependent" means:

(a) a spouse;

(b) ~~an unmarried~~ a child ~~under 25~~ who has not attained 26 years of age:

(i) who otherwise meets the requirements of 33-22-152 and who, for the purposes of determining eligibility for dependent coverage under a grandfathered group health insurance plan until January 1, 2014, 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; and

~~(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)~~(ii) 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)~~(11) (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)~~(12) "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)~~(13) (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)~~(14) "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)~~(15) "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)~~(16) "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)~~(17) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

~~(19)~~(18) "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)~~(19) "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 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)~~(20) "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 and that contains the provisions required pursuant to 33-22-1828.~~"

Section 41. Section 33-22-1810, MCA, is amended to read:

"33-22-1810. Renewability of coverage. (1) A health benefit plan subject to the provisions of this part is renewable with respect to all eligible employees or their dependents, at the option of the small employer, except in any of the following cases:

(a) nonpayment of the required premium;

(b) fraud or intentional misrepresentation of a material fact of the small employer or with respect to coverage of individual insureds or their representatives;

(c) noncompliance with the carrier's minimum participation requirements;

(d) noncompliance with the carrier's employer contribution requirements;

(e) repeated misuse of a restricted network provision;

(f) election by the small employer carrier to not renew all of its health benefit plans delivered or issued for delivery to small employers in this state, in which case the small employer carrier shall:

(i) provide advance notice of this decision under this subsection (1)(f) to the insurance commissioner in each state in which it is licensed; and

(ii) at least 180 days prior to the nonrenewal of all small employer health benefit plans by the carrier, provide notice of the decision not to renew coverage to all affected small employers and to the insurance commissioner in each state in which an affected insured individual is known to reside. Notice to the commissioner under this subsection (1)(f) must be provided at least 3 working days prior to the notice to the affected small employers.

(g) the commissioner finds that the continuation of the coverage would:

(i) not be in the best interests of the policyholders or certificate holders; or

(ii) impair the carrier's ability to meet its contractual obligations.

(2) If the commissioner makes a finding under subsection (1)(g), the commissioner shall assist affected small employers in finding replacement coverage.

(3) (a) A small employer carrier that elects not to renew all of its health benefit plans under subsection (1)(f) is prohibited from writing new business in the small employer market in this state for a period of 5 years from the date of notice to the commissioner.

(b) The provisions of 33-22-524(3) apply to a small employer carrier that elects to renew only a portion, but not all, of its small employer health benefit plans.

(4) In the case of a small employer carrier doing business in one established geographic service area of the state, the rules set forth in this section apply only to the carrier's operations in that service area."

Section 42. 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. ~~One plan must be a basic health benefit plan, and one plan must be a standard health benefit plan.~~

(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.

(c) A small employer carrier that elects not to comply with the requirements of subsections (1)(a) and (1)(b) may continue to provide coverage under health benefit plans previously issued to small employers in this state for a period of no more than 7 years from October 1, 1995, if the carrier:

(i) complies with all other applicable provisions of this part, except 33-22-1810, 33-22-1813, and subsections (2) through (4) of this section;

(ii) does not amend or alter the benefits and coverages of the previously issued health benefit plans unless required to do so by law or rule; and

(iii) complies with all applicable provisions of Public Law 104-91.

~~(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)~~(2) ~~Health~~ Subject to the provisions in [sections 1 and 2], health benefit plans covering small employers ~~must comply with the following provisions~~:

(a) ~~A health benefit plan~~ may not~~:~~ use a preexisting condition exclusion more restrictive than exclusions allowed under 33-22-514 or,

~~(i)~~ because of a preexisting condition, deny, exclude, or limit benefits for a covered individual 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)~~ (2)(b). This subsection ~~(3)(b)~~ (2)(b) does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan except as provided in [sections 1 and 2].

(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) (i)~~(3) (a) 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)~~(b) 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)~~ (2)(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 (4)(a)(ii) 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 43. Section 33-22-1813, MCA, is amended to read:

"33-22-1813. Standards to ensure fair marketing. (1) Each small employer carrier shall actively market health benefit plan coverage~~, including the basic and standard health benefit plans,~~ to eligible small employers in the state.

(2) (a) Except as provided in subsection (2)(b), a small employer carrier or producer may not directly or indirectly engage in the following activities:

(i) encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employer;

(ii) encouraging or directing small employers to seek coverage from another carrier because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employer.

(b) The provisions of subsection (2)(a) do not apply with respect to information provided by a small employer carrier or producer to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

(3) (a) Except as provided in subsection (3)(b), a small employer carrier may not, directly or indirectly, enter into any contract, agreement, or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employer.

(b) Subsection (3)(a) does not apply with respect to a compensation arrangement that provides compensation to a producer on the basis of the percentage of a premium, provided that the percentage may not vary because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic area of the small employer.

~~(4) A small employer carrier shall provide reasonable compensation, as provided under the plan of~~

~~operation of the program, to a producer, if any, for the sale of a basic or standard health benefit plan.~~

~~(5)~~(4) A small employer carrier may not terminate, fail to renew, or limit its contract or agreement of representation with a producer for any reason related to the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employers placed by the producer with the small employer carrier.

~~(6)~~(5) A small employer carrier or producer may not induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

~~(7)~~(6) Denial by a small employer carrier of health insurance coverage for a small employer must be in writing and must state the reason or reasons for the denial.

~~(8)~~(7) The commissioner may adopt rules setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

~~(9)~~(8) (a) A violation of this section by a small employer carrier or a producer is an unfair trade practice under 33-18-102.

(b) If a small employer carrier enters into a contract, agreement, or other arrangement with an administrator who holds a certificate of registration pursuant to 33-17-603 to provide administrative, marketing, or other services related to the offering of health benefit plans to small employers in this state, the administrator is subject to this section as if the administrator were a small employer carrier."

Section 44. Section 33-22-1815, MCA, is amended to read:

"33-22-1815. Qualifications for voluntary purchasing pool. (1) 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~~:~~ in subsections (2) through (5).

(2) The voluntary purchasing pool shall:

~~(1)~~(a) ~~It contains~~ contain at least 51 eligible employees~~.~~;

~~(2)~~(b) ~~It establishes~~ establish 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)~~(c) ~~It holds~~ hold an open enrollment period at least once a year during which new members ~~can~~ may join the voluntary purchasing pool~~.~~;

~~(4)~~(d) ~~It offers~~ offer 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)~~ 33-22-1811(2)(c).

~~(5)~~(3) ~~It does~~ A voluntary purchasing pool may not assume any risk or form self-insurance plans among its members.

~~(6)~~(4) (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) Except for the rates for the small business health insurance pool established in 33-22-2001, 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)~~(5) A person marketing disability insurance policies, certificates, or contracts for a voluntary purchasing pool must be licensed as an insurance producer."

Section 45. Section 33-22-1901, MCA, is amended to read:

"33-22-1901. Scope -- purpose. The provisions of this part apply to all health ~~benefit~~ plans offered to persons who receive health care services in this state. The purpose of this part is to ensure that obstetricians, ~~and~~ gynecologists, and pediatricians may be participating primary care ~~physicians~~ health care professionals under health ~~benefit~~ plans offered to patients who receive health care services in this state and that persons covered by health ~~benefit~~ plans have direct access to the services of a participating obstetrician, ~~or~~ gynecologist, or pediatrician or another primary care health care professional of their choice."

Section 46. Section 33-22-1902, MCA, is amended to read:

"33-22-1902. Definitions. As used in this part, the following definitions apply:

~~(1) "Covered person" means a policyholder, subscriber, certificate holder, enrollee, or other individual who is participating in a health benefit plan.~~

~~(2)~~(1) "Health ~~benefit~~ plan" means any individual or group plan, policy, certificate, subscriber contract, contract of insurance provided by a managed care plan, preferred provider agreement, or health maintenance organization subscriber contract that is issued, delivered, issued for delivery, or renewed in this state by a health ~~carrier~~ insurance issuer that pays for, purchases, or furnishes health care services to covered persons who receive health care services in this state. For the purposes of this part, a health ~~benefit~~ plan located or domiciled outside of the state of Montana is subject to the provisions of this part if it receives, processes, adjudicates, pays, or denies claims for health care services submitted by or on behalf of covered persons who reside or who receive health care services in the state of Montana.

~~(3) "Health carrier" means a disability insurer, health care insurer, health maintenance organization, accident and sickness insurer, fraternal benefit society, nonprofit hospital service corporation, health service corporation, health care service plan, preferred provider organization or arrangement, multiple employer welfare arrangement, or any other person, firm, corporation, joint venture, or similar business entity.~~

~~(4)~~(2) "Obstetrician or gynecologist" means a physician who is board-eligible or board-certified by the American board of obstetrics and gynecology.

~~(5)~~(3) "Participating obstetrician or gynecologist" means an obstetrician or gynecologist who is employed by or under contract with a health ~~benefit~~ plan.

(4) "Participating pediatrician" means a pediatrician who is employed by or under contract with a health plan.

(5) "Pediatrician" means a physician who is board-eligible or board-certified by the American board of pediatricians.

(6) "Primary care ~~physician~~ health care professional" means a ~~physician who has the responsibility for providing~~ health care professional designated by a covered person to supervise, coordinate, or provide initial ~~and primary care to patients, for maintaining the continuity of patient care, and for initiating referrals~~ or continuing care to the covered person and who may be required by the health insurance issuer to initiate a referral for specialist care and maintain supervision of health care services rendered to the covered person."

Section 47. Section 33-22-1903, MCA, is amended to read:

"33-22-1903. Obstetricians or gynecologists as primary care ~~physicians~~ health care professionals. (1) Each health ~~benefit~~ plan that provides coverage for primary care or obstetrical or gynecological care must allow obstetricians and gynecologists to participate as primary care ~~physicians~~ health care professionals. The

health ~~carrier~~ insurance issuer that provides the health ~~benefit~~ plan shall contract with a sufficient number of obstetricians and gynecologists to ensure that covered persons have access to the options under this section without unreasonable delay if there are obstetricians or gynecologists practicing in the geographic service areas in which the plan operates who are willing to participate in the plan. An obstetrician or gynecologist may not be required to accept primary care ~~physician~~ health care professional status if the obstetrician or gynecologist does not wish to be designated as a primary care ~~physician~~ health care professional. A health ~~benefit~~ plan must use the same criteria with regard to credentials and other selection criteria for a participating obstetrician or gynecologist as are applied by the health ~~benefit~~ plan with respect to other physicians who are participating in the health ~~benefit~~ plan. An obstetrician or gynecologist wishing to accept designation as a primary care ~~physician~~ health care professional must meet the same criteria with regard to credentials and other selection criteria for a participating primary care ~~physician~~ health care professional as other ~~physicians~~ health care professionals who are participating as primary care ~~physicians~~ health care professionals in the health ~~benefit~~ plan.

(2) Each health ~~benefit~~ plan must allow a covered person to select any participating obstetrician or gynecologist of the covered person's choice as the covered person's primary care ~~physician~~ health care professional."

Section 48. Section 33-22-1904, MCA, is amended to read:

"33-22-1904. Self-referral for obstetrical or gynecological care permitted. (1) A health ~~benefit~~ plan must permit self-referral to any participating obstetrician or gynecologist by a covered person who has not selected a participating obstetrician or gynecologist as the covered person's primary care ~~physician~~ health care professional for services covered under the health ~~benefit~~ plan. This self-referral is for the purpose of receiving any obstetrical or gynecological examination or care and primary and ~~preventative~~ preventive obstetrical and gynecological services required as a result of any obstetrical or gynecological examination or condition. This self-referral must be allowed without prior authorization or precertification from the health ~~benefit~~ plan or covered person's primary care ~~physician~~ health care professional, but the health ~~benefit~~ plan may require the covered person or the health care professional to notify the plan prior to self-referral or seek prior authorization for a particular treatment plan as required by the terms of the health plan.

(2) The services covered by this section may be limited to those services defined by the most recent published recommendations of the American college of obstetricians and gynecologists. The self-referral permitted by this section may be limited to one participating obstetrician or gynecologist for obstetrical care and

one participating obstetrician or gynecologist for gynecological care of the covered person's choice annually. Health plans that are not grandfathered plan coverage may not limit the self-referral option to once annually.

(3) The participating obstetrician or gynecologist and the covered person shall comply with the health ~~benefit~~ plan's coordination and referral policies, except as provided in subsections (1) and (2). The health ~~benefit~~ plan may require the participating obstetrician or gynecologist to whom the covered person self-refers to discuss with the covered person's primary care ~~physician~~ health care professional any services or treatment the participating obstetrician or gynecologist recommends for the covered person.

(4) Self-referral under this section may not affect the covered person's coverage under the health ~~benefit~~ plan. It is the intent of this section that a covered person must at all times have direct access to the covered services of the participating obstetrician or gynecologist of the covered person's choice under any health ~~benefit~~ plan."

Section 49. Section 33-22-1905, MCA, is amended to read:

"33-22-1905. Surcharges not allowed. A health ~~benefit~~ plan may not impose a surcharge or additional copayments or deductibles upon a covered person who seeks or receives health care services under 33-22-1903 or 33-22-1904 unless similar surcharges or additional copayments or deductibles are imposed for other types of health care services not described in 33-22-1903 and 33-22-1904."

Section 50. Section 33-22-1906, MCA, is amended to read:

"33-22-1906. Payment of covered services provided by certified advanced practice registered nurses. A health ~~benefit~~ plan may not deny payment for covered services provided to a covered person under 33-22-1903 and 33-22-1904 by a certified advanced practice registered nurse practicing in collaboration with the participating obstetrician or gynecologist. ~~This section may not be construed to expand the definitions of participating obstetrician or gynecologist or primary care physician in 33-22-1902 to include certified advanced practice registered nurses.~~"

Section 51. Section 33-22-1907, MCA, is amended to read:

"33-22-1907. Disclosure. Each health ~~benefit~~ plan shall disclose in all of its plan literature, in clear, accurate language, the covered person's option to seek the care described in this part without preapproval, preauthorization, or referral. A health plan that is grandfathered plan coverage must follow the notice provisions

described in [section 11]."

Section 52. Section 33-22-1908, MCA, is amended to read:

"33-22-1908. Enforcement. If the commissioner determines that a health ~~benefit~~ plan does not comply with this part or that a health ~~carrier~~ insurance issuer has not complied with a provision of this part, the commissioner may:

(1) recommend a correction plan that must be followed by the health ~~carrier~~ insurance issuer;

(2) institute corrective action that must be followed by the health ~~carrier~~ insurance issuer;

(3) suspend or revoke the certificate of authority or deny the health ~~carrier's~~ insurance issuer's application for a certificate of authority; or

(4) use any of the commissioner's enforcement powers to obtain the health ~~carrier's~~ insurance issuer's compliance with this part."

Section 53. Section 33-30-1007, MCA, is amended to read:

"33-30-1007. Conversion on termination of eligibility. (1) ~~The~~ A 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 may not be 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~~ 33-22-1521(1)(b) and (2), except that the deductible may not exceed $1,500 for a covered person. The conversion rate for that plan may not exceed 150% of the ~~highest~~ average market rate ~~charged for that plan~~ of the five insurers or health service corporations with the largest premium amount of individual plans of major medical insurance in force in this state.

(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 54. Section 33-30-1014, MCA, is amended to read:

"33-30-1014. Coverage for well-child care. (1) Each disability insurance plan or group disability insurance plan that is delivered, issued for delivery, renewed, extended, or modified in this state by a health service corporation and that provides coverage for a family member of the insured or subscriber must provide coverage for well-child care for children from the moment of birth through 7 years of age. Benefits provided under this coverage are exempt from any deductible provision that may be in force in the plan.

(2) If the provisions of [sections 7 through 9] and 45 CFR 147.130 apply, cost sharing is prohibited except as provided in those sections.

~~(2)~~(3) Coverage for well-child care under subsection (1) must include:

(a) a history, physical examination, developmental assessment, anticipatory guidance, and laboratory tests, according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment services program provided for in 53-6-101; ~~and~~

(b) routine immunizations according to the schedule for immunizations recommended by the immunization practices advisory committee of the U.S. department of health and human services; and

(c) the items and services described in [sections 7 through 9] and, to the extent that federal law preempts

state law, 45 CFR 147.130.

~~(3)~~(4) Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit cited in this section unless the provisions of [sections 7 through 9] and, to the extent that federal law preempts state law, 45 CFR 147.130 provide greater benefits.

~~(4)~~(5) This section does not apply to disability income, specified disease, medicare supplement, or hospital indemnity policies.

~~(5)~~(6) For purposes of this section:

(a) "well-child care" means the services described in [section 7] and subsection ~~(2)~~ (3) of this section and delivered at the intervals required in that subsection by a physician or a health care professional supervised by a physician; and

(b) "developmental assessment" and "anticipatory guidance" mean the services described in the Guidelines for Health Supervision II, published by the American academy of pediatrics.

~~(6)~~(7) When a disability insurance plan or group disability insurance plan issued by a health service corporation provides coverage or benefits to a resident of this state, it is considered to be delivered in this state within the meaning of this section, whether the health service corporation that issued or delivered the policy or certificate is located inside or outside of this state."

Section 55. 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) ~~Title~~ The following apply to health maintenance organizations: 33-1-102, Title 33, chapter 1, parts 12 and 13, Title 33, chapter 2, part 19, 33-2-1114, 33-2-1211, 33-2-1212, 33-3-401, 33-3-422, 33-3-431, 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, 33-22-140, 33-22-141, 33-22-142, 33-22-152, [sections 1 through 13], 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, ~~and~~ 33-22-706, and Title 33, chapter 22, part 19 ~~apply to health maintenance organizations~~."

Section 56. 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:

(a) 33-1-111;

(b) 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;

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

(d) 33-3-308;

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

(f) Title 33, chapter 19;

(g) 33-22-107, 33-22-131, 33-22-134, 33-22-135, 33-22-141, 33-22-142, and 33-22-152; and

(h) [sections 1 through 13], 33-22-512, 33-22-514, 33-22-515, 33-22-525, ~~and~~ 33-22-526, and Title 33, chapter 22, part 19.

(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 57. Repealer.** The following sections of the Montana Code Annotated are repealed:

33-22-245. Uniform health benefit plan -- individual.
33-22-522. Uniform health benefit plan -- group.
33-22-1821. Waiver of certain laws.
33-22-1827. Benefits required in basic health benefit plan.
33-22-1828. Benefits required in standard benefit plan.
33-31-322. Uniform health benefit plan -- health maintenance organization.

NEW SECTION. **Section 58. Codification instruction.** (1) [Sections 1 through 9, 12, and 13] are 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 [sections 1 through 9, 12, and 13].

(2) [Sections 10 and 11] are intended to be codified as an integral part of Title 33, chapter 22, part 19, and the provisions of Title 33, chapter 22, part 19, apply to [sections 10 and 11].

NEW SECTION. **Section 59. Severability.** If a part of [this act] is invalid because the federal law on which the changes are based is repealed in part or in whole or otherwise found to be invalid in a final decision by the U.S. Supreme Court, after all appeal options have been exhausted, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **Section 60. Effective dates -- applicability -- retroactive applicability.** (1) Except as provided in subsection (2), [this act] is effective on passage and approval.

(2) The change in payments for mammograms under [section 23(4)] and [section 37] are effective on January 1, 2012, and apply to policies or certificates issued or renewed on or after January 1, 2012.

(3) Except as provided in subsection (2), [this act] applies retroactively, within the meaning of 1-2-109, to policies or certificates issued or renewed on or after September 23, 2010.

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