SENATE BILL NO. 111

INTRODUCED BY L. NELSON

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT AMENDING THE DEFINITION OF "ELIGIBLE PERSON" AS IT RELATES TO THE COMPREHENSIVE HEALTH ASSOCIATION AND PLAN; AUTHORIZING THE INSURANCE COMMISSIONER TO LIMIT CERTAIN ELIGIBILITY CRITERIA BY ADOPTING RULES ON WHICH TO BASE THE ELIGIBILITY ON INCOME LEVEL; AMENDING SECTIONS 33-22-1501 AND 33-22-1502, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) who is not eligible for coverage under:

(i) a group health plan;

(ii) Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1395c through 1395i-4 or 42 U.S.C. 1395j through 1395w-4; or

(iii) a state plan under Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, or a successor program;

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

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

(f) who has exhausted continuation coverage under the COBRA continuation provision or program described in subsection (8)(e) if the individual elected the continuation coverage described in subsection (8)(e).

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

(10) "Insurance arrangement" means any plan, program, contract, or other arrangement to the extent not

exempt from inclusion by virtue of the provisions of the federal Employee Retirement Income Security Act of 1974 under which one or more employers, unions, or other organizations provide to their employees or members, either directly or indirectly through a trust of a third-party administrator, health care services or benefits other than through an insurer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NEW SECTION. **Section 3. Effective date.** [This act] is effective on passage and approval.

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