AN ACT ALLOWING FOR THE PROVISION OF HEALTH OR DISABILITY INSURANCE BY OUT-OF-STATE INSURERS; PROVIDING A STREAMLINED PROCESS FOR OUT-OF-STATE HEALTH INSURERS TO ISSUE POLICIES IN MONTANA; REQUIRING PAYMENT OF PREMIUM TAXES; REQUIRING SPECIFIC NOTICE IN APPLICATIONS AND IN POLICIES; PROVIDING FOR REVOCATION OF REGISTRATION OR OTHER PENALTIES; PROVIDING RULEMAKING AUTHORITY TO THE INSURANCE COMMISSIONER; AND AMENDING SECTIONS 33-1-102, 33-1-201, 33-2-705, 33-2-710, 33-32-105, AND 33-32-201, MCA.

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

Section 1. Legislative findings. The legislature finds and declares that:

(1) although many Montanans have access to first-rate health care, the affordability of health coverage is problematic without competitive health care policies;

(2) by removing barriers that limit access to affordable health care coverage and expanding opportunities for Montanans to purchase more affordable coverage, the state can improve access to health care and rein in rising health care costs while preserving the first-rate care that so many Montanans enjoy; and

(3) providing Montanans with more choices for selecting a health insurance product will allow individuals and families a greater range of products and increase their ability to purchase affordable health care coverage and, with coverage, increase their access to health care.

Section 2. Out-of-state health or disability insurance policy offers -- injunctions -- waiver for domestic insurers -- reporting requirements -- definitions. (1) Subject to the provisions of [sections 1 through 6], a foreign insurer that has a certificate of authority in another state to issue health or disability insurance policies may issue those health or disability insurance policies in this state after providing evidence to the commissioner as provided in subsection (2).

(2) For the provisions of [sections 1 through 6] to apply and before issuing a health or disability insurance policy in this state, a foreign insurer shall:

(a) provide evidence to the commissioner that for the purposes of providing health or disability insurance the foreign insurer has a certificate of authority in another state and is subject to the jurisdiction of that state's insurance department;

(b) specify the amount of financial reserves required under the foreign insurer's certificate of authority in the jurisdictional state and submit a current copy of the foreign insurer's financial reserves;

(c) provide evidence that the health or disability insurance coverage issued under [sections 1 through 6] meets the benefit requirements of the policies issued in the jurisdictional state. A policy offered by a foreign insurer under [sections 1 through 6] is subject only to the benefit requirements of the jurisdictional state.

(d) register with the commissioner on an application in a form prescribed by the commissioner and pay a fee set by the commissioner by rule. If the commissioner revokes a foreign insurer's registration as provided in [section 3], the commissioner may not register the foreign insurer again under this section for 2 years after the date of revocation. For the purposes of multistate plans authorized by the office of personnel management under 42 U.S.C. 18054, registration as provided in this subsection (2)(d) is equivalent to licensure. A multistate plan authorized under 42 U.S.C. 18054 is considered to meet the standards and requirements in this state if the multistate plan meets the standards and requirements under 42 U.S.C. 18054 in the jurisdictional state.

(3) The commissioner may issue an injunction to prevent a foreign insurer from providing health or disability insurance coverage in this state and shall provide an opportunity for a hearing if any of the following occurs:

(a) the reserves listed in the financial information provided under subsection (2)(b) or (5) are less than the amount required by the jurisdictional state;

(b) the foreign insurer fails to pay the fee or timely meet the obligations provided in 33-2-705; or

(c) the commissioner finds the foreign insurer has violated the provisions in Title 33, chapter 18 or 19, as specified in [section 3(3)].

(4) If a foreign insurer issues a policy in this state that does not include a health benefit mandated under Title 33, chapter 22, any insurer that has a certificate of authority issued by the commissioner to issue a policy in this state is not required to include that mandated health benefit.

(5) A foreign insurer that issues a health or disability insurance policy under [sections 1 through 6] is subject to 33-2-705, and the report required under 33-2-705 must include information on the foreign insurer's financial reserves for each calendar year in which the foreign insurer issued a policy in this state. The information

must be filed as provided in 33-2-705 and must include financial information for the year preceding December 31 for transactions in this state. A foreign insurer that does not file information as provided in 33-2-705 is subject to the penalties provided in 33-2-705 and to a fine not to exceed the sum of $25,000 if, after a hearing conducted pursuant to 33-1-701, the commissioner finds that the foreign insurer intentionally did not file as provided in 33-2-705.

(6) A foreign insurer shall notify the department if the foreign insurer has been subject to any company action level event similar to a company action level event defined in 33-2-1904 in any state where the foreign insurer has a certificate of authority.

(7) A resident in this state may not be prohibited from purchasing a policy from a foreign insurer under [sections 1 through 6].

(8) For the purposes of [sections 1 through 6], the following definitions apply:

(a) "Foreign insurer" has the meaning provided in 33-1-201 and for the purposes of [sections 1 through 6] means a foreign insurer that has a certificate of authority from the jurisdictional state to issue health or disability insurance. The term includes an insurer that offers a multistate plan as provided in 42 U.S.C. 18054. A foreign insurer under [sections 1 through 6] may not be an alien insurer.

(b) "Health or disability insurance" means an individual policy offered by a foreign insurer under [sections 1 through 6] that covers the costs of treatment for bodily injuries, health wellness, or sickness.

(c) "Jurisdictional state" means the state in which the foreign insurer is based and from which the foreign insurer has a certificate of authority.

(d) "Policy" means an individual policy, contract, plan, coverage, or evidence of coverage.

Section 3. Revocation of foreign insurer's registration. The commissioner may revoke a foreign insurer's registration for the purposes of [sections 1 through 6] if, after issuing an injunction and providing an opportunity for a hearing under Title 33, chapter 1, part 7, the commissioner determines that any of the following have occurred:

(1) the foreign insurer's financial reserves are less than the amount required by the jurisdictional state;

(2) the commissioner establishes that any state that has issued a certificate of authority to the foreign insurer has identified and repeatedly enforced penalties on the insurer for violations related to claim denials, prompt payment, poor customer service, deceptive marketing practices, or fraudulent activities;

(3) the foreign insurer failed to comply with any of the following provisions of Title 33:

(a) 33-2-705;

(b) unfair trade practices under Title 33, chapter 18, except for 33-18-103, 33-18-207, 33-18-210, 33-18-214, 33-18-221 through 33-18-225, 33-18-245, 33-18-301 through 33-18-305, or 33-18-502; or

(c) insurance information practices and privacy protection under Title 33, chapter 19.

(4) the foreign insurer has been subject to a company action level event, as defined in 33-2-1904, in any state in which the foreign insurer has a certificate of authority.

Section 4. Policy notice requirements. (1) The following notice must be printed in at least 12-point bold type at the beginning of an application to obtain a foreign insurer's health or disability insurance policy issued under [sections 1 through 6]:

NOTICE

This (policy, contract, plan, coverage, or evidence of coverage) is issued by (name of insurer) and is governed by the laws and rules of the state of (the jurisdictional state that issued the foreign insurer's certificate of authority). This policy is not subject to all of the insurance laws of the State of Montana, including coverage of services or benefits mandated by law in Montana. As with all insurance products, before purchasing this policy, you should carefully review the policy and determine what the policy covers in terms of health care services and what benefits are provided as well as what the policy determines to be exclusions, limitations, or conditions for covered services or provided benefits. For information concerning health or disability insurance under this policy, please consult your insurance agent or the state department of insurance.

(2) Each policy written by a foreign insurer under [sections 1 through 6] for a policyholder in this state must contain the following notice printed in at least 12-point bold type at the beginning of the policy:

NOTICE

The benefits of this (policy, contract, plan, coverage, or evidence of coverage) issued by (name of insurer) are governed primarily by the laws and rules of the state of (the jurisdictional state that issued the foreign insurer's certificate of authority). While the health or disability insurance in this policy may provide you affordable health or disability insurance, the policy also may provide fewer benefits than a policy subject to all of the insurance laws of the State of Montana, including coverage of services or benefits mandated by law in Montana. Please consult your insurance agent to determine which benefits mandated in this state are excluded under this policy.

Section 5. Health care utilization review -- court jurisdiction. (1) A resident of this state who obtains a policy from a foreign insurer may participate in the health care utilization review process provided for in Title 33, chapter 32.

(2) A court of this state may exercise jurisdiction over a foreign insurer that issues a policy in this state under [sections 1 through 6] with respect to the policy that is issued.

Section 6. Commissioner's authority -- rulemaking. (1) (a) The commissioner has the authority to investigate complaints filed by a resident of this state against a foreign insurer selling policies under [sections 1 through 6].

(b) If, after a hearing conducted pursuant to 33-1-701, the commissioner determines that the foreign insurer violated [sections 1 through 6] or other statutes to which the foreign insurer is subject under Title 33, the commissioner may impose penalties ranging from revocation as provided in [section 3] to a fine not to exceed the sum of $25,000, as provided in 33-1-317.

(2) The commissioner shall adopt a fee by rule as provided in [section 2(2)(d)], which may be no greater than the fee listed in 33-2-708(1)(a), and may adopt other rules as necessary to implement [sections 1 through 6].

Section 7. 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 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 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.

(14) (a) Except as provided in subsection (14)(b), a foreign insurer issuing policies in this state as provided in [sections 1 through 6] is not subject to this code.

(b) The following provisions of this code apply to [sections 1 through 6] to the extent that the provisions are related to the commissioner's authority under [sections 1 through 6]:

(i) 33-1-201, 33-1-202, 33-1-314 through 33-1-318, and Title 33, chapter 1, parts 6, 7, and 12;

(ii) 33-2-104, 33-2-105, 33-2-501 through 33-2-503, 33-2-511, 33-2-705, 33-2-707, and 33-2-710;

(iii) chapter 18 except as provided in [section 3];

(iv) chapter 19; and

(v) chapter 32."

Section 8. Section 33-1-201, MCA, is amended to read:

"33-1-201. Definitions -- insurance in general. For the purposes of this code, the following definitions apply unless the context requires otherwise:

(1) "Alien insurer" is an insurer formed under the laws of any country other than the United States or its states, districts, territories, and commonwealths.

(2) "Authorized insurer" is an insurer:

(a) duly authorized by a certificate of authority issued by the commissioner to transact insurance in this

state; or

(b) registered as provided in [section 2] to provide health or disability insurance in this state.

(3) "Domestic insurer" is an insurer incorporated under the laws of this state.

(4) "Foreign insurer" is an insurer formed under the laws of any jurisdiction other than this state. Except when distinguished by context, the term includes an alien insurer.

(5) (a) "Insurance" is a contract through which one undertakes to indemnify another or pay or provide a specified or determinable amount or benefit upon determinable contingencies.

(b) Insurance does not include contracts for the installation, maintenance, and provision of inside telecommunications wiring to residential or business premises.

(6) "Insurer" includes every person engaged as indemnitor, surety, or contractor in the business of entering into contracts of insurance. The term also includes a health service corporation in the provisions listed in 33-30-102.

(7) "Resident domestic insurer" is an insurer incorporated under the laws of this state and:

(a) if a mutual company, not less than one-half of the policyholders are individuals who are residents of this state; or

(b) if a stock insurer, not less than one-half of the shares are owned by individuals who are residents of this state and all of the directors and officers of the insurer are residents of this state.

(8) "State", when used in relation to jurisdiction, means a state, the District of Columbia, or a territory, commonwealth, or possession of the United States.

(9) "Transact", with respect to insurance, means to:

(a) solicit;

(b) negotiate;

(c) sell or effectuate a contract of insurance; or

(d) transact matters subsequent to effectuation of the contract of insurance and arising out of it.

(10) "Unauthorized insurer" is an insurer not authorized by a certificate of authority issued by the commissioner to transact insurance in this state."

Section 9. Section 33-2-705, MCA, is amended to read:

"33-2-705. Report on premiums and other consideration -- tax. (1) (a) Each authorized insurer,

including each foreign insurer that issues policies in this state as provided in [sections 1 through 6], and each formerly authorized insurer with respect to premiums received while an authorized insurer in this state shall file with the commissioner, on or before March 1 each year, a report in a form prescribed by the commissioner ~~showing~~. The report must show the total direct premium income, including policy, membership, and other fees, premiums paid by application of dividends, refunds, savings, savings coupons, and similar returns or credits to payment of premiums for new or additional or extended or renewed insurance, charges for payment of premium in installments, and all other consideration for insurance from all kinds and classes of insurance, whether designated as a premium or otherwise, received by a life insurer or written by an insurer other than a life insurer during the preceding calendar year on account of policies covering property, subjects, or risks located, resident, or to be performed in Montana, with proper proportionate allocation of premium as to property, subjects, or risks in Montana insured under policies or contracts covering property, subjects, or risks located or resident in more than one state~~, after deducting from~~.

(b) Except as provided in subsection (1)(c), the amount shown in subsection (1)(a) must include deductions from the total direct premium income of all applicable cancellations, returned premiums, the unabsorbed portion of any deposit premium, the amount of reduction in or refund of premiums allowed to industrial life policyholders for payment of premiums direct to an office of the insurer, all policy dividends, refunds, savings, savings coupons, and other similar returns paid or credited to policyholders with respect to the policies. As to title insurance, "premium" includes the total charge for the insurance.

(c) (i) A deduction may not be made of the cash surrender values of policies or contracts.

(ii) Considerations received on annuity contracts may not be included in total direct premium income and are not subject to tax.

(2) Coincident with the filing of the tax report referred to in subsection (1), each insurer shall pay to the commissioner a tax upon the net premiums computed at the rate of 2 3/4%.

(3) That portion of the tax paid under this section by an insurer on account of premiums received for fire insurance must be separately specified in the report required by the commissioner for apportionment as provided by law. When insurance against fire is included with insurance of property against other perils at an undivided premium, the insurer shall make a reasonable allocation from the entire premium to the fire portion of the coverage as must be stated in the report and as may be approved or accepted by the commissioner.

(4) With respect to authorized insurers, the premium tax provided by this section must be payment in

full and in lieu of all other demands for any and all state, county, city, district, municipal, and school taxes, licenses, fees, and excises of whatever kind or character, excepting only those prescribed by this code, taxes on real and tangible personal property located in this state, and taxes payable under 50-3-109.

(5) The commissioner may suspend or revoke the certificate of authority of any insurer or foreign insurer that fails to pay its taxes as required under this section.

(6) In addition to the penalty provided for in subsection (5), the commissioner may impose upon an insurer who fails to pay the tax required under this section a fine of $100 plus interest on the delinquent amount at the annual interest rate of 12%.

(7) The commissioner may by rule provide a quarterly schedule for payment of portions of the premium tax under this section during the year in which tax liability is accrued."

Section 10. Section 33-2-710, MCA, is amended to read:

"33-2-710. Premium tax imposed on policy issued through nonresident licensee. Any insurer, including a foreign insurer issuing policies in this state as provided in [sections 1 through 6], who issues a policy on a subject or risk located or to be performed in Montana through a nonresident licensee shall pay a premium tax on ~~such~~ the policy to the state of Montana~~,~~ in an amount and in the manner provided in 33-2-705."

Section 11. Section 33-32-105, MCA, is amended to read:

"33-32-105. Application -- exemptions. (1) The provisions of this chapter apply to a person or entity performing utilization reviews who is, or is affiliated with, under contract with, or acting on behalf of:

(a) a Montana business entity; or

(b) a third party that provides or administers health care benefits to citizens of this state, including:

(i) a health insurer, a foreign insurer that issues policies in this state as provided in [sections 1 through 6], a nonprofit health service plan, a health service corporation, an employees' health and welfare fund, or a preferred provider organization authorized to offer health insurance policies or contracts;

(ii) a health maintenance organization issued a certificate of authority in accordance with Title 33, chapter 31; or

(iii) a state agency.

(2) A general in-house utilization review for a health care provider, including an in-house utilization

review that is conducted by or for a long-term care facility and that is required by medicare or medicaid regulations, is exempt from the provisions of this chapter as long as the review does not directly result in the approval or denial of payment for health care services for a particular case.

(3) A peer review procedure conducted by a professional society or association of providers is exempt from the provisions of this chapter."

Section 12. Section 33-32-201, MCA, is amended to read:

"33-32-201. Conduct of utilization review. A program of utilization review with regard to health care services provided or to be provided in this state must comply with the following:

(1) The insurer, including a foreign insurer as provided in [sections 1 through 6], a health maintenance organization, or their agents conducting the utilization review of outpatient mental health treatment may request only information that is relevant to the payment of the claim.

(2) When a utilization review requires disclosure of personal information regarding the patient or client, including personal and family history or current and past symptoms of a mental disorder, then the identity of that individual must be concealed from anyone having access to that information in order that the patient or client may remain anonymous.

(3) A determination that is made on appeal or reconsideration as provided in 33-32-203 and that is adverse to a patient or to an affected health care provider may not be made on a question relating to the necessity or appropriateness of a health care service without prior written findings, evaluation, and concurrence in the adverse determination by a health care professional trained in the relevant area of health care. Copies of the written findings, evaluation, and concurrence must be provided to the patient on request as provided in Title 33, chapter 19.

(4) A determination made on appeal or reconsideration, as provided in 33-32-203, that health care services rendered or to be rendered are medically inappropriate may not be made unless the health care professional performing the utilization review has made a reasonable attempt to consult with the patient's attending health care provider concerning the necessity or appropriateness of the health care service.

(5) The following provisions must govern the conduct of a utilization review of health care services rendered to a patient by a health care provider who is a licensed social worker, licensed professional counselor, licensed psychiatric nurse, licensed psychiatrist, or a licensed psychologist:

(a) If a review of the patient's or the health care provider's records is required by the insurer in the course of an appeal or a redetermination of an adverse determination of medical necessity or appropriateness made pursuant to an insurer's review, the review must be conducted by a person trained in the field of the provider.

(b) During an appeal or redetermination, the patient may, at the patient's expense, request an independent review of the patient's or the provider's records by a health care provider licensed in the field of the provider that rendered the health care service and may require that review to be considered by the insurer in reaching its decision. If the initial adverse determination of medical necessity or appropriateness is reversed, the insurer shall bear the expense of the independent review."

Section 13. Codification instruction. [Sections 1 through 6] are intended to be codified as an integral part of Title 33, chapter 1, part 1, and the provisions of Title 33, chapter 1, part 1, apply to [sections 1 through 6].

Section 14. Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

- END -

I hereby certify that the within bill,

HB 0280, originated in the House.

Chief Clerk of the House

Speaker of the House

Signed this _____ day

of _____, 2013.

President of the Senate

Signed this _____ day

of _____, 2013.

HOUSE BILL NO. 280

INTRODUCED BY C. SMITH, ARNTZEN, BALLANCE, BLASDEL, BLYTON, BRODEHL, CLARK, CONNELL, DOANE, EHLI, FIELDER, FISCUS, GALT, HAGAN, HALVORSON, HANSEN, HOWARD, JACKSON, D. JONES, L. JONES, KERNS, KNUDSEN, LANG, LASZLOFFY, LENZ, MCNIVEN, MILLER, OSMUNDSON, RANDALL, REDFIELD, REGIER, ROSENDALE, SCHWADERER, TAYLOR, THOMAS, VANCE, WAGONER, WASHBURN, WEBB, WHITE, D. MOORE

AN ACT ALLOWING FOR THE PROVISION OF HEALTH OR DISABILITY INSURANCE BY OUT-OF-STATE INSURERS; PROVIDING A STREAMLINED PROCESS FOR OUT-OF-STATE HEALTH INSURERS TO ISSUE POLICIES IN MONTANA; REQUIRING PAYMENT OF PREMIUM TAXES; REQUIRING SPECIFIC NOTICE IN APPLICATIONS AND IN POLICIES; PROVIDING FOR REVOCATION OF REGISTRATION OR OTHER PENALTIES; PROVIDING RULEMAKING AUTHORITY TO THE INSURANCE COMMISSIONER; AND AMENDING SECTIONS 33-1-102, 33-1-201, 33-2-705, 33-2-710, 33-32-105, AND 33-32-201, MCA.