SENATE BILL NO. 383

INTRODUCED BY D. WANZENRIED

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING HEALTH INSURANCE LAWS; PROHIBITING PREEXISTING CONDITION EXCLUSIONS UNDER CERTAIN CIRCUMSTANCES; PROVIDING OPEN ENROLLMENT PERIODS; PROHIBITING DISCRIMINATION BASED ON HEALTH STATUS; REVISING CERTAIN DOLLAR LIMITS AND LIFETIME LIMITS; PROVIDING FOR CHOICE OF PRIMARY CARE PROVIDERS; PROHIBITING RESCISSIONS AND PROVIDING EXCEPTIONS; EXPANDING COVERAGE FOR CHILDREN UP TO 26 YEARS OF AGE; DELINEATING CHANGES THAT APPLY TO GRANDFATHERED PLAN COVERAGE; PROVIDING FOR COMPREHENSIVE HEALTH CARE COVERAGE; PROVIDING FOR COVERAGE FOR PARTICIPATION IN CLINICAL TRIALS; CREATING QUALITY CARE REPORTING REQUIREMENTS AND FILING FEES; PROVIDING FOR PREVENTIVE CARE SERVICES; EXTENDING RULEMAKING AUTHORITY; AMENDING SECTIONS 2-18-704, 7-21-3710, 33-1-102, 33-15-403, 33-18-215, 33-22-101, 33-22-109, 33-22-110, 33-22-129, 33-22-131, 33-22-132, 33-22-140, 33-22-143, 33-22-152, 33-22-242, 33-22-243, 33-22-244, 33-22-246, 33-22-303, 33-22-508, 33-22-512, 33-22-514, 33-22-515, 33-22-521, 33-22-524, 33-22-526, 33-22-601, 33-22-703, 33-22-706, 33-22-1516, 33-22-1521, 33-22-1704, 33-22-1706, 33-22-1802, 33-22-1803, 33-22-1804, 33-22-1809, 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, 33-22-1814, 33-22-1820, 33-22-1821, AND 33-31-322, MCA; AND PROVIDING EFFECTIVE DATES."

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

NEW SECTION. **Section 1. Guaranteed availability of individual health insurance coverage.** (1) (a) Except as provided in subsections (1)(b), (1)(c), and (1)(d), each health insurance issuer that offers a health plan providing individual health insurance coverage in this state shall issue an applicable health plan to any eligible individual that applies for the plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health plan not inconsistent with this title.

(b) A health insurance issuer may restrict enrollment in individual health insurance coverage to special

enrollment periods described in [section 2] and the same annual open enrollment period used by any exchange operating in Montana.

(c) With respect to coverage offered through a network plan, a health insurance issuer may not be required to offer coverage under that health plan pursuant to this subsection (1):

(i) to an individual who does not reside within the issuer's established geographic service area for the network plan; or

(ii) within the geographic service area for the network plan when the issuer 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 any additional individuals because of its obligations to existing enrollees. A health insurance issuer that refuses to offer coverage under this subsection (1)(c)(ii) may not offer coverage in the individual market in the applicable geographic service area to new individuals until the later of 180 days following each refusal or the date on which the issuer notifies the commissioner that it has regained capacity to deliver services.

(d) A health insurance issuer shall apply the provisions of subsection (2) uniformly to all individuals without regard to the claims experience of those individuals and their dependents or any health status-related factor relating to the individuals and their dependents.

(2) (a) A health insurance issuer offering individual health insurance coverage may not be required to provide coverage if:

(i) for any period of time the issuer demonstrates and the commissioner determines that the issuer does not have the financial reserves necessary to underwrite additional coverage; and

(ii) the issuer is applying this subsection (2)(a) uniformly to all individuals in the individual market consistent with applicable state and federal law and without regard to the claims experience of individuals and their dependents or any health status-related factor relating to the individuals and their dependents.

(b) A health insurance issuer that denies coverage in accordance with subsection (2)(a) may not offer coverage in the individual market in this state for the later of a period of 180 days after the date the coverage is denied or until the issuer has demonstrated to the commissioner that it has sufficient financial reserves to underwrite additional coverage.

(3) This section may not be construed to require a health insurance issuer offering health plans only in connection with employer group health plans to offer coverage in the individual market.

(4) A health insurance issuer offering only student health insurance coverage is not required to offer

coverage to individuals who are not eligible for coverage under that student health plan as long as the issuer is otherwise in compliance with state and federal law that applies to student health plans.

NEW SECTION. **Section 2. Prohibition of preexisting condition exclusions -- special enrollment periods.** (1) Health insurance issuers offering individual health insurance coverage in this state may not impose any preexisting condition exclusions with respect to the coverage.

(2) (a) A health insurance issuer that makes coverage available under a health plan with respect to a dependent of an individual shall provide for a dependent special enrollment period described in subsection (2)(b) during which the dependent may be enrolled as a dependent of the individual if the person becomes a dependent through marriage, birth, adoption, or placement for adoption. In the case of the birth or adoption of a child, the spouse of the individual may also be enrolled as a dependent of the individual if the spouse is otherwise eligible for coverage.

(b) The special enrollment period for individuals that meet the provisions of subsection (2)(a) must be a period of not less than 30 days and begin on the later of:

(i) the date dependent coverage is made available; or

(ii) the date of the marriage, birth, or adoption or placement for adoption described in subsection (2)(a).

(3) If an individual seeks to enroll a dependent during the dependent special enrollment period described in subsection (2)(b), the coverage of the dependent is effective:

(a) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(b) in the case of a dependent's birth, as of the date of birth; and

(c) in the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(4) A health insurance issuer that offers coverage in the individual market shall offer coverage during a special enrollment period described in this subsection to individuals and their dependents who have lost coverage in an employer group health plan. The special enrollment period for individuals and their dependants that meet the provisions of this subsection (4) must be a period of not less than 63 days after the mailing of the notice of creditable coverage described in 33-22-142.

NEW SECTION. **Section 3. Prohibition on discrimination based on health status -- genetic testing**

exception for grandfathered health plans. (1) A health insurance issuer offering individual health insurance coverage in this state may not establish rules for eligibility, including continuing eligibility, for any individual to enroll in individual health insurance coverage based on any health status-related factor relating to the individual or dependent of the individual.

(2) A health insurance issuer offering individual health insurance coverage may not require any individual as a condition of enrollment or continued enrollment under a health plan to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor relating to the individual or to a dependent of the individual.

(3) The provisions of subsections (1) and (2) do not apply to grandfathered individual health insurance coverage.

(4) A health insurance issuer offering individual health insurance coverage in this state may not:

(a) establish rules for eligibility, including continued eligibility, for any individual or individual's dependent to enroll in individual health insurance coverage based on genetic information;

(b) adjust premium or contribution amounts for an individual on the basis of genetic information concerning the individual or a family member of the individual;

(c) impose any preexisting condition exclusion with respect to coverage under the plan on the basis of genetic information; or

(d) request or require an individual or a family member of an individual to undergo a genetic test.

(5) (a) Subsection (4) may not be construed to limit the authority of a health care professional who is providing health care services to an individual to request that the individual undergo a genetic test.

(b) Subsection (4) may not be construed to preclude the health insurance issuer from obtaining and using the results of a genetic test in making a determination regarding payment, as that term is defined for purposes of applying the regulations promulgated by the secretary.

(c) For purposes of subsection (5)(a), the health insurance issuer may request only the minimum amount of information necessary to accomplish the intended purpose.

(6) A health insurance issuer may request, but not require, that an individual or a family member of the individual undergo a genetic test if each of the following conditions is met:

(a) the request is made pursuant to research that complies with 45CFR, part 46, or equivalent federal regulations and any applicable state law for the protection of human subjects in research;

(b) the health insurance issuer clearly indicates to each individual or, in the case of a minor child, to the

legal guardian of the child to whom the request is made that:

(i) compliance with the request is voluntary; and

(ii) noncompliance will have no effect on enrollment status or premium or contribution amounts;

(c) no genetic information collected or acquired under this subsection (6) may be used for underwriting purposes;

(d) the health insurance issuer notifies the secretary in writing that the issuer is conducting activities pursuant to the exception provided in this section, including a description of the activities conducted; and

(e) the insurance issuer complies with any other conditions as the secretary may by regulation require for activities conducted under this section.

(7) A health insurance issuer offering health plans providing individual health insurance coverage may not request, require, or purchase genetic information:

(a) for underwriting purposes; or

(b) in connection with enrollment with respect to any individual prior to the individual's enrollment under the plan.

(8) If the health insurance issuer obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, the request, requirement, or purchase may not be considered a violation of this section.

(9) Any reference in this section to genetic information concerning an individual or family member of an individual must:

(a) with respect to the individual or family member of an individual who is a pregnant woman, include genetic information of any fetus carried by the pregnant woman; and

(b) with respect to an individual or family member utilizing an assisted reproductive technology, include genetic information of any embryo legally held by the individual or family member.

NEW SECTION. **Section 4. Restriction relating to premium rates -- rulemaking.** (1) With respect to the premium rates charged by a health insurance issuer offering a health plan providing nongrandfathered individual health insurance coverage, the health insurance issuer shall develop its premium rates based on the provisions of this section and may vary the premium rates with respect to a particular plan or coverage only based on:

(a) whether the plan or coverage covers an individual or family;

(b) a geographic rating area, established by the commissioner in accordance with section 2701 of the federal Public Health Service Act;

(c) age, except that the rate may not vary by more than 3 to 1 for adults; and

(d) tobacco use, except that the rate may not vary by more than 1.5 to 1.

(2) A premium rate may not vary with respect to any particular health plan or individual health insurance coverage by any other factor, except as described in subsection (1).

(3) With respect to family coverage under a health plan providing individual health insurance coverage, the rating variations permitted under subsections (1)(c) and (1)(d) must be applied based on the portion of the premium that is attributable to each family member covered under the plan.

(4) The premium charged with respect to any particular health plan or individual health insurance coverage may not be adjusted more frequently than annually except that the premium rates may be changed to reflect:

(a) changes to the family composition of the policyholder;

(b) changes in geographic rating area of the policyholder;

(c) changes in tobacco use;

(d) changes to the health plan requested by the policyholder; or

(e) other changes permitted by state or federal law or regulations.

(5) A health insurance issuer shall consider all enrollees residing in Montana in all health plans, other than grandfathered health plans, offered by the health insurance issuer in the individual market to be members of a single risk pool, including those enrollees who do not enroll in a health plan through an exchange, as established under the federal act.

(6) The commissioner may establish rules to implement the provisions of this section and to ensure that rating practices used by health insurance issuers are consistent with the purposes of this part.

(7) In connection with the offering for sale of individual health insurance coverage under this part, a health insurance issuer shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

(a) the provisions of the coverage concerning the health insurance issuer's right to change premium rates and the factors that may affect changes in premium rates; and

(b) a listing of and descriptive information, including benefits and premiums, about all health plans offered by the health insurance issuer that provide individual health insurance coverage and the availability of the plans

for which the individual is qualified.

(8) Each health insurance issuer shall maintain at its principal place of business a complete and detailed description of its rating practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

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

(10) A health insurance issuer shall make the information and documentation described in subsection (8) available to the commissioner upon request.

(11) Except in cases of violations of this part, the information required under subsection (8) must be considered proprietary and trade secret information if it meets the requirements of Title 30, chapter 14, part 4, and may not be disclosed by the commissioner to persons outside of the department, except for other state or federal government agencies or as agreed to by the health insurance issuer or as ordered by a court of competent jurisdiction.

NEW SECTION. **Section 5. Comprehensive health insurance coverage requirements.** (1) Health insurance issuers offering nongrandfathered health plans providing individual health insurance coverage shall ensure that the coverage includes the essential health benefits package required under the federal act, as described in subsection (2).

(2) For purposes of this section, "essential health benefits package" means coverage that:

(a) provides for the essential health benefits, as defined in 33-22-140;

(b) limits cost-sharing for the coverage in accordance with section 1302(c) of the federal act; and

(c) subject to section 1302 of the federal act, provides bronze, silver, gold, or platinum levels of coverage described as follows:

(i) a bronze level health plan must provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60% of the full actuarial value of the benefits provided under the plan;

(ii) a silver level health plan must provide a level of coverage that is designed to provide benefits that are

actuarially equivalent to 70% of the full actuarial value of the benefits provided under the plan;

(iii) a gold level health plan must provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80% of the full actuarial value of the benefits provided under the plan; and

(iv) a platinum level health plan must provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90% of the full actuarial value of the benefits provided under the plan.

(3) If a health insurance issuer offers health insurance coverage in any level of coverage described in subsection (2), the insurance issuer shall also offer coverage in that level as a health plan in which the only enrollees are individuals who, as of the beginning of a policy year, have not attained the age of 21 years.

(4) A health insurance issuer may offer a catastrophic plan that meets the requirements of the federal act. A catastrophic plan may be offered only to individuals who are eligible under section 1302 of the federal act.

(5) This section does not apply to stand-alone dental plans offering pediatric dental services required by essential health benefits and described in section 1311 of the federal act.

NEW SECTION. **Section 6. Coverage for participation in approved clinical trials -- definitions.** (1) A health insurance issuer that offers a health plan providing individual or group health insurance coverage in this state may not:

(a) deny participation by a qualified individual in an approved clinical trial;

(b) deny, limit, or impose additional conditions on the coverage of routine patient costs for items or services furnished in connection with participation in an approved clinical trial; or

(c) discriminate against an individual on the basis of the individual's participation in an approved clinical trial.

(2) A network plan may require a qualified individual who wishes to participate in an approved clinical trial to participate in a trial that is offered through a health care provider who is part of the network plan if the provider is participating in the trial and the provider accepts the individual as a participant in the trial.

(3) This section applies to a qualified individual residing in this state who participates in an approved clinical trial that is conducted inside or outside of this state and applies to all individual and group health insurance coverage issued in this state.

(4) This section may not be construed to require a health insurance issuer offering individual or group health insurance coverage to provide benefits for routine patient costs if the services are provided outside of the network plan offered by the individual health insurance coverage unless the out-of-network benefits are otherwise

provided under the coverage.

(5) This section may not be construed to limit a health insurance issuer's coverage with respect to clinical trials.

(6) As used in this section, the following definitions apply:

(a) "Approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or a life-threatening condition and is not designed exclusively to test toxicity or disease pathophysiology. The trial must be:

(i) conducted under an investigational new drug application reviewed by the U.S. food and drug administration;

(ii) exempt from obtaining an investigational new drug application; or

(iii) approved or funded by:

(A) the national institutes of health, the centers for disease control and prevention, the agency for healthcare research and quality, the centers for medicare and medicaid services, or a cooperative group or center of any of these entities;

(B) a cooperative group or center of the U.S. department of defense or the U.S. department of veterans affairs;

(C) a qualified nongovernmental research entity identified in the guidelines issued by the national institutes of health for cancer center support grants; or

(D) the U.S. departments of veterans affairs, defense, or energy if the trial has been reviewed or approved through a system of peer review determined by the secretary to be comparable to the system of peer review of studies and investigations used by the national institutes of health and provide an unbiased scientific review by qualified individuals who have no interest in the outcome of the review.

(b) "Life-threatening condition" means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(c) "Qualified individual" means an individual with individual health insurance coverage or employer group health insurance who is eligible to participate in an approved clinical trial according to the trial protocol for the treatment of cancer or a life-threatening condition because:

(i) the referring health care professional is participating in the trial and has concluded that the individual's participation in the trial would be appropriate; or

(ii) the individual provides medical and scientific information establishing that the individual's participation

in the trial is appropriate because the individual meets the conditions described in the trial protocol.

(d) (i) "Routine patient costs" include all items and services covered by the health plan of individual health insurance coverage when the items or services are typically covered for an enrollee who is not a qualified individual enrolled in an approved clinical trial.

(ii) The term does not include:

(A) an investigational item, device, or service that is part of the trial;

(B) an item or service provided solely to satisfy data collection and analysis needs for the trial if the item or services are not used in the direct clinical management of the patient;

(C) a service that is clearly inconsistent with widely accepted and established standards of care for the individual's diagnosis; or

(D) an item or service customarily provided and paid for by the sponsor of a trial.

NEW SECTION. **Section 7. Standards to ensure fair marketing -- rulemaking.** (1) Except as provided in [section 1], each health insurance issuer providing individual health insurance coverage shall actively market all health plans sold by the health insurance issuer to eligible individuals in this state.

(2) Except as provided in subsection (3), a health insurance issuer or a producer may not, directly or indirectly:

(a) encourage or direct individuals to refrain from filing an application for coverage with the health insurance issuer because of the any health status-related factor, occupation, or geographic location of the individual; or

(b) encourage or direct individuals to seek coverage from another health insurance issuer because of the any health status-related factor, occupation, or geographic location of the individual.

(3) The provisions of subsection (2) do not apply to information provided by a health insurance issuer or producer to an individual regarding the established geographic service area or a restricted network provision of a health insurance issuer.

(4) Except as provided in subsection (5), a health insurance issuer 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 plan to be varied because of any initial or renewal health status-related factor, occupation, or geographic location of the individual or the individual's dependents.

(5) Subsection (4) does not apply to a compensation arrangement that provides compensation to a

producer on the basis of percentage of premium, provided that the percentage may not vary because of any health status-related factor, occupation, or geographic area of the individual or the individual's dependents.

(6) A health insurance issuer may not terminate, fail to renew, or limit its contract or agreement of representation with a producer for any reason related to any initial or renewal health status-related factor, occupation, or geographic location of any individual or the individual's dependents placed by the producer with the health insurance issuer.

(7) Denial by a health insurance issuer of an application for coverage from an individual must be in writing or electronically provided and must state the reason or reasons for the denial. Nothing in this subsection allows any denial by a health insurance issuer that is not in compliance with this part.

(8) The commissioner may establish rules setting forth additional standards to provide for the fair marketing and broad availability of health plans providing individual health insurance coverage to individuals in this state.

(9) A violation of this section by a health insurance issuer or a producer is an unfair trade practice under Title 33, chapter 18.

(10) If a health insurance issuer enters into a contract, agreement, or other arrangement with a third-party administrator to provide administrative, marketing, or other services related to the offering of health plans providing individual health insurance coverage in this state, the third-party administrator is subject to this section as if it were a health insurance issuer.

NEW SECTION. **Section 8. Quality of care reporting requirements -- fee.** (1) Health insurance issuers offering health plans providing individual and group health insurance coverage in this state shall annually submit to the commissioner and to policyholders under the coverage a report on whether the benefits under the coverage satisfy the elements described in subsection (2). This report must be made available to each policyholder under the coverage during each open enrollment period.

(2) The report must follow the reporting requirements developed by the commissioner and must be accompanied by a $50 filing fee. A health insurance issuer shall report on coverage benefits and health care provider reimbursement structures that:

(a) improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives for treatment or services under the coverage;

(b) implement activities that prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement by an appropriate health care professional;

(c) implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence-based medicine, and health information technology under the coverage; and

(d) implement wellness and health promotion activities.

(3) For purposes of subsection (2)(d), wellness and health promotion activities may include personalized wellness and prevention services that are coordinated, maintained, or delivered by a health care provider, a wellness and prevention plan manager, or a health, wellness, or prevention services organization that conducts health risk assessments or offers ongoing face-to-face, telephone, or web-based intervention efforts for each of the program's participants and that may include the following wellness and prevention efforts:

(a) smoking cessation;

(b) weight management;

(c) stress management;

(d) physical fitness;

(e) nutrition;

(f) heart disease prevention;

(g) healthy lifestyle support; and

(h) diabetes prevention.

NEW SECTION. **Section 9. Applicability of prohibition on lifetime and annual limits.** (1) Except as provided in subsection (2), this section and [section 10] apply to all individual health insurance coverage or group health insurance coverage but do not apply to coverage consisting solely of excepted benefits. This section and [section 10] 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 health insurance plans. The prohibition and restrictions on annual limits provided for in [section 10] do not apply to grandfathered individual health insurance plans.

NEW SECTION. **Section 10. 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;

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

(iii) a health savings account, as provided 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) (a) 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 not less than $2 million for a plan or policy year beginning after September 22, 2012, but before January 1, 2014.

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

(5) (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 the requirements by the U.S. department of health and human services. However, the exemption under this subsection (5) 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 11. 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 13], may not impose any cost-sharing requirements with respect to the following items and services:

(a) evidence-based items or services that have a rating of "A" or "B" in the recommendations of the U.S. 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, adolescents, and 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 U.S. preventive services task force, the advisory committee on immunization practices, 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 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 U.S. 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) 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.

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

(a) providing coverage for items and services in addition to those recommended by the U.S. preventive services task force or the advisory committee on immunization practices 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).

(5) 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 otherwise described in this section.

(6) (a) Except as provided in subsection (6)(b), the provisions of [sections 12 and 13] 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 12 and 13] and this section do not apply to coverage consisting solely of excepted benefits or to grandfathered group or individual health insurance plans.

(7) For the purposes of [sections 12 and 13] and this section, a cost-sharing requirement includes but is not limited to a copayment, coinsurance, or deductible.

NEW SECTION. **Section 12. 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 11] 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 11] 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 11] 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 13. Preventive items and services delivered by out-of-network providers.** (1) Nothing in [sections 11 and 12] requires a health insurance issuer that has a network of providers to provide benefits for items and services described in [section 11] that are delivered by an out-of-network provider.

(2) Nothing in [section 11] precludes a health insurance issuer that has a network of providers from imposing cost-sharing requirements for items or services described in [section 11] that are delivered by an out-of-network provider.

NEW SECTION. **Section 14. 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 15. 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 16. Applicability.** (1) The provisions of [sections 14 and 15] 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, any self-funded student health plan established under Title 20, chapter 25, part 14, any health maintenance organization that is subject to the requirements of Title 33, chapter 31, and any self-funded multiple employer welfare arrangement that is subject to licensing requirements under Title 33, chapter 35.

(2) The provisions of [sections 14 and 15] do not apply to a grandfathered individual or group health insurance plan.

NEW SECTION. **Section 17. 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 written notice at least 30 days in advance of the rescission 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 to the primary subscriber who would be affected by the proposed rescission of coverage for individual health insurance coverage.

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

(4) 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.

(5) (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.

Section 18. 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, 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 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.

(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) (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. 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 (8)(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 advisory committee on immunization practice ~~advisory committee~~ of the ~~U.S. department of health and human services~~ centers for disease control and prevention; and

(iii) the items and services described in [sections 11 through 13] and 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 (8).

(d) For purposes of this subsection (8):

(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 11] and subsection (8)(b) of this section and delivered by a physician or a health care professional supervised by a physician.

(9) Upon renewal, an insurance contract or plan issued under this part under which coverage of a dependent terminates at a specified age must continue to provide coverage for any dependent, as defined in the insurance contract or plan and in 33-22-140(6)(b), until the dependent reaches 26 years of age. For insurance contracts or plans issued under this part, the premium charged for the additional coverage of a dependent, as defined in the insurance contract or plan, may be required to be paid by the insured and not by the employer.

(10) 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.

(11) The state employee group benefit plans and the Montana university system group benefits plans must provide coverage for hospital inpatient care for a period of time as is determined by the attending physician and, in the case of a health maintenance organization, the primary care physician, in consultation with the patient to be medically necessary following a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer.

(12) (a) The state employee group benefit plans and the Montana university system group benefits plans 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.

(b) 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.

(c) The state employee group benefit plans and the Montana university system group benefits plans must provide coverage for diabetic equipment and supplies that at a minimum includes insulin, syringes, injection aids, devices 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.

(d) Nothing in subsection (12)(a), (12)(b), or (12)(c) prohibits the state or the Montana university group benefit plans from providing a greater benefit or an alternative benefit of substantially equal value, in which case subsection (12)(a), (12)(b), or (12)(c), as appropriate, does not apply.

(e) Annual copayment and deductible provisions are subject to the same terms and conditions applicable to all other covered benefits within a given policy.

(f) This subsection (12) does not apply to disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, specific disease, or long-term care policies offered by the state or the Montana university system as benefits to employees, retirees, and their dependents.

(13) (a) The state employee group benefit plans and the Montana university system group benefits plans that provide coverage to the spouse or dependents of a peace officer as defined in 45-2-101, a game warden as defined in 19-8-101, a firefighter as defined in 19-13-104, or a volunteer firefighter as defined in 19-17-102 shall renew the coverage of the spouse or dependents if the peace officer, game warden, firefighter, or volunteer firefighter dies within the course and scope of employment. Except as provided in subsection (13)(b), the continuation of the coverage is at the option of the spouse or dependents. Renewals of coverage under this section must provide for the same level of benefits as are available to other members of the group. Premiums charged to a spouse or dependent under this section must be the same as premiums charged to other similarly situated members of the group. Dependent special enrollment must be allowed under the terms of the insurance contract or plan. The provisions of this subsection (13)(a) are applicable to a spouse or dependent who is insured under a COBRA continuation provision.

(b) The state employee group benefit plans and the Montana university system group benefits plans subject to the provisions of subsection (13)(a) may discontinue or not renew the coverage of a spouse or dependent only if:

(i) the spouse or dependent has failed to pay premiums or contributions in accordance with the terms of the state employee group benefit plans and the Montana university system group benefits plans or if the plans have not received timely premium payments;

(ii) the spouse or dependent has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of a material fact under the terms of the coverage; or

(iii) the state employee group benefit plans and the Montana university system group benefits plans are ceasing to offer coverage in accordance with applicable state law.

(14) The provisions of [sections 6 and 9 through 16], 33-22-152, 33-22-515, 33-22-1516, and Title 33, chapter 22, part 19, apply to insurance contracts or plans issued under this part. (See compiler's comments for contingent termination of certain text.)"

Section 19. 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)~~ Title 33, chapter 22, part 18, 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 20. 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) ~~This~~ Except as provided in 33-31-111, this code does not apply to health maintenance organizations to the extent that the existence and operations of those organizations are governed by chapter 31.

(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) This code does not apply to the state employee group insurance program established in Title 2, chapter 18, part 8, or the Montana university system group benefits plans established in Title 20, chapter 25, part 13.

(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.

(12) ~~This~~ Except for 33-1-102, [sections 1 through 17], 33-15-403, 33-18-215, 33-22-101, 33-22-109, 33-22-303, 33-22-515, 33-22-601, 33-22-703, 33-22-706, 33-22-1704, 33-22-1706, 33-22-1901 through 33-22-1908, 33-30-1014, and 33-31-111, this code does not apply to the self-insured student health plan established in Title 20, chapter 25, part 14.

(13) This code does not apply to private air ambulance services that are in compliance with 50-6-320 and that solicit membership subscriptions, accept membership applications, charge membership fees, and provide air ambulance services to subscription members and designated members of their households."

Section 21. 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) Except as provided in subsection (2)(b), misrepresentations, ~~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) 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 22. 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 23. 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, and 33-22-301 apply to group or blanket policies. [Sections 6 and 9 through 17] apply to group policies."

Section 24. 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 nongrandfathered individual health insurance coverage may not impose an elimination rider on an individual for conditions for which medical advice, diagnosis, care, or treatment was previously recommended by or received from a provider of health care services."

Section 25. Section 33-22-110, MCA, is amended to read:

"33-22-110. Preexisting conditions. (1) Except as provided in [section 2], 33-22-246, and 33-22-514, a policy or certificate of disability insurance may not exclude coverage for a condition for which medical advice or treatment was recommended by or received from a provider of health care services unless the condition occurred within 5 years preceding the effective date of coverage of an insured person. The condition may only be excluded for a maximum of 12 months.

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

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

Section 26. 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~~ Except as provided in [sections 11 through 13], annual copayment and deductible provisions are subject to the same terms and conditions applicable to all other covered benefits within a given policy.

(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 provided in [sections 11 through 13], this section does not apply to 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) 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 27. 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 10], and deductibles, ~~and copayment~~ copayments, or other cost-sharing provisions except as provided in [sections 5 and 11 through 13] 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 28. 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 administered under the provisions of [section 11] and, to the extent that federal law preempts state law, 45 CFR 147.130.

(3) The restrictions on cost-sharing as provided in [sections 11 through 13] apply to the types of health insurance coverage described in those sections.

~~(3)~~(4) ~~A~~ If restrictions on cost-sharing as provided in [sections 11 through 13] 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~~ and 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 29. 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, dependent, 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~~ who has not attained ~~25~~ 26 years of age:

(i) who otherwise meets the requirements of 33-22-152; and ~~is not an employee eligible for coverage under a group health plan offered by the child's employer for which the child's premium contribution amount is no greater than the premium amount for coverage as a dependent under a parent's individual or group health plan;~~

~~(ii) who is not a named subscriber, insured, enrollee, or covered individual under any other individual health insurance coverage, group health plan, government plan, church plan, or group health insurance;~~

~~(iii) who is not entitled to benefits under 42 U.S.C. 1395, et seq.; and~~

~~(iv)~~(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.

(8) "Employee" means any individual employed by an employer.

~~(7)~~(9) "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.

(10) "Essential health benefits" has the meaning provided under section 1302 of the federal act and applicable regulations and guidance and includes the following categories:

(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) preventive 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 health benefits.

~~(8)~~(11) "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.

(12) "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.

(13) "Family member" means with respect to an individual:

(a) a dependent of the individual; and

(b) any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of the individual.

(14) "Federal act" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any regulations or guidance issued pursuant to those acts.

~~(9)~~(15) "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)~~ (15)(f) if the individual elected the continuation coverage described in subsection ~~(9)(f)~~ (15)(f).

(16) (a) "Genetic information" means, with respect to any individual, information about:

(i) the individual's genetic tests;

(ii) the genetic tests of the individual's family members; and

(iii) the manifestation of a disease or disorder in family members of the individual.

(b) The term includes:

(i) with respect to any individual, any request for or receipt of genetic services or participation in clinical research that includes genetic services by the individual or any family member of the individual;

(ii) any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, including genetic information of any fetus carried by the pregnant woman; or

(iii) with respect to an individual or family member of the individual utilizing reproductive technology, genetic information of any embryo legally held by an individual or family member.

(c) The term does not include information about the sex or age of an individual.

(17) "Genetic services" means a genetic test.

(18) (a) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes.

(b) The term does not mean:

(i) an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes;

(ii) an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved;

(iii) genetic counseling, including obtaining, interpreting, or assessing genetic information; or

(iv) genetic education.

(19) "Geographic rating area" means an area established by the commissioner in accordance with section 2701(a)(2) of the federal act, or any federal regulation adopted under the act, for purposes of adjusting the rates for a health plan.

(20) "Grandfathered", when referring to individual or group health insurance or health plan coverage, means coverage provided by a health insurance issuer in which an individual or employer group health plan was enrolled on March 23, 2010, for as long as the individual or 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)~~(21) "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)~~(22) "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.

(23) "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.

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

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

~~(12)~~(26) "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)~~(27) "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.

(28) (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.

(29) "Health status-related factor" means any of the following factors:

(a) health status;

(b) medical condition, including both physical and mental illnesses;

(c) claims experience;

(d) receipt of health care services;

(e) medical history;

(f) genetic information;

(g) evidence of insurability, including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities;

(h) disability; or

(i) any other health status-related factor determined appropriate by the secretary or the commissioner.

~~(14)~~(30) (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)~~(31) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with group health insurance coverage.

~~(16)~~(32) "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)~~(33) "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)~~(34) "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)~~(35) "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)~~ (35)(a); or

(c) insurance ~~covering~~ that pays benefits for medical care referred to in subsections ~~(19)(a) and (19)(b)~~ (35)(a) and (35)(b).

~~(20)~~(36) "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.

(37) "Nongrandfathered", when referring to individual or group health insurance or health plan coverage, means coverage that is not grandfathered as defined in subsection (20).

~~(21)~~(38) "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).

(39) "Policyholder" means an individual who has paid premiums for the individual or the individual's dependents, if any, that are also covered under a health plan providing individual health insurance coverage, and who is responsible for continued premium payments under the terms of the health plan.

~~(22)~~(40) (a) "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.

(b) Genetic information may not be treated as a condition under subsection (40)(a) for which a preexisting condition exclusion may be imposed in the absence of a diagnosis of the condition related to the information.

(41) "Premium" means all money paid by a policyholder or plan sponsor as a condition of receiving individual or group health insurance coverage from a health insurance issuer, including any fees or other contributions associated with the health plan and including any portion of premium paid on behalf of a policyholder or plan sponsor.

(42) (a) "Rescission" means a cancellation or discontinuance of coverage under a health plan that has a retroactive effect.

(b) The term does not include a cancellation or discontinuance of coverage under a health plan 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 it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage, except as provided in 33-22-121 and 33-22-530.

(43) "Secretary" means the secretary of the U.S. department of health and human services.

(44) (a) "Small employer" means an employer that employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

(b) For the purposes of subsection (44)(a):

(i) all persons treated as a single employer under 26 U.S.C. must be treated as a small employer;

(ii) an employer and any predecessor employer must be treated as a single employer;

(iii) if an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer must be based on the average number of employees that it is reasonably expected that employer will employ on business days in the current calendar year; and

(iv) any reference in this subsection (44) to an employer includes a reference to any predecessor of the employer.

~~(23)~~(45) "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.

(46) "Underwriting purposes" means:

(a) rules for or determination of eligibility, including enrollment and continued eligibility for benefits under a health plan;

(b) the computation of premium or contribution amounts under a health plan; and

(c) other activities related to the creation, renewal, or replacement of a contract of health insurance coverage.

~~(24)~~(47) "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 30. 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, 33-22-246, 33-22-247, 33-22-514, 33-22-523 through 33-22-526, and 33-22-1523~~ the provisions of this chapter."

Section 31. Section 33-22-152, MCA, is amended to read:

"33-22-152. ~~Continuation of~~ Eligibility for dependent coverage. (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, 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, 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:

(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.

(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."

Section 32. Section 33-22-242, MCA, is amended to read:

"33-22-242. Waiver of preexisting condition exclusion -- exclusion prohibited. (1) ~~A~~ In grandfathered individual health insurance coverage 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 nongrandfathered individual health insurance coverage may not impose a preexisting condition exclusion on any covered person."

Section 33. Section 33-22-243, MCA, is amended to read:

"33-22-243. Premium increases to be distributed proportionately. (1) A health care insurer may increase the health ~~benefit~~ plan charges for ~~an~~ a grandfathered individual policy, certificate, or contract previously issued by that insurer because of a change in the attained age of the insured. Increases in premium, certificate, or contract charges for individual policies, certificates, or contracts previously issued by that insurer, based on factors other than attained age, must be distributed proportionately across the block of business as defined in 33-22-241.

(2) As used in this section, the following definitions apply:

(a) (i) "~~H~~Health ~~benefit~~ plan" means a 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.

(ii) Health ~~benefit~~ plan does not include:

(A) accident-only, credit, dental, vision, specified disease, medicare supplement, long-term care, or disability income insurance;

(B) coverage issued as a supplement to liability insurance, workers' compensation insurance, or similar insurance; or

(C) automobile medical payment insurance.

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

(3) The provisions of Title 33, chapter 1, parts 3 and 7, apply to this section.

(4) This section does not apply to nongrandfathered individual health insurance coverage that must comply with the provisions of [sections 1 through 5]."

Section 34. Section 33-22-244, MCA, is amended to read:

"33-22-244. Disclosure standards -- individual policy. (1) In order to provide for full and fair disclosure

in the sale of ~~disability~~ health insurance coverage, an individual ~~disability~~ health insurance policy may not be delivered or issued for delivery in this state unless an outline of coverage is filed with and approved by the insurance commissioner in accordance with 33-1-501 and is delivered to the applicant at the time the application is made and at each renewal.

(2) The outline of coverage must include:

~~(a) a general description of the principal benefits and coverages provided by the policy;~~

~~(b) a general description of the insured's financial responsibility under the policy, including, if applicable, the amount of the deductible, the amount or percentage of copayment, and the maximum annual out-of-pocket expenses to be paid by the insured;~~

~~(c) a statement of the maximum lifetime benefit available under the policy;~~

~~(d)~~(a) a statement of the estimated periodic premium to be paid by the insured;

~~(e)~~(b) a general description of the factors or case characteristics that the insurer may consider in establishing or changing the premiums and, if applicable, in determining the insurability of the applicant;

~~(f)~~(c) a description of any preauthorization or other preapproval requirements for medical care;

~~(g)~~(d) a prominently displayed statement of the insured's responsibility for payment of billed charges beyond those charges reimbursed by the insurer when the insured uses health care services from a health care provider who is outside a network of health care providers used by the insurer; and

~~(h)~~(e) a general description of the trend of premium increases or decreases for comparable policies issued by the insurer during the preceding 5 years, if the trend data is available.

(3) The outline of coverage may include any other information that the insurer considers relevant to the applicant's selection of an appropriate individual ~~disability~~ health insurance policy.

(4) An insurer or producer shall provide to an individual, upon request, an outline of coverage for any health ~~benefit product~~ plan marketed to the general public. The outline of coverage provided under this subsection may exclude the statement of the estimated periodic premium to be paid by the insured.

(5) Prior to issuance of an individual ~~disability~~ health insurance policy, written informational materials describing the policy's cancer screening coverages must be provided to a potential applicant. The informational materials are not subject to filing with and approval of the insurance commissioner.

(6) (a) The outline of coverage must be delivered in conjunction with the summary of benefits and coverage explanation required by the federal act.

(b) Health insurance issuers offering health plans providing individual health insurance coverage shall

provide a summary of benefits and coverage explanation pursuant to the standards adopted by the secretary under the federal act to:

(i) an applicant at the time of application;

(ii) an enrollee prior to the time of enrollment or reenrollment, as applicable; and

(iii) a policyholder at the time of issuance of the policy.

(c) A health insurance issuer described in subsection (6)(b) is considered to have complied with subsection (6)(b) if the summary of benefits and coverage described in the federal act is provided in paper or electronic form.

(d) Except in connection with a policy renewal or reissuance, if a health insurance issuer makes any material modifications in any of the terms of the coverage that is not reflected in the most recently provided summary of benefits and coverage, the issuer shall provide notice of the modification to covered persons not later than 60 days prior to the date on which the modification will become effective.

(e) The summary of benefits and coverage must be filed for approval by the commissioner in compliance with 33-1-501 at the same time that the outline of coverage form is filed."

Section 35. Section 33-22-246, MCA, is amended to read:

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

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

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

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

Section 36. 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 11 through 13] 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 advisory committee on immunization practices ~~advisory committee~~ of the ~~U.S. department of health and human services~~ centers for disease control and prevention; and

(c) for nongrandfathered health insurance coverage, the items and services described in [sections 11 through 13] and 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.

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

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

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

(b) "well-child care" means the services described in subsection ~~(2)~~ (3) and delivered by a physician or a health care professional supervised by a physician.

~~(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 37. 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 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 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~~ 33-22-1521(1)(b) and (2), except that the deductible may not exceed $1,500 for a covered person. The conversion rate 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 38. 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 11 through 13] 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 advisory committee on immunization practices ~~advisory committee~~ of the ~~U.S. department of health and human services~~ centers for disease control and prevention; and

(c) the items and services described in [sections 11 through 13] and 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 11 through 13] and 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) "developmental assessment" and "anticipatory guidance" mean the services described in the Guidelines for Health Supervision II, published by the American academy of pediatrics; and

(b) "well-child care" means the services described in subsection ~~(2)~~ (3) and delivered by a physician or a health care professional supervised by a physician.

~~(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 39. Section 33-22-514, MCA, is amended to read:

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

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

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

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

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

(3) 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 on an individual under 19 years of age because of a preexisting condition.

(5) A nongrandfathered group health plan or a health insurance issuer renewing or issuing nongrandfathered group health insurance coverage on or after January 1, 2014, may not exclude coverage for a preexisting condition for any individual covered under that health plan."

Section 40. 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 health benefits as described in 42 U.S.C. 18022 and applicable federal regulations."

Section 41. Section 33-22-521, MCA, is amended to read:

"33-22-521. Disclosure standards -- group policy. (1) In order to provide for full and fair disclosure

in the sale of disability insurance, a group disability insurance policy may not be delivered or issued for delivery in this state unless an outline of coverage is filed with and approved by the insurance commissioner in accordance with 33-1-501 and is delivered to the applicant at the time the application is made.

(2) The outline of coverage must include:

~~(a) a general description of the principal benefits and coverages provided by the policy;~~

~~(b) a general description of the insured's financial responsibility under the policy, including, if applicable, the amount of the deductible, the amount or percentage of copayment, and the maximum annual out-of-pocket expenses to be paid by the insured;~~

~~(c) a statement of the maximum lifetime benefit available under the policy;~~

~~(d)~~(a) a statement of the estimated periodic premium to be paid by the insured;

~~(e)~~(b) a general description of the factors or case characteristics that the insurer may consider in establishing or changing the premiums and, if applicable, in determining the insurability of the applicant;

~~(f)~~(c) a description of any preauthorization or other preapproval requirements for medical care;

~~(g)~~(d) a prominently displayed statement of the insured's responsibility for payment of billed charges beyond those charges reimbursed by the insurer when the insured uses health care services from a health care provider who is outside a network of health care providers used by the insurer; and

~~(h)~~(e) a general description of the trend of premium increases or decreases for comparable policies issued by the insurer during the preceding 5 years, if the trend data is available.

(3) If applicable, the outline of coverage must disclose that the policy does not contain coverage for mental illness or chemical dependency.

(4) The outline of coverage may include any other information that the insurer considers relevant to the applicant's selection of an appropriate group ~~disability~~ health insurance policy.

(5) An insurer or producer shall provide to an individual, upon request, an outline of coverage for any health ~~benefit product~~ plan marketed to the general public. The outline of coverage provided under this subsection may exclude the statement of the estimated periodic premium to be paid by the insured.

(6) An outline of coverage must also be sent to an employee when an employee is sent a certificate of insurance.

(7) Prior to issuance of a group disability insurance policy, written informational materials describing the policy's cancer screening coverages must be provided to a prospective applicant. The informational materials are not subject to filing with and approval of the insurance commissioner.

(8) (a) The outline of coverage must be delivered in conjunction with the summary of benefits and coverage explanation required by the federal act.

(b) Health insurance issuers offering health plans providing group health insurance coverage shall provide a summary of benefits and coverage explanation pursuant to the standards adopted by the secretary under the federal act to:

(i) an applicant at the time of application;

(ii) an enrollee prior to the time of enrollment or reenrollment, as applicable; and

(iii) a policyholder and certificate holder at the time of issuance of the policy.

(c) A health insurance issuer described in subsection (8)(b) is considered to have complied with subsection (8)(b) if the summary of benefits and coverage is provided in paper or electronic form, in accordance with the standards adopted by the secretary under the federal act.

(d) Except in connection with a policy renewal or reissuance, if a health insurance issuer makes any material modifications in any of the terms of the coverage, as defined for purposes of section 102 of the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. 1022, that is not reflected in the most recently provided summary of benefits and coverage, the issuer shall provide notice of the modification to covered persons not later than 60 days prior to the date on which the modification will become effective.

(e) The summary of benefits and coverage must be filed for approval by the commissioner in compliance with 33-1-501 at the same time that the outline of coverage form is filed."

Section 42. Section 33-22-524, MCA, is amended to read:

"33-22-524. Guaranteed renewability of coverage for employers in group market. (1) Except as provided in this section, if a health insurance issuer offers health insurance coverage in the small group market or large group market in connection with a group health plan, the health insurance issuer shall renew or continue the coverage in force at the option of the plan sponsor.

(2) A health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a group health plan in the small group market or large group market if:

(a) the plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or if the health insurance issuer has not received timely premium payments;

(b) the plan sponsor has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact under the terms of the coverage;

(c) the plan sponsor has failed to comply with a material plan provision relating to employer contribution or group health plan participation rules;

(d) the health insurance issuer is ceasing to offer coverage in that group market in accordance with this section and applicable state law;

(e) in the case of a health insurance issuer that offers health insurance coverage in the group market through a network plan, there is no longer any enrollee in connection with the group health plan who lives, resides, or works in the service area of the health insurance issuer and, in the case of the small group market, if the health insurance issuer would deny enrollment with respect to the plan under ~~33-22-1811(4)(a)(i)~~ 33-22-1811(3)(a); or

(f) in the case of health insurance coverage that is made available in the small group market or large group market only through one or more bona fide associations, the membership of an employer in the bona fide association ceases, but only if the coverage is terminated under this subsection (2)(f) uniformly without regard to any health status-related factor of a covered individual.

(3) A health insurance issuer may not discontinue offering a particular type of group health insurance coverage offered in the small group market or large group market unless in accordance with applicable state law and unless:

(a) the issuer provides notice to each plan sponsor, participant, and beneficiary provided coverage of this type in that group market of the discontinuation at least 90 days prior to the date of the discontinuation of the coverage;

(b) the issuer offers to each plan sponsor provided coverage of this type in the market the option to purchase any other health insurance coverage currently being offered by the health insurance issuer to a group health plan in the market; and

(c) the health insurance issuer acts uniformly without regard to the claims experience of those sponsors or any health status-related factor of any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for the coverage.

(4) (a) A health insurance issuer may not discontinue offering all health insurance coverage in the small group market, the large group market, or both the small group market and the large group market, unless in accordance with applicable state law and unless:

(i) the issuer provides notice of discontinuation to the commissioner and to each plan sponsor, participant, and beneficiary covered at least 180 days prior to the date of the discontinuation of coverage; and

(ii) all health insurance issued or delivered for issuance in Montana in the group market or markets is discontinued and coverage under the health insurance coverage in the group market or markets is not renewed.

(b) In the case of a discontinuation under this section in a group market, the health insurance issuer may not provide for the issuance of any health insurance coverage in the group market for a period of 5 years beginning on the date of the discontinuation of the last health insurance coverage not renewed.

(5) A health insurance issuer may modify upon renewal health insurance coverage for a product offered to a group health plan in the large group market or in the small group market if, for coverage that is available in the small group market other than only through one or more bona fide associations, modification is consistent with applicable state law and effective on a uniform basis among group health plans with that product.

(6) In the case of health insurance coverage that is made available by a health insurance issuer in the small group market or large group market to employers only through one or more bona fide associations, references to "plan sponsor" under this section include those employers."

Section 43. Section 33-22-526, MCA, is amended to read:

"33-22-526. Group health discrimination prohibited. (1) (a) A group health plan or a health insurance issuer offering group health insurance coverage may not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of the group health plan based on any of the following health status-related factors of the individual or a dependent of the individual:

(i) health status;

(ii) medical condition, including both physical and mental illnesses;

(iii) claims experience;

(iv) receipt of health care;

(v) medical history;

(vi) genetic information;

(vii) evidence of insurability, including conditions arising out of acts of domestic violence; or

(viii) disability.

(b) This subsection does not:

(i) require a group health plan or group health insurance coverage to provide particular benefits other than those provided under the terms of the group health plan or group health insurance coverage and as provided in [section 60]; or

(ii) prevent the group health plan or group health insurance coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the group health plan or group health insurance coverage that otherwise comply with the provisions of this chapter and the federal act.

(c) (i) For purposes of subsection (1)(a), rules for eligibility to enroll under a group health plan include rules defining an applicable waiting period for the enrollment.

(ii) Waiting periods may not exceed 90 days from the first date of employment.

(2) (a) A group health plan and a health insurance issuer offering health insurance coverage in connection with a group health plan may not require an individual, as a condition of enrollment or continued enrollment under the group health plan, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the group health plan on the basis of any health status-related factor of the individual or of an individual enrolled under the plan as a dependent of the individual.

(b) This subsection (2) does not:

(i) restrict the amount that an employer may be charged for coverage under a group health plan, except as provided in [section 55]; or

(ii) prevent a group health plan and a health insurance issuer offering group health insurance coverage from establishing premium discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention."

Section 44. Section 33-22-601, MCA, is amended to read:

"33-22-601. Blanket disability insurance defined. Blanket disability insurance is hereby declared to be that form of disability insurance covering groups of persons as enumerated in one of the following subsections:

(1) under a policy or contract issued to any common carrier or to any operator, owner, or lessee of a means of transportation, ~~who or which shall be deemed~~ which is considered the policyholder, covering a group defined as all persons or all persons of a class who may become passengers on ~~such~~ the common carrier or ~~such~~ the means of transportation;

(2) under a policy or contract issued to an employer, ~~who shall be deemed~~ which is considered the policyholder, covering all employees, dependents, or guests, defined by reference to specified hazards incident to the activities or operations of the employer or any class of employees, dependents, or guests similarly defined;

(3) under a policy or contract issued to a school or other institution of learning, or to a camp or sponsor

~~thereof~~; or to the head or principal ~~thereof~~ of a school or other institution of learning, ~~who or which shall be deemed~~ which is considered the policyholder, covering students or campers. Supervisors and employees may be included. Student health plan coverage as defined in the federal act is not blanket disability insurance.

(4) under a policy or contract issued in the name of any religious, charitable, recreational, educational, or civic organization, which ~~shall be deemed~~ is considered the policyholder, covering participants in activities sponsored by the organization;

(5) under a policy or contract issued to a sports team or sponsors ~~thereof~~ of a sports team, which ~~shall be deemed~~ is considered the policyholder, covering members, officials, and supervisors;

(6) under a policy or contract issued in the name of any volunteer fire department, first aid, or other such volunteer group, or agency having jurisdiction thereof, which ~~shall be deemed~~ is considered the policyholder, covering all of the members of ~~such~~ the fire department or group;

(7) under a policy or contract issued to cover any other risk or class of risks which in the discretion of the commissioner may be properly eligible for blanket disability insurance. The discretion of the commissioner may be exercised on an individual risk basis or class of risks, or both."

Section 45. Section 33-22-703, MCA, is amended to read:

"33-22-703. Coverage for mental illness, alcoholism, and drug addiction. (1) A grandfathered small employer group health plan or a health insurance issuer that provides grandfathered small employer 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)~~(a) 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)~~(i) inpatient treatment for mental illness is subject to a maximum yearly benefit of 21 days;

~~(b)~~(ii) 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)~~(iii) 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)~~(b) 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 for grandfathered small employer health plans only:

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

~~(b)~~(ii) 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)~~(iii) 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~~.

(2) On or after January 1, 2014, all large employer group health plan coverage and nongrandfathered group and individual health insurance coverage that is delivered, issued for delivery, renewed, extended, or modified in this state must provide a level of benefits for the necessary care and treatment of mental illness and chemical dependency that is no less favorable than that level provided for other physical illness."

Section 46. Section 33-22-706, MCA, is amended to read:

"33-22-706. Coverage for severe mental illness -- definition. (1) A policy or certificate of health insurance or disability insurance that is delivered, issued for delivery, renewed, extended, or modified in this state must provide a level of benefits for the necessary care and treatment of severe mental illness, as defined in subsection (6), that is no less favorable than that level provided for other physical illness generally. Benefits for treatment of severe mental illness may be subject to managed care provisions contained in the policy or certificate.

(2) Benefits provided pursuant to subsection (1) include but are not limited to:

(a) inpatient hospital services;

(b) outpatient services;

(c) rehabilitative services;

(d) medication;

(e) services rendered by a licensed physician, licensed advanced practice registered nurse with a specialty in mental health, licensed social worker, licensed psychologist, or licensed professional counselor when those services are part of a treatment plan recommended and authorized by a licensed physician; and

(f) services rendered by a licensed advanced practice registered nurse with prescriptive authority and specializing in mental health.

(3) Benefits provided pursuant to this section must be included when determining maximum lifetime benefits, copayments, and deductibles.

(4) (a) This section applies to health service benefits provided by:

(i) individual and group health and disability insurance;

(ii) individual and group hospital or medical expense insurance;

(iii) medical subscriber contracts;

(iv) membership contracts of a health service corporation;

(v) health maintenance organizations; and

(vi) the comprehensive health association created by 33-22-1503.

(b) This section does not apply to the following coverages:

(i) blanket;

(ii) short-term travel;

(iii) accident only;

(iv) limited or specific disease;

(v) Title XVIII of the Social Security Act (medicare); or

(vi) any other similar coverage under state or federal government plans.

(5) This section does not limit benefits for an illness or condition that does not constitute a severe mental illness, as defined in subsection (6), but that does constitute a mental illness, as defined in 33-22-702.

(6) As used in this section, "severe mental illness" means the following disorders as defined by the American psychiatric association:

(a) schizophrenia;

(b) schizoaffective disorder;

(c) bipolar disorder;

(d) major depression;

(e) panic disorder;

(f) obsessive-compulsive disorder; and

(g) autism.

(7) Coverage for a child with autism who is 18 years of age or younger must comply with 33-22-515(3) through (5) if the child is diagnosed with:

(a) autistic disorder;

(b) Asperger's disorder; or

(c) pervasive developmental disorder not otherwise specified.

(8) On or after January 1, 2014, all large employer group health coverage and nongrandfathered small employer group or individual health insurance coverage that is delivered, issued for delivery, renewed, extended, or modified in this state must provide a level of benefits for the necessary care and treatment of severe mental illness that is no less favorable than that level provided for other physical illness."

Section 47. 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 person who obtains coverage under the association plan may not be covered for any preexisting~~

~~condition during the first 12 months of coverage under the association plan if the person was diagnosed or treated for that condition during the 3 years immediately preceding the filing of an application. The association may not apply a preexisting condition exclusion to coverage under the association portability plan if application for association portability plan coverage is made by a federally defined eligible individual or a qualified TAA-eligible individual within 63 days following termination of the applicant's most recent prior creditable coverage. The association shall waive any time period applicable to a preexisting condition exclusion for the 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.~~

(4) The association may not impose a preexisting condition exclusion on any individual on or after January 1, 2014."

Section 48. 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 9 and 10]. 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 9 and 10]. This association plan must provide a maximum lifetime benefit of at least $2 million, 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 patient's medical condition when approved in advance by the insurer; and

(w) coverage for ~~severe~~ mental illness as required in 33-22-703 and 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 9 and 13];

(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 the charge exceeds the facility's charge for its most common semiprivate room, unless the private room is prescribed as medically necessary by a physician;

(v) services or articles that are not within the scope of authorized practice of the facility 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)~~(vi) reversal of sterilization;

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

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

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

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

Section 49. 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 50. 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 11]. The commissioner shall review differences between copayments, deductibles, and other cost-sharing arrangements. The difference between the insured's total out-of-pocket expenses for in-network services and out-of-network services cannot exceed 25%.

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

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

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

(b) to prevent abusive rating practices;

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

(d) to establish rules regarding renewability of coverage;

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

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

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

~~(h)~~(f) 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 52. 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)~~(3) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

~~(5) "Basic health benefit plan" means a health benefit plan, except a uniform health benefit plan, developed by a small employer carrier, that has a lower benefit value than the small employer carrier's standard benefit plan.~~

~~(6)~~(4) "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)~~(5) "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)~~(6) "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)~~(7) "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)~~(8) "Class of business" means all or a separate grouping of small employers established pursuant to 33-22-1808.

~~(11)~~(9) "Dependent" means:

(a) a spouse;

(b) ~~an unmarried~~ child under ~~25~~ 26 years of age~~:~~

~~(i) who is not an employee eligible for coverage under a group health plan offered by the child's employer for which the child's premium contribution amount is no greater than the premium amount for coverage as a dependent under a parent's individual or group health plan;~~

~~(ii) who is not a named subscriber, insured, enrollee, or covered individual under any other individual health insurance coverage, group health plan, government plan, church plan, or group health insurance;~~

~~(iii) who is not entitled to benefits under 42 U.S.C. 1395, et seq.; and~~

~~(iv)~~ for whom the parent has requested coverage;

(c) a child of any age who is disabled and dependent upon the parent as provided in 33-22-506 and 33-30-1003; or

(d) any other individual defined as a dependent in the health benefit plan covering the employee.

~~(12)~~(10) (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)~~(11) "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)~~(12) (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)~~(13) "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)~~(14) "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)~~(15) "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)~~(16) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

~~(19)~~(17) "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)~~(18) "Small employer" has the meaning provided for in 33-22-140. ~~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)~~(19) "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.~~"

Section 53. Section 33-22-1804, MCA, is amended to read:

"33-22-1804. Applicability and scope. ~~(1)~~ This part applies to a health benefit plan marketed through a small employer that provides coverage to the employees of a small employer in this state if any of the following conditions are met:

~~(a)~~(1) a portion of the premium or benefits is paid by or on behalf of the small employer;

~~(b)~~(2) an eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium;

~~(c)~~(3) the health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of section 106, 125, or 162 of the Internal Revenue Code, except a plan or program that is funded entirely by contributions from the employees; or

~~(d)~~(4) all of the premium is paid by the employee who obtains coverage through the employer's group health benefit plan.

~~(2) This part does not apply to an individual health benefit plan for which the entire premium is paid by an employee through payroll deduction or other means.~~

~~(3) Unless prohibited by a written opinion from a federal agency, by final regulations implementing Public Law 104-191, or by a ruling by a court of competent jurisdiction, this part does not apply to an individual health benefit plan if the eligible employee or dependent is directly or indirectly reimbursed, whether through wage~~

~~adjustments or otherwise, by or on behalf of the small employer for any portion of the premium. However, this part does apply to an individual health benefit plan if the employer making the direct or indirect reimbursement for any portion of the premium has had in place an employer-sponsored group health benefit plan in the 12 months preceding the reimbursement.~~"

Section 54. Section 33-22-1809, MCA, is amended to read:

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

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

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

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

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

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

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

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

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

(f) A small employer carrier shall:

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

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

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

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

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

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

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

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

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

(d) the provisions relating to any preexisting condition.

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

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

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

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

NEW SECTION. **Section 55. Restrictions relating to premium rates in nongrandfathered small employer group health benefit plans -- rulemaking.** (1) With respect to the premium rates charged by a health carrier offering a nongrandfathered small employer group health benefit plan providing small group market health insurance coverage, the carrier shall develop its premium rates based on the following and vary the premium rates with respect to the particular plan or coverage only by:

(a) whether the plan or coverage covers an individual or family;

(b) geographic rating area, established in accordance with section 2701 of the federal Public Health Service Act;

(c) age, except that the rate may not vary by more than 3 to 1 for adults; and

(d) tobacco use, except that the rate may not vary by more than 1.5 to 1.

(2) A premium rate may not vary with respect to any particular health benefit plan or small group market health insurance coverage by any factor not described in subsection (1).

(3) With respect to family coverage under a health benefit plan providing small group market health insurance coverage, the rating variations permitted under subsections (1)(c) and (1)(d) must be applied based on the portion of the premium that is attributable to each family member covered under the plan.

(4) The premium charged with respect to any particular health benefit plan or small group market health insurance coverage may not be adjusted more frequently than annually except that the premium rates may be changed to reflect:

(a) changes to the enrollment of the small employer;

(b) changes to the family composition of an employee;

(c) changes in tobacco use;

(d) changes to the health benefit plan requested by the small employer; or

(e) other changes required by federal law or regulations or permitted by state law.

(5) A health carrier shall consider all enrollees in all health benefit plans, other than grandfathered health plan coverage, offered by the carrier in the small group market, including those covered persons who do not enroll in a health benefit plan through an exchange, as established under the federal act, to be members of a single risk pool.

(6) The commissioner may establish rules to implement the provisions of this section and to ensure that rating practices used by health carriers are consistent with the purposes of this chapter, including regulations that ensure that differences in rates charged for health benefit plans by carriers are reasonable and reflect objective differences in plan design or coverage.

(7) In connection with the offering for sale of small group market health insurance coverage, a health carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of the following:

(a) the provisions of the coverage concerning the right to change premium rates and the factors that may affect changes in premium rates; and

(b) a listing of and descriptive information, including benefits and premiums, about all health insurance coverage for which the small employer is qualified.

(8) Each health carrier shall maintain at its principal place of business a complete and detailed description of its rating practices, including information and documentation that demonstrate that its rating

methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(9) Each health carrier shall file with the commissioner annually, on or before March 15, an actuarial certification certifying that the carrier is in compliance with this section and that the rating methods of the carrier are actuarially sound. The certification must be in a form and manner and must contain any information specified by the commissioner. The certification must be accompanied by a $50 filing fee. A copy of the certification must be retained by the carrier at its principal place of business.

(10) (a) A health carrier shall make the information and documentation described in this section available to the commissioner upon request.

(b) Except in cases of violations of this chapter, the information must be considered proprietary and trade secret information if it satisfies the requirements of Title 30, chapter 14, part 4. If the information is determined to be a trade secret, it may not be subject to disclosure by the commissioner to persons outside of the department, except to another state or federal agency pursuant to 33-1-311 or as agreed to by the health carrier or as ordered by a court of competent jurisdiction.

Section 56. 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 by 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~~ if coverage is offered only through a network plan, the fact that there is no longer any employee living, working, or residing within the carrier's established geographic service area;

(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 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 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 57. 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)~~ (1) A small employer carrier shall issue all nongrandfathered 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 104-191.~~

~~(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~~ Grandfathered health benefit plans covering small employers must comply with the following provisions:

(a) A grandfathered health benefit plan may not:

(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 grandfathered health benefit plan must waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period of time that an individual was previously covered by creditable coverage that provided benefits with respect to those services if the creditable coverage was continuous to a date not more than 63 days prior to the submission of an application for new coverage. ~~A health benefit plan may determine waivers of time periods applicable to preexisting condition exclusions or limitations on the basis of prior coverage of benefits within each of several classes or categories as specified in regulations implementing Public Law 104-191, rather than as provided in this subsection (3)(b).~~ This subsection ~~(3)(b)~~ (2)(b) does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

(c) A grandfathered 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) A small employer carrier may not impose a preexisting condition exclusion period or a waiting period longer than 90 days on any covered person in any nongrandfathered health benefit plan.

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

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

(iii) A health carrier may not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

~~(e)~~(f) (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 in grandfathered health benefit plans 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)~~(3) (a) A small employer carrier may not be required to offer coverage or accept applications pursuant to subsection (1) in the case of the following:

(i) to an employer whose employees do not work or reside within the small employer carrier's established geographic service area for a network plan, as defined in 33-22-140; or

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

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

days after the date on which coverage is denied or until the small employer carrier has demonstrated to the commissioner that the small employer carrier has sufficient financial reserves to underwrite additional coverage, whichever is later."

Section 58. 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 all nongrandfathered 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 59. Section 33-22-1815, MCA, is amended to read:

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

(1) It contains at least 51 eligible employees.

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

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

(4) It offers coverage to eligible employees of member employers and to the employees' dependents. Coverage may not be limited to certain employees of member small employers except as provided in ~~33-22-1811(3)(c)~~ 33-22-1811(2)(c).

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

(6) (a) ~~Disability~~ Grandfathered 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. Nongrandfathered health benefit plans issued to voluntary purchasing pool members must be rated pursuant to [section 55].

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

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

NEW SECTION. **Section 60. Comprehensive health insurance coverage requirements.** (1) Health carriers offering nongrandfathered health benefit plans providing small group market health insurance coverage in this state shall ensure that the coverage includes the essential health benefits package required under the federal act, as described in subsection (2).

(2) For purposes of this section, "essential health benefits package" means coverage that:

(a) provides for the essential health benefits, as defined in 33-22-140;

(b) limits cost-sharing for the coverage in accordance with section 1302(c) of the federal act; and

(c) provides bronze, silver, gold, or platinum levels of coverage described in the federal act as follows:

(i) a bronze level health benefit plan must provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60% of the full actuarial value of the benefits provided under the plan;

(ii) a silver level health benefit plan must provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70% of the full actuarial value of the benefits provided under the plan;

(iii) a gold level health benefit plan must provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80% of the full actuarial value of the benefits provided under the plan; and

(iv) a platinum level health benefit plan must provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90% of the full actuarial value of the benefits provided under the plan.

(3) A health carrier issuing nongrandfathered health benefit plans to small employers shall ensure that any annual cost-sharing imposed under the health benefit plan does not exceed the limitations provided for under the federal act.

(4) This section does not apply to a dental plan described in the federal act.

NEW SECTION. **Section 61. Prohibited activities.** The commissioner may by rule prescribe standards for determining whether a policy issued as a stop-loss policy is a health benefit plan for the purposes of this chapter.

Section 62. 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, a participating pediatrician, or another primary care health care professional of their choice."

Section 63. 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 pediatrics.

(6) "Primary care ~~physician~~ health care professional" means a ~~physician who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referrals for specialist care~~ health care professional designated by a covered person to supervise, coordinate, or provide initial 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 64. 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~~ heath care professional."

Section 65. 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 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. Nongrandfathered health plans 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 66. 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 67. 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 68. 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."

Section 69. 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 70. 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 for grandfathered health plans. The rate for a nongrandfathered health plan must comply with the provisions of [section 55].

(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~~ 12 months of coverage of the individual policy."

Section 71. 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 11 through 13] 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 advisory committee on immunization practices ~~advisory committee~~ of the ~~U.S. department of health and human services~~ centers for disease control and prevention; and

(c) the items and services described in [sections 11 through 13] 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 11 through 13] and 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) "developmental assessment" and "anticipatory guidance" mean the services described in the Guidelines for Health Supervision II, published by the American academy of pediatrics; and

(b) "well-child care" means the services described in [section 11] and subsection ~~(2)~~ (3) and delivered at the intervals required in that subsection by a physician or a health care professional supervised by a physician.

~~(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 72. 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) Section 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~~ chapters 18 and 19, 33-22-107, 33-22-129, 33-22-131, 33-22-136, 33-22-137, 33-22-141, 33-22-142, 33-22-152, [sections 1 through 17, 55, and 60], 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 18 and part 19 apply to health maintenance organizations."

Section 73. 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, 33-22-140, 33-22-141, 33-22-142, and 33-22-152; and

(h) [sections 6, 9 through 16, and 55], 33-22-512, 33-22-514, 33-22-515, 33-22-525, ~~and~~ 33-22-526, 33-22-703, 33-22-705, 33-22-706, 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 74. 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.
33-22-1814. Restoration of terminated coverage.
33-22-1820. Periodic market evaluation -- report.
33-22-1821. Waiver of certain laws.
33-31-322. Uniform health benefit plan -- health maintenance organization.

NEW SECTION. **Section 75. Codification instruction.** (1) [Sections 1 through 17] 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 17].

(2) [Sections 55, 60, and 61] are intended to be codified as an integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [sections 55, 60, and 61].

NEW SECTION. **Section 76. Effective dates.** (1) Except as provided in subsection (2), [this act] is effective January 1, 2014.

(2) [Sections 9 through 16] and this section are effective on passage and approval.

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